

PUBLIC RECORD

Dates: 01/06/2026 - 10/06/2026

Doctor: Dr Elliot BURNS
GMC reference number: 6119007
Primary medical qualification: MB ChB 2005 University of Sheffield

Type of case	Outcome on facts	Outcome on impairment
Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Ms Samantha Jones
Lay Tribunal Member:	Dr Caroline Friendship
Registrant Tribunal Member:	Dr Suzanne Joels

Tribunal Clerk:	Joel Taylor-Garratt (01/06/2026) Matt O'Reilly (02/06/2026 – 10/06/2026)
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Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Scott Ivill, Counsel, instructed by CMS Law
GMC Representative:	Mr Ryan Donoghue, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 05/06/2026

Background

1. Dr Burns qualified with degree MBChB from the University of Sheffield Medical School and in 2013 obtained his membership of the Royal College of General Practitioners.
2. Dr Burns was employed as a General Practitioner ('GP') at Anston Medical Centre ('the GP Practice'), where he worked as a Locum GP initially between 2 July 2013 to 20 December 2013, and then again between 13 May 2014 to 5 September 2014, before taking up a salaried position on 8 September 2014, which he held until he left the GP Practice on 27 October 2017. Dr Burns then became a Non-Equity Partner at Newgate Street Surgery and became a Partner of that surgery in 2019. He left Newgate Street Surgery in 2021.
3. Dr Burns worked as a Home based/remote worker for the National 111 service from September 2022 until December 2022. He thereafter commenced a role as a remote GP for a practice based in Cornwall from January 2023 until December 2024. From February 2025 until March 2026 Dr Burns worked for Kings Medical Practice as a Salaried GP. He is not currently employed in a medical role.
4. The Allegation can be summarised in that it is alleged that Dr Burns engaged in an improper emotional and sexual relationship with a vulnerable patient, Patient A, by engaging in the sending of emails and inappropriate images and by engaging in three instances of sexual activity.
5. Dr Burns saw Patient A for the first time on XXX July 2013, when Patient A attended the GP Practice due to concerns regarding her mental health. Dr Burns' notes of the consultation recorded that Patient A had been XXX following problems at work, that she was becoming very socially isolated, paranoid and very anxious, and that she was suffering with

poor sleep and thoughts of wanting to kill herself. The plan was that Patient A would be provided with medication and return to see Dr Burns two weeks later.

6. Dr Burns saw Patient A at the GP Practice on five further occasions, there being six consultations in total. These took place on XXX July 2013 (with Patient A's mother), XXX July 2013, XXX August 2013 (with Patient A's mother), XXX September 2013, when Dr Burns referred Patient A to a counsellor/mental health practitioner, and XXX December 2013. All of the appointments, except the appointment on XXX December 2013, discussed Patient A's mental health issues.

7. Patient A did not see Dr Burns again at the GP Practice after XXX December 2013. Between January 2014 and March 2015, Dr Burns and Patient A engaged in text messages and email communications with each other and the email exchange referred to one occasion when they coincidentally drove past each other. During this time period, it is alleged that Dr Burns requested Patient A to send inappropriate images of herself to him, he received inappropriate images of her, he sent inappropriate images of himself to her and the email discussions and text messages evidenced an improper emotional and/or sexual relationship with Patient A.

8. The emails exchanged between Dr Burns and Patient A contained explicit sexual language where they expressed their sexual fantasies and sexual desires towards one another. The email messages also included conversations between Dr Burns and Patient A about contacting each other and meeting. In one of the email exchanges, Dr Burns proposed that Patient A could stay with him and Dr Burns asked if they could film themselves. The intimate photos sent by Dr Burns to Patient A included an image of his naked torso, an image of him wearing a shirt but with the shirt open and so exposing his torso, an image of his naked back, bum and thighs, an image of part of his penis/groin area, an image of his hand covering his penis, an image of his naked torso wearing red brief style pants and an image of his torso where he is holding his erect penis. Patient A also sent photographs to Dr Burns of a sexual nature.

9. It is alleged that between July 2013 and March 2015, when Dr Burns' was treating and/or consulting with Patient A and engaging with her via email and text communications, Patient A was vulnerable by reason of her medical history or conditions, and/or her mental health, and that Dr Burns knew or ought to have known that she was vulnerable or likely to be vulnerable.

10. Concerns regarding Dr Burns' relationship with Patient A first came to light on or around 30 March 2021, when Patient A spoke to a Community Mental Health Nurse, Ms B,

during an appointment. Patient A was seeing Ms B for XXX mental health issues and their sessions involved Cognitive Analytical Therapy. Over a course of appointments with Ms B, Patient A reported that she had been in a relationship with her GP, and that Dr Burns had been the first person she had asked for help regarding her mental health after a period of XXX. Patient A did not disclose Dr Burns' name at first but provided his name at her appointment with Ms B on 30 March 2021.

11. In discussions with Ms B, Patient A stated that she initially saw her interactions with Dr Burns as a relationship but that they never went out on dates and it was all to do with sex. Patient A disclosed that she had engaged in sexual activity with Dr Burns and she felt that she had to do things she did not want to do, referring to oral sex and anal sex, and that they had exchanged a large number of emails which she had kept.

12. As a result of these disclosures, Ms B informed Patient A that she would need to make a safeguarding referral and the concerns were subsequently reported to the police.

13. On 27 April 2021, Patient A reported to the police that between 2013 and 2014 she had engaged in an inappropriate sexual relationship with her GP, Dr Burns, and that they had engaged in sexual activity on at least three occasions, including once in a consultation room at the GP Practice.

14. On 28 April 2021, Patient A provided a Video Recorded Interview to the police ('VRI'), as part of the investigation into Dr Burns on suspicion of the criminal offence of misconduct in public office. Patient A provided information in relation to her reason for attending the GP Practice and her appointments with Dr Burns, the relationship with Dr Burns, details regarding sexual activity with Dr Burns on three separate occasions and she discussed that she had exchanged emails and text messages with Dr Burns. The police investigation resulted in no further action being taken against Dr Burns.

15. It is alleged that Dr Burns engaged in an improper emotional and/or sexual relationship with Patient A in communicating with her via emails and messages, the content of the messaging being intimate and sexualised and also included intimate photographs sent by both.

16. In late 2014, Dr Burns said he was texted by a male, possibly Patient A's XXX. The message told Dr Burns to stop contacting Patient A.

17. On or around XXX January 2015, Patient A's then XXX partner to complained to a receptionist at the GP Practice who passed it on to the Practice Manager. Patient A's partner

complained about Dr Burns' contact with Patient A and asked that he stop contacting her. The Group Manager of the GP Practice, Ms C, decided to speak to Dr Burns to ask if he had been texting the patient but Dr Burns initially stated he had not. Then, during the course of the conversation, Dr Burns stated that he had exchanged a few text messages with Patient A but stated that they had never gone out and he had not seen or heard from her since he had re-joined the practice in 2014 as a locum.

18. On 13 May 2021, Dr Burns was arrested and interviewed regarding the allegations made in Patient A's VRI. Dr Burns was represented by a solicitor during the interview. At the start of the interview, Dr Burns provided a prepared statement in which he denied asking Patient A if she wanted to meet up, denied meeting Patient A outside of her GP appointments and denied any sexual activity with her. He then provided a 'no comment' interview.

The Outcome of Applications made during the Facts Stage

19. On day 1 of the hearing, Mr Scott Ivill, Counsel on behalf of Dr Burns, made an application to adduce further evidence, the witness statement of Patient A's mother as hearsay evidence. He also made an application in respect of making redactions in Patient A's mother's witness statement. Mr Ivill also made an application to redact comments made by Patient A which he submitted were prejudicial to Dr Burns. Mr Ryan Donoghue, counsel on behalf of the GMC, opposed the admission of Patient A's mother's witness statement as it was not relevant to the case. In the alternative, he submitted a different redacted version of Patient A's mother's witness statement and submitted that the GMC's version should be used. Mr Donoghue also opposed Mr Ivill's application to redact comments made by Patient A stating that they were relevant to the Allegation. The Tribunal determined that Patient A's mother's statement was relevant and could be admitted into evidence but preferred to use the version of the statement submitted by the GMC. It also granted Mr Ivill's application to redact the comments made by Patient A. The Tribunal's full written decision can be found at Annex A.

20. On day 2 of the hearing, Mr Donoghue made an application to amend the Allegation. Mr Ivill made no objection to the application. The Tribunal granted the application. The Tribunal's full written decision can be found at Annex B.

The Allegation and the Doctor's Response

21. The Allegation made against Dr Burns is as follows:

1. At all material times:
 - a. Patient A was a patient at the general practitioner practice, the details of which are set out at schedule 1; **Admitted and found proved**
 - b. Patient A was vulnerable by reason of her:
 - i. medical history/conditions, and/or;
Admitted and found proved
 - ii. mental health; **Admitted and found proved**
 - c. you knew or ought to have known that Patient A was vulnerable or likely to be vulnerable. **Admitted and found proved**
2. Between July 2013 and December 2013, you consulted with and/or treated Patient A as her General Practitioner. **Admitted and found proved**
3. Between ~~January 2014~~ July 2013 and March 2015 you engaged in an improper emotional and/or sexual relationship with Patient A in that on one or more occasion you:
 - a. communicated with her via text messages;
Admitted and found proved
 - b. communicated with her via electronic mail;
Admitted and found proved
 - c. requested she sent inappropriate images of herself to you;
Admitted and found proved
 - d. received inappropriate images of her; **Admitted and found proved**
 - e. sent inappropriate images of yourself to her;
Admitted and found proved
 - f. engaged in sexual activity with Patient A, the details of which are set out at schedule 2. **To be determined**

And that by reason of the matters set out above your fitness to practise is impaired

because of your misconduct. **To be determined**

The Admitted Facts

22. At the outset of these proceedings, Mr Ivill, on behalf of Dr Burns, made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (“the Rules”). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

23. The Tribunal received oral evidence on behalf of the GMC from Ms C, Group Manager of Dinnington Group Practice. Ms C also provided a witness statement, dated 22 February 2024.

24. Dr Burns provided a witness statement, dated 14 May 2026. He also gave oral evidence during these proceedings.

25. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- DC D, witness statement dated 23 April 2024. DC D also provided two supplemental statements, dated 17 February 2026 and 8 April 2026;
- Ms B, XXX Community Mental Health Nurse, XXX Hospital (at the time of the matters before the Tribunal), witness statement dated 3 February 2026.

26. The parties agreed that DC D and Ms B did not need to be called to give oral evidence.

Documentary Evidence

27. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, the following:

- Patient A’s GP medical records, various;
- Ms C’s witness statement to the police, dated 7 June 2021;
- Ms C’s note made at the GP Practice following a complaint regarding Dr Burns’ contact with Patient A, from someone purporting to be Patient A’s partner. It

included a summary of a conversation Ms C had with Dr Burns about the matter, dated XXX January 2015;

- Crime report, undated;
- Statement on investigation, dated 7 April 2022;
- Emails and images sent between Dr Burns and Patient A, various;
- Text messages between Dr Burns and Patient A, various;
- Police Statement of Ms B, dated 28 April 2021;
- Police video of Patient A's interview and a transcript of that interview, dated 28 April 2021;
- Police audio recording of Dr Burns' interview and a transcript of that interview, which included his prepared statement, dated 13 May 2021;
- Police witness statement of Patient A's mother, dated 12 August 2021;
- Testimonial and associated correspondence, various.

The Tribunal's Approach

28. In reaching its decision on the facts, the Tribunal applied the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The Tribunal acknowledged that the burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything. The Tribunal was advised by the Legally Qualified Chair of the principles set out in *Byrne v GMC [2021] EWHC 2237 (Admin)*, *O v Secretary of State for Education [2014] EWHC 22 (Admin)*. The Tribunal was advised to consider and take account of section 3 of Part A of the MPTS Guidance published in November 2025. The Tribunal was also advised on the principles set out *R (Dutta) v General Medical Council [2020] EHC 1974 (Admin)* in assessing the credibility of witnesses, and the principles relevant to considering hearsay evidence as set out in *Thornycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*.

29. The Tribunal decided to approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the Tribunal assessed the evidence in the round. It considered what conclusions and inferences can be drawn from the documentary evidence. The Tribunal then considered the available oral evidence and subjected that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. It was mindful that an individual's memory is fallible. The Tribunal was aware and took account of the fact that it should not decide reliability and credibility of a witness based on the demeanour of a witness alone.

The Tribunal's Analysis of the Evidence and Findings

30. The Tribunal has considered the remaining disputed paragraph of the Allegation and has evaluated the evidence to make its findings on the facts.

Paragraph 3f of the Allegation

3. Between July 2013 and March 2015 you engaged in an improper emotional and/or sexual relationship with Patient A in that on one or more occasion you:
 - f. engaged in sexual activity with Patient A, the details of which are set out at schedule 2.

31. At the outset of its deliberations regarding the outstanding allegation, the Tribunal was of the view that it would be assisted in making its decision after having made an assessment of the witness evidence in this case.

Patient A

32. The Tribunal first considered the evidence it had before it in respect of Patient A. It considered whether her account was reliable, and in terms of credibility, what documentary evidence there was to support her account.

33. The Tribunal first noted that Patient A's account has not been tested under cross examination. Further, there was a delay in her reporting her concerns. The Tribunal considered whether this undermined Patient A's account. Patient A first made her disclosure about the alleged interactions with Dr Burns to Ms B in a couple of therapy sessions on or around 30 March 2021. Ms B then reported the concerns to the Police.

34. The Tribunal considered that the circumstances under which the allegations came to light was during a mental health therapy session to help Patient A with mental health concerns and past trauma. The Tribunal noted that it appeared as though there was no particular reason as to why Patient A told Ms B of the relationship, and there did not appear to the Tribunal that there was any agenda or motive behind the report. It was only after Ms B, had made a Person in Position of Trust safeguarding referral that it was reported to the police and it thereafter followed that Patient A gave a statement to the police. The Tribunal noted that Patient A appeared to be reluctant to name Dr Burns. The Tribunal was mindful that where there is trauma relating to matters of a sexual nature, it is a known fact that it may take some time for an individual to come forward and report those matters. The

Tribunal did not therefore consider that the delay in the reporting of these matters, or the way in which the reporting of them came about, diminished the credibility or reliability of Patient A's account.

35. When considering the documentary evidence which may either support or undermine the account of Patient A, it had before it the contemporaneous emails and text messages sent between Patient A and Dr Burns, a transcript of her police interview and the video recording of her police interview. The Tribunal noted that when Patient A gave her interview to the police, she stated that 'she could probably find the emails and messages between her and Dr Burns'. It considered that Patient A did not go into the police interview with the emails and messages prepared to support her account, rather that the emails and messages were provided at a later point in time, which then supported her account. The Tribunal also considered it noteworthy that Patient A was also not going to report these matters to the police and only did so with some reluctance following Ms B making a safeguarding referral.

36. The Tribunal considered that there were inconsistencies in the account provided by Ms B as to what Patient A had initially reported to her, which were not then later reported by Patient A in her VRI. For example, Ms B had recorded that Patient A had told her that she had gone to Dr Burns' home on one occasion, that he would book appointments for her at the GP Practice so that they could engage in sexual acts and that the relationship lasted two years. The Tribunal considered that the notes taken by Ms B were not a forensic account of what occurred, rather it was a part of a mental health therapy session, her notes were written up after the consultation and it was her interpretation of what Patient A had told her. Ms B was helping Patient A with her mental health problems rather than undertaking an interview of what happened as Patient A alleged. The Tribunal also noted that there was no suggestion that Ms B's notes had been provided to Patient A to verify what she had said during the meeting. All of that was in contrast to her police statement where she was asked detailed questions about the allegations, asked to repeat the allegations in detail and in which she was asked to verify her account. It therefore considered that the inconsistencies in Ms B's notes did not undermine Patient A's reliability and credibility and the Tribunal placed more weight on her VRI than on the notes recorded by Ms B.

37. The Tribunal also considered that Patient A was asked about the three alleged incidents of physical sexual activity between her and Dr Burns early on in the police interview and was asked for more details later on in the interview. It noted that Patient A provided a significant amount of consistency throughout the interview when she was providing details of the events which added to her credibility and reliability. She did not appear to exaggerate or embellish her accounts of these alleged instances but included specific details, and she

accepted occasions where she was unable to recall the detail due to the length of time that had passed.

38. The Tribunal considered that whilst it had watched the video of Patient A's police interview it could not make any assessment as to her demeanour which would have any significant bearing on its decision. It reminded itself that Patient A did not provide evidence in these proceedings and that her evidence had not been tested under cross examination, it could not therefore make any assessment of her demeanour in that regard.

39. The Tribunal considered that Dr Burns' admissions to having engaged in an emotional and/or sexual relationship in that he communicated with Patient A via text message and email and shared inappropriate pictures with Patient A, was a known fact that provided credibility to her account as Patient A also stated that is what had happened between them.

40. The Tribunal reminded itself that the account of Patient A was hearsay evidence which had not been tested under oath and under cross-examination and therefore it had to determine what weight to attach to it. It accepted that the reason for her not attending these proceedings was due to the traumatic and distressing nature of the matters that were before the Tribunal. Given her vulnerability, and the reasons for her non-attendance, the Tribunal decided that it could give sufficient weight to her evidence.

Patient A's mother

41. Patient A's mother's witness statement provided evidence regarding Patient A's mother approaching Dr Burns after work when they were both in their cars. She flashed him with her vehicle lights and indicated to him to pull over which he did. She told him that Patient A liked him and, she alleged, she passed on Patient A's phone number to him.

42. The Tribunal considered that it had heard a different version of accounts from Patient A, Patient A's mother and Dr Burns. Patient A and Patient A's mother provided the same account that Patient A's mother gave Dr Burns the phone number of Patient A, Dr Burns disputed that and stated he had provided his number to Patient A's mother as a point of contact for medical matters.

43. The evidence suggests that whilst Patient A's mother's account provided context, albeit unusual, it supported the account, uncontested by Dr Burns, that it was Patient A's mother who initiated the contact with him when she flashed her headlights after he had left work one evening. Neither of their accounts alluded to any mention or discussion around Patient A's health or medical matters. Dr Burns agreed that no health or medical matters

were discussed. The Tribunal considered that Patient A's mother's account was reliable and credible. Although the Tribunal had not had the opportunity to cross-examine Patient A's mother, it considered that the consistency of her account with the majority of Dr Burns's evidence on the encounter gave it credibility. The Tribunal considered it was more likely that Patient A's mother gave Dr Burns the number of Patient A in order to encourage him to contact her to start a relationship, rather than Dr Burns providing his telephone number to Patient A's mother as a point of contact for medical reasons. The Tribunal considered that the version of events preferred by Dr Burns was unlikely given that there had not been any mention of any medical issues in his conversation with Patient A's mother.

44. The Tribunal also considered Patient A's mother's account to be reliable in its recounting of consistent details.

45. The Tribunal reminded itself that the account of Patient A's mother was hearsay evidence which had not been tested under oath and under cross-examination and therefore it had to determine what weight to attach to it. It accepted that the reason for her not attending these proceedings was because Dr Burns' legal team had been unable to find her contact details despite reasonable enquiries. However, the fact that Dr Burns had proffered the evidence and accepted the majority of it was consistent with his version of events, except where it undermined his own defence, meant that the Tribunal could attach significant weight to it.

Ms C

46. The Tribunal considered that it had before it Ms C's contemporaneous note which she stated she made immediately after the meeting with Dr Burns on XXX January 2015 after a complaint had been received at the GP Practice by someone purporting to be the partner of Patient A. It also had before it Ms C's statement to the police, and emails to the GMC in respect of confirming the dates when Dr Burns saw Patient A at the GP Practice and various other background details, and her GMC witness statement. She also provided oral evidence under oath.

47. The Tribunal was of the view that Ms C was a reliable witness. It considered that when the complaint to the GP Practice was made, she thought that it was so unusual she decided to address the matter with Dr Burns, make a note of it, date it and file it in case any further complaints were made. She accepted that her note was not a verbatim report but that it was contemporaneous and to the best of her recollection at that time. She said that when she wrote the note, she had not misremembered what was said. She confirmed that she did not provide her note to Dr Burns to verify what was said.

48. In her oral evidence Ms C fairly accepted that areas of the conversation that she was unsure of and she was consistent in her responses. She accepted that the conversation with Dr Burns about the complaint lasted less than 5 minutes. Ms C was helpful to the Tribunal, and a credible witness given her answers were consistent with her contemporaneous note and the Tribunal considered her to have been a reliable and credible witness.

Dr Burns

49. The Tribunal was satisfied that Dr Burns was entitled to an effective good character direction on both limbs: credibility and propensity (relying on *R v Hunter [2015] EWCA Crim 631* which albeit was a criminal case, would have bearing on good character directions in the regulatory context). The Tribunal was satisfied, after hearing advice from the Legally Qualified Chair, that an effective good character direction should be given on the basis that despite the admissions that Dr Burns had made at the outset of the hearing to the improper emotional and sexual relationship he had engaged in with Patient A by way of emails and text messages, that he had no previous complaints, convictions or fitness to practise findings for physical sexual activity with a patient. In accordance with the MPTS Guidance, the Tribunal attached significant weight to the good character direction given that at the date of these proceedings he had been in practice as a GP since 2013, so for around 13 years, and he had qualified as a doctor some years before that.

50. The Tribunal had before it the emails and text messages between Dr Burns and Patient A, which had been provided to the police by Patient A, Dr Burns' witness statement to the police, and the audio recording of his interview, his prepared statement to the police, and his GMC witness statement. The Tribunal had also witnessed Dr Burns give evidence under oath and under cross examination.

51. The Tribunal noted that Dr Burns' defence was that he had not engaged in any physical sexual activity at all with Patient A, and that he had not seen her again after his last appointment with her on XXX December 2013. His case was that any references to alleged sexual activity made by Patient A were references to roleplay scenarios that he and Patient A had engaged in between XXX January 2014 before he went travelling and before the email conversations, seen by the Tribunal, commenced.

52. The Tribunal considered that there were a considerable number of aspects of Dr Burns' evidence which were not credible. The Tribunal considered that it was not credible that Dr Burns presumed or assumed that Patient A had changed GP practices between XXX December 2013 and that when he said she first contacted him XXX January 2014. The

Tribunal considered it was more likely than not that Dr Burns had initiated the first contact with Patient A, having taken her number from Patient A's mother, and that it was not credible that she had contacted him. Looking at the words used in the emails between Dr Burns and Patient A, and the tenses used to describe their sexual activity and desires for each other, the Tribunal considered the documentary evidence was highly inconsistent with Dr Burns' account that the conversations discussed historical roleplay rather than sexual activity that had actually taken place. The Tribunal made allowances for the passage of time in recalling events from 2013 to 2015, but even making such allowances, it noted for example, Dr Burns' difficulty in his recollections as to what car he had owned at the time and that there were inconsistencies in his evidence as to whether the roleplay included the car or not. The Tribunal considered that there was a disparity between the accounts of witnesses that they had found to be credible and reliable, and that of Dr Burns and often where Dr Burns disagreed with their evidence, was where the evidence undermined his defence or where distancing himself from the evidence helped to minimise his involvement with Patient A.

53. It was Dr Burns' account that the sexual activity as described by Patient A referred to roleplays that they had previously enacted. The Tribunal considered that the grammatical tenses used in the emails and text messages did not appear to relate to any past roleplays and there was no mention of the word 'roleplay' anywhere in the emails or text messages. The Tribunal took account of the fact that there was no mention of roleplay in Dr Burns' prepared statement to the police at a time when he knew of the allegation made by Patient A. She had explained that they had exchanged emails and photographs of a sexual nature. Dr Burns was aware of the time period of the allegations and the fact that he was being given an opportunity to present his defence. The Tribunal considered that the documentary evidence and Dr Burns' prepared statement in 2021 significantly undermined his account and his credibility.

54. The Tribunal noted that in Dr Burns' favour, he admitted to sending sexualised emails, texts and sexual pictures of himself. He did not deny having contact with Patient A or that he knew she was vulnerable.

55. When Dr Burns provided his oral evidence, the Tribunal considered him to have been measured in his responses but did not, at times, provide much detail in his responses and was vague in a number of his answers, even to the Tribunal's questions. The Tribunal considered that his evidence was inconsistent with the documentary evidence, with earlier answers he had given and with others' accounts. When Dr Burns was asked to accept a point on uncontroversial matters, he was reluctant to do so. The Tribunal was mindful that Dr Burns did not need to prove anything, and the burden rested on the GMC to prove its case,

but as regards his evidence, the Tribunal did not find Dr Burns to have been a credible or reliable witness.

56. The Tribunal then considered relevant disputed aspects of factual background matters relevant to the disputed paragraph of the Allegation.

57. When considering how Dr Burns and Patient A came to have each other's telephone numbers, the Tribunal was of the view that Patient A's and her mother's accounts were more credible. The Tribunal has already accepted that Patient A's health was not discussed when Patient A's mother and Dr Burns interacted after Patient A's mother approached him. In both Patient A's and Patient A's mother's accounts they both said that Patient A's mother had given Patient A's telephone number to Dr Burns. Dr Burns said that he gave his telephone number to Patient A's mother. The Tribunal was satisfied that it was more likely than not that Dr Burns received Patient A's telephone number from her mother, especially as there had been no discussion of medical matters in the conversation between Patient A's mother and Dr Burns. The Tribunal was satisfied that it was more likely than not that Patient A did not initially have Dr Burns' telephone number and, it follows therefore that it is more likely than not that Dr Burns initiated contact with Patient A.

58. The Tribunal went on to consider whether Dr Burns and/or Patient A were interested in pursuing an emotional and/or sexual relationship. The Tribunal reminded itself that Patient A's mother wanted Dr Burns to pursue a relationship with her daughter, and Dr Burns has accepted that he did engage with Patient A in an emotionally and sexually inappropriate way, albeit not a physical one. The Tribunal was satisfied that both Patient A and Dr Burns were interested in pursuing an emotional and/or sexual relationship. It reminded itself that Patient A was vulnerable at this time.

Paragraph 3f of the Allegation

3. Between July 2013 and March 2015 you engaged in an improper emotional and/or sexual relationship with Patient A in that on one or more occasion you:
 - f. engaged in sexual activity with Patient A, the details of which are set out at schedule 2.

59. The Tribunal considered the evidence as to when it was likely that the three instances of sexual activity occurred between Dr Burns and Patient A. The Tribunal noted that the first alleged sexual activity occurred between Dr Burns and Patient A sometime after Patient A's mother had attended a medical appointment with her and Dr Burns on XXX July 2013. The third instance of sexual activity was said by Patient A to have happened at her last

appointment at the GP Practice, which the Tribunal noted from the medical records took place on XXX December 2013. Patient A stated that she was the last but one patient that day and that Dr Burns had tried to switch her and the last patient's appointment time around. In considering the medical records, which noted that Patient A's medical appointment with Dr Burns was recorded at 17:45 on XXX December 2013, the Tribunal considered it was more likely that this was the appointment where the last alleged sexual activity took place. Therefore, the Tribunal determined that it was more likely than not that the alleged sexual activity took place between XXX July 2013 and XXX December 2013.

First activity:

You drove Patient A from a XXX where you kissed, she performed oral sex on you and masturbated you.

60. In respect of the first activity as set out at Schedule 2, the Tribunal considered that there was no documentary evidence definitively describing the sexual activity alleged between Dr Burns and Patient A in the car in the emails or text messages. Patient A had provided an account of this alleged interaction in her police interview and said that it had happened near XXX. The Tribunal noted however that in an email thread sent on 8 February 2014 between Dr Burns and Patient A, Patient A made reference to a previous sexual interaction saying she wished they had *"the chance to go back to those [XXX]"*. Dr Burns continued the email conversation and did not correct her recollection. The Tribunal considered that it was likely that this was a reference to the alleged first sexual activity.

61. In her police interview, Patient A was quite specific as to the location details, how they had met up, it being after work, Dr Burns having been to the gym and very specific as to the sexual activity having happened in the car. The police had later asked Patient A for more details of this interaction and Patient A's account was consistent with her earlier initial account.

62. Patient A had an expectation which was quite different to what then happened in the car and her account of this appeared plausible. The Tribunal considered that her account to the police appeared to be credible. In considering the documentary evidence and that it preferred Patient A's account, that there was no support for the suggestion that the alleged sexual activity had been one of roleplay only. The Tribunal preferred the account of Patient A to that of Dr Burns.

63. The Tribunal determined that it was more likely than not that the first activity occurred as alleged.

Second activity

You had vaginal and anal intercourse with Patient A at XXX house.

64. In respect of the second sexual activity as set out at Schedule 2, the Tribunal had before it an email from Patient A to Dr Burns on XXX February 2014 in which she referenced a sexual encounter between her and Dr Burns taking place at XXX house. The email said “*I can't sleep ... Thinking about that time at [XXX] house ...I wish you were here to remind me what happened ..*”. Dr Burns responded, “*That was pretty amazing... couldn't stop thinking about you.*” He did not correct her that it had not been at XXX house, that it had not occurred or it was only a roleplay. In her evidence to the police, the Tribunal found that Patient A was quite detailed in her recollection of the events and was balanced in her description of what took place. She acknowledged in that interview that she could not recollect the exact order in which everything happened. Patient A was however very specific about the day on which the second activity occurred. She said that she thought it was a Sunday at around 5pm. She was also able to recall what she had been wearing, what Dr Burns was wearing, and which room the sexual activity took place in. She told the police that they had ‘normal’ sex, as in vaginal sex, as well as anal sex.

65. The Tribunal considered Patient A’s account to the police, supported by reference to sexual activity at XXX house in the emails, to have been more credible than the account of Dr Burns that it was a description of roleplay.

66. The Tribunal determined that it was more likely than not that the second sexual activity occurred as alleged.

Third activity

At the Anston Medical Centre you attempted to have anal intercourse with Patient A and they performed oral sex on you.

67. In respect of the third sexual activity as set out at Schedule 2, the Tribunal noted that in an email on XXX February 2014, Patient A sent an email to Dr Burns in which she described an act of oral sex she performed on Dr Burns when they were at the GP Practice. Dr Burns responded enthusiastically saying he could not wait to have sex with her again. In her interview with the police Patient A described the lead up to this incident. She was in the waiting area of the GP Practice with another patient. Dr Burns called the other patient but

was corrected by the receptionist and he then called Patient A in for her appointment. The Tribunal considered that the extra details Patient A was able to provide accorded with her GP record as to the timing of this appointment. This was also consistent with Patient A's account that this was the last time that she had seen Dr Burns.

68. The Tribunal noted that in her interview with the police Patient A was very detailed and consistent in her recollection of this appointment at the GP Practice and how the events unfolded and her account was consistent when she was asked to repeat it and go into further detail later on in the interview.

69. The Tribunal preferred the account of Patient A over that of Dr Burns who stated that he never had a physical sexual relationship with Patient A and that the contents of his communications related to roleplay.

70. The Tribunal determined that it was more likely than not that the third sexual activity occurred as alleged.

Whether Patient A was a patient at the GP Practice at the time of these events

71. The Tribunal considered that it was Ms C's evidence that Patient A and her mother were patients at the GP Practice and had been since July 2013 and certainly when the person purporting to be the partner of Patient A contacted the GP Practice on XXX January 2015 to request Dr Burns to stop contact with her. Further, the Tribunal has found that the three instances of sexual activity likely occurred between XXX July 2013 and XXX December 2013. During that time, Patient A was clearly a patient under the care of Dr Burns.

72. The Tribunal determined that Dr Burns had been treating Patient A as a patient between the dates upon which he had engaged in a physical sexual relationship with her. During this time Dr Burns treated her on four occasions. The Tribunal was satisfied that there was no doubt he was aware that she was a patient at the GP Practice whilst he was engaging in sexual activity with her.

Improper emotional or sexual relationship

73. The Tribunal determined that Dr Burns did have an improper emotional and sexual relationship by virtue of the findings of the three instances of sexual activity. This was improper as Dr Burns was a doctor who was treating her during this period. He had a professional doctor patient relationship with her and he knew that she was vulnerable. He had initiated contact with her and had pursued a sexual relationship with her.

74. The Tribunal also found that during the course of 2014 and early 2015, Dr Burns maintained contact with Patient A and during that time period he tried to re-initiate contact with her in November 2014 to try and restart the relationship suggesting they meet up without any prior re-engagement from Patient A.

75. The Tribunal also noted that Dr Burns had continued contact with Patient A when she contacted him in March 2015, despite that fact Patient A's partner had been in contact with the GP Practice to complain about him and request he stop further contact and despite Ms C's conversation with him to that effect. The Tribunal did not consider it credible that Dr Burns was trying to, as he said, keep Patient A happy as this did not accord with the contents of the email evidence.

76. The Tribunal has therefore found that between July 2013 and March 2015 Dr Burns engaged in an improper emotional and/or sexual relationship with Patient A in that on one or more occasion he engaged in sexual activity with Patient A, as set out in Schedule 2.

The Tribunal's Overall Determination on the Facts

77. The Tribunal has determined the facts as follows:

1. At all material times:
 - a. Patient A was a patient at the general practitioner practice, the details of which are set out at schedule 1; **Admitted and found proved**
 - b. Patient A was vulnerable by reason of her:
 - i. medical history/conditions, and/or; **Admitted and found proved**
 - ii. mental health; **Admitted and found proved**
 - c. you knew or ought to have known that Patient A was vulnerable or likely to be vulnerable. **Admitted and found proved**
2. Between July 2013 and December 2013, you consulted with and/or treated Patient A as her General Practitioner. **Admitted and found proved**
3. Between July 2013 and March 2015 you engaged in an improper emotional

and/or sexual relationship with Patient A in that on one or more occasion you:

- a. communicated with her via text messages;
Admitted and found proved
- b. communicated with her via electronic mail;
Admitted and found proved
- c. requested she sent inappropriate images of herself to you;
Admitted and found proved
- d. received inappropriate images of her; **Admitted and found proved**
- e. sent inappropriate images of yourself to her;
Admitted and found proved
- f. engaged in sexual activity with Patient A, the details of which are set out at schedule 2. **Determined and found proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. **To be determined**

Determination on Impairment - 10/06/2026

1. This determination was handed down in private. The Tribunal exercised its powers under Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended (the Rules), to sit in private when the matters under consideration were confidential.

2. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved, Dr Burns' fitness to practise is impaired by reason of misconduct.

The evidence

3. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received a Stage 2 defence bundle which included, but was not limited to Dr Burns' reflections, and reflections on Good Medical Practice, both undated. He also provided "Colleague Feedback Summary", from December 2024 to January 2025, and November 2025 to December 2025; a Certificate of completion of a course entitled "Maintaining Professional Boundaries" completed by Dr Burns on 8 to 10 October 2025; "Patient Feedback Summary", from November 2025; XXX. The Tribunal also took account of the joint written character statement from King's Medical Practice dated 13 May 2026 it had received from Dr Burns at Stage 1.

Submissions on behalf of the GMC

4. Mr Donoghue referred the Tribunal to the relevant paragraphs of the *MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e), ('the Guidance')*. He explained how each step was engaged.

5. As to step 2(a), in respect of whether there is a legal basis for considering impairment by reason of misconduct, Mr Donoghue submitted that the Guidance sets out a helpful definition of misconduct, that the behaviour will be a serious departure from the professional standards as set out in Good Medical Practice. He submitted that in determining whether Dr Burns' actions amounted to misconduct, the Tribunal should have regard to the standards expected of medical practitioners. He submitted that paragraphs 53 and 65 of *Good Medical Practice (2013) ('GMP')*, as set out below, are engaged in this case.

6. Mr Donoghue also relied on the GMC's guidance entitled "*Maintaining a professional boundary between you and your patient*" (*published 25 March 2013 / came into effect 22 April 2013*) ("*the Professional Boundaries Guidance*"). He submitted that paragraphs 3 to 5 of the Professional Boundaries Guidance were engaged. In respect of paragraphs 8 to 10 of the Professional Boundaries Guidance, which provide guidance regarding relationships with former patients and the timing of a relationship with a former patient, Mr Donoghue submitted that these were of limited relevance given the most serious aspects of this case was the sexual relationship between Dr Burns and Patient A. The Tribunal had found that the sexual activity had taken place while Patient A was still a patient between July to December 2013. Therefore, the serious behaviour was covered by the earlier parts of the Professional Boundaries Guidance. Mr Donoghue submitted that even when the relationship between Dr Burns and Patient A moved to email from early 2014 into early 2015, Patient A remained a patient of the practice, even if Dr Burns did not see her again. Mr Donoghue submitted that paragraphs 11 to 13 of the Professional Boundaries Guidance, regarding vulnerability of the patient, were engaged in this case given Patient A was vulnerable, and that increased the

seriousness of Dr Burns' behaviour. He submitted that although Dr Burns was neither Patient A's psychiatrist nor a paediatrician (as set out at paragraph 12 of the Professional Boundaries Guidance), there was still an abuse of his position as he was Patient A's GP. He was treating Patient A for poor mental health and a history of XXX. As such, the relationship represented an abuse of Dr Burns' position of trust.

7. Mr Donoghue submitted these were clear and serious breaches of GMP and the Professional Boundaries Guidance. He submitted that Dr Burns actions in this case were a very serious departure from the standards expected of medical practitioners, and that consequently the departures easily reach the level required to establish misconduct.

8. In respect of step 2b of the Guidance, Mr Donoghue reminded the Tribunal that it must make an assessment on the spectrum of seriousness, assess the risk to public protection, the nature of the allegation and any features that increase seriousness. He submitted that the actual consequences or outcome for an individual patient should not be considered in isolation and said that there was evidence in this case that those consequences were significant for Patient A. In particular, that Patient A was not seeking a sexual relationship when she attended the surgery to see Dr Burns, that Dr Burns was the first person she had seen regarding her mental health, and the relationship with Dr Burns had had a bigger impact on her than she had realised at the time, and she has felt that when visiting doctors that she was wasting their time. She had also felt unable to take part in these proceedings because the prospect of re-living the events had caused her such trauma. He said that the Tribunal should attach more weight to evidence about the risk to patients and members of the public associated with the specific departure from the professional standards. Mr Donoghue reminded the Tribunal that the Guidance stated that an improper sexual or emotional relationship with a patient would usually fall at the higher end of the spectrum of seriousness. He said that there were two aspects of the relationship in this case. Firstly, the admitted relationship through communications, largely via e-mail. Secondly, the physical sexual relationship found proved by the Tribunal. Mr Donoghue submitted that this case was already at the very top end of the spectrum of seriousness.

9. When considering features which may increase seriousness, as set out in the Guidance, Mr Donoghue submitted that the following features were engaged: that the behaviour was persistent or repeated; directed towards a person with a particular vulnerability; premeditated; an abuse of Dr Burns' professional position; and a reckless disregard for patient safety and professional standards. Mr Donoghue submitted that these five features further increased the seriousness of this case above the high starting point. The events were therefore at the top end of the high end of the spectrum of seriousness. Mr

Donoghue reminded the Tribunal of paragraph 44 of the Guidance, which he said applied in this case. Paragraph 44 states:

“In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.”

10. In respect of step 2c of the Guidance and any relevant context, Mr Donoghue submitted that Dr Burns was a relatively new GP when the relationship with Patient A first arose. He submitted however that the conduct which Dr Burns engaged in involved a breach of a fundamental principle of the doctor-patient relationship and such a fundamental principle that it could not be said that Dr Burns would not have known of the seriousness of his behaviour at the time. He reminded the Tribunal that Dr Burns also sought to pursue the relationship with Patient A into early 2015.

11. Mr Donoghue referred the Tribunal to documents provided by Dr Burns that XXX and that there is reference to this in his reflections. Mr Donoghue submitted that there was no suggestion that XXX directly impacted on Dr Burns’ behaviour or conduct, primarily because there is little to no evidence as to how that XXX may have affected Dr Burns in 2013. He submitted that, were that to be a suggestion much more detailed XXX evidence would be required. Mr Donoghue submitted that this XXX provided very little, if any, context to the events in this case. Mr Donoghue submitted that the two matters of relevant context referred to should have little, if any, impact upon the Tribunal's assessment of the overall seriousness of the conduct. He said that the ongoing risk to public protection, by reason of Dr Burns’ conduct remains high.

12. In respect of step 2d of the Guidance, which asks the Tribunal how Dr Burns has responded to the allegations, Mr Donoghue submitted that Dr Burns had made admissions to the majority of the paragraphs of the Allegation, albeit not to the paragraph that the GMC would submit was the most serious element relating to the physical sexual activity with Patient A. Mr Donoghue stated that, when considered in totality, the Tribunal may consider Dr Burns has demonstrated through those admissions at least some insight into his conduct. He said that Dr Burns accepted that he could and should have acted differently during this relationship. Mr Donoghue said that Dr Burns had insisted that he was not seeking to re-establish the relationship with Patient A in late 2014 and early 2015, which flew in the face of

the evidence. He submitted that the Tribunal should be cautious not to equate Dr Burns' denial of paragraph 3f of the Allegation to mean that he lacks insight. However, given the more serious matters found proved by the Tribunal, Dr Burns can only be considered to have limited insight into the issues which occurred in this case. Mr Donoghue submitted that even where there are reflections and remediation offered by Dr Burns, they do not engage with the fact that the Tribunal had found proved the physical sexual activity.

13. In respect of step 2e of the Guidance, which guides the Tribunal to consider the overall risk to public protection, Mr Donoghue submitted that the Guidance makes clear that the starting point for the Tribunal is the assessment as to where the case falls on the spectrum of seriousness. He submitted that this case was at the very top end and therefore the risk to public protection is high. Mr Donoghue submitted that this type of conduct is irremediable for a member of the medical profession. He submitted that the Guidance sets out that where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current ongoing risk to public protection will be high. He submitted that this case engages all three elements of public protection and therefore a finding of impairment is required on that basis in this case.

Submissions on behalf of Dr Burns

14. Mr Ivill submitted that in relation to misconduct, Dr Burns accepts that the proven conduct fell short of the standard expected and that it is serious. He said that he would therefore focus his submissions on the issue of impairment. He reminded the Tribunal that its task is to determine if Dr Burns' fitness to practise is currently impaired, whether there is a current and ongoing risk to one or more of the three parts of public protection, such that restrictive action is necessary.

15. Mr Ivill reminded the Tribunal of the distinction between whether Dr Burns' fitness to practise was impaired at the time and whether his fitness to practise is currently impaired. He said that the Tribunal would be well aware of the assessment as to whether Dr Burns' fitness to practise is impaired as at today, taking into account relevant factors, such as whether the matters are remediable, have been remedied and the likelihood of repetition.

16. Mr Ivill referred the Tribunal to Dr Burns' reflective statement in which he set out that he believed there were a number of contributing factors to his behaviour with Patient A. This included Dr Burns' XXX which affected XXX and also his judgment. Mr Ivill submitted that this was not advanced as an excuse, rather a factor that was present and therefore relevant to the context.

17. In respect of how Dr Burns has responded to the allegations, Mr Ivill submitted that Dr Burns had admitted many of the charges and did so at an early stage. He said that it is right that Dr Burns challenged that he did not act in the way proved at allegation 3f. Mr Ivill referred the Tribunal to the case of *Yusuff v GMC [2018] EWHC 13 (Admin)* in which Yip J, having reviewed all the relevant authorities, stated that, '*Admitting the misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it*'. Mr Ivill submitted that what this points to is that admitting misconduct is not a condition precedent to establishing either insight or remediation. Mr Ivill then referred the Tribunal to the case of *Blakely v GMC [2019] EWHC 905 (Admin)* in which it was said that it is for the doctor to demonstrate how, given the Tribunal's findings, he or she can reassure the Tribunal that sufficient insight has been acquired, which was different from accepting that they had done what they were accused of. Mr Ivill said that although those two cases concerned review hearings, the principles remain equally applicable in relation to a substantive hearing.

18. Mr Ivill submitted that Dr Burns has demonstrated insight by showing an understanding of the significance of the proven behaviour. He said that in the reflective statement, Dr Burns makes clear that he appreciates the seriousness and the impact of such behaviour on patients, colleagues, the wider profession and the public confidence in it. Mr Ivill submitted that Dr Burns remarked upon the impact on Patient A, that he expressed his regret and apology and understands the importance of trust and of his responsibility to maintain professional boundaries. Mr Ivill submitted that when applying what was said in *Blakeley*, Dr Burns recognises the significance of his actions, acknowledged wrongdoing and understands why his actions cannot be repeated. He submitted that Dr Burns recognises the existence of the doctor patient power dynamic and his responsibility to control and maintain professional boundaries.

19. Mr Ivill submitted that Dr Burns has provided evidence of remediation in his reflections with a view to addressing the concerns raised in this case. He said that Dr Burns has attended a highly relevant three-day course on maintaining professional boundaries. He has summarised in his reflections the learning that he has undertaken and the changes he has made to guard against repetition. Mr Ivill said that Dr Burns has taken the concerns seriously and worked hard on embedding his remediation and taken steps to avoid the circumstances arising again, which in turn reduces the level of current and ongoing risk to public protection. Mr Ivill submitted that there has been no previous fitness to practise history. He said that the proven conduct could perhaps be best described as an isolated period in an otherwise unblemished career.

20. In respect of the lapse of time, Mr Ivill said that there has now been a period of more than 13 years without these concerns being repeated. He said the fact the proven conduct has not been repeated is relevant, not only to insight but also to whether the conduct is remediable and the likelihood of repetition. Mr Ivill referred the Tribunal to Dr Burns' positive colleague and patient feedback. He submitted that the matters are remediable with relevant steps having been taken and evidence of what has been done. He said that there is also evidence to show that remediation has been achieved and that the conduct is highly unlikely to be repeated. He said the lapse of time and the remediation reduces the risk of repetition and is directly relevant to the assessment of the level of current and ongoing risk to public protection.

21. Mr Ivill referred the Tribunal to the case of *Cohen v GMC [2008] EWHC 581* in which it was said that there must always be situations in which a panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner. Further, that the chance of it being repeated in the future was so remote that the doctor's fitness to practise has not been impaired. Mr Ivill invited the Tribunal to conclude that Dr Burns does have insight, has embedded his remediation and that the risk of repetition is highly unlikely. He reminded the Tribunal that Dr Burns has remained fully engaged with the GMC process throughout. Mr Ivill said that Dr Burns has also referenced the impact the investigation has had upon him, though not in an attempt to elicit sympathy, rather by way of relevant context as it may lend further support to Dr Burns being highly unlikely to place himself in a position where allegations of this nature could be made again.

22. Mr Ivill submitted that bearing in mind the passage of those 13 years, this is not a case where there is a sufficiency of evidence to suggest Dr Burns poses a demonstrable current risk to patient safety. He acknowledged that in certain cases a finding of impairment is required to maintain public confidence and uphold proper professional standards and that it was a matter for the Tribunal's professional judgement.

The relevant legal principles

23. The Legally Qualified Chair delivered legal advice to the Tribunal as follows. There is no burden or standard of proof at this stage of the proceedings, and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of

the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

24. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious, and then whether the finding of that misconduct which was serious, poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

25. To assess whether Dr Burns poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider and follow the steps set out in the Introduction to the Guidance and in Part B of Section 3 of the Guidance, particularly:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved, the impact of any relevant context known about Dr Burns and/or their working environment, and
- how Dr Burns has responded to the allegations which includes his insight and remediation.

26. The Tribunal had regard to the case of *Roylance v GMC (No.2) [2000] 1 AC 311*:

'Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

27. The Tribunal noted the case of *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*:

'31 [misconduct is observed] as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent

conduct to amount to serious professional misconduct, but the negligence must be to a high degree.'

28. The Tribunal was reminded of the guidance of Silber J at paragraph 62 of *Cohen*, that:

“Any approach to the issue of whether a doctor’s fitness to practice should be regarded as “impaired” must take account of “the need to protect the individual patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the [profession]”.

29. The Legally Qualified chair explained that Cox J in *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)* (“*Grant*”) had stated that it was essential not to lose sight of the fundamental considerations set out by Silber J in *Cohen*. The Panel also had regard to paragraph 76 of *Grant* in which Cox J set out the helpful and comprehensive approach to determining issues of impairment set out by Dame Janet Smith in her Fifth Shipman Report:

‘Do our findings of fact in respect of the doctor’s misconduct...show that his/her fitness to practise is impaired in the sense that s/he:

- a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession...’*

The Tribunal’s determination on impairment

Step 2a: Is there a legal basis for considering impairment?

30. The Tribunal first considered whether the proven facts engage one or more of the statutory grounds for impairment, in accordance with Step 2a of the Guidance.

31. The Guidance states:

'9. An MPT must be satisfied that there is a legal basis for considering whether a doctor's fitness to practise is impaired, meaning that there is a current and ongoing risk to public protection. The table below explains the grounds of impairment that apply to taking regulatory action in respect of doctors.

10. A finding of impairment can only be made by an MPT where the facts found proved engage at least one of these grounds of impairment and the doctor is assessed to pose a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response.'

'11 ...

'Ground of impairment

Misconduct

Description

This is about behaviour. It could consist of acts and/or omissions arising in or outside of a doctor's working life and includes failing to act appropriately or demonstrating behaviour that falls short of what can reasonably be expected.

To amount to misconduct, the behaviour will be a serious departure from the professional standards, as set out in Good medical practice. This includes single clinical acts or omissions that are serious, or a limited number of clinical acts or omissions that taken together are serious.'

32. The Tribunal reminded itself of its finding at the fact-finding stage. It found the Dr Burns had an improper emotional and sexual relationship with Patient A, by virtue of the three instances of physical sexual activity. He knew that she was his patient and that she was vulnerable by virtue of her mental health issues for which he saw her as a patient at the GP Practice. Dr Burns further engaged in sending inappropriate emails and inappropriate images to Patient A. The emails exchanged between Dr Burns and Patient A contained explicit sexual language where they expressed their sexual fantasies and sexual desires towards one another. The email messages also included conversations between Dr Burns and Patient A about contacting each other and meeting. In one of the email exchanges, Dr Burns proposed that Patient A could stay with him and Dr Burns asked if they could film themselves. The intimate photos sent by Dr Burns to Patient A included an image of his naked torso, an image of him wearing a shirt but with the shirt open and so exposing his torso, an image of his

naked back, bum and thighs, an image of part of his penis/groin area, an image of his hand covering his penis, an image of his naked torso wearing red brief style pants and an image of his torso where he is holding his erect penis.

33. The Tribunal was satisfied that thar Dr Burns' conduct engaged paragraphs 53 and 65 of GMP:

'53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.'

'65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

34. The Tribunal had regard to paragraphs 3, 4, 5, 8, 9, 10, 11 and 15 of the Maintaining Professional Boundaries Guidance, as referred to by Mr Donoghue in his submissions:

'Doctor-patient partnership

3 Trust is the foundation of the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner.

Current patients

4 You must not pursue a sexual or improper emotional relationship with a current patient.

5 If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately and try to re-establish a professional boundary. If trust has broken down and you find it necessary to end the professional relationship, you must follow the guidance in Ending your professional relationship with a patient.'

'Former patients

8 Personal relationships with former patients may also be inappropriate depending on factors such as:

a the length of time since the professional relationship ended...

- b the nature of the previous professional relationship*
- c whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable...*
- d whether you will be caring for other members of the patient’s family.*

You must consider these issues carefully before pursuing a personal relationship with a former patient.

Timing

9 It is not possible to specify a length of time after which it would be acceptable to begin a relationship with a former patient. However, the more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate.

10 The duration of the professional relationship may also be relevant. For example, a relationship with a former patient you treated over a number of years is more likely to be inappropriate than a relationship with a patient with whom you had a single consultation.’

‘Vulnerability of the patient

11 Some patients may be more vulnerable than others and the more vulnerable someone is, the more likely it is that having a relationship with them would be an abuse of power and your position as a doctor.’

...

‘13 Whatever your specialty, you must not pursue a personal relationship with a former patient who is still vulnerable. If the former patient was vulnerable at the time that you treated them, but is no longer vulnerable, you should be satisfied that:

- the patient’s decisions and actions are not influenced by the previous relationship between you*
- you are not (and could not be seen to be) abusing your professional position.’*

‘Help and advice

15 *If you are not sure whether you are (or could be seen to be) abusing your professional position, you should seek advice about your situation from an impartial colleague, your defence body or your medical association.'*

35. The Tribunal was satisfied that paragraphs 3, 4, 5, 11, 13 and 15, of the Maintaining Professional Boundaries Guidance were engaged.

36. In respect of paragraph 8, the Tribunal was of the view that as it related to *'former patients'*, it was of limited relevance. It determined that Patient A was not a former patient, and Dr Burns knew that she was not a former patient at the time they engaged in physical sexual activity. He also knew she was vulnerable. The Tribunal considered even on Dr Burns' case that she was a former patient, the timescale between when he last saw her in December 2013 and started to communicate with her in January 2014 would have amounted to a breach of the guidance. Dr Burns should not have relied upon the assurance of Patient A's mother that Patient A would move to a different GP practice and should have sought advice and reviewed the relevant guidance.

37. The Tribunal was also of the view that paragraphs 9 and 10 of this guidance were of limited relevance as they related to the *'timing'* of the relationship. These paragraphs again relate to a relationship with a former patient. But the Tribunal again considered that even on Dr Burns' own admissions, and his case that she was a former patient, he should have followed this guidance but did not and therefore breached it.

38. The Tribunal determined that Dr Burns' conduct would be regarded as deplorable by fellow practitioners, it fell below the standards expected and undermined public confidence in the profession and that it amounted to serious professional misconduct. It was satisfied that there is a clear legal basis for considering impairment on the grounds of Dr Burns' misconduct.

Step 2b: Where on the spectrum of seriousness does the allegation lie?

39. The Tribunal then went on to consider where on the spectrum of seriousness the facts found proved lie. It had regard to paragraph 31 of the Guidance:

'31. Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:

- *...an improper sexual or emotional relationship with a patient ...'*

40. The Tribunal considered that even on Dr Burns' admissions in respect of the correspondence with Patient A, there were highly sexualised emails and inappropriate photos with a vulnerable patient constituting an improper emotional and sexual relationship which would place this conduct at the higher end on the spectrum of seriousness. In respect of the three instances of physical sexual activity between Dr Burns and Patient A, one being at the GP Practice, the Tribunal was satisfied that Dr Burns had clearly engaged in an improper emotional and sexual relationship with Patient A and that this also meant that the behaviour was at the higher end on the spectrum of seriousness. Taken individually and together, the misconduct was at the higher end on the spectrum of seriousness.

41. The Tribunal then went on to consider whether there were any features which may increase the seriousness of an allegation as set out in the Guidance. The Tribunal was satisfied that the following features were present in this case:

The behaviour was persistent or repeated

'Behaviour or poor performance will be persistent or repeated where the same, or similar, act(s) or omission(s) occur(s) multiple times and/or where an act or omission continues over a prolonged period.'

42. Dr Burns' behaviour persisted over a period of 18 months with one patient and while it was an isolated event in the context of his whole career as a GP to date, the behaviour was repeated throughout the 18-month period.

The behaviour was directed towards or involved interaction with, a person with impaired capacity or a person with a particular vulnerability

'Certain characteristics indicating vulnerability include the presence of mental health issues...'

43. Patient A was vulnerable at the time of these events due to her mental health issues, which was the context in which she had seen Dr Burns at the GP Practice. Dr Burns was aware of her vulnerability at the time he commenced his sexual relationship with her and engaged in physical sexual activity which continued on to sexualised emails and the sending of inappropriate photos.

Premeditated behaviour

‘Premeditated behaviour is characterised by the doctor having acted intentionally and with planning. It usually arises where a doctor looks for, or identifies, an opportunity to take advantage of a person or situation and takes steps towards doing so.’

44. The Tribunal recognised that Dr Burns had been approached by Patient A’s mother in a highly unusual situation and that it was Patient A’s mother who had suggested to Dr Burns that he commenced a relationship with her daughter. The Tribunal recognised that Dr Burns had not sought out Patient A’s contact details. However, the Tribunal considered that Dr Burns’ behaviour was premeditated. He intentionally initiated contact with Patient A, after Patient A’s mother had given him her daughter’s phone number. Dr Burns had taken advantage of the unusual situation in which he had found himself with Patient A’s mother, had taken advantage of the opportunity to contact Patient A, and in so doing had taken advantage of Patient A. Dr Burns had continued to act intentionally, with planning and had continued to take advantage of Patient A when engaging in sexual activity with her. He had also taken advantage of the situation by sending the sexually explicit emails and images of himself to Patient A. Dr Burns also positively tried to re-initiate contact with Patient A and pursue the relationship over an 18-month period.

Predatory behaviour

‘Predatory behaviour is characterised by the doctor taking, or attempting to take, advantage of an opportunity to exploit a person or situation. It can involve premeditation or be opportunistic.’

45. The Tribunal considered carefully the definition of predatory behaviour and concluded that Dr Burns’ behaviour was predatory. After Dr Burns knew that Patient A’s mother had encouraged him to pursue a relationship with her daughter, he took advantage of the opportunity to exploit the situation and strike up an emotional and sexual relationship with a vulnerable person. The Tribunal considered that his actions were opportunistic and met the definition of predatory behaviour.

Abuse of professional position

‘Abuse of professional position is where a doctor misuses their position of power. It arises because the relationship between the doctor and the individual is not equal.’

46. The Tribunal determined that Dr Burns had abused his professional position. Patient A had attended the GP Practice to see a doctor about her mental health issues. Dr Burns was the first GP that Patient A had spoken to about these matters. The relationship was unequal between them by virtue of the doctor-patient relationship but the Tribunal considered that the fact that Patient A was vulnerable served to increase the apparent inequality between them.

A reckless disregard for patient safety or professional standards

‘A reckless disregard for patient safety is where a doctor knew, or ought to have known, that their behaviour, poor performance or the impact of a health condition was causing harm, or risked causing harm, to patients and should have taken steps to prevent this, or where they deliberately closed their mind to the existence of such a risk.

A reckless disregard for professional standards is where a doctor knew, or ought to have known, they should have followed professional guidance and chose not to do so without having first considered any associated risks and taking reasonable steps to mitigate them...’

47. The Tribunal determined that Dr Burns had a reckless disregard for patient safety and professional standards. Dr Burns did not take steps to mitigate the risk of harm to Patient A, he did not follow professional guidance and he did not seek advice from colleagues or his professional body about the situation in which he found himself. Dr Burns knew, or ought to have known at the time, that he was required to follow professional guidance and standards and Dr Burns should have taken steps to do so but instead demonstrated a reckless disregard for patient safety and professional standards.

Putting their own interests before those of patients

‘This occurs when a doctor puts their personal interests above those of a patient in a way that could compromise their judgment, decisions or actions...’

48. The Tribunal determined that Dr Burns had seen Patient A in the context of a patient in need of help with her mental health issues, but he put his own interests first in pursuing an inappropriate sexual relationship with her, albeit initiated at the suggestion of Patient A’s mother.

49. The Tribunal was satisfied that taking these seven factors into account reinforced its view of the high level of seriousness on the spectrum, namely that the behaviour was at the higher end of the spectrum of seriousness.

Step 2c: What is the impact of any relevant context known about Dr Burns and/or their working environment?

50. The Tribunal considered that at the time of the events before it, Dr Burns was a relatively new GP at the early stages of his career. He was approached by Patient A's mother in very unusual circumstances and encouraged to start a relationship with Patient A and it was Patient A's mother who provided Patient A's phone number to him. The Tribunal was mindful that Dr Burns had not sought out Patient A's contact details of his own accord.

51. The Tribunal also noted that there was no evidence of any other fitness to practise history or concerns having been raised in regards to Dr Burns.

52. In his reflective statement, Dr Burns provided some personal context to his situation at the time of the matters before the Tribunal which the Tribunal considered to be especially relevant to the relevant context:

'...At the time of these events, I had become disconnected and isolated from the profession, my colleagues and friends. I can see that the reasons for this was multifactorial and is not an excuse for my behaviour but an acknowledgement of my vulnerabilities at the time – father deceased, struggled through VTS and felt unable to reach out for support, friendship group moved away, [XXX]...'

53. Dr Burns set out in his reflections how the death of a close and significant family relative had impacted on him in the years prior to the events with Patient A, how that led to him struggling to complete his vocational training scheme (VTS) to qualify as a GP and that he had lost someone on whom he had been able to rely in the past for support. Dr Burns also stated in his reflections that he was socially isolated at the time of the events before this Tribunal.

54. The Tribunal also took account of XXX. Though, the Tribunal noted that it did not have any independent expert evidence as to how this XXX at the material time of the events with Patient A, would have impacted on Dr Burns' judgment or his behaviour which the Tribunal has found proved.

55. When considering the impact of any relevant context known about Dr Burns

and/or his working environment, the Tribunal had particular regard to paragraph 44 of the Guidance which it considered to be engaged:

'44. In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.'

56. The Tribunal did not have any evidence to explain the cause of Dr Burns' departure from the standard expected or of his serious professional misconduct. It determined that given its findings on seriousness, the relevant context carried less weight and had less of an impact and therefore, the risk to public protection remained at the higher end of the spectrum of seriousness.

Step 2d: How has Dr Burns responded to the allegations?

57. The Tribunal had regard to paragraphs 66 and 67 of the 'Guidance for MPTS tribunals > Guidance introduction', in which it stated:

'66. Most allegations relating to sexual misconduct have a starting point of a high level of seriousness and therefore fall at the higher end of the spectrum of seriousness. This means the starting point for assessing current and ongoing risk to public protection will usually be high.

67. Where this is the case, evidence of relevant context known about the doctor and/or their working environment and evidence of insight and remediation that decrease risk will usually have less impact because sexual misconduct allegations falling at the higher end of the spectrum of seriousness can be more difficult to remediate.'

58. The Tribunal also had regard to paragraphs 74 and 80 of the Guidance which state:

'74. The MPT should consider the evidence available to them to establish if the doctor has:

- a. shown insight into their own practice, behaviour and/or impact of a health condition*

b. *taken steps which have reduced the risk of similar allegations occurring again (remediation), such as participating in training, supervision, coaching or mentoring relevant to the allegation, and*

c. *kept their knowledge and skills up to date.'*

...

'80. However, in cases where the allegation falls at the higher end of the spectrum of seriousness, and therefore the starting point for assessing current and ongoing risk to public protection is high, evidence of insight and remediation will usually carry less weight and therefore will have less impact, if any, on the assessment of current and ongoing risk to public protection. This is because the risk to public protection arising from these allegations is generally more difficult to address, particularly where the allegation is connected to deep seated attitude issues and beliefs.'

59. The Tribunal did not consider Dr Burns having kept his knowledge and skills up to date to be a relevant factor given he has been practising as a GP since these events and there were no clinical concerns.

60. When considering Dr Burns' insight into his behaviour, the Tribunal considered that he had made admissions to most of the Allegation, albeit, not to the more serious allegation of physical sexual activity with Patient A, which it has found proved.

61. The Tribunal considered that it had little evidence from Dr Burns as to his understanding of the cause of his behaviour, why it happened in the first place, and he did not overtly state that he accepted all of the Tribunal's findings, in particular paragraph 3f. Dr Burns did not address these matters in his reflections, which were undated.

62. The Tribunal considered Dr Burns' reflective statement where he expressed remorse and reflected on the impact of his behaviour on Patient A and his colleagues. The Tribunal also acknowledged that he had undertaken a relevant professional course and reflected on his learning which had deepened his level of insight. The Tribunal however was of the view that it had not seen evidence that Dr Burns has fully developed insight into his behaviour and particularly the impact of his behaviour on professional standards, and the reputation of the profession.

63. The Tribunal carefully examined Dr Burns' stage 2 bundle, having regard to his reflections, the 3-day maintaining professional boundaries course undertaken in October 2025, and his reflections of his learning from that course in respect of the doctor patient relationship. It also had regard to the patient and colleague feedback forms, XXX, and the testimonial which was received at Stage 1. There were no character testimonials which would have provided evidence of his personal conduct outside of his professional practice.

64. The Tribunal was assisted by paragraph 87 when assessing the impact of insight:

'87. While all evidence of insight is important when assessing risk, some factors will enhance the impact of insight which means they may carry more weight. The following are relevant considerations:

...the timing – for example, an apology given soon after the relevant events to the appropriate person may carry more weight than if it were given following a delay and just before, or at, the decision point, and a self-referral may carry more weight if it is made voluntarily rather than to avoid a referral by a third party.'

65. The Tribunal was of the view that its assessment of the current and ongoing risk to public protection, given Dr Burns' lack of insight into his behaviour, is compounded by the limited evidence of remediation.

66. The Tribunal took into account the fact that although Dr Burns was aware of the allegations made by Patient A since 2021, it has only been relatively recently that he has provided an apology, expressed remorse and reflected on his behaviour.

67. The Tribunal had regard to Dr Burns reflections, undated, in which he stated:

'Since 2015 my life has changed significantly which would mean that any future boundary violation would be unimaginable. At the time I was self-destructing and was not coping in life. Since 2015 have worked to maintain the highest of professional standards and progress my career. I have married and have two young children. When I look at my daughter I am devastated by the damage that I have done to his person – who is a daughter, sister, wife and mother. Since my arrest and GMC investigation 2021 I have reflected continuously on Patient A and the impact of my behaviour on her. My behaviour was abhorrent and unacceptable; it is something I will be forever ashamed of. Over the last 5 years, I have engaged with the GMC and worked in accordance with my restrictions, consulted with NHS England throughout this process.'

I have reviewed and reflected on GMC guidance, received counselling to reflect on my behaviour, read literature on Psychology, [XXX] and attended a Professional Boundaries course.'

68. The Tribunal was satisfied that Dr Burns has shown genuine regret and remorse. He has engaged throughout the regulatory process and with NHS England.

69. When assessing the quality of remediation, paragraph 111 of the Guidance sets out that the Tribunal should consider whether it is relevant, measurable and effective.

70. The Tribunal considered that Dr Burns has undertaken a single 3-day course on Maintaining Professional Boundaries. The Tribunal was satisfied that this was objective evidence that Dr Burns had completed this course and that it was therefore measurable. When considering whether this was effective remediation, the Tribunal noted that Dr Burns had completed a lengthy reflective statement. However, the Tribunal was not satisfied that this went far enough. The Tribunal was concerned that it had only been eight months since Dr Burns had undertaken this course and it was the only example of objective remediation.

71. The Tribunal then went on to consider whether the allegation was highly unlikely to be repeated. Given the Tribunal's decision that Dr Burns does not have full insight into his behaviour and has not fully remediated his conduct, the Tribunal could not reach the conclusion that the behaviour was *highly* unlikely to be repeated.

72. The Tribunal has taken into account that it did not have any evidence of repetition of the conduct. No fitness to practise concerns have been raised since these events and Dr Burns has been practising as GP for the last 13 years. The Tribunal reminded itself however that Dr Burns' learning has been relatively recent, and he has not yet taken full ownership for his actions, specifically in relation to the physical sexual activity with Patient A. It recognised that Dr Burns was entitled to a defence and to deny the Allegation, but it considered that at this stage Dr Burns had not shown sufficient insight into his actions.

73. The Tribunal had regard to paragraph 116 of the Guidance which states:

'116. The MPT needs to make sure that a low risk of repetition is carefully distinguished from identifying no risk of repetition. This is because a low, but nonetheless real, risk of repetition might be significant and/or have a very serious outcome where the case involves behaviour or poor performance which falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high.'

74. The Tribunal was satisfied there was a risk of repetition, albeit that risk was low. The behaviour was at the higher end on the spectrum of seriousness and Dr Burns had displayed limited insight and remediation.

Step 2e: Tribunal’s decision as to whether Dr Burns poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

75. In deciding whether Dr Burns poses any current and ongoing risk to public protection which may require restrictive action, the Tribunal was assisted by the approach of Dame Janet Smith as affirmed in the case of *Grant*.

76. The Tribunal determined that Dr Burns has in the past acted so as to put a patient at unwarranted risk of harm, has in the past brought the medical profession into disrepute and has in the past breached one of the fundamental tenets of the medical profession.

77. The Tribunal was of the view that Dr Burns actions had caused harm to a vulnerable patient in a course of conduct which lasted approximately 18 months. It considered that a member of the public with full knowledge of all the circumstances of this case would be shocked if a finding of impairment were not made and that public confidence in the medical profession would be undermined. The Tribunal was also of the view that Dr Burns’ misconduct has undermined proper professional standards for members of the profession. Given its findings, as set out above, the Tribunal considered that Dr Burns was liable to act so as to put patients at unwarranted risk of harm in the future, that if he did repeat his behaviour, he would be liable in the future to bring the medical profession into disrepute and liable to breach one of the fundamental tenets of the medical profession.

78. The Tribunal determined therefore that all three limbs of public protection are engaged in this case, namely, the need to:

- a. protect, promote and maintain the health, safety and wellbeing of the public;
- b. promote and maintain public confidence in the profession, and
- c. promote and maintain proper professional standards and conduct for members of the profession.

79. The Tribunal has therefore determined that in all the circumstances of this case, for the reasons set out above, that Dr Burns’ fitness to practise is currently impaired by reason of his misconduct on all three limbs of public protection.

Determination on Sanction - 10/06/2026

The Evidence

1. The Tribunal has reviewed its findings at the facts and impairment stages and taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions on behalf of the GMC

2. Mr Donoghue submitted that the only sanction which can appropriately reflect the facts of this case was one of erasure. He referred the Tribunal to the case of *Arunachalam v GMC [2018] EWHC 758 (Admin)*. He submitted that this was a case of sexual misconduct in which Kerr J said:

'This was undoubtedly a sexual misconduct case. Such cases are inherently serious, such that they may well lead to erasure, even for a first time offender with a good clinical record. Often, maintaining public confidence in the profession and upholding high standards of behaviour by stamping out unacceptable behaviour of this kind will require erasure in a sexual misconduct case...

...In other parts of the world where the culture is different, and in some isolated sectors in this country, there is still a culture which regards such behaviour as acceptable. That is completely wrong and now regularly proclaimed to be so. The days are gone when mainstream discourse was in any way split on the issue of sexual misconduct, particularly in the workplace. The mainstream in our society, reflected in our law, is now that there is virtual zero tolerance of such behaviour.'

3. Mr Donoghue submitted that the tenor of those comments applied equally to this case. He referred the Tribunal to the sanctions banding in the Guidance which indicated a suspension of 12 months to erasure. Mr Donoghue reminded the Tribunal of its decision at the impairment stage that Patient A was vulnerable due to her mental health, the very issues which she had seen Dr Burns about, and that there were three instances of physical sexual activity, which was added to by the exchange of sexual emails and intimate photos. He reminded the Tribunal that it had identified seven factors which increased the seriousness in this case and that all three limbs of public protection were engaged. Mr Donoghue submitted that the only appropriate view was that this case fell at the very top end in respect of sanction.

4. Mr Donoghue referred the Tribunal to the relevant paragraphs of Part C of Section 3 of the Guidance in respect of suspension, particularly paragraph 45. He submitted that suspension may be appropriate where the level of current and ongoing risk to the public can be safely managed by suspension. He said that this is not a case where there is a risk to manage whilst Dr Burns is working, rather the level of current and ongoing risk to public protection is such that patient safety is not an issue.

5. Mr Donoghue then referred the Tribunal to the relevant paragraphs of the Guidance in relation to erasure, in particular paragraph 57 of Part C, Section 3 of the Guidance. He submitted that erasure is an appropriate response where conditions are not appropriate and suspension is not sufficient to protect the public. He said that Dr Burns had caused serious harm, which cannot be mitigated sufficiently by conditions of practice or suspension, and that Dr Burns has shown a lack of insight into the seriousness of the allegation, and the evidence of remediation is limited and recent. He submitted that the seriousness of the facts found proven and/or the impact of any relevant context increased the current and ongoing risk to public protection.

6. Mr Donoghue submitted that the central issue was that given the fundamental breach of the doctor-patient relationship in this matter, public confidence in the profession and the maintenance of proper professional standards would be undermined if erasure was not imposed. Erasure was the appropriate and proportionate sanction in order to maintain public confidence in the profession and uphold proper professional standards.

Submissions on behalf of Dr Burns

7. Mr Ivill submitted that the decision as to what sanction to impose was a matter for the Tribunal's own judgment. He said that the reference to the caselaw made by Mr Donoghue did not set a precedent because each case is to be decided on its own facts.

8. Mr Ivill submitted eight mitigating factors. He submitted that Dr Burns has shown a degree of insight, albeit not yet fully developed and provided a genuine expression of apology, regret and remorse. Dr Burns has undertaken learning, including the targeted and relevant gold standard three-day course concerning maintaining professional boundaries. He said Dr Burns provided testimonial evidence and patient and colleague feedback which confirmed not only Dr Burns' clinical competence, but that there are no clinical concerns or issues with Dr Burns being able to maintain professional boundaries. Mr Ivill reminded the Tribunal of the lapse of time since these events occurred and that there has been no previous fitness to practise history.

9. Mr Ivill submitted that the events before the Tribunal occurred when Dr Burns was going through a difficult period in his life and he has since matured and now has support systems in place. He submitted that the support systems Dr Burns has in place promote stability and reduce the risk of recurrence. Mr Ivill reminded the Tribunal that Dr Burns has engaged with the GMC process throughout and he is committed to maintaining professional standards in the future.

10. Mr Ivill referred the Tribunal to the relevant paragraphs of Part C, Section 3 of the Guidance in respect of suspension. He submitted that a period of suspension is a proportionate response which would send out a sufficiently strong message to Dr Burns, the public and the profession. He reminded the Tribunal that, as is set out at paragraph 44 of Part C, Section 3 the Guidance, suspension can have a deterrent effect. Further, that suspension may be proportionate where the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions. He also submitted that suspension may be necessary to stop the doctor from working, to prevent patients from being put at risk, and to allow the doctor to address the deficiencies identified by the Tribunal.

11. Mr Ivill invited the Tribunal to take account of the details of Dr Burns' personal circumstances, his financial and family commitments and the impact that a lengthy suspension would have. He submitted that a suspension for a period of 12 months would mark the seriousness of the conduct, maintain public confidence in the profession and uphold proper professional standards.

12. Mr Ivill submitted that erasure would be disproportionate and not in the public interest. He submitted that erasure should only be imposed where there are no other means to protect the public and required a finding of the conduct being fundamentally incompatible with continued registration. He submitted that erasure was only appropriate where there were no circumstances where the doctor should be permitted to practise. Mr Ivill submitted however that Dr Burns has been safely practising medicine for more than a decade since the events with Patient A occurred and there has been no suggestion of a breach of professional boundaries during that time.

13. Mr Ivill submitted that the mitigating factors were of considerable weight and that there was no evidence that demonstrates remediation cannot be successful. He said that this was not a case where there had been previous unsuccessful attempts at remediation. He reminded the Tribunal that there is no fitness to practise history and that Dr Burns is willing to engage. Mr Ivill submitted that Dr Burns has been safely practising medicine for many years and has done good things for many patients. He said that the public interest would be

served by Dr Burns being able to provide his medical skills in the future and by retaining his services as a competent practitioner.

14. Mr Ivill submitted that a period of suspension with a review would allow a further opportunity for insight and remediation.

The Tribunal's Determination on Sanction

15. The Tribunal had regard to the statutory overarching objective in Section 1 of the Medical Act 1983 throughout its deliberations. It considered all the evidence in this case and the submissions made by both parties. The Tribunal had regard to Part C of Section 3 of the Guidance and followed the approach set out in the Guidance.

16. The Tribunal took account of paragraph 10 of Part C of Section 3 of the Guidance that highlighted that the purpose of imposing a sanction is to protect the public. The Tribunal acknowledged that sanctions are not meant to be punitive but may have a punitive effect. It also bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor.

17. In making its decision on sanction, the Tribunal reviewed its decisions on facts and impairment and it considered the level of current and ongoing risk which Dr Burns poses to public protection.

18. The Tribunal reminded itself of the serious nature of Dr Burns' misconduct. It had found, because of the nature of the misconduct and the seven factors that increased the seriousness of the behaviour, that the risk to public protection was at the higher level. Furthermore, it had determined that Dr Burns had demonstrated limited insight and remediation. It also considered that all three parts of public protection were engaged in this case, albeit that there was a low risk of repetition.

19. The Tribunal considered the sanctions bandings for cases of sexual misconduct, set out at paragraph 62 of Part C of Section 3 of the Guidance. It noted that given its finding that there was a higher level of risk to public protection that the range of sanctions was between 12 months suspension and erasure. The Tribunal also considered the impact of any specific sanction type on Dr Burns.

20. With the bandings guidance and the need to follow the least restrictive principle in mind, the Tribunal considered that it would work through all of the available sanctions, starting with the least restrictive.

No action

21. The Tribunal considered that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be sufficient, proportionate, or in the public interest.

Conditions

22. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Burns' registration. It considered that any conditions imposed should be appropriate, workable, and measurable. The Tribunal reminded itself that Dr Burns' behaviour occurred outside of his workplace as a GP and that conditions could not be formulated to mitigate such conduct occurring in a doctor's personal life.

23. The Tribunal determined that the imposition of conditions on Dr Burns' registration would be inappropriate as it would not address the seriousness of his behaviour which has led to these proceedings and the high level of risk to public protection, particularly in regard to the serious harm that has been caused to public confidence in the profession and the maintenance of professional standards.

24. The Tribunal was of the view therefore that conditions would not be appropriate, measurable and/or workable. It concluded that conditions would not adequately mark the seriousness of its findings or address the high level of current and ongoing risk that it has identified.

Suspension

25. The Tribunal then went on to consider whether suspending Dr Burns' registration would be appropriate and proportionate.

26. The Tribunal considered that a period of suspension for 12 months may be appropriate and was the least restrictive response to Dr Burns' misconduct, as set out in the sanctions banding in Part C of Section 3 of the Guidance. It reminded itself that a period of suspension can have a deterrent effect and can send out a message to the doctor, the public and members of the profession that such conduct is not acceptable.

27. In considering whether suspension was the appropriate sanction, the Tribunal considered that Dr Burns is a competent doctor who has practised for 13 years since the events with Patient A took place. There have been no other concerns raised and no other fitness to practise history. The Tribunal acknowledged that Dr Burns had submitted a positive professional testimonial and had received positive colleague and patient feedback. The Tribunal reminded itself that there had been a passage of time since the matters before it and that Dr Burns has engaged with the regulatory process and with NHS England. The Tribunal considered that Dr Burns has provided some evidence of remediation and some level of insight into his misconduct. The Tribunal also noted Dr Burns' personal circumstances, and the submissions that had been made regarding his current support system and financial responsibilities. However, the Tribunal also noted that it had not received any personal testimonials attesting to Dr Burns' character or the support systems in place.

28. The Tribunal considered its findings that Dr Burns' insight was limited and not fully developed. The Tribunal also considered its findings that he had not addressed or taken responsibility for the physical sexual activity with Patient A, who was a patient of his and vulnerable at the material time. The Tribunal reminded itself that it had found that he had pursued a sexual and emotional relationship with Patient A which lasted for a period of 18 months and therefore was not an isolated incident. Dr Burns had not addressed the impact of his actions on maintaining public confidence in the profession and the consequences of his actions on the profession and upholding professional standards.

29. The Tribunal has already determined at the impairment stage that the following seven features increased the seriousness of Dr Burns' behaviour: the behaviour was persistent and repeated; the behaviour was directed towards and involved interaction with a person with a particular vulnerability; it was premeditated behaviour; it was predatory behaviour; there was an abuse of Dr Burns' professional position; there was a reckless disregard for patient safety and professional standards; and Dr Burns put his own interests before those of Patient A.

30. The Tribunal then had regard to paragraph 45 of Part C of the Section 3 of the Guidance:

"Suspension may be proportionate in cases where some, or all, of the following factors are present:

- a. conditions are not appropriate, measurable and/or workable*

- b. *the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
- c. *the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.”*

31. The Tribunal considered each factor in turn. It has already determined that conditions are not appropriate, measurable and/or workable. Dr Burns has some insight and he provided some remediation, but that neither were complete. In that regard the Tribunal considered that suspension may be an appropriate response to allow Dr Burns to remedy the deficiencies it had identified. The Tribunal were also mindful of the fact that he was willing to maintain professional standards and he had engaged with the regulatory process to date. However, the Tribunal considered the central issue in this case was that public confidence in the profession and the maintenance of proper professional standards for members of the profession had been seriously undermined given the high level of seriousness of Dr Burns’ behaviour. The doctor-patient relationship had been fundamentally breached and sexual misconduct with a patient, especially a vulnerable one, was unacceptable.

32. Given the seriousness of the misconduct found proved and the limited level of insight and remediation shown, the Tribunal determined it was not appropriate or sufficient in terms of public protection to impose a period of suspension on Dr Burns’ registration.

Erasure

33. The Tribunal considered whether it would be proportionate to erase Dr Burns’ name from the medical register and whether it was the only proportionate response.

34. The Tribunal had regard to paragraphs 55 to 57 of Part C of Section 3 of the Guidance:

‘55. Erasure is action available for those cases where a doctor’s behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.

56. *Erasure takes away a doctor's registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.'*

57. *'Erasure may be the proportionate response where:*

- a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
- b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
- c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
- d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.'*

35. The Tribunal considered the factors set out at paragraph 57. The Tribunal has found that conditions would not be appropriate, measurable or workable and suspension was not sufficient to protect the public. It has found that Dr Burns' behaviour caused serious harm to Patient A. The Tribunal considered that the factors which may have mitigated Dr Burns' misconduct were outweighed by the impact to public confidence in the profession and to the maintenance of proper professional standards.

36. The Tribunal considered that Dr Burns had displayed limited insight and he has not addressed the more serious aspects of his behaviour, namely the physical sexual activity with Patient A, or the Tribunal's findings on those matters. He had also not demonstrated insight into the impact of his behaviour on public confidence in the profession or the maintenance of professional standards. It reminded itself of the seven features it identified as being present in this case which increased the seriousness of Dr Burns' behaviour.

37. The Tribunal recognised that there is a public interest in keeping competent doctors on the medical register. The Tribunal determined that the seriousness of the facts found proved and the current and ongoing high risk to public protection meant that the effect of Dr

Burns continuing to hold registration would seriously undermine public confidence in the profession and the maintenance of proper professional standards.

38. Given the level of current and ongoing risk to public protection, the Tribunal determined to erase Dr Burns' name from the medical register.

Determination on Immediate Order - 10/06/2026

1. Having determined to erase Dr Burns' name from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Burns' registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Mr Donoghue referred the Tribunal to paragraphs 79 to 86 of Part C of Section 3 of the Guidance. He submitted that an immediate order can be imposed to protect the public, where it is in the public interest, or in the doctor's best interests. He submitted that an immediate order is necessary in this case as the risk to one or more parts of public protection is high, and immediate action is needed to maintain public confidence in the medical profession. He submitted that given the seriousness of this case immediate action is needed to maintain public confidence.

3. Mr Ivill, on behalf of Dr Burns, made no submission.

The Tribunal's Determination

4. The Tribunal considered its findings at the previous stages of this hearing in relation to Dr Burns' misconduct. It had regard to the relevant paragraphs of the Guidance in respect of whether to impose an immediate order. In particular, it had regard to paragraphs 79 and 84 of Part C of Section 3 of the Guidance, which states:

'79 The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.'

'84. It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

- a. the doctor poses a risk to patient safety*
- b. the risk to one or more parts of public protection is high, and/or*
- c. immediate action is needed to maintain public confidence in the medical profession.'*

5. The Tribunal determined that the seriousness of the proven Allegation and the level of current and ongoing risk to public protection posed by the doctor was at the higher end. All three parts of public protection were engaged, as evidenced in its determinations on impairment and sanction. The Tribunal determined that an immediate order of suspension is necessary to protect the public and that the only way to manage the current and ongoing risk is to impose an immediate order.

6. This means that Dr Burns' registration will be suspended from today. The substantive sanction, as already announced, will take effect 28 days from the date when written notification of this decision is deemed to have been served upon him, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

7. The Tribunal determined that any interim order in place on Dr Burns' registration is revoked with immediate effect.

8. This case is concluded.

ANNEX A – 02/06/2026

Application to Adduce further evidence and to redact witness statement

1. On day one of the hearing, Mr Ivill, Counsel for Dr Burns, made an application pursuant to Rule 34(1), to admit as hearsay evidence a statement made by Patient A's mother, written on 12 August 2021. Each party provided skeleton arguments and a copy of the statement with what they considered to be appropriate redactions and invited the Tribunal to determine which version should be included if Mr Ivill's application were successful.

2. As part of the same application, Mr Ivill made an application to redact references in Patient A's statements to something Dr Burns allegedly said to her in the Surgery.

Submissions

3. On behalf of Dr Burns, Mr Ivill submitted that the mother's statement was relevant to the case and was fair to admit. He said that the most relevant parts were that she indicates she initiated contact with Dr Burns, expressed support for his relationship with Patient A and that she could change GP practices to facilitate the relationship.

4. Mr Ivill submitted that the statement was relevant because it could go to the credibility of Dr Burns' account of events, which would be important in a case largely of one person's account against another's. He acknowledged the GMC's case that Patient A's mother could not confirm or deny whether a sexual relationship took place, but submitted that the statement provided important background information.

5. Mr Ivill submitted that this statement would be admitted as hearsay evidence as it had not been possible to contact the witness to ask her to give evidence at the hearing. He said that reasonable efforts had been made to contact the witness. He submitted that the absence of a witness does not automatically mean that their evidence should be excluded and that to do so would unfairly deprive Dr Burns of evidence that supports his account of events. Mr Ivill reminded the Tribunal that the GMC relied upon hearsay evidence in this case as Patient A is not being called to give evidence, and that to deny this application would be unfair. He said that it would still be open for the Tribunal to further safeguard the fairness of proceedings by deciding at a later date how much weight should be applied to the statement.

6. Mr Ivill explained the efforts those instructing him had made to contact Patient A's mother by reference to a bundle of correspondence. Mr Ivill explained that on 30 April 2026, those instructing him had requested the contact details from the GMC, who explained on the

same day that they were unable to provide them as they did not hold them and they would need to contact the police. The GMC provided the relevant contact details for the police on 5 May 2026. Mr Ivill then explained that on 18 and 19 May 2026, his solicitor was in correspondence with South Yorkshire Police & Humberside Police Legal Services (“the Police”) to request the contact details of Patient A’s mother. On 26 May 2026, Mr Ivill’s solicitors received a response from the Police to explain that they had written to the persons concerns seeking their consent to provide Mr Ivill’s solicitor with the names and contact details requested. The Tribunal was told that no response had been received.

7. Mr Ivill then turned to address the Tribunal on the proposed redactions to Patient A’s statement. He submitted that the inclusion of these statements, XXX, would essentially bring an allegation XXX which was not part of the Allegation and which the Tribunal was not required to decide, and would therefore be unfair. He submitted that there was no evidence to support such a claim. Mr Ivill submitted that to include such a suggestion would unfairly expand the scope of the Allegation and the comment by Patient A was unnecessary to resolve the factual dispute. He submitted that the Tribunal should limit itself to the Allegation and not invite speculation on XXX that did not form part of the Allegation.

8. On behalf of the GMC, Mr Donoghue, Counsel, first addressed the Tribunal on the admissibility of the witness statement of Patient A’s mother. He submitted that the relevance of the mother’s statement was the key issue. He said that, whilst the Tribunal had not yet reached the point of Dr Burns making any admissions, paragraph 3(f) of the Allegation – the three instances of alleged sexual activity – were the focus of the case. He submitted that the mother’s statement did not address this issue and was therefore not relevant to the case.

9. Mr Donoghue submitted that the mother’s statement could, at the most, give some contextual mitigation to how the relationship came about, but that this would be for consideration by the Tribunal at the impairment stage, not the factual stage. Mr Donoghue acknowledged Mr Ivill’s assertion that fairness required the Defence be permitted to call hearsay evidence when the GMC did so as well. However, he submitted that the fact of the GMC’s reliance on hearsay did not affect the relevance or fairness tests that must be considered in this application.

10. In relation to Patient A’s comment, Mr Donoghue submitted that this was a relevant piece of contextual information, which went to the likeliness or otherwise that the sexual activity occurred as alleged. He submitted that the comment added a minimal amount to the case and did not change the scope of the Allegation. Mr Donoghue suggested that the

Tribunal would be able to treat the comment with caution and would not allow itself to expand its considerations into areas of XXX.

The legal principles

11. Rule 34(1) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 sets out that the Tribunal can admit any evidence that it considers fair and relevant. The Tribunal will consider whether the evidence is admissible. If it determines to admit the evidence, it will then decide how much weight to be given to that evidence during the Tribunal's deliberations on the facts.

12. The Tribunal was mindful of the principles set out in the case of *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin)*. This set out various factors that the Tribunal is entitled to take into account when considering whether or not to admit evidence as hearsay. The relevant principles are set out at paragraph 45 of the judgment:

'1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.

1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.

1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.

1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability.'

13. The Tribunal was mindful that it should consider the reasons for Patient A's mother not being available to give evidence and be cross examined by the GMC. It should also consider any injustice that may be caused to Dr Burns or the GMC if the evidence were to be admitted or excluded and whether this could be addressed.

The Tribunal's decision

14. The Tribunal dealt first with the application to admit the statement of Patient A's mother.

15. The Tribunal was mindful that this case was one of its assessment of the credibility of the two key witnesses, namely Dr Burns and Patient A. In determining whether the statement of Patient A's mother was relevant, the Tribunal accepted that the statement did not directly relate to the paragraphs of the Allegation that it was to consider, but the evidence did relate to the surrounding facts of the case.

16. The Tribunal considered that the mother's statement, whilst not commenting directly on the alleged sexual activity, was relevant to the context of how the relationship between Dr Burns and Patient A came about, including about how contact was first made. The Tribunal determined that it was therefore relevant.

17. The Tribunal was satisfied that sufficient efforts had been made to contact Patient A's mother and that her non-attendance was not a reason to deny the application. The Tribunal was particularly mindful of the fact that it was only on 8 May 2026 that a differently constituted Tribunal of the MPTS had determined that the VR interview of Patient A and the police crime report were to be admitted into evidence as part of the GMC's case. It was therefore on that date that the GMC's case had crystallised. For that reason, the efforts made by the Defence to contact Patient A's mother, albeit only recently, appeared to be reasonable.

18. In determining whether it was fair to admit the statement, the Tribunal considered that the evidence of Patient A's mother was not the sole or decisive evidence to support the Allegation. In any event, it still went on to make a careful assessment, weighing up the competing factors, that contributed to the fairness of admitting the statement. The Tribunal considered that the information contained within the mother's statement was important contextual evidence, which would be important to establishing the broader picture and could go to Dr Burns' credibility. It was therefore fair to Dr Burns to allow in the statement so he could have the best opportunity of presenting his defence. The Tribunal considered that the GMC's evidence was also based on hearsay and therefore it was reasonable and equitable to allow Dr Burns to rely on hearsay evidence in support of his defence. The Tribunal was mindful of the fact that even if admitted, it would be for them to determine how much weight could be given to the statement.

19. Having regard to the case of *Thorneycroft*, the Tribunal considered that the absence of the witness could be reflected in the weight given to the evidence especially as the statement was not the sole or decisive evidence in the case.
20. The Tribunal therefore determined that it was fair and relevant to admit the mother's statement.
21. The Tribunal then moved on to consider which version of redactions to the statement should be applied.
22. The Tribunal considered that the redactions proposed by Mr Ivill were more extensive than those proposed by the GMC. It considered that, if the statement were being admitted as hearsay evidence, then it was likely to be more fair to both parties to include it in its more full form, as proposed by the GMC. The Tribunal was mindful that it was not admitting this evidence in favour of the doctor, but because it was fair and relevant to the case. As such, it considered that fairness to both parties required the less redacted version. The Tribunal considered that some of the proposed redactions were relevant to the wider context of the case and should be included.
23. As such, the Tribunal determined to apply the GMC's proposed version of the redactions.
24. The Tribunal then moved on to consider the proposed redactions to Patient A's evidence.
25. The Tribunal considered that the statements in question were relevant to the context and provided circumstantial evidence for one of the allegations of sexual activity, but it was mindful of the serious matters that were implied in such comments. Whilst the Tribunal was mindful that there was no evidence of XXX, and no such allegation, the inclusion of such comments could imply XXX on the part of Dr Burns.
26. The Tribunal considered that the comments related to events immediately after one of the allegations of sexual activity, showing Patient A's perception of events. It also considered that this could potentially go to the credibility of Patient A's account. However, the Tribunal was mindful of the very serious implications of the comment made by Patient A, XXX, and the Tribunal considered there was no other evidence to support this assertion.
27. The Tribunal considered that the decision was finely balanced but concluded that, in all the circumstances, the risk of causing prejudice to Dr Burns outweighed the benefit of

including this single piece of circumstantial evidence that is not the sole and decisive evidence in the case. As such, it determined to grant Mr Ivill's application to redact such references.

ANNEX B – 03/06/2026

Application to amend the Allegation

1. On day 2 of the hearing, the Tribunal invited submissions from parties as to whether amendments to the Allegation were required. In particular, the stem of paragraph 3 and of sub paragraph 3.f. In respect of the stem of paragraph 3, the Tribunal was concerned that the date range did not appear to encompass the full period of the alleged conduct of Dr Burns. The Tribunal invited parties to consider whether the date range should be amended to start from 'July 2013' as opposed to starting from 'January 2014'.

2. Further, the Tribunal was concerned that the way in which sub paragraph 3f was worded, relating to Schedule 2, and the three particulars therein, would mean that the Tribunal would have to find the entirety of the three separate particulars of Schedule 2 all proved, or all not proved. It did not appear the Tribunal could find one or more of the particulars in Schedule 2 either proved or not proved in the way it was worded. Paragraph 3f stated:

"3. Between January 2014 and March 2015 you engaged in an improper emotional and/or sexual relationship with Patient A in that on one or more occasion you:

f. engaged in sexual activity with Patient A, the details of which are set out at Schedule 2."

3. Having taken instructions, Mr Donoghue, Counsel, on behalf of the GMC, and Mr Ivill, Counsel, on behalf of Dr Burns, made their respective submissions.

Submissions on behalf of the GMC

4. Mr Donoghue submitted that in respect of paragraph 1 of the Allegation, as raised by the Tribunal on day 1 of the hearing, regarding the wording 'At all material times', that it concerned the dates set out at paragraphs 2 and 3 of the Allegation and that it did not need to be altered.

5. Mr Donoghue made an application to amend the stem of paragraph 3 of the

Allegation, from ‘January 2014’ to ‘July 2013’, pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise) Rules 2004 (‘the Rules’), to reflect the period of the conduct alleged. He submitted that there would be no injustice or prejudice caused by the proposed amendment.

6. Mr Donoghue did not propose to amend sub-paragraph 3f, as the words ‘on one or more occasion’ already appeared in the stem of paragraph 3 and was therefore applicable to all sub-paragraphs under paragraph 3.

Submissions on behalf of Dr Burns

7. Mr Ivill made no objection to the submission of Mr Donoghue or the proposed amendment to the Allegation.

The Tribunal’s Approach

8. Paragraph 17(6) of the Rules states:

*‘17(6) Where, at any time, it appears to the Medical Practitioners Tribunal that—
(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*

(b) the amendment can be made without injustice,

it may, after hearing the parties, amend the allegation in appropriate terms.’

9. The Tribunal accepted the submissions made by Mr Donoghue in respect of paragraph 1, the stem of paragraph 3 and sub-paragraph 3f of the Allegation. It was satisfied with the reasoning provided by Mr Donoghue in respect of paragraph 1 and sub-paragraph 3f that no amendment was necessary given that ‘At all times’ addressed the time period in which Dr Burns was allegedly messaging and engaging in sexual activity with Patient A, as set out at paragraphs 2 and 3 of the Allegation. Further, the Tribunal was satisfied that ‘on one or more occasions’ as set out in the stem of paragraph 3, related to sub-paragraph 3f, and the GMC’s position that this meant it could relate to one or more of the particulars set out in Schedule 2.

10. The Tribunal determined that the proposed amendment in respect of the stem of paragraph 3 from ‘January 2014’ to ‘July 2013’ could be made without any injustice or

prejudice to Dr Burns or the GMC. It therefore determined to make this amendment pursuant to Rule 17(6) of the Rules.

Schedule 1

Anston Medical Centre

Schedule 2

First activity:

You drove Patient A from XXX where you kissed, she performed oral sex on you and masturbated you.

Second activity

You had vaginal and anal intercourse with Patient A at XXX house.

Third activity

At the Anston Medical Centre you attempted to have anal intercourse with Patient A and they performed oral sex on you.