PUBLIC RECORD

Dates: 20/10/2025 – 07/11/2025
23/02/2026 – 06/03/2026
16/04/2026 – 21/04/2026
17/06/2026 – 26/06/2026
14/07/2026 – 17/07/2026
20/08/2026 – 21/08/2026

Doctor: Dr William SMERDON

GMC reference number: 6167906

Primary medical qualification: MB BS 2008 University of East Anglia

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	Adrian Phillips
Lay Tribunal Member:	Vince Cullen
Registrant Tribunal Member:	Dr Bridget Langham

Tribunal Clerk:	20/10/2025 – 07/11/2025 Keely Crabtree (03/11/2025 Ms Hinna Safdar) 23/02/2026 – 06/03/2026 Keely Crabtree 16/04/2026 – 21/04/2026 Hinna Safdar 17/06/2026 – 26/06/2026 Larry Millea 20/08/2026 – 21/08/2026 Larry Millea

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Vivienne Tanchel, Counsel, instructed by CMS Law
GMC Representative:	Mr Alan Taylor, 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 - 25/06/2026

1. This document is the Medical Practitioners Tribunal's (MPT's) findings of facts and reasons given under rule 17(2)(j) of the of the General Medical Council (Fitness to Practise) Rules 2004 ("the Rules") and recorded in writing by the Tribunal under Rule 37(a).

2. Parts of this hearing were heard in private in accordance with Rule 41 of the Rules. This determination will be handed down in private due to the confidential nature of matters under consideration. However, as this case concerns Dr Smerdon's alleged misconduct a redacted version will be published by the MPTS at the close of the hearing.

Background

3. Dr William Smerdon qualified in 2008 with a Bachelor of Medicine and Bachelor of Surgery (MBBS) degree from the University of East Anglia. He obtained Membership of the Royal College of General Practitioners (GP) in 2014.

4. Dr Smerdon was first employed by Medical Centre D as a Foundation Year 2 doctor in 2010 and did locum work there in 2015. He then returned to the practice as a salaried GP in 2015. Dr Smerdon became a GP Partner in January 2017 and remains in that position.

5. The allegations that have led to Dr Smerdon's hearing can be summarised as that, in January 2013 and November 2019, Dr Smerdon behaved in a sexually motivated way towards Patients A and B respectively when he knew that each patient was vulnerable by reason of their mental health.

6. It is alleged that Dr Smerdon's actions towards Patients A and B were carried out with the intention of pursuing a sexual relationship.

7. It is further alleged that in the case of Patient A, Dr Smerdon's actions were controlling and manipulative and in the case of Patient B, Dr Smerdon's actions were carried out without her consent and constituted sexual harassment.

The Outcome of Applications Made during the Facts Stage

8. On 21 October 2025 the Tribunal refused Ms Tanchel's application, made on behalf of Dr Smerdon, for the Tribunal to recuse itself. The Tribunal's full decision on the application is included at Annex A.

9. On 24 October 2025 the Tribunal decided to admit into evidence, pursuant to the Rules, a supplemental witness statement of Ms E, dated 23 October 2025 and copies of written electronic communications. The Tribunal also determined that Patient A should see the supplemental witness statement and electronic communications before continuing her oral evidence. The Tribunal's full decision is included at Annex B.

10. On 3 November 2025 the Tribunal refused Mr Taylor's application, made on behalf of the GMC, for the Tribunal under Rule 17(6) of the Rules to amend the Allegation. The Tribunal's full decision on the application is included at Annex C.

11. On 7 November 2025 the Tribunal made directions to the parties made under rule 16 of the Rules. The Tribunal's full decision is included at Annex D. Subsequent to these directions, Ms Tanchel on behalf of Dr Smerdon informed the Tribunal that there would be no application under Rule 17(2)(g) of no case to answer.

12. On day 14 of the hearing Mr Taylor made an application on behalf of the GMC, under Rule 34(1), for the Tribunal to admit further evidence, namely an email that Patient A sent to the GMC on Friday 31 October 2025 and a Facebook post after she had completed her oral evidence. The Facebook post contained the same photograph as one already in the bundle (in the Instagram post of 26 February 2013) but with an earlier date of posting. This was opposed by Ms Tanchel on behalf of Dr Smerdon in the interest of relevance and fairness. The chair gave legal advice to the Tribunal regarding Rule 34(1).

13. As regards to the legal tests that need to be satisfied for the Tribunal to admit new evidence, the key words in Rule 34(1) are "relevant", "fair" and "may". The Tribunal considered that it was not relevant as the Tribunal will not be required to determine the precise date the photograph was taken and may be unfair to Dr Smerdon to admit this evidence at this late stage in the proceedings and therefore the application was refused.

The Allegation and the Doctor's Response

14. The Allegation made against Dr Smerdon is as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. At all material times the nature of your relationship with Patient A was that Patient A was your patient and thereafter in a relationship with you.
To be determined

2. While working at Hospital C on or around December 2012 to January 2013 you:

a) said the following, or words to that effect, to Patient A:

i. she had 'really sexy veins'; To be determined

ii. that you walked the halls of her ward at night to see if her bedroom lights were on; To be determined

iii. 'you don't need to be here you're too special and you're too beautiful'; To be determined

iv. that you really liked her; To be determined

b) stared at Patient A; To be determined

c) asked to exchange numbers with Patient A; To be determined

d) kissed Patient A; To be determined

e) sent Patient A a text message on 5 January 2013 saying 'It is, and you're a naughty girl. I'm not far off leaving now. Kissing u was amazing. I think u are absolutely gorgeous. Please bare in mind you are no longer my patient, but even still please please don't tell anyone cos i could get into serious trouble and be struck off (no joke). To see me on the outside" would be fine. Kiss. Will';

To be determined

f) touched Patient A, over her clothes, on her:

i. chest; To be determined

ii. bottom. To be determined

3. After you stopped working at Hospital C you:

a) said the following, or words to that effect, to Patient A:

i. she could move to be with you; To be determined

ii. that she did not need to be in the hospital;
To be determined

iii. that she could start a new life with you; To be determined

iv. there was nothing for her to go back to if she discharged herself; To be determined

v. that you would be the start of a new life for her;
To be determined

vi. 'you need to eat more; XXX; To be determined

vii. XXX; To be determined

b) allowed Patient A to stay at your flat; Admitted and found proved

c) cooked huge meals for Patient A; To be determined

d) offered Patient A anti-psychotic medication without prescription; To be determined

e) controlled what Patient A ate; To be determined

f) bought bottles of wine for Patient A in spite of her not supposed to be drinking; To be determined

g) stayed at Patient A's flat; Admitted and found proved

h) made Patient A sleep on the sofa bed when she was not willing to take medication you gave her; To be determined

i) kept Patient A in your flat and rendered her unable to leave as she did not:

i. have a key to re-enter; To be determined

ii. know where she was; To be determined

j) entered into a sexual relationship with Patient A in that you, on one or more occasions, engaged in sexual intercourse with Patient A. To be determined

4. Your actions at paragraphs 2, 3ai, 3aiii, 3av, 3b and/or 3g were:

a) carried out with the intention of pursuing a sexual relationship with Patient A; To be determined

b) sexually motivated. To be determined

5. Your actions at paragraphs 2, 3a-i and/or 4 were:

a. controlling; To be determined

b. manipulative. To be determined

6. Patient A was vulnerable due to her mental health at the time of the events described in paragraphs 1, 2, 3 and/or 4. To be determined

7. You knew that Patient A was vulnerable due to her mental health.
To be determined

Patient B

8. On 6 November 2019 while working at Medical Centre D you consulted with Patient B where you said the following, or words to that effect:

    a) 'do you live alone?'; To be determined

    b) 'are you single?'; To be determined

    c) 'that's shocking that you're single when you're so pretty';
    To be determined

    d) 'oh that's surprising, but a good surprise' when seeing Patient B's tattoo; To be determined

    e) 'don't worry, I won't do anything weird'; To be determined

    f) 'you can book an appointment to see me again, you don't even have to be ill'. To be determined

9. On 15 November 2019 while working at Medical Centre D you consulted with Patient B where you:

    a) put your hand or hands on Patient B's shoulder;
    Admitted and found proved

    b) checked Patient B's heart rate with your hands;
    Admitted and found proved

    c) held Patient B's hand after checking her heart rate;
    To be determined

    d) gave Patient B a massage; To be determined

    e) put your hands under Patient B's jumper and onto her skin;

Admitted and found proved

f) pressed your groin against Patient B's back; To be determined

g) grabbed Patient B and hugged her; To be determined

h) kissed Patient B on the cheek; To be determined

i) kissed Patient B on the mouth using your tongue;

To be determined

j) touched Patient B's knee; To be determined

k) said the following, or words to that effect:

i. 'it's really good to see you again, I'm glad you're here';
To be determined

ii. 'I want to hug you. Is it okay if I hug you?'; To be determined

iii. 'I want to take you out but can't because you are a patient';
To be determined

iv. 'I have your details'; To be determined

v. 'if things go badly, you could get me into trouble by reporting me for having a relationship with a patient'.
To be determined

10. Your actions at paragraphs 8 and/or 9 were carried out with the intention of pursuing a sexual relationship with Patient B. To be determined

11. Patient B was vulnerable due to her mental health at the time of the events described in paragraphs 8 and/or 9. To be determined

12. You knew that Patient B was vulnerable due to her mental health.
To be determined

13. Your actions at paragraph 9 constituted sexual harassment as defined in Section 26 (2) of the Equality Act 2010, in that you engaged in unwanted

conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient B.
To be determined

14. Your actions as set out at paragraphs:

a) 8, 9 and/or 10 were sexually motivated; To be determined

b) 9a to 9j, were carried out without Patient B's consent.
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 (at the impairment stage)

The Admitted Facts

15. On 22 October 2025, through his counsel, Ms Tanchel, Dr Smerdon made admissions to paragraphs 3(b), 3(g), 9(a), 9(b) and 9(e) of the Allegation, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e), the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

16. The Tribunal is required to determine whether the remaining paragraphs and sub-paragraphs of the Allegation have been proved.

Witness Evidence

17. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Patient A, by video link
- Ms E, by video link
- Patient B, by video link
- Ms F, colleague of Patient B, by video link

18. Dr Smerdon provided his own witness statement dated 3 August 2025 and also gave oral evidence at the hearing.

19. The Tribunal also received eight testimonials in support of Dr Smerdon.

Documentary Evidence

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

- Photograph of mobile phone showing text (SMS) messages between Dr Smerdon and Patient A
- Photographs of text (SMS) messages between Patient A and Ms E
- Screenshots of Facebook Messenger messages between Patient A and Ms E with dates from 11 April 2013 to 23 August 2013
- Screenshots of WhatsApp messages between Patient A and Ms E with dates from 14 July 2022 to 21 October 2025
- Hospital C "Outline minutes of Investigation of Allegation on Locum Doctor by ex-patient: [Patient A]", meeting date 5 May 2023
- Hospital C Investigation Report dated 31 May 2023
- Photographs of Patient A posted to Instagram taken inside Dr Smerdon's home, posted on 26 February 2013 and 14 May 2013
- Webform report submitted by Ms G, Senior Social Worker to Norfolk Police dated 5 July 2022
- Hospital C Medical Records (including care notes) for Patient A, with dates from 14 December 2012 to 14 April 2014
- Bed receipt for Dr Smerdon dated 2 February 2013
- Completed form for report to Norfolk LADO (Local Authority Designated Officer) regarding alleged incident of 15 November 2019
- Medical Centre D Medical Records for Patient B, with dates from 6 November 2019 to 15 November 2019
- Transcripts of telephone calls between Patient B and Medical Centre D with dates from 6 November 2019 to 25 November 2019
- Transcripts of telephone calls from Ms F to Medical Centre D on 19 and 20 November 2019
- Extract of Police Report relating to Patient B dated 15 January 2020

- Statement of agreed facts
- Police witness statement (form MG11) of Patient B dated 26 November 2019
- Screenshot of Dr Smerdon's GMC contact profile (Siebel record)
- Dr Smerdon's CV

Advice of the Legally Qualified Chair (LQC)

21. On 4 March 2026 the LQC gave written legal advice to the Tribunal.

22. The Tribunal accepted the legal advice and in particular noted:

In this hearing, the burden of proof (or onus) rests on the GMC. It is for the GMC to prove each allegation against the practitioner and the standard of proof is that applicable to civil proceedings, that is, on the balance of probabilities.

The "balance of probabilities" standard of proof needs to be applied carefully where there are more than two possibilities (or alternative explanations) about what happened, because "more likely than not" is not the same as "more likely than any other particular possibility".

- *Re D (A Child) (Fact-finding Hearing)* [2014] EWHC 121 (Fam); [2014] 1 WLUK 692 (29 January 2014), which at paragraph [31(v)] cites the case *Rhesa Shipping Co SA v Edmunds (The Popi M)* [1985] UKHL 15; [1985] 1 WLR 948 (16 May 1985).

A standard of proof is applied in fact-finding, but no standard of proof is applied in a decision that is essentially evaluative.

In the case *Byrne v GMC* [2021] EWHC 2237 (Admin) (10 August 2021), at paragraph [22] Mr Justice Morris quoted his previous decision in the case *O v Secretary of State for Education* [2014] EWHC 22 (Admin) (17 January 2014) in which, at paragraph [66], he summarised the law relating to the standard of proof and said:

> However it does not follow, as a rule of law, that the more serious the allegation, the less likely it is to have occurred. So whilst the court may take account of inherent probabilities, there is no logical or necessary connection

between seriousness and probability. Thus, it is not the case that "the more serious the allegation the more cogent the evidence need[ed] to prove it".

Good character of the registrant

23. Evidence of a registrant's good character may be taken into account by an MPT in assessing whether his/her conduct was sexually motivated.

- *Arunkalaivanan v GMC* [2014] EWHC 873 (Admin); Evidence of a registrant's good character may be taken into account by an MPT in assessing his/her credibility generally.
    - *Wisson v Health Professions Council* [2013] EWHC 1036 (Admin);

In the case of *Sawati v GMC* [2022] EWHC 283 (Admin) (11 February 2022) the Honourable Mrs Justice Collins Rice referred, at paragraph [54] to *Wisson v Health Professions Council* saying:

> 54. *Wisson v Health Professions Council* [2013] EWHC 1036 (Admin) expanded on the relevance of good character (paragraphs 41-44). It has two aspects. First, it can go to credibility – how reasonable it is to believe or disbelieve what an individual says. Second, it can go to propensity – the probability that they have misconducted themselves. It may be considered less likely that an erstwhile blameless person has seriously misconducted themselves if they have never done so before. Again, the weight to be attached to good character is a matter for the Tribunal undertaking the factual evaluation.

24. The "two aspects" referred to in paragraph [54] of *Sawati v GMC* are commonly referred to as the two "limbs" of a good character advice: the "credibility limb" and the "propensity limb".

25. In the current case of Dr Smerdon, the approach to the "propensity limb" should be modified to take into account that Dr Smerdon has made admissions such that the reference in paragraph [54] of *Sawati v GMC* to a "blameless person" would not be applicable to him.

26. It is agreed that the registrant, Dr Smerdon, has never been before a fitness to practise tribunal and has no findings against him. Good character is not a defence to the allegations but it is relevant in two ways.

27. First, Dr Smerdon has given evidence and the Tribunal has received unchallenged testimonials (see bundle D1, pages 28-42) from people who have spoken about Dr Smerdon's personal qualities. Dr Smerdon's good character is a positive feature which the Tribunal should take into account in Dr Smerdon's favour when considering whether the Tribunal accepts what Dr Smerdon told the Tribunal. Secondly, the fact that Dr Smerdon has no previous findings against him may make it less likely that Dr Smerdon acted as the GMC alleges in this case. However, he has made admissions in the current case, and specifically to having had a sexual relationship with a former patient.

28. What importance the Tribunal attaches to Dr Smerdon's good character and the extent to which it assists on the facts of this particular case are for the Tribunal to decide. In making that assessment the Tribunal may take account of everything the Tribunal has heard about Dr Smerdon.

Cross-admissibility of evidence

29. "Cross-admissibility" of evidence is, in the context of the current case, not about whether evidence is admissible into the proceedings (such as might be considered in criminal proceedings under section 101 of the Criminal Justice Act 2003, or in an MPT hearing under rule 34(1) of the Rules), but about to what use evidence relating to one allegation may properly be put in relation to another allegation.

30. In the case *Sadiq v GMC* [2025] EWHC 3062 (Admin) (20 November 2025), Ms Justice Obi DBE said, at paragraphs [70] and [71]:

> 70. Evidence from one allegation may be cross-admissible to another allegation in the same proceedings where (i) it may establish propensity to commit that kind of conduct and/or (ii) it may rebut coincidence (*Freeman* [2008] EWCA Crim 1863 at [14] and [15]). …
>
> 71. The authorities cited by Dr Sadiq (*H*, *Lamb*, *Chopra*, and *Garrard*) concern cases involving multiple complainants, where the similarity of accounts may improperly bolster credibility. In such cases, the Tribunal must

> expressly consider and exclude the possibility of contamination or collusion before relying on the consistency of witness accounts to rebut coincidence. …

31. On behalf of the GMC, Mr Taylor submitted that both grounds of cross-admissibility (that is, propensity and rebuttal of coincidence) were applicable in this case.

32. In the case *Professional Standards Authority for Health and Social Care v General Medical Council & Garrard* [2025] EWHC 318 (Admin) (14 February 2025) ("*Garrard*") Mr Justice MacDonald said at paragraph [47]:

> In the foregoing context, and having regard to the authorities summarised above, in determining an issue of cross-admissibility a Tribunal will need to bear in mind the following matters:
>
> i) There are two primary grounds on which evidence may be cross-admissible. Namely, (a) where it may establish propensity to commit that kind of conduct and/or (b) where it may rebut coincidence (*Freeman* [2008] EWCA Crim 1863 at [14] and [15]).
> ii) The Tribunal will need to decide on which ground or grounds it is being asked to cross admit the evidence and advise itself accordingly, in terms that are relevant to and reflect the particular circumstances in which the questions of cross-admissibility arise (*Brennand* [2023] EWCA Crim 1384).
> iii) The Tribunal will need to take care to distinguish clearly between the grounds and to not advise itself on the other ground if only one ground is applicable, in order to avoid confusion (*Nicholson* [2012] EWCA Crim 1568 and BQC [2021] EWCA Crim 1944).
> iv) The Tribunal will need to consider whether the evidence in question is capable of being cross-admitted, by evaluating whether there is a sufficient connection and similarity between the facts of the allegations (*Chopra* [2006] EWCA Crim 2133).
> v) Where the evidence is cross-admitted to prove propensity in a case involving two allegations, before attaching weight to the evidence the Tribunal will need to be satisfied to the required standard that the first allegation took place before relying on evidence in respect of the first allegation to deduce propensity from the second allegation (*Adams* [2019] EWCA Crim 1363 at [14] and *R v Mitchell* [2016] UKSC at [43])

vi) Where the evidence is admitted to rebut coincidence, before attaching weight to the evidence the Tribunal will need to advise itself that (a) it must exclude collusion or contamination as an explanation for the similarity of the complainants' evidence before it can assess the force of the argument that the allegations are unlikely to be the product of coincidence, (b) if collusion or contamination is excluded, considering the evidence as a whole, the fact of two patients making such allegations reduces the likelihood of there being an innocent explanation for them (*R v H* [2011] EWCA Crim 2344 at [24]) and (c) it is not necessary to find one allegation to be proved before relying upon the evidence in respect of that allegation in support of the other allegation concerning the other patient (*Adams* [2019] EWCA Crim 1363 at [15]).

Meaning of "sexual harassment"

33. The GMC's Allegation 13 against Dr Smerdon refers to "sexual harassment as defined in Section 26 (2) of the Equality Act 2010". Section 26 of the Equality Act 2010 says:

> 26 Harassment
> (1) A person (A) harasses another (B) if—
> (a) A engages in unwanted conduct related to a relevant protected characteristic, and
> (b) the conduct has the purpose or effect of—
> (i) violating B's dignity, or
> (ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.
> (2) A also harasses B if—
> (a) A engages in unwanted conduct of a sexual nature, and
> (b) the conduct has the purpose or effect referred to in subsection (1)(b).
> (3) A also harasses B if—
> (a) A or another person engages in unwanted conduct of a sexual nature or that is related to gender reassignment or sex,
> (b) the conduct has the purpose or effect referred to in subsection (1)(b), and

(c) because of B's rejection of or submission to the conduct, A treats B less favourably than A would treat B if B had not rejected or submitted to the conduct.

(4) In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—

(a) the perception of B;

(b) the other circumstances of the case;

(c) whether it is reasonable for the conduct to have that effect.

(5) The relevant protected characteristics are—

age;

disability;

gender reassignment;

race;

religion or belief;

sex;

sexual orientation.

34. The phrase "sexual harassment" does not appear in section 26, though confirmation of its definition can be garnered from section 40A(2). Section 40A says:

40A Employer duty to prevent sexual harassment of employees

(1) An employer (A) must take reasonable steps to prevent sexual harassment of employees of A in the course of their employment.

(2) "Sexual harassment" in subsection (1) means harassment of the kind described in section 26(2) (unwanted conduct of a sexual nature).

…

35. In any event, the definition to be applied in the current case is agreed: paragraph 19 of the written submissions on behalf of Dr Smerdon dated 27 February 2026 says:

> 19. The definition of sexual harassment is accepted to be that contained within s26 of the Equality Act 2010, as provided to the Tribunal by the GMC.

Meaning of "sexually motivated"

The GMC's Allegation 4(b) against Dr Smerdon is:

Your actions at paragraphs 2, 3ai, 3aiii, 3av, 3b and/or 3g were:

…

b. sexually motivated.

The GMC's Allegation 14(a) against Dr Smerdon is:

Your actions as set out at paragraphs:

a. 8, 9 and/or 10 were sexually motivated;

In the case *Basson v GMC* [2018] EWHC 505 (Admin) (21 February 2018), Mr Justice Mostyn said, at paragraph [14]:

> … A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship. …

36. The parties are agreed that this definition from paragraph [14] of *Basson v GMC* should be applied in the current case (see paragraph 11 of the written submissions on behalf of the GMC dated 27 February 2026 and paragraph 21 of the written submissions on behalf of Dr Smerdon dated 27 February 2026).

37. In the case *Altemimi v GMC* [2024] EWHC 1731 (Admin) (5 July 2024), Fordham J said, at paragraph [4]:

> Sexually Motivated
>
> 4. As to the meaning of "sexually motivated" in … the Allegation, the Tribunal said this in the Determination:
>
> … The Tribunal also had regard to the case of *Arunkalaivanan v General Medical Council* [2014] EWHC 873 (Admin) which notes that it is important not to equate inappropriate conduct with sexually motivated conduct and that the Tribunal should consider whether there could be any other explanation for inappropriate conduct.
>
> …

38. In the case *GMC v Haris* [2020] EWHC 2518 (Admin) (22 September 2020), which was subsequently upheld on appeal (*Haris v GMC* [2021] EWCA Civ 763 (20 May 2021)), Mrs

Justice Foster indicated (especially at paragraph [51]) that, when considering sexual motivation, a tribunal should make a deduction from all the facts and circumstances of the case and looking at the material in the round.

Meaning of "controlling" and "manipulative"

The GMC's Allegation 5 against Dr Smerdon is:

5. Your actions at paragraphs 2, 3a-i and/or 4 were:
   a. controlling;
   b. manipulative.

39. One needs to be cautious about importing definitions from one area of law to another, but the Tribunal might find some assistance in a definition contained in regulation 2(1) of the Housing Benefit Regulations 2006, which says:

> "controlling behaviour" means an act designed to make a person subordinate or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance or escape or regulating their everyday behaviour;

40. The Oxford English Dictionary (OED) gives the meaning of the adjective "manipulative" (other than in the sense of manual handling and dexterity) as:

> Exercising control or influence over others, especially in a malign, devious, or underhand way.

The Tribunal's Approach

41. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Smerdon does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

42. Several of the paragraphs of the Allegation refer to multiple previous paragraphs. The distinction between primary findings of fact and secondary (or inferential) findings of fact is well-established.

43. The Tribunal has made primary findings of fact (on paragraphs that do not refer to previous paragraphs) before making secondary findings of fact (on paragraphs that do refer to previous paragraphs).

44. The Tribunal has been careful, when making secondary findings of fact, to disregard those sub-paragraphs of the previous paragraphs referred to that the Tribunal has found not proved.

The Tribunal's Analysis of the Evidence and Findings

45. In accordance with rule 17(2)(i) of the Rules, the parties have given the Tribunal written submissions on findings of fact that were supplemented by oral submissions.

46. The Tribunal has considered each outstanding paragraph of the Allegation and has evaluated the evidence in order to make its findings on the facts.

The Good Character of Dr Smerdon

47. As indicated in the legal advice of the LQC, which the Tribunal has accepted, the Tribunal has received unchallenged testimonials from people who have spoken about Dr Smerdon's personal qualities. They all state that they have found him to be professional, dedicated, compassionate, hard-working, respectful, kind, friendly and popular with patients.

48. The Tribunal noted that an interpreter at Medical Centre D said of Dr Smerdon that,

> *I have interpreted for Dr Smerdon for many occasions. And never ever he gave me any reasons to question his integrity. He …*
> *Always treats patients with kindness, courtesy, respecting their dignity and individual needs.*

49. The Tribunal has taken into account the testimonials in assessing Dr Smerdon's credibility, in assessing his propensity to engage in the conduct alleged, and in assessing whether his conduct was sexually motivated.

50. The Tribunal noted that Dr Smerdon has not previously been before his regulator but has made admissions in this case. When the Tribunal considered the weight to attach to the evidence of Dr Smerdon's good character, it took into account these admissions.

Patient A

Background

51. On Friday 14 December 2012 at 12 noon, Patient A was admitted as an inpatient on the XXX at Hospital C which was situated on the first floor. While Patient A was admitted to Hospital C, she was under a named consultant psychiatrist. Her XXX was chronic, and she described herself as a "*revolving door patient".* XXX.

52. During Patient A's admission to Hospital C in December 2012 to February 2013, Patient A met Ms E, and in due course they became friends. Patient A was discharged on or around 21 February 2013 from Hospital C. Dr Smerdon began working at Hospital C, on Thursday 27 December 2012 after midday, as a Resident Medical Officer (RMO) on a 10-day residential locum shift. This period of work ended on Saturday, 5 January 2013.

53. Patient A met Dr Smerdon at Hospital C during his time working there. They had never met before. Dr Smerdon stated that part of his duties included covering the XXX unit which is where he met Patient A during ward rounds and when taking bloods, which was part of his routine clinical duties.

54. At the time of these events Patient A was aged XXX and Dr Smerdon was 39.

Reasoning and Decision

Paragraph 1: At all material times the nature of your relationship with Patient A was that Patient A was your patient and thereafter in a relationship with you.

55. For paragraphs 2 -7 of the allegations 'the material time' was from December 2012, when Patient A was an inpatient at Hospital C and Dr Smerdon was a resident medical officer until January 2013, and thereafter whilst Dr Smerdon no longer worked at Hospital C but remained in a relationship with Patient A.

56. During the time that Dr Smerdon worked at Hospital C, Patient A was one of Dr Smerdon's patients. Confirmation of the clinical relationship between Dr Smerdon and Patient A is provided by his clinical notes entry on 4 January 2013.

57. After Dr Smerdon's professional engagement at Hospital C concluded, Patient A describes herself as having had a "*relationship*" (meaning a relationship other than a professional patient-doctor relationship) with Dr Smerdon. Dr Smerdon accepted that he was in a relationship (other than a professional doctor-patient relationship) with Patient A, saying in his witness statement *"… I did engage in a relationship with Patient A."*

58. The length of the relationship was somewhere between 6 – 9 months according to Patient A and Dr Smerdon.

59. The Tribunal accordingly finds paragraph 1 of the Allegation determined and found proved.

Paragraph 2: While working at Hospital C on or around December 2012 to January 2013:

60. One of the key issues the Tribunal has to decide is whether the events alleged in paragraph 2 if they happened at all, are things that Dr Smerdon did "While working at Hospital C".

61. The Tribunal understood that Dr Smerdon's position in his oral evidence was:

> *"My recollection was that I was on that floor when I handed my paperwork in and I then had erroneously thought my duties as her doctor had come to an end and then I had gone to her room to say goodbye, so I think that was what was going through my mind sir*."

62. Dr Smerdon also sent a text message to Patient A on 5 January 2013 saying:

> "*It is, and you're a naughty girl. I'm not far off leaving now. Kissing u was amazing…"*

63. The Tribunal interpreted the sentence "*I'm not far off leaving now"* to mean that, at the time that Dr Smerdon sent the text message to Patient A on 5 January 2013, Dr Smerdon had not left Hospital C.

64. The Tribunal found as fact that, from 27 December 2012 to 5 January 2013, Dr Smerdon was not at Hospital C as a patient, visitor, non-clinical staff member or volunteer, or in any capacity other than as a doctor by virtue of the "locum contract" he had under which he had been appointed as a "Resident Medical Officer" for Hospital C. In the view of the Tribunal, Dr Smerdon's obligations to conduct himself in a professional manner with respect to the patients of Hospital C continued whilst he remained on the premises, and so the stem of paragraph 2 is established.

65. The Tribunal's findings in this determination on "While working at Hospital C" are consistent with the Tribunal's decision of 3 November 2025 refusing the GMC's application to amend the stem of paragraph 2, and are consistent, specifically, with paragraph 19 of Annex C.

Paragraph 2(a) you said the following, or words to that effect to Patient A:

(i). she had really sexy veins

66. Patient A said of Dr Smerdon in her witness statement:

> *"Whilst taking my bloods, he said, 'you have got really sexy veins.' A flirtatious vibe was coming off him that I had not experienced before with any other doctor who had treated me."*

67. Patient A gave the same account in her oral evidence:

> *"We were in the – so the room where you get your blood taken and your ECGs, and – yeah, I think I was still on daily bloods and, yeah, we were alone and he was taking my blood and just said I had very, very sexy veins*."

68. In the response to the suggestion that this never happened Patient A stated: "*It did happen because it is a really weird thing to make up to say you've been told you have sexy veins."*

69. A similar account of Dr Smerdon saying that Patient A had "*sexy veins*" is contained in both the Hospital C "*Outline minutes of Investigation of Allegation on Locum Doctor by ex-patient: [Patient A]*" of 5 May 2023 and the report submitted by a Senior Social Worker to Norfolk Police dated 5 July 2022.

70. Dr Smerdon said in his witness statement:

> *"I deny saying any of these things to Patient A while working at the hospital. I may have made a comment that she had good veins in the context of being able to easily draw blood and to put her at ease, but I deny saying "really sexy veins" or any of the above comments."*

71. Dr Smerdon said in his oral evidence to the Tribunal:

> *"I may have said she had good veins, I cannot exactly recall. I often say to people who have got good veins that they have good veins and it is part of the general chit-chat of taking someone's blood and making the feel at ease which is why I was chatting and she was very receptive to the chatting as well, but I certainly would not have said you have got sexy veins. That is definitely not something that I said or would ever say to anyone in the clinical context."*

72. He also stated, *"I think she is confused that that was what I said. It is possible during the course of our relationship later that I may have said she had nice veins or sexy veins but not during the time in* [Hospital C]."

73. He also stated in oral evidence:

> *"I felt she was attractive and that we had a good rapport, but I did not act inappropriate on any of those thoughts until after I had finished my responsibilities at [Hospital C] as I have said in the statement and when I went over to say goodbye and not before"*

74. The Tribunal noted that Patient A had stated that Dr Smerdon was giving off a *'flirtatious vibe'*, and that Dr Smerdon states he had developed a good rapport with Patient A who he found attractive. In view of this and the relationship that later transpired, the Tribunal considered that on the balance of probabilities this comment was said.

75. Accordingly, the Tribunal finds paragraph 2(a)(i) of the Allegation determined and found proved.

Paragraph 2(a)

(ii). that you walked the halls of her ward at night to see if her bedroom lights were on

76. The Tribunal is required to determine whether Dr Smerdon said this whilst working at Hospital C, not whether he actually walked the halls of Patient A's ward at night to see if her bedroom lights were on.

77. Dr Smerdon denies the allegation stating he did not say this whilst working at Hospital C.

78. Patient A, in cross-examination, clarified that these words were spoken by Dr Smerdon when she was at his flat when they were in a relationship.

79. Patient A – on any account – did not visit Dr Smerdon's flat until after he had stopped working at Hospital C. In the view of the Tribunal, Patient A's written evidence that he said this to her "*later*", combined with her oral evidence that Dr Smerdon said this to her *"when we were at his flat*" (and, therefore, after he had stopped working at Hospital C) and "*when, outside of, when we were in a relationship*", undermined the allegation that he said this while working at Hospital C.

80. Accordingly, the Tribunal found paragraph 2(a)(ii) of the Allegation not proved.

Paragraph 2(a)

(iii). you don't need to be here you're too special and you're too beautiful

81. The Tribunal noted that Patient A said of Dr Smerdon in her witness statement:

> *"One of the things I thought was that Dr Smerdon was able to say the right things, like, 'you don't need to be here, you're too special and you're too beautiful.' Even though I was a grown adult, I had not heard that in so long.*
>
> *… he would repeat that I was beautiful and how I was different from the others."*

82. This is supported by her evidence in the Hospital C Investigation of Allegations and her oral evidence to the Tribunal.

83. Dr Smerdon denied saying this to Patient A whilst working at the hospital in both his witness statement and oral evidence.

84. The Tribunal noted its previous finding of 2 (a)(i) and the reason for this finding in that Patient A had stated that Dr Smerdon was giving off a "*flirtatious vibe,"* and that Dr Smerdon states he had developed a good rapport with Patient A who he found attractive. In view of this and the relationship that later transpired, the tribunal considered that on the balance of probabilities Dr Smerdon did say this.

85. Accordingly, the Tribunal finds paragraph 2(a)(iii) of the Allegation determined and found proved.

Paragraph 2(a)

(iv). that you really liked her

86. The Tribunal noted that Dr Smerdon in his witness statement denied saying this whilst working at the hospital. However, whilst he said he did not remember saying this, he said it is possible he may have said this on the last day after completing his contract when he went to say goodbye to Patient A.

87. In his oral evidence he stated:

> *"That was really my purpose, to say goodbye to her, to say that I liked her and that we would remain in contact and we shared a kiss and that was it."*

88. Patient A said in her witness statement:

> *"He shut the door, and he told me that he was leaving soon and that he really liked me. I said that I really liked him too."*

89. The Tribunal considered that Dr Smerdon did like Patient A, and that it would be entirely natural for Dr Smerdon to tell Patient A that he liked her. Dr Smerdon suggests that this was after he finished working at Hospital C on the last day.

90. The Tribunal found as fact that, from 27 December 2012 to 5 January 2013, Dr Smerdon was not at Hospital C as a patient, visitor, non-clinical staff member or volunteer, or in any capacity other than as a doctor by virtue of the locum contract he had under which he had been appointed as a Resident Medical Officer for Hospital C.

91. Therefore the Tribunal considered that these words were said whilst Dr Smerdon was working at Hospital C.

92. Accordingly, the Tribunal found paragraph 2(a)(iv) of the Allegation determined and found proved.

Paragraph 2

(b). stared at patient A

93. The Tribunal noted that throughout her evidence she remained consistent in stating that Dr Smerdon stared at her. She conceded that on occasions she may have initiated glances, but went on to say in cross-examination:

> "*I would not be behaving this way if somebody else was not behaving that way back … you can catch somebody's stare at any given time but then he wouldn't let – so even if I caught his stare, he would then not let that contact go and if he caught my stare, I would not let that contact go. So, it would be – I would never ever say it was me trying to stare at him, because that would, I didn't have the confidence at the time to do that. I felt like a piece of crap at the time, so I would not have the confidence unless I was pretty sure that somebody was giving me the vibe back*"

94. The Tribunal noted that Dr Smerdon in his witness statement said:

> *'I deny intentionally staring at Patient A, we may have exchanged glances during my time there.'*

95. In his oral evidence he admitted that, whilst he did not stare at her, their eyes would cross quite regularly, and his eyes met hers regularly. Dr Smerdon said in his oral evidence to the Tribunal:

'I told you already I did not stare at her, our eyes cross paths and therefore we looked at each other.'

96. The Tribunal previously noted that Patient A had stated that Dr Smerdon was giving off a "*flirtatious vibe*" and that Dr Smerdon stated he had developed a good rapport with Patient A who he found attractive. In view of this and the relationship that later transpired, the Tribunal considered that on the balance of probabilities he did stare at her.

97. Accordingly, the Tribunal found paragraph 2(b) of the Allegation determined and found proved.

Paragraph 2

(c). asked to exchange numbers with Patient A:

98. The Tribunal noted that on 5 January 2013, Dr Smerdon went to Patient A's room, entered it and shut the door. He went to Patient A's room on his own initiative. It was his "decision".

99. Dr Smerdon said in his witness statement that:

'… I had gone to her room to say goodbye.
It was at this point we exchanged numbers and exchanged a consensual kiss, I do not recall who initiated either of these.'

100. In the view of the Tribunal, there was no clinical or other professional reason for, or purpose in, Dr Smerdon's visit to Patient A on 5 January 2013.

101. In all the evidence before the Tribunal, there is no indication that Dr Smerdon felt the need to "say goodbye" to any other patient at Hospital C, or that visiting patients in their individual rooms to "say goodbye" at the end of a doctor's locum contract was in any way standard practice for Dr Smerdon or generally.

102. Dr Smerdon described his decision to visit Patient A as an "*extremely impulsive irrational decision*" and as an "*impulsive, erratic decision*".

103. The Tribunal noted that Dr Smerdon had also stated:

"That was really my purpose, to say goodbye to her, to say that I liked her and that we would remain in contact and we shared a kiss and that was it."

104. Patient A said in her written statement of 30 September 2024 that, after Dr Smerdon entered her room and shut the door:

'He asked if we could exchange numbers.'

105. Patient A was consistent in her evidence throughout and stated in cross-examination that this happened when he came into her room.

106. Dr Smerdon said in his written statement:

"I admit that we exchanged numbers, but I do not recall who initiated this."

107. Dr Smerdon said in oral evidence:

'I do not remember which one of us asked, we just exchanged. She may have asked me, I may have asked her, but I cannot remember who asked who.'

108. Dr Smerdon also stated in his oral evidence:

"I just had an impulse to go and say goodbye to her and that was really the only reason why I went to her room and to maintain contact."
"I admit that I like and found her attractive and wanted to continue seeing her, that is obviously for all of us to see here."

109. In the view of the Tribunal, this oral evidence of Dr Smerdon supports the proposition that he went to Patient A's room to enable him to remain in contact with her, and to do this he asked to exchange numbers.

110. The Tribunal found as fact that Dr Smerdon asked Patient A to exchange telephone numbers.

111. Accordingly, the Tribunal found paragraph 2(c) of the Allegation determined and found proved.

Paragraph 2

(d). Kissed Patient A

112. Patient A said in her written statement of 30 September 2024 that, after Dr Smerdon entered her room and shut the door:

> *"Dr Smerdon … kissed me."*

113. Patient A's account to the investigation by Hospital C and in her witness statement corresponded with Ms E's account of what Patient A told her:

> *"Patient A told me Dr Smerdon had come into her bedroom at [Hospital C] and kissed her …"*

114. Dr Smerdon said, in his written statement dated 3 August 2025:

> *"… I went to say good-bye and the kiss happened.*
> *…*
> *I admit that Patient A and I kissed on the last day that I was at [Hospital C], I do not recall who initiated the kiss"*

115. Dr Smerdon said in oral evidence:

> "*We exchanged a mutual kiss …"*

116. The Tribunal bore in mind the LQC's advice that the "balance of probabilities" standard of proof needs to be applied carefully where there are more than two possibilities about what happened as the kiss could have been initiated by Dr Smerdon, by Patient A or it could have been mutual.

117. The Tribunal noted that in cross-examination Patient A reiterated that she did not have confidence at the time and '*felt like a piece of crap'.*

118. The Tribunal noted that Dr Smerdon described his behaviour in going to see Patient A on 5 January 2013 as an *"extremely impulsive irrational decision*" and as an *"impulsive, erratic decision*" and he also stated in his written statement:

"Patient A had been voluntarily admitted. She had shown an interest in me. I had felt we had a good rapport. I had been feeling particularly low at this time and her interest had boosted my confidence."

119. The Tribunal accepted the GMC's submission that it was Dr Smerdon who was the one taking the initiative and making the running in the developing relationship between himself and Patient A.

120. The Tribunal concluded that it could fairly be said that, on 5 January 2013 in Patient A's room in Hospital C, Dr Smerdon kissed Patient A.

121. Accordingly, the Tribunal found paragraph 2(d) of the Allegation determined and found proved.

Paragraph 2

(e). sent Patient A a text message on 5 January 2013 saying 'It is, and you're a naughty girl. I'm not far off leaving now. Kissing u was amazing. I think u are absolutely gorgeous. Please bare in mind you are no longer my patient, but even still please please don't tell anyone cos i could get into serious trouble and be struck off (no joke). To see me on the outside" would be fine. Kiss. Will'

122. The text message that Dr Smerdon sent on 5 January 2013 is an authentic, contemporaneous document that gives a direct insight into Dr Smerdon's thoughts and awareness, including that he knew that he "*could get into serious trouble and be struck off*" for what he had done.

123. Ms Tanchel, on behalf of Dr Smerdon, explained in her oral submissions on his admissions under rule 17(2)(d), that paragraph 2(e) of the Allegation is denied by Dr Smerdon purely because of the stem of paragraph 2. Therefore, the only issue in dispute regarding allegation 2(e) is whether Dr Smerdon sent the message "*While working at Hospital C".*

124. The Tribunal previously determined that, from 27 December 2012 to 5 January 2013, Dr Smerdon was not at Hospital C as a patient, visitor, non-clinical staff member or volunteer, or in any capacity other than as a doctor whilst he remained on the premises.

125. This text message was sent in reply to a text message from Patient A:

"Just thought I'd text you while your still on the premises because its naughty! [Patient A] xxx"

126. Dr Smerdon has said in evidence, and the Tribunal accepted, that when Patient A texted him on 5 January 2013, he was "in the car park" of Hospital C.

127. The Tribunal concluded that it can fairly be said that the conduct set out in paragraph 2(e), which is admitted, happened while Dr Smerdon was working at Hospital C. The Tribunal accordingly found paragraph 2(e) of the Allegation determined and found proved.

Paragraph 2

(f). you touched Patient A, over her clothes, on her:

(i) chest;
(ii) bottom.

128. Patient A said, in her witness statement that, at the time Dr Smerdon kissed her on 5 January 2013:

"He touched me over my clothes.
…
He touched my chest area and my bottom."

129. Patient A confirmed this account in her oral evidence to the Tribunal.

130. In relation to paragraph 2(f) of the Allegation, Dr Smerdon said in his witness statement:

"When approaching a first kiss situation with a woman, I would likely put my hands around her waist and never on her chest and/or bottom."

131. Dr Smerdon similarly said in oral evidence:

"It did not happen. We had a kiss and I would never engage in [s]uch a sexual practice if you like on a first kiss with anyone."

132. In the view of the Tribunal, the believability of this assertion by Dr Smerdon, which seems to be essentially that he was restrained by his own personal boundaries as to proper behaviour is diminished by his admission that:

"…there must have been some blurring of the boundaries at that point"

133. The Tribunal was not inclined to believe that, at the same time as Dr Smerdon was acting in a way he describes as "extremely impulsive", "irrational" and "erratic", his behaviour with a woman whom he shortly afterwards told he thought was "absolutely gorgeous" was inhibited by a sense of personal propriety in how to treat a woman in "a first kiss situation".

134. There is a direct contrast between Patient A and Dr Smerdon as to whether their kissing on 5 January 2013 was passionate.

135. In her oral evidence to the Tribunal, Patient A said of the kissing between Dr Smerdon and herself on 5 January 2013 that:

"… I would say it was passionate."

136. Conversely, in his oral evidence to the Tribunal, Dr Smerdon said of the kissing between Patient A and himself on 5 January 2013 that:

"I would not say it was passionate."

137. Bearing in mind that shortly afterwards Dr Smerdon told Patient A that he thought she was "*absolutely gorgeous",* and that Dr Smerdon went on to enter into a sexual relationship with Patient A (see the parts of this determination relating to paragraph 3(j) of the Allegation). In relation to paragraph 2(f) of the Allegation the Tribunal preferred Patient A's account (specifically, that the kissing could fairly be described as "*passionate*" and that Dr Smerdon touched Patient A, over her clothes, on her chest and bottom) to that of Dr Smerdon. The Tribunal did not accept Dr Smerdon's characterisation of the kiss as "*a quick kiss".*

138. Accordingly, the Tribunal found paragraph 2(f) (including paragraphs 2(f)(i) and 2(f)(ii)) of the Allegation proved.

Paragraph 3 After you stopped working at Hospital C you:

(a). said the following, or words to that effect, to Patient A:

i. she could move to be with you;

ii. that she did not need to be in the hospital;

iii. that she could start a new life with you;

iv. there was nothing for her to go back to if she discharged herself;

v. that you would be the start of a new life for her;

vi. 'you need to eat more; XXX;

vii. XXX;

139. Patient A said in her witness statement dated 30 September 2024:

"After Dr Smerdon left the hospital, I was allowed weekend leave. … I would leave on weekends, I would tell the hospital that I was going back to my parents, but really, I was going back to Dr Smerdon's flat. I would always discharge myself [XXX], that was my pattern. The hospital would always encourage me to stay, but at this point Dr Smerdon was promising me that I could move up to be with him. He would say that I did not need to be in the hospital, and that I could start a new life with him. He was always just making me feel like I did not need to be at the hospital, but there was not an exact conversation of him saying, 'discharge yourself now.' When Dr Smerdon would say these things, I was thinking 'yes, get me out of here.' At that point, he had highlighted that there was nothing for me to go back to if I were to discharge myself and he would be the start of a new life which was also amazing to hear that at the time. We were talking about college up where he lived and all these things that I had stopped thinking about, he would start talking about."

"Whilst staying at Dr Smerdon's flat …
He would say, 'no, you need to eat more; [XXX].' He would comment on my body [XXX]."

140. These matters remained consistent in her supplemental witness statement of 16 May 2025.

141. Patient A said in her oral evidence in response to questions from Ms Tanchel in cross-examination:

> Question: *"Let me be plain that what is denied – so what's not denied is that there were conversations about aspirations, dreams, and hopes, but I'm going to say to you that Dr Smerdon never told you that you could move to be with him."*
> Patient A answer: *"He did."*
>
> Question: *"What about that – I'm suggesting that he did not say to you that you could start a new life with him?"*
> Patient A answer: "*He did… those promises of a new life were happening very, very soon towards the end of my discharge, shortly after my discharge."* …
>
> Question: "*Is it the position, is it your evidence that he said this, "You need to eat more, [XXX]"?"*
> Patient A answer: "*Yes*."
> Question: "*He said those exact words? …is it your position that those were the exact words he said to you?"*
> Patient A answer: *Yes*.
> Question*: "What about – the next proposition I'm putting to you is it your evidence that he said exactly "[XXX]"?"*
> Patient A answer: *"Yes."*
> …
> Question: *"… your evidence is that he used the exact words that I have put to you, namely, "You need to eat more, [XXX]"*
> Patient A answer: *"Yes."*

142. The Tribunal noted that Patient A, while giving oral evidence in the hearing, described her own body as a "XXX", saying:

> *"… I was still a complete [XXX]."*
>
> *"… I was an absolutely destroyed [XXX] …"*

"… I was a [XXX] …"

143. In her oral evidence relating to 3(a)(ii) Patient A, when asked the question: …

Ms Tanchel: *"I'm asking you about what he said … after he had left the hospital. You're right, you may still have been there. But after he had left the hospital, did he say to you that you did not need to be in the hospital?"*

Patient A replied: *" I can't be sure – because he said that to me when I was in the hospital, so I assume – so, he must – so whether he said those exact words afterwards, the planning of my life would suggest that I didn't need – he made me think I didn't – well, yes, you know ..."*

144. Dr Smerdon said in his witness statement:

"After I left [Hospital C], I did engage in a relationship with Patient A. At the time, I had understood that she had been discharged from [Hospital C], although I now understand that this was apparently not the case. The relationship lasted around 8 or 9 months. … I had always been under the impression she had been discharged and was not aware she had been going back and forth into [Hospital C] as a voluntary patient during this time."

145. In relation to paragraphs 3(a)(i)-(v) of the Allegation, Dr Smerdon said in his witness statement:

"I deny saying these things to Patient A, it is not within my nature to be so committed to a relationship and would not say such things especially in such a short relationship."

146. In relation to paragraphs 3(a)(vi)-(vii) of the Allegation, Dr Smerdon said in his witness statement:

"I deny using those phrases, but I do accept that I expressed concern about her low weight and encouraged her to eat more. At the time, I believed I was being supportive and attentive to her wellbeing as her boyfriend."

147. Dr Smerdon, in his oral evidence to the Tribunal denied that he had used any of the phrases in 3(a)(i) – (vii) and stated:

"As in my statement, I made clear that I did not make any comments that were body shaming or derogatory about her physical appearance in any way, shape or form at any point during the relationship. I was merely being supportive of her at all times during our relationship."

148. The Tribunal was conscious of the phrase *"or words to that effect*" in the stem of paragraph 3(a) of the Allegation.

149. The Tribunal noted that there were conversations about aspirations, dreams, and hopes and that Dr Smerdon expressed concerns about Patient A's low weight and encouraged her to eat more and that Patient A described her body as a [XXX]. Therefore, on the balance of probabilities the Tribunal considered that comments using those words or words to that effect in 3(a)(i), (iii), (v), (vi), (vii) were made during their time together.

150. The Tribunal noted that Patient A in her oral evidence conceded that she was not sure that he had said that she '*did not need to be in hospital'* when Dr Smerdon had ceased working at Hospital C.

151. The Tribunal found 3(a)(ii) not proved and considered that 3(a)(iv), in the context of Patient A not needing to be in hospital, similarly may not have been said during this period. The Tribunal determined that the GMC had not discharged the burden on it to adduce the evidence on this sub-paragraph of the Allegation.

152. Accordingly, the Tribunal finds paragraph 3(a)(i), 3(a)(iii), 3(a)(v), 3(a)(vi), 3(a)(vii)) of the Allegation determined and found proved.

153. The Tribunal found paragraph 3(a)(ii) and 3(a)(iv) of the Allegation not proved.

Paragraphs 3

(c). cooked huge meals for Patient A

154. The Tribunal observed that Patient A said in her witness statement:

'Whilst staying at Dr Smerdon's flat, [XXX]. He would cook huge meals …'

155. Additionally in her oral evidence Patient A said to the Tribunal:

[XXX]

156. In a contemporaneous text message to Ms E, she said:

[XXX]

157. Dr Smerdon said in his witness statement:

"I admit cooking meals for Patient A, as part of our relationship. I have always exercised regularly and used to compete in triathlons, hence nutrition and healthy eating were always very important to me. I would tend to cook large meals according to my nutritional demands, and, due to lack of time, would tend to cook more than I needed in order to eat the leftovers the next day at work."

158. Dr Smerdon said in his oral evidence to the Tribunal:

Question: "*As part of that, you cooked what she describes as huge meals for her."*

Dr Smerdon answer: "*Well, if you look at my statement I explained that in which I cook as I would always for myself and for others which is to cook a normal sized meal, I ate a lot, I have always been athletic, I ran track and so I would always cook a decent sized meal and I would eat the leftovers the next morning … I was not willingly overfeeding Patient A which is what the assertion seems to be, not at all.*

… If she felt in any way that I was overfeeding her and she had said something like that, then I would have stopped.

… there was no indication to me that [XXX]. So no, and I reiterate, I was not overfeeding her or there was no manipulation of diet, I was just having a normal diet sharing that with her and being encouraging. That is all, nothing more than that."

159. There was no evidence before the Tribunal that Dr Smerdon was XXX. Additionally, there was no evidence that Patient A told Dr Smerdon XXX, or that Patient A told Dr Smerdon that there was something that Dr Smerdon was buying, cooking or preparing for her or serving to her that she was not supposed to be eating.

160. In the view of the Tribunal, the evidence before it did not establish that Dr Smerdon knew (or ought to have known) that the food that he was giving to Patient A ought not be given to a person with the medical conditions that she had.

161. In considering whether Dr Smerdon cooked huge meals for Patient A, the Tribunal accepted that Dr Smerdon cooked large meals for himself and shared what he thought was a normal size portion with Patient A.

162. In Patient A's oral evidence she acknowledged that XXX.

163. In the view of the Tribunal, the evidence before the Tribunal does not establish that Dr Smerdon knew (or ought to have known) that Patient A ought not to be consuming the meals that he gave her.

164. In light of the above, the Tribunal found paragraph 3(c) of the Allegation not proved.

Paragraph 3

(d). offered Patient A anti-psychotic medication without prescription

165. The way the case has been presented by the GMC, "offered Patient A anti-psychotic medication" in paragraph 3(d) of the Allegation does not simply relate to the words used by Dr Smerdon, but means that Dr Smerdon had in his possession anti-psychotic medication to offer to Patient A. The GMC's case was not that Dr Smerdon gave Patient A a herbal supplement and told her that it was an antipsychotic, but that he was in fact in possession of antipsychotic medication.

166. The Background to this allegation is found in a text message from Patient A to Ms E:

> *"If you mean wills then yes!I seriously was shocked at how he spoke to me last night, I woke up at about 2am with the worst anxiety and he just went mad! saying I'd ruined his night, I needed to get a grip and control my emotions, then tried to get me to take some random anti psychotic then got mad because I didn't want to!its so awkward now!ahhhhhh"*

167. Patient A was unable to name the "*anti-psychotic medication*" or give any details or description about what it was. On her account, Patient A had not heard of antipsychotics before. Dr Smerdon's evidence is that he never had any antipsychotic drug and had not had access to any.

168. The Tribunal has received no explanation of how Dr Smerdon is supposed to have come into possession of the "*anti-psychotic medication*", or why he would have it in his possession, or what he would be keeping it for or how prescription-only drugs would be held by Dr Smerdon without a prescription. In the view of the Tribunal, a finding based on prescription-only anti-psychotic medication inexplicably appearing in a Tupperware box under Dr Smerdon's bed would be unsupportable.

169. The Tribunal accepted Dr Smerdon's evidence that he may have offered Patient A herbal valerian root and/or ashwagandha during an anxiety attack and argument in the middle of the night. It was of the view, that in the heat of the moment and because she was upset, Patient A could have been confused as to what Dr Smerdon was offering her during the night.

170. The Tribunal therefore concluded that the GMC has not discharged its burden of proof in relation to the facts alleged. Accordingly, the Tribunal found Paragraph 3(d) of the Allegation not proved.

Paragraph 3

(e). controlled what Patient A ate

171. Patient A and Dr Smerdon went food shopping together and Dr Smerdon would pay for the food.

172. Patient A said that when she went food shopping with Dr Smerdon she had no money to spend and would not have been able to afford the weekend shop. She indicated that she would find it difficult to suggest different food whilst out food shopping with Dr Smerdon as she felt that he had more influence over what they bought because he had the money and he would be the one paying for the shopping.

173. The Tribunal accepted that it could be natural for Patient A to feel that Dr Smerdon had more influence over the purchasing decisions if he was paying. However, in the view of

the Tribunal, this did not mean that it would be fair to describe Dr Smerdon as controlling what Patient A ate.

174. The Tribunal therefore concluded that the GMC has not discharged its burden of proof in relation to the facts alleged. The evidence before the Tribunal does not establish that Dr Smerdon controlled what Patient A ate.

175. Accordingly the Tribunal found paragraph 3(e) of the allegation not proved.

Paragraph 3

(f). Bought bottles of wine for Patient A in spite of her not supposed to be drinking.

176. The Tribunal noted that the Allegation, is phrased "*in spite of her not supposed to be drinking*" and in particular, the phrase "*in spite of*" indicated that the GMC is alleging that Dr Smerdon knew that Patient A was not supposed to drink alcohol.

177. XXX

178. XXX

179. Patient A said in her witness statement dated 30 September 2024:

"I was also not supposed to be drinking but he would buy me bottles of wine to drink."

180. Patient A said in her supplemental witness statement dated 16 May 2025:

"There was another occasion, when Dr Smerdon bought three bottles of wine, despite being aware that I was not supposed to be consuming alcohol due to [XXX] and as part of my recovery. He would encourage me to drink the wine, and I specifically recall the anxiety I experienced and desperately trying to fight it."

181. Patient A said in her oral evidence to the Tribunal:

"MS TANCHEL: *"… There was no time that you said – you said to Dr Smerdon, "I shouldn't be drinking wine", was there?"*
Patient A answer: "*No*."

182. Dr Smerdon said in his witness statement:

"I … provided in the way a boyfriend would to his girlfriend including cooking meals and drinking a glass of wine with them …

I did not pressure alcohol use onto Patient A, nor did she ever complain to me that I was trying to do so. …I was never aware of any active treatment plan for her that would restrict alcohol. Had I been aware I would not have offered her any form of alcohol."

183. In considering whether Dr Smerdon bought bottles of wine for Patient A in spite of her not supposed to be drinking, the Tribunal accepted that Dr Smerdon was buying alcohol for them to share and that he was not made aware by Patient A that she should not drink alcohol. In the view of the Tribunal, the evidence before it does not establish that Dr Smerdon knew that the alcohol that he was giving to Patient A ought not be given to a person with the medical conditions she had.

184. The Tribunal therefore concluded that the GMC has not discharged its burden of proof in relation to the facts alleged.

185. Accordingly the Tribunal found paragraph 3(f) of the allegation not proved.

Paragraph 3

(h). Made Patient A sleep on the sofa bed when she was not willing to take medication you gave her.

186. The Tribunal considered this Allegation a continuation of the episode of the anxiety attack, argument and offering 'antipsychotic medication' from paragraph 3(d).

187. Patient A in a contemporaneous text message to Ms E says:

"actually got up and slept on the sofa last night!"

188. Patient A said in her supplemental witness statement dated 16 May 2025:

"There was another occasion, when Dr Smerdon tried to give me some medication to take. This was an occasion when I felt scared, and I left the bedroom and slept on the

sofa. He thought I needed the medication as he believed I was upset and anxious. There was an argument over my refusal to take it and he was angered by this."

189. Patient A said in her oral evidence to the Tribunal, in response to questions from Ms Tanchel:

Question *"… Next question I have for you, if you don't mind, is about the sofa bed. I'm a little bit confused and I hope you'll forgive me if I've misunderstood. But it's not right, is it, that Dr Smerdon made you sleep on the sofa bed, it was you on the nights that you were offered the medication you chose to go and sleep on the sofa bed. Would that be fair?"*

Answer: *"I felt like I didn't really have any choice, like the – you know, he – it got to the point where I was scared of him. I wasn't going to sleep in his bed, he didn't want to speak to me anymore. The only place I could go was that sofa."*

Question: *"But he didn't say to you you must go and sleep on the sofa bed or, "Get out, you must sleep on the sofa bed"?"*

Answer: *"I can't remember the exact words. I had – I had to sleep on – I had to go and sleep on the – it was the couch, I think, I don't know."*

Question: "*But which is it, Ms A? Was it that he said to you, "You must go and sleep on the sofa bed", or was it you, feeling discomfort or fear, whichever way you describe it, took yourself off to the sofa bed?"*

Answer: *"I think it was he didn't want me to sleep in there because I was acting crazy, so the only place I could go was that sofa."*

Question: *"I'm going to ask one more time, sir, I hope you forgive me. My question is clear, I think. It was not Dr Smerdon who at any stage said to you, "Get out, you must sleep on the sofa bed"?"*

Answer: *"He definitely said for me to get out of the bedroom because I was acting crazy, so the only other place for me to be was the sofa. When I refused to take the – whatever he was offering, he just kept going, "Get out of the room, you're acting crazy"."*

190. The position of both parties is in agreement that there was an argument, as Ms Tanchel said, *"You could see there, you say there was an argument and to the extent that it was an argument, that's not disputed.".* Dr Smerdon said in oral evidence, "*I would say we had a row rather than an argument*.". Patient A said that Dr Smerdon was angered by her behaviour, and Dr Smerdon said that Patient A may have been angry with him and that she was "*screaming*". All these statements are consistent with each other and also with there having been an argument that night.

191. Dr Smerdon accepted that Patient A may have, as Patient A says, gone to sleep by herself on the sofa bed in Dr Smerdon's flat.

192. The Tribunal was mindful that Patient A's message to Ms E the same day as the episode did not suggest that Dr Smerdon had made her sleep on the sofa bed or even told her to do so, but read as if she did this of her own initiative.

193. The Tribunal therefore concluded that the GMC has not discharged its burden of proof in relation to the facts alleged. Accordingly, the Tribunal found Paragraph 3(h) of the Allegation not proved.

Paragraph 3

(i). Kept Patient A in your flat and rendered her unable to leave as she did not:
(i) have a key to re-enter
(ii) know where she was.

194. Patient A said in her witness statement:

"When Dr Smerdon would leave for work every morning, I would not be able to leave the flat. He would do a 12-hour shift at a GP surgery; he would leave at 8am and come home anywhere between 5pm and 7pm. I did not have a car and he did not have a spare key. If I left, I would not be able to get back in and I did not know where I was. There was no TV in the flat so it was silent, and I would just be waiting for a text. That was scary …"

195. Patient A said in her oral evidence to the Tribunal:

"I would have had no idea if I had left the front door because it was on like a new housing estate and then you couldn't walk, there was nowhere to walk. There was a big Tesco but I wouldn't have known how to have got there. It was all like roundabouts and main roads. It was on a newly-built housing estate so I wouldn't have known … I wouldn't even have known how to have got out of the housing estate I don't think."

196. However, Patient A also said, when questioned by Mr Cullen:

Question: *"… But I just wanted to clarify, towards the end of there, you said: "…and he leave me there alone and locked me in when he left until he got home." Can you clarify what this means to take on ---?"*
Answer: *"So like I say, so I was able to open the door, because I smoked. So I was able to open the door, but if I – but I didn't have a key. So if the door shut on me, I wouldn't be able to get back in. So he didn't, like even if, you know, yes, he didn't sort of – there was no way of locking me in, because I could always get out from the inside. If I left, I wouldn't be – if the door shut on me, I wouldn't be able to get back in. Yes."*

197. The Tribunal noted that there was a contradiction between "*he … locked me in when he left"* and "*there was no way of locking me in".*

198. In relation paragraph 3(i)(ii) of the Allegation (that "*Patient A… did not… know where she was*" when she was at Dr Smerdon's flat), it was relevant to note that Patient A visited Dr Smerdon's flat on multiple occasions. Patient A said "*I think Dr Smerdon and I were together for about six months after I was discharged from hospital, but then he slowly withdrew contact. I would see him every weekend and on one occasion he came to my flat…*" and *"I went to Dr Smerdon's flat on a number of occasions".* In oral evidence, Patient A referred to events at Dr Smerdon's flat "*after I've been to Dr Smerdon's flat on several occasions".* The Tribunal did not accept the GMC's submission that, while Patient A was in Dr Smerdon's flat, "*she was in an unknown place."*

199. Patient A was capable of travelling around the country by herself and was aware that public transport systems existed.

200. Dr Smerdon said in his witness statement:

"I deny keeping Patient A in my flat in such a manner rendering her unable to leave. I did only have one key to the apartment, but I would leave my flat unlocked when I went to work. Patient A did ask me to lock the flat as she felt safer that way and at no point did she ask me to make a second key. Patient A was free to leave when she wanted to. As mentioned above I even had a bed delivered to the flat while I was at work and Patient A accepted the delivery. Patient A knew where the flat was as I would collect her from the train station and drive her there."

201. Dr Smerdon said in his oral evidence to the Tribunal:

"She had the internet, she had her phone, she could have researched where she wanted to go if she wanted to. She chose not to. She chose not to, she was quite happy to stay in the flat chatting to friends on Instagram, taking photographs of herself, she seemed to be very happy. At no point did she say Will, I need to go out, give me the keys to your car, let me, you know, I feel trapped here. Let me do something. At no point Mr Taylor did she say that."

202. While Patient A was at Dr Smerdon's flat, she had a mobile phone and she also had access to a laptop computer that was connected to the Internet, either of which could have given her geographical and navigation information.

203. The Tribunal found as fact that, Patient A and Dr Smerdon never cohabited and that, throughout the time that Patient A and Dr Smerdon were in a relationship, Patient A had her own flat to live in.

204. There was no spare key to Dr Smerdon's flat and, when Dr Smerdon left his flat, he took the key with him. On 2 March 2026, during oral submissions, Ms Tanchel made the point that, if Patient A had simply wanted to leave Dr Smerdon's flat, she would not need to have a key to get back in – she could just leave. The Tribunal accepted this submission.

205. The Tribunal did not accept the GMC's submission regarding Patient A that "*In practical terms, once Dr Smerdon brought her back to his flat, she was unable to leave."* It may well have been true for Patient A that "*It didn't even cross my mind"* to leave Dr Smerdon's flat, but that is not at all the same as saying that Dr Smerdon "*rendered her unable to leave".*

206. The Tribunal therefore concluded that the GMC had not discharged its burden of proof in relation to the facts alleged. Accordingly, the Tribunal found paragraph 3(i)(i) and 3(i)(ii) of the Allegation not proved.

Paragraph 3

(j). entered into a sexual relationship with patient A in that you, on one or more occasions, engaged in sexual intercourse with Patient A.

207. Patient A said in her witness statement:

"I was asked by the GMC how many times I had sexual intercourse with Dr Smerdon. As mentioned earlier in my statement, [XXX]."

208. Patient A said in her oral evidence to the Tribunal, when questioned by Ms Tanchel:

Question: *"It's right, isn't it, that during the course of that relationship, that was a sexual relationship, that's agreed, isn't it?"*
Answer: "*Yes*"

209. Dr Smerdon said in his witness statement:

"We had a consensual sexual relationship.
…
I admit having sexual intercourse with Patient A as part of a normal consensual adult relationship, …"

210. Dr Smerdon said in his oral evidence to the Tribunal, when questioned by Mr Taylor:

Question: *"Turning to 3(j). I do not think there is any dispute that you entered into a sexual relationship with her, engaging I think you would agree that you---You can read it if you like doctor, engaging in sexual intercourse with her every time."*
Answer: "*Well, probably not every time, but we had a sexual relationship. Yes. I did not deny that."*
Question: "*Engaging in sexual intercourse with her."*
Answer: *"That is what a sexual relationship means I believe."*

211. The evidence from both Patient A and Dr Smerdon is that they had a sexual relationship and engaged in sexual intercourse.

212. Accordingly, the Tribunal found paragraph 3(j) of the Allegation determined and found proved.

Paragraph 4 Your actions at paragraphs 2, 3ai, 3aiii, 3av, 3b and/or 3g were:

(a). carried out with the intention of pursuing a sexual relationship with Patient A;

(b). sexually motivated.

213. In considering paragraph 4 of the Allegation, the Tribunal was careful when considering its reference to paragraph 2 to disregard paragraph 2(a)(ii), which the Tribunal had found not proved.

214. The Tribunal bore in mind the previously quoted advice of the LQC on the meaning of "*sexually motivated"* and how sexual motivation may properly be found by a legal decision-maker. As mentioned above, the Tribunal took into account the testimonials in support of Dr Smerdon in assessing whether his conduct was sexually motivated.

215. Ms Tanchel, on behalf of Dr Smerdon, submitted in writing that *"Allegation 4 a and b are duplicitous."* The legal definition of sexual motivation is set out in the legal advice of the LQC:

> In the case *Basson v GMC* [2018] EWHC 505 (Admin) (21 February 2018), Mr Justice Mostyn said, at paragraph [14]:
>
> *14. … A sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship. …*

216. On 2 March 2026, Ms Tanchel gave oral submissions on this point. The Tribunal understood Ms Tanchel's submission to be that paragraphs 4(a) and 4(b) allege the same thing, and so paragraph 4 is badly drafted. In the view of the Tribunal, paragraphs 4(a) and 4(b) do not allege the identical same thing. 4(b) is broader than 4(a) but entirely encompasses it. It is possible for behaviour to be *"sexually motivated*" without it being "*carried out with the intention of pursuing a sexual relationship"*. For example, an act that is committed for immediate sexual gratification with a person whom the perpetrator intends never to see or otherwise be in contact with again would be "*sexually motivated*" without being "*carried out with the intention of pursuing a sexual relationship*" with that person. If two overlapping allegations are found proved, the Tribunal should avoid "*double counting"* at a later stage of the proceedings.

217. In finding paragraphs 2(d), 2(f) and 2(c) proved, the Tribunal determined that on 5 January 2013 Dr Smerdon took the initiative in going to Patient A's room where he then kissed and touched her and asked to exchange numbers with her. In finding paragraph 3(j) of the Allegation proved, the Tribunal has found that Dr Smerdon then entered into a sexual relationship with Patient A.

218. As set out above, the Tribunal did not accept Dr Smerdon's characterisation of the kiss in Patient A's room on 5 January 2013 as "*a quick kiss".* It found that Dr Smerdon's interactions with Patient A had gone beyond the professional before his last day working at Hospital C (5 January 2013). The Tribunal does not accept Dr Smerdon's evidence that, on 5 January 2013, "*My feeling was that I wanted to keep in touch with Patient A and to see what blossomed from that I suppose. The intent was not to want sex, the intent was to remain in touch with somebody who I had enjoyed the rapport with".* The Tribunal found that Dr Smerdon had a desire to form a sexual relationship with Patient A before 5 January 2013.

219. The Tribunal found that Dr Smerdon's actions in relation to each of all six of the paragraphs listed in paragraph 4 of the Allegation (taking paragraph 2 as a whole, after first disregarding paragraph 2(a)(ii), which had been found not proved) were carried out with the intention of pursuing a sexual relationship with Patient A. Accordingly, the Tribunal found paragraphs 4(a) of the Allegation determined and found proved.

220. As set out above, paragraph 4(b) entirely encompassed paragraph 4(a). Accordingly, the Tribunal found Paragraph 4(b) of the Allegation proved.

Paragraph 5 Your actions at paragraphs 2, 3(a) –(i) and/or 4 were

(a). controlling

(b). manipulative

221. In considering paragraph 5 of the Allegation, the Tribunal was careful when considering its reference to paragraph 2 to disregard paragraph 2(a)(ii), and when considering paragraphs 3(a)(i) to disregard paragraphs 3(a)(ii) and (iv), 3(c), 3(d), 3(e), 3(f), 3(h) and 3(i), which the Tribunal had found not proved. The GMC's submissions in relation to paragraph 5 of the Allegation were based to a significant degree on conduct found not proved by the Tribunal.

222. The Tribunal bore in mind the previously quoted advice of the legally qualified chair on the meaning of "*controlling*" and "*manipulative*" behaviour.

223. Dr Smerdon said in his witness statement:

"I deny acting in a controlling or manipulative manner, as alleged or at all. I was engaged in a consensual relationship with Patient A and acted as any partner would. However, with hindsight I acknowledge that I was the person in a position of power and authority, and Patient A was a former patient who was vulnerable by virtue of [XXX]. I was completely in the wrong to have had a relationship with her, but there was no intention to be controlling or manipulative."

224. Patient A said in relation to the sex she had with Dr Smerdon that *"It was consensual sex".* Patient A's comment that "*she's got nowhere else to go*" (referring to herself when in Dr Smerdon's flat) should be understood in the context of Patient A having had her own flat to live in the whole time. She chose to travel by herself from there to visit Dr Smerdon. Although Dr Smerdon bought food for himself and Patient A and paid for it all, he did not prevent Patient A from buying things for herself.

225. Dr Smerdon told the Tribunal that he knew that Patient A was vulnerable and that he "*was the person in a position of power and authority".* Nevertheless, the Tribunal found that Dr Smerdon was not himself controlling or manipulative.

226. The Tribunal therefore concluded that the GMC did not discharge its burden of proof in relation to the facts alleged. Accordingly, the Tribunal found paragraphs 5(a) and (b) of the Allegation not proved.

Paragraph 6 Patient A was vulnerable due to her mental health at the time of the events described in paragraphs 1, 2, 3 and/or 4

227. In considering paragraph 6 of the Allegation, the Tribunal was careful when considering its reference to paragraph 2 to disregard paragraph 2(a)(ii), and when considering paragraph 3 to disregard paragraphs 3(a) ii and (iv), 3(c), 3(d), 3(e), 3(f), 3(h) and 3(i), which the Tribunal had found not proved.

228. As previously noted in this determination in relation to paragraph 1 of the Allegation, in December 2012 Patient A was admitted as an inpatient on the XXX at Hospital C for the treatment of XXX. When Patient A was admitted to Hospital C, her XXX was '*chronic*'. Patient A had been a *'revolving door patient'* at the unit. Patient A had "*been in and out of hospital since [XXX]*". Patient A's stay as an in-patient at Hospital C began on 14 December 2012 and was her "*[XXX]".* When in Hospital C, Patient A was under a psychiatrist's care.

229. When Patient A was admitted to Hospital C on 14 December 2012, XXX.

230. Patient A said in oral evidence, and the Tribunal accepted, that, when she was in Hospital C:

> *"I was an absolutely destroyed [XXX] … I was a very, very weakened person."*

231. During Patient's A stay in Hospital C, she was given medication for anxiety and to help her relax.

232. Some indication of Patient A's mental state was gained from her description of her extreme anxiety around XXX, given during her oral evidence:

> *XXX*

233. In oral evidence, Dr Smerdon said:

> *'I do not deny her [XXX] would regard her as a vulnerable patient, I do not deny that.*
>
> *… I know in retrospect that because of her disease and condition she was vulnerable …'*
>
> Question: *"You accept just looking at paragraph 6 of the allegation, you accept that she was vulnerable at the time of these events?"*
> Answer: *"I accept in hindsight she was vulnerable by virtue of her diagnosis. "*

234. In the view of the Tribunal, there was plenty of evidence of Patient's A vulnerability. The Tribunal found as fact that Patient A was vulnerable due to her mental health throughout the time that she was a patient at Hospital C and throughout the time that she was in a relationship with Dr Smerdon.

235. Accordingly, the Tribunal found Paragraph 6 of the Allegation proved.

Paragraph 7 You knew that Patient A was vulnerable due to her mental health

236. Dr Smerdon denied paragraph 7 of the Allegation. Dr Smerdon's position appeared to be consistent in that he was unaware at the time that Patient A was vulnerable, and that it

was only "*in retrospect*" and "*with the benefit of hindsight*" that he recognised that Patient A was vulnerable.

237. Dr Smerdon said in his witness statement:

> *"… with hindsight I acknowledge that I was the person in a position of power and authority, and Patient A was a former patient who was vulnerable by virtue of her [XXX].*
> *…*
> *With hindsight, however, I accept that she was vulnerable, and that this relationship was wrong and inappropriate.*
> *…*
> *I viewed her as an ex-patient with whom I had felt a genuine connection, but who in retrospect was nonetheless psychologically vulnerable at the time due to [XXX]."*

238. Dr Smerdon said in his oral evidence to the Tribunal:

> Question: *"She was not a well young woman was she doctor?"*
> Answer: "*In retrospect not. In retrospect no. Up until that point Mr Taylor, I had felt that Patient A was well, it was my gross error of judgement. Yes, I know that but I was not aware that she was unwell in clear manifesting in front of my eyes until that moment and then I realised and that was one of the main reasons why in fact I ended the relationship because I realised it was wrong, I realised that it was the wrong thing for me to have done and I felt bad about it and of course I still do. I feel terrible."*
>
> Question: "*The fact that she was ill and vulnerable."*
> Answer: "*She was not ill when I was seeing her. She did not come over as being an ill or vulnerable person."*
> Question: *"You accept just looking at paragraph 6 of the allegation, you accept that she was vulnerable at the time of these events?"*
> Answer: "*I accept in hindsight she was vulnerable by virtue of her diagnosis. At the time I felt that she was well enough to be in a relationship with me. It was obviously a misguided belief at the time; I recognise that now."*
> Question: "*At the time did you think she was vulnerable due to her mental health?"*
> Answer: *"I did not perceive her as being vulnerable, although obviously in retrospect I recognise that her diagnosis rendered her as being that, but I did not regard her as being a vulnerable adult otherwise I would not have proceeded. She had full mental*

capacity, we reciprocated each other's feelings, I did not view her as a vulnerable adult. I recognise with the benefit of hindsight and for many years not just now that I was erroneous in my assumption, deeply misguided and have made many, many hundreds of hours of efforts to understand the psychological---"

239. As indicated previously in relation to paragraph 6, there was plenty of evidence of Patient A's vulnerability. Dr Smerdon was a Resident Medical Officer (RMO) at Hospital C, and part of his duties included covering the [XXX] in which patients were closely supervised in basic daily activities.

240. The Tribunal would expect an RMO to know that patients are discharged from being hospital in-patients before they are fully recovered from their condition. In the view of the Tribunal, Dr Smerdon would have known from his education, training and experience as a doctor that a patient with [XXX] would be vulnerable and that recovery would be a complex process.

241. The Tribunal regards Dr Smerdon's account in relation to the vulnerability of Patient A as lacking credibility and does not accept it. Dr Smerdon's case appears to be based on him knowing Patient A well enough to form *"a romantic relationship which involved sex"* that was not "*purely driven"* by sex and yet not knowing her well enough to realise that she was vulnerable.

242. The Tribunal concluded that Dr Smerdon knew that Patient A was vulnerable due to her mental health.

243. Accordingly, the Tribunal found Paragraph 7 of the Allegation determined and found proved.

Patient B

Background:

244. At the time of the allegations, Patient B was XXX. She was a patient at Medical Centre D. Dr Smerdon was 46 years of age and a partner in Medical Centre D.

245. Patient B attended the Medical Centre D on the 6 November 2019 complaining of neck pain and dizziness following a telephone triage and conversation with Dr Smerdon who asked her to attend in person XXX. She was seen by Dr Smerdon who she had not met before.

246. On 7 November 2019, Patient B called the surgery with worsening symptoms and requested to see the same doctor as she had seen the day before. Dr Smerdon returned her telephone call and suggested further treatment options and that if symptoms did not resolve she may be referred to a specialist clinic. He also indicated that she may see him any time.

247. Patient B contacted Medical Centre D on 14 November 2019 requesting an emergency appointment. Another doctor from the surgery returned the call and Patient B requested an appointment *'to see someone today, um if not tomorrow'.* Two appointments were offered for 14 November, but Patient B was unable to attend, and Patient B was advised to call back on 15 November.

248. On 15 November, Patient B rang Medical Centre D and asked for a call back to arrange an appointment. She asked to see Dr Smerdon if possible as he had asked her to come back and see him if the problem had not resolved. She was asked to ring again after 1pm as Dr Smerdon was then on call.

249. Patient B contacted the surgery in the afternoon and received a call back from a Nurse Practitioner at Medical Centre D. Patient B asked for an appointment that day and was told to attend the surgery. She was told that there was no guarantee that she would see Dr Smerdon.

250. Patient B attended Medical Centre D on the afternoon of 15 November and was seen by Dr Smerdon.

251. On 19 November 2019, Patient B told Ms F about the consultation of the 15 November. Ms F contacted Medical Practice D on that day.

Reasoning and decision

252. Patient B had two appointments with Dr Smerdon as a GP at Medical Centre D, on 6 November 2019 and 15 November 2019. The allegation paragraphs relate to those two appointments.

253. The evidence about what happened in the appointments is ultimately derived from two sources: Patient B and Dr Smerdon. There is no other alternative account of what happened in each appointment being suggested in this case other than the account of

Patient B and the account of Dr Smerdon. The Tribunal is not in possession of evidence that would enable it to fashion (in a forensically appropriate way) an account of what happened in the appointments that is different from both the account of Patient B and the account of Dr Smerdon. Essentially, the Tribunal has no other option than to decide (in relation to each appointment, and for each part of the appointments) which account is correct.

254. The Tribunal bore in mind the previously quoted advice of the legally qualified chair on cross-admissibility of evidence.

255. The Tribunal is satisfied that, in this case, that there has been no collusion between Patient A (and people associated with her) and Patient B (and people associated with her) and that there is no contamination of the evidence relating to Patient B by anything relating to Patient A (and vice versa).

256. In the GMC's submissions, Mr Taylor cited the similarities between the cases of Patient A and Patient B. These being:

- he had it in him to see younger female patients as potential sexual partners because of the sexual relationship he had with Patient A even if it was some years before.
- Dr Smerdon told Patient B he could not take her out as she was a patient and she could get him into trouble by reporting him for having a relationship with a patient. These remarks bear a striking similarity to the text message Dr Smerdon wrote to Patient A on the day he kissed her.
- Dr Smerdon's case against Patient B is that she came on to him and that bears a similarity to his assertion that Patient A showed an interest in him, which he went on to reciprocate.
- Dr Smerdon kissed both patients on Hospital/ Practice premises and considered that they would not report it. Both were told he could be struck off if the truth came out.

257. Ms Tanchel submitted that jurisprudence does not support that the threshold has been reached such that you can rely on similarities from one patient to deal with another patient.

258. The Tribunal was satisfied that there was sufficient connection and similarity between the facts of the allegations in respect of Patient A and Patient B to make it appropriate to consider the findings already made relating to Patient A when determining findings relating to Patient B.

259. The Tribunal considers that its findings in relation to Patient A are indicative of a propensity on the part of Dr Smerdon to act in a sexually inappropriate manner towards young female patients.

Paragraph 8 On 6 November 2019 while working at Medical Centre D you consulted with Patient B where you said the following, or words to that effect:

(a). 'do you live alone?';

260. Patient B told the Tribunal in her oral evidence and in her witness statement that Dr Smerdon asked her at the start of the consultation whether she lived alone. At the time she did not consider this out of the ordinary.

261. Dr Smerdon in his witness statement stated:

> *"I do not recall the specific wording I would have used, but I would very likely have asked Patient B about her relationship status and social circumstances which I would do in the context of this kind of consultation as Patient B was on medication for [XXX]. This information is accordingly relevant in terms of assessing safeguarding risks."*

262. The Tribunal considered that these words or words to that effect were consistent with a legitimate medical consultation process.

263. Accordingly the Tribunal found paragraph 8(a) of the Allegation proved.

Paragraph 8

(b). 'are you single?';

264. Patient B told the Tribunal in her oral evidence and in her witness statement that Dr Smerdon asked her at the start of the consultation whether she was single. At the time she did not consider this out of the ordinary and that he was being quite friendly. She mentioned that she was single XXX.

265. The Tribunal noted Dr Smerdon's witness statement, as set out above in relation to paragraph 8(a) of the Allegation.

266. The Tribunal considered that these words or words to that effect were consistent with a legitimate medical consultation process.

267. Accordingly the Tribunal found paragraph 8(b) of the Allegation proved.

Paragraph 8

(c). 'that's shocking that you're single when you're so pretty';

268. The Tribunal noted the witness statement of Patient B in which she said:

> *"He was being quite friendly. I cannot remember his exact words anymore. I did not think much of it and answered his questions, mentioning that I was single and [XXX]. Dr Smerdon then said, 'That's shocking that you're single when you're so pretty'. To be honest, I didn't really know why he said that. I was flattered and didn't think it was inappropriate after this first appointment."*

269. In his witness statement, Dr Smerdon stated:

> *"I was taught the Calgary-Cambridge consultation Model which is underpinned by building rapport and ensuring the patient is at ease; … I admit to having developed an over familiar style in the past to break the ice and gain trust in the doctor patient relationship. Whilst my intention was to put her at ease, I now understand how this style of consultation might have been misinterpreted, particularly in a context where she might have been seeking emotional validation."*

270. Dr Smerdon elaborated on his consultation style in his oral evidence. Throughout his evidence he denied saying 'that's shocking when you are so pretty' as this would be inappropriate, but confirmed that his consultation style was relaxed, bordering on the overfamiliar.

271. The Tribunal considered that with Dr Smerdon's overfamiliar consultation style and that this was perceived by Patient B as being quite friendly, on the balance of probabilities these words or words to this effect were said.

272. Accordingly the Tribunal found paragraph 8(c) of the Allegation proved.

Paragraph 8

(d). 'oh that's surprising, but a good surprise' when seeing Patient B's tattoo;

273. Patient B in her witness statement says that Dr Smerdon commented on her tattoo XXX, telling her '*oh that's surprising, but a good surprise'*. She could not remember the details but did not think much of it at the time.

274. Dr Smerdon in both his witness statement and during oral evidence denied commenting on Patient B's tattoo. In answering a question from the GMC regarding the tattoo, Dr Smerdon indicated that many patients had tattoos, but he did not remember seeing a tattoo on Patient B and would not have said the words that are alleged as it would have been inappropriate.

275. The Tribunal considered that with Dr Smerdon's overfamiliar consultation style at this time, which he admitted was an attempt to put patients at ease, on the balance of probabilities these words or words to this effect were said.

276. Accordingly the Tribunal found paragraph 8(d) of the Allegation proved.

Paragraph 8

(e). 'don't worry, I won't do anything weird';

277. Patient B in her oral evidence stated:

> *"…around laying on the bed and the comment around, ' I won't do anything weird', for me it was just more a bit of a joke, maybe to lighten the mood sometimes."*

278. Dr Smerdon denied saying this. In answer to a question from the GMC about what he would say as part of his overly friendly or over familiar consultation style, he replied:

> *"I do not have stock lines I am afraid, I ad lib while I am doing consultation so it would be whatever is appropriate for the moment or the time of day or month or year or celebration going on."*

279. The Tribunal considered that, with Dr Smerdon's overfamiliar consultation style at this time, which he admitted was an attempt to put patients at ease, on the balance of probabilities these words or words to this effect were said.

280. Accordingly the Tribunal found paragraph 8(e) of the Allegation proved.

Paragraph 8

(f). 'you can book an appointment to see me again, you don't even have to be ill'.

281. In Patient B's oral evidence she told the Tribunal in an answer to questions during cross-examination:

> *"I remember just discussing that if it does, if things get worse or whether they are not better, basically, then to come back, as you would usually expect from a medical appointment, and then at the end of the appointment, it was kind of said, "Oh, feel free to come back any time. You don't have to be ill", kind of – and I think I kind of took it as a bit of a joke. I didn't really take it seriously because it was just a bit of a joke…"*

282. Dr Smerdon confirmed that he would say to patients to feel free to book appointments with him again, but he denied that he would qualify this with the words *'you do not even have to be ill'.*

283. The Tribunal considered that with Dr Smerdon's overfamiliar consultation style at this time which he admitted was an attempt to put patients at ease, on the balance of probabilities these words or words to this effect were said.

284. Accordingly the Tribunal found paragraph 8(f) of the Allegation proved.

Paragraph 9 On 15 November 2019 while working at Medical Centre D you consulted with Patient B where you:

(c). held Patient B's hand after checking her heart rate;

285. Patient B described the incident in her witness statement:

> *"..but he held my hand for a few seconds in a weird way after he finished checking my pule/heart rate. It lasted a couple of seconds, and I am not sure if this was an extended period."*

286. The Tribunal noted that in her oral evidence in answer to the question:

> *"At no time did he hold your hand for any reason other than to take the pulse?*

287. Patient B said:

"*Well, I think that alone is generally not common in a medical examination. As I said, usually a doctor would put like a finger thing on your finger to test your pulse. They wouldn't actually do it with their hand because how would you test that? How would you know what the pulse is by doing that?*"

288. Dr Smerdon, during his oral evidence, explained that he needed to check Patient B's vital signs and examine her. As part of this he used his hand to check her heart rate. He was asked by the GMC why he did not use a pulse machine. In reply he said:

"I never use a pulse oximeter to take a patient's pulse because I regard it as laziness and just like using an automated blood pressure monitor, again it can over or under analyse estimate and be incorrect if the patient has an arrythmia."

289. Dr Smerdon, throughout the proceedings denied that he held Patient B's hand after taking her pulse. However, in his witness statement he says:

"I was not holding her hand, I may have steadied her hand whilst taking her heart rate, but did not hold it afterwards."

290. The Tribunal considered that Dr Smerdon's account was a plausible, alternative explanation to that of Patient B, in that he was taking Patient B's pulse as he described. Patient B had, by her own account, not experienced anyone checking her heart rate by palpation (with their hand) and therefore may have misinterpreted this.

291. The Tribunal therefore concluded that the GMC had not discharged the burden of proof in relation to the facts alleged. Accordingly, the Tribunal found paragraph 9(c) of the Allegation not proved

Paragraph 9

(d). gave Patient B a massage;

292. In Patient B's witness statement she described sitting sideways on the chair in the consulting room and Dr Smerdon got up and started giving her a massage, with both of his hands on her shoulders.

293. Dr Smerdon denied giving Patient B a massage and in his witness statement, he said:

"I stood behind Patient B and palpated the muscles of the shoulder region. I cannot recall precisely what she said but Patient B expressed something akin to "I liked what you were doing with my neck" and said she would like a massage. I did not acknowledge this comment. I also examined both Patient B's shoulders posteriorly, laterally then anteriorly first by looking and then asking her to abduct, adduct, internally and externally rotate her shoulders."

294. The Tribunal noted that, by his own admission, Dr Smerdon had a relaxed, over-friendly consultation style and the examination may have been perceived by Patient B as a massage.

295. In the view of the Tribunal there was a plausible alternative account to what was alleged by the GMC, namely that what took place was a clinically indicated examination by Dr Smerdon, involving palpation across the shoulders, even if it felt like a massage to Patient B, and even if it may have been informally described as "massage" by Dr Smerdon. Accordingly, the Tribunal found paragraph 9(d) of the Allegation not proved.

Paragraph 9

(f). pressed your groin against Patient B's back;

296. In Patient Bs witness statement, she said that during the 'massage' Dr Smerdon pressed his groin area against the middle of her back whilst touching her shoulders. She also said that she could not recall the duration of this pressing. She stated that she was shocked at what he was doing and wondered why he needed to touch her like that. This was consistent with other evidence that she provided.

297. Dr Smerdon denied pressing his groin against Patient B's back. In his witness statement he stated:

"I would have to have been close enough to her so I could gain some purchase on the spine. It is possible that there could have been some contact between us, but I was not aware of it, and it would have been entirely inadvertent. My focus would have been on the examination."

298. The Tribunal finding regarding 9(d) above was that it could not discount that this was part of a legitimate clinical examination. Similarly, it is plausible that as part of the clinical examination there was inadvertent contact between Dr Smerdon and Patient B at this point.

299. The Tribunal considered that there was an alternative plausible explanation to the GMC's allegation, in that Dr Smerdon was undertaking a legitimate clinical examination of Patient B as he described and he inadvertently touched her. Patient B may have misinterpreted this.

300. The Tribunal therefore concluded that the GMC has not discharged its burden of proof in relation to the facts alleged. Accordingly, the Tribunal found paragraph 9(f) of the Allegation not proved.

Paragraph 9

(g). grabbed Patient B and hugged her;

(h). kissed Patient B on the cheek;

(i). kissed Patient B on the mouth using your tongue;

(j). touched Patient B's knee.

301. The Tribunal have found paragraphs 9 (c), (d) and (f) not proved as there was a reasonable alternative explanation, provided by Dr Smerdon, where his actions could have been misinterpreted during a legitimate clinical examination. The Tribunal was of the opinion that there was no justifiable clinical examination that could be misinterpreted as hugging and kissing and touching Patient B's knee.

302. The GMC submitted that Dr Smerdon's physical acts on 15 November 2019 at the second appointment (touching, hugging, kissing etc) went way beyond what was clinically indicated and were non-consensual.

303. Dr Smerdon denied that he hugged Patient B but accepted a kiss did happen. However, he said this was initiated by Patient B and that he did not kiss her. In his witness statement he said:

> *"I moved back around in front of Patient B and she said that she had pain and gestured that the area of tenderness was over the occiput. I had already examined this region whilst stood behind her but as she had indicated tenderness, I placed my hands over the occipital insertion point of trapezius muscle on each side and palpated in that region. This might have moved her hair depending on how it was*

worn. In order to look for any sign of discomfort I would have been looking at her face whilst palpating."

"At this point Patient B leant forward to kiss me. This was a considerable shock. She briefly made contact with my lips but I pulled away from her immediately and told her this was not appropriate. I did not seek to hug Patient B at any time, nor did I try to kiss Patient B at any point."

304. Dr Smerdon also suggested in oral evidence that Patient B was fabricating her symptoms in an attempt to see him in person at a second appointment. When asked about this by the GMC he replied:

"Yeah, well these are all things which I have in retrospect come to understand. She made conflicting statements to the nurse practitioner about her symptoms which differed from when I called about the severity of her symptoms, so they were at odds with what she was saying to reception.

I think there are multiple instances of her symptoms have got worse and then in order to get an appointment with me saying that she had not been offered any emergency appointments when she had been and wanted to get an appointment just with me and went out of her way, there was a message left for me with Nurse [H] through those telephone consultations with reception and then with the nurse prior to then finally seeing me."

305. Dr Smerdon denied touching Patient B's knee in any inappropriate manner and said:

*"I would not have touched her knee at all on [*second appointment]."

306. In contrast Patient B described the event in the following terms in her witness statement:

"At the end of the appointment, Dr Smerdon moved some hair from my face and said, "I want to hug you. Is it okay if I hug you?" I was still standing at this point. Before I could respond, he grabbed and hugged me and kissed me on the cheek. The grab was not aggressive or forceful. As far as I recall, his arms were around me, and my arms were by my side, making me feel somewhat trapped. The kiss was not prolonged but also not just a peck. I did not hug or kiss him back; I was frozen."

"I then told Dr Smerdon his behaviour was inappropriate. He did not respond. Dr Smerdon then leaned forward, kissed me on the lips, and shoved his tongue into my mouth…"

307. Patient B explained to the Tribunal that she returned to see Dr Smerdon as he had told her to do that on her first appointment if her condition worsened. She also said in her oral evidence regarding this first appointment:

"Then I just remember leaving the appointment thinking he was nice, friendly. I think sometimes you attend the doctors and they don't really pay much interest in you and they don't ask you many questions, and sometimes you feel a little bit dismissed. I think I felt he was friendly. He seemed to listen to how I felt and, you know, maybe asked me some personal questions, but I didn't really think too much of it other than that was nice, friendly, and that, yes, he listened when I shared what my medical concerns were."

308. Patient B explained that, after the kiss, they then sat down and:

"I am unsure whether he sat next to me or in front of me. I was wearing a skirt and tights, with the skirt knee-length and above my knee. Dr Smerdon touched my right knee."

309. During cross-examination Patient B was questioned about the description of the hug in her police statement dated 26 November 2019 in which she stated:

"He then hugged me, placing his arms around my waist and his head across my right shoulder area. I put my arms over his shoulders and kind of hugged him back. This lasted about 5 seconds and I pulled away."

310. Patient B stated that this was not necessarily what she had told the police, it is what they had written in the notes. She went on to say that she had not seen the statement until it was provided to her by the GMC. The discrepancies between her recollection of events and the police statement were dealt with in her supplemental witness statement of the 28 May 2025.

311. Patient B was also asked in cross-examination about the police statement in which it is said:

"SMERDON has then placed his hand under [Patient B's] skirt and touched her on the knee —"

312. Patient B replied:

"Yes, that's everything I said about yesterday saying that I'd read it and said I didn't agree with that."

313. She went on to say:

"I'm being honest in saying that. I'm not trying to make it seem worse than it was by saying, "Oh yes, he did put his hand up my skirt." I'm saying actually, no, that's not true. Surely, that's me being honest in a way that's making it less bad, as it says on here, in my eyes, because I'm saying, "Oh no, that's not right, he didn't put his hand up my skirt", because actually it was a shorter skirt so he didn't put his hand up my skirt."

314. The Tribunal noted that in giving evidence in chief she had wished to clarify a phrase in her first exhibit saying:

"Yes, let me just have a little look. It was on page – now I don't know what page it is but it's on that form, and it's just what's written, and it says: "…placed his hand under [I'm not sure that's my name] the skirt and touched her on the knee". Maybe I've kind of glossed over the bit where it said, "under my skirt", but that's not something I remember happening, and that's not something I think I've written down."

315. Ms Tanchel submitted to the Tribunal that Patient B was inconsistent in her written and oral evidence given in this case and that this demonstrated she was not a credible or reliable witness.

316. The Tribunal was reminded by the GMC that, as per *Byrne,* it is commonplace in a case of this nature for there to be inconsistency and confusion in some of the detail, particularly as the incident occurred over six years ago. It submitted that Patient B had been credible and consistent in the substance of her core allegations in her accounts to the practice, the police and the GMC and before this Tribunal.

317. In particular, the Tribunal noted the GMC's written submissions, relating to refuting the fabrication of evidence on the part of Patient B. These included the following point that Patient B made while giving oral evidence and being cross-examined by Ms Tanchel:

"Like, why would I be here if I had lied? Like, why would I put myself through this and have to talk to you like this, if I had made this up?

…Yes, and in my way of trying to help, why would I spend a year and a half of my life supporting the GMC for something that didn't happen?...

…I am only doing this because I did not want the same thing that happened to me to happen to other women and patients… Why would I go through all of this and ruin my own mental health to sit here and have you talk to me like this over making something up? I wouldn't. Why would I bother?"

318. The Tribunal concluded that the answer to the "why would I?" questions Patient B posed was that "she wouldn't", and that Patient B put herself through the ordeal of giving evidence because she genuinely believed that what she said was true, and because, as she said, she wanted to prevent what she genuinely believed happened to her from happening to other people. The Tribunal concluded that Patient B was being credible and consistent in her account of the core details.

319. The Tribunal also took into account the legal advice on cross-admissibility of evidence and noted the similarities between this case and that of Patient A in the submission of the GMC.

320. The Tribunal noted that it was asked to consider cross-admissibility on both the grounds of propensity and rebuttal of coincidence by the GMC. The Tribunal already determined that Dr Smerdon kissed and touched Patient A, over her clothes, on her chest and bottom. At the time he described his actions as 'ill-judged', 'impulsive', 'irrational' and 'erratic'.

321. The Tribunal considered and was satisfied that, in this case, that there had been no collusion between Patient A and Patient B and that there was no contamination of the evidence relating to Patient B by anything relating to Patient A (and vice versa).The Tribunal was satisfied that there was sufficient connection and similarity between the facts of the allegations in respect of Patient A and Patient B to make it appropriate to consider the findings already made relating to Patient A when determining findings relating to Patient B.

322. The Tribunal considered that the similarities were:

- He kissed Patient A on hospital premises and allegedly kissed Patient B in Medical Practice D during the consultation.

- He had physical contact, by touching Patient A on the chest and bottom during the kiss and allegedly hugged Patient B before kissing her in Medical Practice D during the consultation.

- Patient A and Patient B were both young female patients with mental health conditions that he would have been aware of.

- Dr Smerdon asserted that Patient A showed an interest in him which he reciprocated. He further alleged that it was obvious, through the telephone transcripts, that Patient B was pursuing him and that she hugged and kissed him. In his oral evidence, during cross examination, he said that the interest was entirely unilateral from her towards him.

- Dr Smerdon had sent a Text message to Patient A on the day of the kiss, in which he told her *'please please don't tell anyone cos I could get into serious trouble and be struck off'*. This bears similarities to the words he is alleged to have said to Patient B in Medical Practice D at the consultation after the alleged hug and kiss occurred.

323. The Tribunal concluded that Patient B was credible in her account of the events that led to the allegations. It accepted that it was not uncommon in cases of this nature for there to be inconsistencies and confusion in some of the detail particularly when a considerable period of time has passed.

324. Following the appointment of 15 November 2019, Dr Smerdon made clinical entries in Patient B's medical record. He made no note of an untoward incident in Patient B's medical records (or any other records) and made no report to the Practice Manager of Medical Centre D or any colleague), as would have been appropriate if what had happened in the appointment was what Dr Smerdon said had happened. In the view of the Tribunal, there would not have needed to be any specific protocol in place for it to have been obvious to Dr Smerdon that he ought to record and report the incident not least to protect other doctors at Medical Centre D. Dr Smerdon said nothing about the incident until after he was informed that Patient B had complained. In the view of the Tribunal, the reason that Dr Smerdon did not record or report that Patient B had leant forward and kissed him– because it did not happen as he claimed.

325. The Tribunal gave less weight to the evidence of Dr Smerdon's good character when considering the allegations concerning Patient B, bearing in mind the findings it had made regarding Dr Smerdon's conduct in respect of Patient A.

326. For the reasons set out above, the Tribunal concluded that Dr Smerdon grabbed Patient B and hugged her, kissed her on the cheek, and touched her knee.

327. Accordingly the Tribunal found paragraphs 9(g), (h), (i) and (j) proved.

Paragraph 9

(k). said the following, or words to that effect:

(i). 'it's really good to see you again, I'm glad you're here';

328. Dr Smerdon in his witness statement recognised communication errors on his part which created ambiguity in the doctor patient relationship and acknowledged he may have been over-friendly and warm and that his manner may have come across as too informal or overfamiliar. Dr Smerdon, in his oral evidence, in answer to the question, "*You said to her it is really good to see you again; I am glad you are here*" replied,

> *"I do not recall saying that, no. I would have said it, I often would say it is good to see you, that sort of thing, it is part of my consultation style."*

329. On the balance of probability, the Tribunal concluded that '*it's really good to see you again, I'm glad you're here'* or words to that effect were said by Dr Smerdon to Patient B.

330. Accordingly, the Tribunal found paragraph 9(k)(i) proved.

Paragraph 9

(k). said the following, or words to that effect:

(ii) 'I want to hug you. Is it okay if I hug you?';

(iii) 'I want to take you out but can't because you are a patient';

(iv) 'I have your details';

(v) 'if things go badly, you could get me into trouble by reporting me for having a relationship with a patient'.

331. According to Patient B's oral evidence and witness statement, in the Consultation of 15 November 2019, these words or words to that effect were all said immediately prior to the hug or after the hug and kiss took place.

332. The Tribunal already determined that Dr Smerdon did hug, kiss and touch Patient B. It concluded that Patient B was credible and consistent in her account about the events notwithstanding the inevitable confusion that may occur in recalling the detail of events after six years has elapsed.

333. In addition, the Tribunal have noted in paragraph 9(k)(iii) and (v) the similarity with the words used in the Text messages to Patient A which was admitted.

334. The Tribunal considered that there was no plausible alternative explanation to the words alleged in 9(k)(ii) –(v), and consequently, the Tribunal accepted Patient B's witness statement and oral evidence on these points.

335. Accordingly, the Tribunal found paragraphs 9(k)(ii), (iii), (iv) and (v) proved.

Paragraph 10 Your actions at paragraphs 8 and/or 9 were carried out with the intention of pursuing a sexual relationship with Patient B

336. In relation to paragraph 10 of the Allegation insofar as it refers to paragraph 8, in the view of the Tribunal there is a plausible alternative account to what is alleged by the GMC that cannot properly be discounted, namely that the words that were said are consistent with a legitimate medical consultation, albeit one conducted with a very relaxed consultation style.

337. In relation to paragraph 10 of the Allegation insofar as it refers to paragraph 9, in the view of the Tribunal there is a plausible alternative account to what is alleged by the GMC that cannot properly be discounted, namely that, in relation to paragraphs 9(a), (b), (e) and k(i) the actions of Dr Smerdon could form part of a legitimate medical consultation. In relation to paragraphs 9(g)-(k)(ii)-(v), taken globally, the actions of Dr Smerdon were carried out for the purpose of immediate personal gratification, without any intention to form an ongoing relationship with Patient B. In particular, the Tribunal noted Dr Smerdon saying *"I want to take you out but can't because you are a patient"* indicated the lack of intention to

form an ongoing relationship. The Tribunal found as fact that Dr Smerdon's conduct in relation to paragraphs 9(g)-(k)(ii)-(v), taken globally, was conduct of a sexual nature.

338. The Tribunal considered that, whilst the conduct was of a sexual nature, there was insufficient evidence to conclude that Dr Smerdon intended to form an ongoing sexual relationship with Patient B.

339. Accordingly, the Tribunal found paragraph 10 of the Allegation not proved.

Paragraph 11 Patient B was vulnerable due to her mental health at the time of the events described in paragraphs 8 and/or 9.

340. The Tribunal was told by Dr Smerdon that Patient B had a history of XXX. He stated that, technically, she could be considered as vulnerable.

341. Patient B, in her evidence, stated that she was vulnerable due to her mental health.

342. The Tribunal considered that the evidence demonstrated that, at the time of the events, Patient B was vulnerable due to her mental health.

343. Accordingly, the Tribunal found paragraph 11 of the Allegation proved.

Paragraph 12 You knew that Patient B was vulnerable due to her mental health.

344. The Tribunal determined that Patient B was vulnerable at the time of the events due to her mental health. The Tribunal went on to consider whether Dr Smerdon knew that she was vulnerable.

345. Dr Smerdon told the tribunal that Patient B was taking Venlafaxine to treat anxiety and depression, and Quetiapine and that this is why he asked a number of questions in the social history such as '*are you single'* and '*do you live alone'.*

346. In cross-examination in response to the question: '*you accepted, I think you have accepted that given what you knew about her she was a vulnerable patient. If I am wrong about that then correct me. You knew that,'* Dr Smerdon answered '*Yes*.'

347. The Tribunal found that the evidence demonstrated that Dr Smerdon knew that Patient B, at the time of the events, was vulnerable due to her mental health.

348. Accordingly, the Tribunal found paragraph 12 of the Allegation proved.

Paragraph 13 Your actions at paragraph 9 constituted sexual harassment as defined in Section 26 (2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient B.

349. The Tribunal bore in mind the previously quoted advice of the legally qualified chair on the meaning of "*sexual harassment*".

350. The Tribunal found that Dr Smerdon's behaviour towards Patient B on 15 November 2019 constituted unwanted conduct of a sexual nature.

351. Patient B's reaction to the events of 15 November 2019 was, she said, that she "*was shocked at what he was doing and thinking why he needed to touch me like that*". She said she told Dr Smerdon that his behaviour was inappropriate, and that what he did was wrong. Patient B said that she was shocked and did not know what to do. Patient B said that since her interactions with Dr Smerdon, she had struggled with trusting people in positions of authority, especially men, which had caused her to worry about interactions with professionals in case the same thing were to happen again. She said that, additionally, her interactions with Dr Smerdon had led her to struggle with trusting people and their intentions and that, after she had fully processed what had happened, she felt deeply sad and that she had been manipulated by someone who should have been helping her.

352. The Tribunal accepted this evidence of Patient B as truly reflecting her perception of events and her response to it. Although Patient B did not use these exact words, the Tribunal took the evidence of Patient B to amount to her saying that she perceived herself to have suffered the effect of her dignity having been violated and Dr Smerdon's conduct to have created an adverse environment for her.

353. The Tribunal took into account all the circumstances of the case.

354. The Tribunal considered that it is reasonable for Dr Smerdon's conduct in the appointment of 15 November 2019 to be regarded as having been a violation of Patient B's dignity and to be regarded as having created an intimidating environment for Patient B, and found that Dr Smerdon's conduct did have those effects.

355. Accordingly, the Tribunal found paragraph 13 of the Allegation proved.

Paragraph 14 Your actions as set out at paragraphs:

(a). 8, 9 and/or 10 were sexually motivated;

356. Ms Tanchel, on behalf of Dr Smerdon, submitted that Allegations 10 and 14(a) were duplicitous, in that the legal definition of sexual motivation included the pursuit of a sexual relationship.

357. The Tribunal bore in mind the previously quoted advice of the legally qualified chair on the meaning of "*sexual motivation*", that is that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship.

358. The Tribunal noted its finding of Paragraph 10 above and that it determined that the actions of Dr Smerdon in Paragraphs 8 and /or 9 were not carried out in pursuit of a sexual relationship. The Tribunal therefore considered whether the actions carried out and found proved were sexually motivated on the grounds of sexual gratification. In doing so, it considered whether there could have been any other explanation for the inappropriate conduct.

359. In relation to paragraph 14(a) of the Allegation insofar as it referred to paragraph 8, in the view of the Tribunal there was a plausible alternative account to what is alleged by the GMC that cannot properly be discounted, namely that the words that were said were consistent with a legitimate medical consultation, albeit one conducted with a very relaxed consultation style.

360. In relation to paragraph 14(a) of the Allegation insofar as it referred (through its reference to paragraph 9) to paragraphs 9(a), (b), (e) and 9(k)(i), in the view of the Tribunal, there was a plausible alternative account to what was alleged by the GMC that could not properly be discounted, namely that the actions of Dr Smerdon could properly form part of a legitimate medical consultation.

361. In relation to paragraph 14(a) of the Allegation insofar as it referred (through its reference to paragraph 9) to paragraphs 9(g)-(j) and 9(k)(ii)-(v), taken globally, the Tribunal found that the actions of Dr Smerdon were carried out for the purpose of immediate sexual gratification and so were sexually motivated.

362. Accordingly, the Tribunal found paragraph 14(a) of the Allegation proved.

Paragraph 14

(b). 9(a) to 9(j) were carried out without Patient B's consent.

363. In relation to paragraph 14(b) of the Allegation insofar as it referred to paragraphs 9(a), (b) and (e), in the view of the Tribunal, there was a plausible alternative account to what was alleged by the GMC that could not properly be discounted, namely that the actions of Dr Smerdon could properly form part of a legitimate medical consultation.

364. Neither Patient B nor Dr Smerdon said that the kissing in the appointment of 15 November 2019 was, or might have been, consensual. As set out above in relation to 9(g)-9(j) of the Allegation, the Tribunal concluded that Patient B was credible and consistent in her account in relation to the core details of the allegations. It therefore preferred the evidence of Patient B to that of Dr Smerdon. The Tribunal found as fact that Dr Smerdon engaged in the behaviour set out paragraphs 9(g)-(j) of the Allegation without the consent of Patient B.

365. Accordingly, the Tribunal found paragraph 14(b) of the Allegation proved.

The Tribunal's Overall Determination on the Facts

366. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. At all material times the nature of your relationship with Patient A was that Patient A was your patient and thereafter in a relationship with you. **Determined and found proved**

2. While working at Hospital C on or around December 2012 to January 2013 you:

   a. said the following, or words to that effect, to Patient A:

      i. she had 'really sexy veins'; **Determined and found proved**

      ii. that you walked the halls of her ward at night to see if her bedroom lights were on; **Found not proved**

iii. 'you don't need to be here you're too special and you're too beautiful'; **Determined and found proved**

iv. that you really liked her; **Determined and found proved**

b. stared at Patient A; **Determined and found proved**

c. asked to exchange numbers with Patient A; **Determined and found proved**

d. kissed Patient A; **Determined and found proved**

e. sent Patient A a text message on 5 January 2013 saying 'It is, and you're a naughty girl. I'm not far off leaving now. Kissing u was amazing. I think u are absolutely gorgeous. Please bare in mind you are no longer my patient, but even still please please don't tell anyone cos i could get into serious trouble and be struck off (no joke). To see me "on the outside" would be fine. Kiss. Will'; **Determined and found proved**

f. touched Patient A, over her clothes, on her:

i. chest; **Determined and found proved**

ii. bottom. **Determined and found proved**

3. After you stopped working at Hospital C you:

a. said the following, or words to that effect, to Patient A:

i. she could move to be with you; **Determined and found proved**

ii. that she did not need to be in the hospital; **Found not proved**

iii. that she could start a new life with you; **Determined and found proved**

iv. there was nothing for her to go back to if she discharged herself; **Found not proved**

v. that you would be the start of a new life for her; **Determined and found proved**

vi. you need to eat more; XXX; **Determined and found proved**

vii. XXX; **Determined and found proved**

b. allowed Patient A to stay at your flat; **Admitted and found proved**

c. cooked huge meals for Patient A; **Found not proved**

d. offered Patient A anti-psychotic medication without prescription; **Found not proved**

e. controlled what Patient A ate; **Found not proved**

f. bought bottles of wine for Patient A in spite of her not supposed to be drinking; **Found not proved**

g. stayed at Patient A's flat; **Admitted and found proved**

h. made Patient A sleep on the sofa bed when she was not willing to take medication you gave her; **Found not proved**

i. kept Patient A in your flat and rendered her unable to leave as she did not:

i. have a key to re-enter; **Found not proved**

ii. know where she was; **Found not proved**

j. entered into a sexual relationship with Patient A in that you, on one or more occasions, engaged in sexual intercourse with Patient A. **Determined and found proved**

4. Your actions at paragraphs 2, 3ai, 3aiii, 3av, 3b and/or 3g were:

a. carried out with the intention of pursuing a sexual relationship with Patient A; **Determined and found proved (in relation to each of all six of the listed paragraphs (taking paragraph 2 as a whole, after first disregarding paragraph 2(a)(ii), which had been found not proved)).**

b. sexually motivated. **Determined and found proved (in relation to each of all six of the listed paragraphs (taking paragraph 2 as a whole, after**

first disregarding paragraph 2(a)(ii), which had been found not proved)).

5. Your actions at paragraphs 2, 3a-i and/or 4 were:

   a. controlling; Found not proved (after first disregarding paragraphs 2(a)(ii), 3(a)(ii), 3(a)(iv), 3(c), 3(d), 3(e), 3(f), 3(h), 3(i)(i) and 3(i)(ii), which had been found not proved).

   b. manipulative. Found not proved (after first disregarding paragraphs 2(a)(ii), 3(a)(ii), 3(a)(iv), 3(c), 3(d), 3(e), 3(f), 3(h), 3(i)(i) and 3(i)(ii), which had been found not proved)

6. Patient A was vulnerable due to her mental health at the time of the events described in paragraphs 1, 2, 3 and/or 4. Determined and found proved (in relation to each of all four of the listed paragraphs (after first disregarding paragraphs 2(a)(ii), 3(a)(ii), 3(a)(iv), 3(c), 3(d), 3(e), 3(f), 3(h), 3(i)(i) and 3(i)(ii), which had been found not proved)).

7. You knew that Patient A was vulnerable due to her mental health. Determined and found proved

Patient B

8. On 6 November 2019 while working at Medical Centre D you consulted with Patient B where you said the following, or words to that effect:

   a. 'do you live alone?'; Determined and found proved

   b. 'are you single?'; Determined and found proved

   c. 'that's shocking that you're single when you're so pretty'; Determined and found proved

   d. 'oh that's surprising, but a good surprise' when seeing Patient B's tattoo; Determined and found proved

   e. 'don't worry, I won't do anything weird'; Determined and found proved

f. ‘you can book an appointment to see me again, you don’t even have to be ill’. **Determined and found proved**

9. On 15 November 2019 while working at Medical Centre D you consulted with Patient B where you:

a. put your hand or hands on Patient B’s shoulder; **Admitted and found proved**

b. checked Patient B’s heart rate with your hands; **Admitted and found proved**

c. held Patient B’s hand after checking her heart rate; **Found not proved**

d. gave Patient B a massage; **Found not proved**

e. put your hands under Patient B’s jumper and onto her skin; **Admitted and found proved**

f. pressed your groin against Patient B’s back; **Found not proved**

g. grabbed Patient B and hugged her; **Determined and found proved**

h. kissed Patient B on the cheek; **Determined and found proved**

i. kissed Patient B on the mouth using your tongue; **Determined and found proved**

j. touched Patient B’s knee; **Determined and found proved**

k. said the following, or words to that effect:

i. ‘it’s really good to see you again, I’m glad you’re here’; **Determined and found proved**

ii. ‘I want to hug you. Is it okay if I hug you?’; **Determined and found proved**

iii. ‘I want to take you out but can’t because you are a patient’; **Determined and found proved**

iv. ‘I have your details’; **Determined and found proved**

v. 'if things go badly, you could get me into trouble by reporting me for having a relationship with a patient'. **Determined and found proved**

10. Your actions at paragraphs 8 and/or 9 were carried out with the intention of pursuing a sexual relationship with Patient B. **Found not proved**

11. Patient B was vulnerable due to her mental health at the time of the events described in paragraphs 8 and/or 9. **Determined and found proved**

12. You knew that Patient B was vulnerable due to her mental health. **Determined and found proved**

13. Your actions at paragraph 9 constituted sexual harassment as defined in Section 26 (2) of the Equality Act 2010, in that you engaged in unwanted conduct of a sexual nature which had the purpose or effect of violating the dignity of Patient B, or creating an intimidating, hostile, degrading, humiliating or offensive environment for Patient B. **Determined and found proved**

14. Your actions as set out at paragraphs:

    a. 8, 9 and/or 10 were sexually motivated;
    Determined and found proved in relation to paragraphs 9(g) to 9(j) and 9(k)(ii)-(v).

    b. 9a to 9j, were carried out without Patient B's consent.
    Determined and found proved in relation to paragraphs 9(g) to 9(j).

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 - 17/07/2026

1. Parts of this hearing were heard in private in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 ('the Rules'). This determination will be handed down in private due to the confidential nature of matters under consideration.

However, as this case concerns Dr Smerdon's alleged misconduct, a redacted version will be published at the close of the hearing.

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 as set out before, Dr Smerdon's fitness to practise is impaired by reason of misconduct.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows:

- A statement from Dr Smerdon's Responsible Officer, Dr J, dated 10 April 2025;
- Written reflection from Dr Smerdon after completing a Professional Boundaries in Practice course, dated 10 April 2020;
- Reflective Statement from Dr Smerdon
- Continuing Professional Development (CPD) Certificates, various dates.

Submissions

On behalf of the GMC

4. On misconduct, Mr Taylor submitted that the Tribunal must decide whether the proved facts constitute serious professional misconduct. He submitted that misconduct is qualified by its professional nature and its seriousness, the latter being conduct that fellow practitioners would regard as "*deplorable*". He contended that both categories of misconduct identified in the case of *R (Remedy UK Ltd) v GMC* [2010] EWHC 1245 (Admin) are present: misconduct arising in the exercise of professional practice, and misconduct that is morally culpable or disgraceful and brings the profession into disrepute.

5. Mr Taylor highlighted that Dr Smerdon's behaviour towards Patients A and B occurred in a clinical context, involved sexual motivation, and exploited vulnerable patients. He noted that the Tribunal had found that in 2013 Dr Smerdon kissed and fondled Patient A, obtained her number, sent her a message describing her as "*absolutely gorgeous*", and entered into a sexual relationship with her. In 2019, he hugged and kissed Patient B, including kissing her on the mouth, conduct the Tribunal found to be non-consensual and constituted sexual

harassment. Mr Taylor submitted that this behaviour was *"predatory", "dishonourable and disgraceful",* and would be regarded as utterly deplorable by fellow practitioners. Mr Taylor emphasised that each incident alone amounted to serious professional misconduct and, taken together, the seriousness was even greater.

6. Turning to impairment, Mr Alan Taylor submitted that Dr Smerdon's fitness to practise is impaired under Section 35C(2) of the Medical Act 1983 and Rule 17(2)(k) because the case engages all three limbs of the statutory over-arching objective of the protection of the public: protecting, promoting and maintaining the health, safety and well-being of the public; promoting and maintaining public confidence in the medical profession; and promoting and maintaining proper professional standards and conduct for members of the medical profession.

7. Mr Taylor submitted that the Tribunal must look forward, but must also consider past misconduct and whether it has been remedied. He submitted that sexual misconduct of this nature is not easily remediable, and that in such cases the doctor's efforts to address behaviour for the future carry "*very much less weight".* He submitted that the risk of repetition cannot be dismissed, given that Dr Smerdon repeated similar misconduct six years after the first incident.

8. Mr Taylor submitted that Dr Smerdon lacked genuine insight, noting that he denied key allegations, minimised his conduct, and in Patient B's case, suggested she initiated the behaviour, which was rejected by the Tribunal. He submitted that insight requires understanding motivations and triggers, which is difficult without accepting the underlying conduct.

9. Mr Taylor submitted that Dr Smerdon breached multiple provisions of Good Medical Practice ('GMP') 2006 and 2013 versions, and the *Maintaining Boundaries* guidance applicable to those, including the prohibitions on pursuing sexual or improper relationships with patients or former patients, particularly those who are vulnerable. He submitted that these were fundamental tenets of the profession.

10. Applying Dame Janet Smith's Shipman test (set out below under *Advice of the Legally Qualified Chair (LQC)*), Mr Taylor submitted that all three relevant limbs were engaged: Dr Smerdon had put patients at unwarranted risk of harm, brought the profession into disrepute, and breached fundamental professional standards. For these reasons, Mr Taylor

submitted that a finding of impairment was required to protect the public, uphold proper standards and maintain public confidence.

On behalf of Dr Smerdon

11. Ms Vivienne Tanchel submitted that the Tribunal should rely on the most recent authority, *Sawati v GMC* [2022] EWHC 283 (Admin), which provides a detailed analysis of how a rejected defence should be treated. She quoted the judgment's warning that a rejected defence cannot be determinative because doing so would undermine a doctor's Article 6 right to defend themselves. Ms Tanchel submitted that before a rejected defence can be treated as evidence of lack of insight, the Tribunal must first consider other evidence of insight or lack of insight. She submitted that the GMC's submissions wrongly invited the Tribunal to start with the rejected defence, which was contrary to that approach. She submitted that before a tribunal can be sure of making fair use of a rejected defence, the Tribunal must examine the broader evidential picture.

12. Ms Tanchel noted that in his reflective piece, prepared after the Tribunal's determination on the facts, Dr Smerdon accepted that the facts found proved amounted to misconduct but submitted that this did not amount to a "*Damascene conversion".* She acknowledged that he did not accept the disputed facts, and that the Tribunal remained free to reach its own judgement on misconduct. Ms Tanchel submitted that the central issue was not misconduct but current impairment.

13. Turning to the two patient cases, Ms Tanchel submitted that the circumstances of Patient A and Patient B were materially different. She outlined that the Tribunal had rejected Patient A's evidence of coercion and had found she had capacity to make decisions, including entering a consensual relationship. She submitted that this placed the misconduct at the *"lower end"* of the spectrum of sexual misconduct and made it more readily remediable. She contrasted this with more serious cases, such as rape, arguing that the GMC's approach left no room for gradation.

14. Ms Tanchel submitted that Dr Smerdon had undertaken extensive, early and genuine remediation. She referred to his CPD and reflective work beginning in March and April 2020, quoting his reflections on power imbalance and boundary-keeping, including his written statement. Ms Tanchel highlighted Dr Smerdon's further remediation in 2025, his detailed reflections on the impact on both patients, and his structured development and restoration plan, which she described as unusually thorough for a non-clinical case.

15. Ms Tanchel submitted that there was no basis for finding impairment on public protection grounds, arguing that the risk of repetition was negligible given the passage of time, the early stage of his career when the incidents occurred, and the depth of his remediation. She accepted that the public interest limbs were more difficult but argued that a fully informed member of the public, aware of the remediation, would not consider him currently impaired. Ms Tanchel concluded that the Tribunal must start with the evidence of insight and remediation, not the rejected defence, and that Dr Smerdon is not currently impaired.

Advice of the Legally Qualified Chair (LQC)

16. On 26 March 2026 the LQC gave written legal advice to the Tribunal on impairment. The Tribunal accepted the legal advice.

17. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

18. 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 led to a finding of impairment.

19. The Tribunal must determine whether Dr Smerdon's fitness to practise is impaired today, taking into account Dr Smerdon's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, whether they have been remedied, and whether there is a likelihood of repetition.

20. The LQC reminded the Tribunal that whilst there is no statutory definition of impairment, the Tribunal is assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as adopted by the High Court in *CHRE v NMC and Paula Grant* [2011] EWHC 297 Admin. The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

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 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; and/or

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

The Tribunal's Determination on Impairment

Misconduct

21. The Tribunal first considered whether Dr Smerdon's actions in respect of Patient A amounted to misconduct.

22. The Tribunal reminded itself of its findings at the facts stage that Dr Smerdon had engaged in a course of sexually motivated conduct and entered into a sexual relationship with a patient that he knew was vulnerable due to her mental health.

23. The Tribunal considered that due to Patient A's vulnerability and that she was his patient at the time he began this course of conduct, Dr Smerdon was in a position of power. It also found that Dr Smerdon had told Patient A, in a text message, not to tell anyone because he *"could get into serious trouble and be struck off"*, and that once he had stopped working at Hospital C he continued to pursue a sexual relationship with Patient A, telling her that she could move to be with him and start a new life with him.

24. The Tribunal considered Dr Smerdon's actions in relation to Patient A to be a single course of action which occurred over a period of time and that he had stated that it was his intention to keep in contact with her.

25. In reaching its determination on misconduct, the Tribunal considered the applicable paragraphs of Good Medical Practice (2006) ('GMP 2006'), which was in force until 22 April 2013, as set out below.

'20 Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs.

21 Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs. To fulfil your role in the doctor-patient partnership you must:

…

(b) treat patients with dignity

25 You must safeguard and protect the health and well-being of children and young people.

28 The guidance in paragraphs 25–27 is about children and young people, but the principles also apply to other vulnerable groups.

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

56 Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.

57 You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.'

26. The Tribunal also considered the applicable paragraphs of the guidance *Maintaining Boundaries* (2006) which was also in force until 22 April 2013.

'1 In our core guidance for doctors, Good Medical Practice we advise that:

…

You must treat patients with dignity.

…

4 In order to maintain professional boundaries, and the trust of patients and the public, you must not establish or pursue a sexual or improper emotional relationship with a patient. …

5 You must not pursue a sexual relationship with a former patient, where at the time of the professional relationship the patient was vulnerable, for example because of mental health problems, or because of their lack of maturity.

6 Pursuing a sexual relationship with a former patient may be inappropriate, regardless of the length of time elapsed since the therapeutic relationship ended. This is because it may be difficult to be certain that the professional relationship is not being abused.'

27. The Tribunal concluded that Dr Smerdon's actions breached all the above paragraphs of GMP and *Maintaining Boundaries* and that in relation to paragraph 20, on 5 January 2013 he failed to build a doctor-patient relationship based on trust and good communication.

28. The Tribunal also considered the applicable paragraphs of Good Medical Practice (2013) ('GMP 2013'), which was in force from 22 April 2013, when Dr Smerdon's sexual relationship with Patient A, which commenced when she was still his patient, remained ongoing.

'2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

47 You must treat patients as individuals and respect their dignity and privacy.

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.'

29. The Tribunal also considered that Dr Smerdon's actions breached paragraph 8(c) of *Maintaining a professional boundary between you and your patient* (2013 – 2024), which states:

> *'8 Personal relationships with former patients may also be inappropriate depending on factors such as:*
>
> *…*
>
> *c whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable.'*

30. The Tribunal determined that Dr Smerodn's actions in respect of Patient A breached numerous paragraphs of the applicable guidance and that members of the public and members of the profession alike would consider his behaviour deplorable. It concluded that Dr Smerdon's actions lacked integrity, undermined public and patient trust and failed to treat Patient A with dignity.

31. The Tribunal considered that all cases of sexual misconduct are necessarily serious and noted that both counsel submitted that Dr Smerdon's actions amounted to serious misconduct.

32. The Tribunal concluded that Dr Smerdon's conduct in respect of Patient A fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

33. The Tribunal then went on to consider whether Dr Smerdon's actions in respect of Patient B amounted to misconduct. It reminded itself of its findings at the fact stage that Dr Smerdon engaged in a sexually motivated course of behaviour with a patient who he knew was vulnerable due to her mental health. This behaviour included non-consensual touching and kissing for the purposes of sexual gratification and constituted sexual harassment.

34. As with Patient A, Dr Smerdon was in a position of power owing to the doctor-patient relationship and Patient B's vulnerability, and warned Patient B *"if things go badly, you could get me into trouble by reporting me for having a relationship with a patient."*

35. The Tribunal considered Dr Smerdon's actions in relation to Patient B to be a single course of action which occurred during a consultation with Patient B on 15 November 2019.

36. In reaching its determination on misconduct, the Tribunal considered the applicable paragraphs of GMP 2013, as set out below.

> *'2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.*
>
> *47 You must treat patients as individuals and respect their dignity and privacy.*
>
> *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.'*

37. The Tribunal also considered that Dr Smerdon's actions breached paragraph 4 of *Maintaining a professional boundary between you and your patient* (2013 – 2024), which states:

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

38. The Tribunal determined that Dr Smerdon's actions in respect of Patient B breached multiple paragraphs of the applicable guidance and that members of the public and members of the profession alike would consider his behaviour deplorable. It concluded that Dr Smerdon's actions lacked integrity, undermined public and patient trust and failed to treat Patient B with dignity.

39. The Tribunal considered that all cases of sexual misconduct are necessarily serious and noted that both counsel submitted that Dr Smerdon's actions amounted to serious misconduct.

40. The Tribunal concluded that Dr Smerdon's conduct in respect of Patient B fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

41. The Tribunal therefore determined that Dr Smerdon's conduct in respect of Patient A and Patient B individually amounted to misconduct.

Impairment

42. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Smerdon's fitness to practise is currently impaired.

43. In considering impairment, the Tribunal first considered whether Dr Smerdon's misconduct was remediable.

44. The Tribunal bore in mind that the authority *Yeong v GMC* [2009] EWHC 1923 (Admin) indicated that sexual misconduct is not easily remediable.

45. The Tribunal found that Dr Smerdon's knew that Patient A and Patient B were vulnerable at the time, and was aware that what he was doing was a breach of standards as demonstrated by his messages and comments to Patient A and Patient B. Nonetheless, he chose to deliberately disregard these standards and the expectations upon him with two separate vulnerable patients approximately seven years apart. The Tribunal was of the opinion that this intentional disregard and repetition indicated a deep-seated or attitudinal component to Dr Smerdon's misconduct.

46. The Tribunal therefore concluded that whilst potentially remediable, Dr Smerdon's misconduct was difficult to remediate.

47. The Tribunal then went on to consider whether Dr Smerdon's misconduct had been remedied, including looking for evidence that demonstrates insight and genuine remorse.

48. The Tribunal first considered the evidence of remediation provided by Dr Smerdon, which included the CPD certificates for: *Professional Boundaries in Practice* (7 hours) March 2020; *Chaperoning* January 2025; *Sexual harassment in the workplace* March 2025; *Maintaining Professional Boundaries* (22 hours) April 2025; *Bullying and Harassment* April

2025; *Essential Communication Skills* April 2025; Coaching with the *Professional Boundaries Company* (4.5 hours) June 2025; *Your Personal Development* June 2026; *Managing Difficult Situations* June 2026; *Safeguarding Children Level 3* January 2026; *Safeguarding Adults – Level 3* January 2026.

49. Dr Smerdon also provided his written reflections on the *Professional Boundaries in Practice* course, dated 10 April 2020, and written reflections drafted following the Tribunal's findings of facts.

50. In his most recent written reflections, Dr Smerdon stated that he accepted that the Tribunal's findings on fact amount to serious professional misconduct. In respect of his actions he states that he had:

> *"…come to understand how my natural communication style, which has tended toward over-familiarity in the past, had contributed to professional boundary transgression. Through these reflections I have identified several both personal and professional vulnerabilities that have contributed to my poor conduct at that time."*

51. In respect of his sexual misconduct towards Patient A he states:

> *"I have understood now, after my professional boundary course that what led to this in the past was emotional vulnerability and [XXX] alongside extensive work and financial pressures. In retrospect I had not taken time to recognize this and I was unconsciously in need of love and validation. I believe this led to my threshold being lowered at the time, leading to my irrational and impulsive need to maintain a connection with pt A.*
>
> *…*
>
> *I wish to again extend my sincere heartfelt apologies to pt A for any suffering which I may have unwittingly caused by my actions.*
>
> *…*
>
> *Through the remediation process, I have since undertaken the comprehensive intensive 3-day Professional Boundaries course in 2025 and then arranged and tailored further reflective and rehabilitative work through multiple one-to-one*

coaching sessions with [Ms K], the author of the Boundaries programme. These sessions helped me develop greater self-awareness and clearer insight into how my words and actions can be perceived.

…

I now approach communication with greater caution and sensitivity, ensuring I avoid any comments that could be misunderstood or feel intrusive, and I am much more attuned to how past roles or dynamics may influence current interactions."

52. The Tribunal was concerned that despite its findings and the evidence of the impact upon Patient A and Patient B, including their oral evidence, Dr Smerdon appeared to avoid accepting full responsibility for his actions and seemed to be minimising the impact of his actions. Patient B said that since her interactions with Dr Smerdon, she had struggled with trusting people in positions of authority, especially men, which had caused her to worry about interactions with professionals in case the same thing were to happen again.

53. The Tribunal was of the opinion that Dr Smerdon's comments such as "… *suffering which I **may** have unwittingly caused… insight into how my words and actions **can be perceived**… any comments that **could be misunderstood** or feel intrusive"* appeared to demonstrate that he was failing to acknowledge the findings of the Tribunal, their seriousness, and the impact that they did have.

54. This concern of the Tribunal extended to the section of his written reflections headed *"Impact and consequences"* where Dr Smerdon states:

*"Since learning of the complaints against me from NHSE in April 2023, learning about the Police involvement, the Hospital A investigation, NHSE investigation, DBS, and subsequent GMC involvement, I have been reminded of the far-reaching consequences of my actions. I have spent the last 3 years under constant reflection and undertaken remedial action to mitigate against any future transgression of professional boundaries. I have reflected on the **possible** impact my actions had on pt A and B and how this **might have** impacted on a long-term psychological distress which **might** have ensued as a direct consequence. I have reflected upon the breach of trust between myself as doctor and them as patients and how this **could have** had a damaging effect on their ability to trust healthcare professionals in the future.*

I have also reflected on a wider impact. The public places trust in doctors. I now fully understand that maintaining public confidence always requires doctors to uphold professional standards regardless of personal circumstances or intentions. I recognize also the wider negative impact this ***might have*** *on bringing the medical profession into ill repute and damaging public trust in the profession. This is not something I take lightly, and I take full responsibility for my actions. I have also reflected on the effect of my actions on my own workplace and the disruption to working practice because of my actions. Finally, the impact on my own life, including friends, family and my colleagues has been significant. I have caused embarrassment to my colleagues, experienced professional snubbing, lost friends and breakdown of a significant relationship. [XXX]."*

55. The Tribunal considered that Dr Smerdon had failed to acknowledge the specific findings made against him, particularly in relation to Patient B and sought to minimise his misconduct and its impact. In his reflections, as set out above, he described the impact to himself in far more concrete terms than for either Patient A or Patient B, which he framed as potential or theoretical. Similarly, the Tribunal considered that his written reflections minimised or did not fully acknowledge the impact his actions had on the wider profession and public confidence.

56. In respect of his *"vulnerabilities"* leading to his "*threshold being lowered at the time, leading to my irrational and impulsive"* behaviour, the Tribunal was not provided with any medical or otherwise compelling evidence as to how this materially contributed to his behaviour. The Tribunal found that at the time Dr Smerdon knew that his behaviour was inappropriate and nonetheless consciously proceeded.

57. Dr Smerdon's reflections on the *Professional Boundaries in Practice* course, written in 2020 described what he had learnt in generalised terms and did not apply this to the specific circumstances of this case.

58. The Tribunal concluded that whilst Dr Smerdon had taken steps to remediate and demonstrate insight, his insight remained limited. His development and restoration plan, though detailed, appeared to focus on reducing stressors in his life that could lead to his 'threshold being lowered' or him behaving in an impulsive or irrational fashion, but the Tribunal considered that such stresses or personal challenges could reoccur and Dr Smerdon had not explained how he would avoid acting in a similar fashion were this to happen. Dr Smerdon stated that he had not had any specific training on maintaining professional

boundaries at the time of the events but, in the view of the Tribunal, it should be obvious that such behaviour is inappropriate, and the evidence demonstrates that Dr Smerdon knew this. The Tribunal did not receive any clear explanation from Dr Smerdon as to why he chose to proceed with his sexual misconduct in the circumstances or how he had developed meaningful insight in this regard.

59. The Tribunal then went on to consider whether there was any likelihood of repetition of Dr Smerdon's misconduct.

60. Ms Tanchel submitted that these events had occurred a long time ago and that Dr Smerdon had undertaken XXX and CPD and that the risk of repetition was negligible.

61. The Tribunal considered that whilst Dr Smerdon's reflections stated that he had "*fully implemented the use of chaperones in all consultations with female patients and now maintain[s] a more structured and formal approach in all clinical encounters"* and was committed to *"Noticing and challenging distorted perceptions before acting"* he had not sufficiently described or explained how he would prevent repetition.

62. The Tribunal reminded itself of its findings at the facts stage that there was a *"connection and similarity between the facts of the allegations in respect of Patient A and Patient B"* and that *"its findings in relation to Patient A are indicative of a propensity on the part of Dr Smerdon to act in a sexually inappropriate manner towards young female patients."*

63. The Tribunal concluded that in light of the absence of meaningful insight and Dr Smerdon's propensity to behave in such a manner, when considered with the fact that he had repeated similar behaviour with two patients, seven years apart. Accordingly, the Tribunal attributed the passage of time since the events little weight in terms of reducing the risk of repetition.

64. The Tribunal considered the positive testimonials provided on Dr Smerdon's behalf, which spoke of his good character and demonstrated that he is a highly regarded practitioner. However, given the seriousness of its findings and that the testimonials did not specifically address the sexual misconduct in this case, the Tribunal attributed them little weight in assessing the risk of repetition or reaching its determination on impairment.

65. The Tribunal also took into account that Dr Smerdon has no previous adverse fitness to practise findings against him.

66. In its decision-making on impairment, the Tribunal was also conscious, that notwithstanding Mr Taylor's submission at the impairment stage that Dr Smerdon's conduct was *"predatory"*, the Allegation (which was lengthy and detailed) did not contain the word *"predatory"*, and the Tribunal had not made a specific finding of fact that Dr Smerdon's conduct was *"predatory"*.

67. In its decision-making on impairment, in the interests of fairness to Dr Smerdon, the Tribunal, notwithstanding Mr Taylor's submissions, gave no weight to any *"rejected defence"* of Dr Smerdon as indicating lack of insight.

68. Overall, the Tribunal concluded that given the absence of meaningful insight and incomplete remediation, there remained a risk of repetition.

69. In reaching its decision as to whether Dr Smerdon's fitness to practise is currently impaired, the Tribunal considered the test set out in *Grant*, above. It concluded that limbs a, b and c of the test were applicable in this case, namely that Dr Smerdon:

> *(a) Has in the past acted, and is liable in the future to act, so as to put a patient or patients at unwarranted risk of harm;*
> *(b) Has in the past brought, and is liable in the future to bring, the profession into disrepute;*
> *(c) Has in the past breached, and is liable in the future to breach, one of the fundamental tenets of the profession.*

70. The Tribunal considered that Dr Smerdon's actions had a tangible detrimental psychological effect on Patient A and Patient B, which had been demonstrated (and the Tribunal observed) during their evidence. It had also heard evidence that Patient A had not realised how much of an effect the events had on her until a later crisis involving the mental health team.

71. The Tribunal considered Dr Smerdon's actions had brought the profession into disrepute, particularly given that he knew what he was doing was wrong at the time. It considered that a doctor taking advantage of vulnerable, young female patients with mental health issues would undermine public confidence in the profession.

72. The Tribunal also considered that Dr Smerdon's actions breached fundamental tenets of the profession in that he failed to put the interests of patients first, he failed to treat patients with dignity, and he failed to uphold the trust placed in doctors and the profession.

73. The Tribunal considered whether, in light of its findings set out above, a finding of impairment was necessary in order to uphold any of the three limbs of the over-arching objective.

74. The Tribunal concluded that given the lack of meaningful insight and the identified risk of repetition, a finding of current impairment was necessary in order to uphold the first limb of the over-arching objective, namely to protect, promote and maintain the health, safety and well-being of the public.

75. The Tribunal considered that a well-informed member of the public knowing all of the facts of the case, and in particular that at the time he knew what he was doing was wrong but still proceeded with his course of action, would be of the opinion that Dr Smerdon's fitness to practise was currently impaired.

76. The Tribunal concluded that given the seriousness of its findings, a finding of impairment was necessary in order to uphold the second and third limbs of the over-arching objective, namely to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

77. The Tribunal considered what message it would be sending were no finding of current impairment to be made and the impact this would have on patients about feeling safe when undergoing medical care with any doctor. Given the finding that Dr Smerdon's insight was incomplete and a risk of repetition remained, this reinforced the need to make a finding of impairment.

78. The Tribunal has therefore determined that Dr Smerdon's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 21/08/2026

1. Parts of this hearing were heard in private in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 ('the Rules'). This determination will be

handed down in private due to the confidential nature of matters under consideration. However, as this case concerns Dr Smerdon's alleged misconduct, a redacted version will be published at the close of the hearing.

2. Having determined that Dr Smerdon's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

3. The Tribunal has taken into account evidence received during the earlier stages of the hearing, where relevant, to reaching a decision on sanction. The Tribunal also took into account an additional one-page XXX letter dated 26 June 2026, which the Tribunal received as "further evidence" at the sanction stage under Rule 17(2)(m).

Submissions

4. Both parties provided written submissions on sanction in advance of the hearing on 20 August 2026, which they supplemented with oral submissions during the hearing.

<u>On behalf of the GMC</u>

5. On behalf of the GMC, Mr Taylor submitted that the Tribunal should have regard to its findings at the impairment stage when reaching a decision on sanction. He submitted that the Tribunal found that in relation to Patient A and Patient B, Dr Smerdon had, whilst in a position of power, engaged in a course of sexually motivated conduct. Dr Smerdon had entered into a sexual relationship with Patient A when he knew she was vulnerable due to her mental health. Dr Smerdon's behaviour in respect of Patient B included non-consensual touching and kissing for the purposes of sexual gratification and constituted sexual harassment.

6. Mr Taylor submitted that Dr Smerdon was aware that what he was doing was a breach of standards, which he chose to deliberately disregard in respect of two separate vulnerable patients approximately seven years apart, and that the Tribunal's conclusion, in its determination on impairment, was that this intentional disregard and repetition indicated a deep-seated or attitudinal component to Dr Smerdon's misconduct.

7. Mr Taylor submitted that the Tribunal concluded that whilst Dr Smerdon had taken steps to remediate and demonstrate insight, his insight remained limited. He submitted that there has been limited acknowledgement of fault in relation to Patient A and no acknowledgement of fault in relation to Patient B and that the Tribunal did not receive any clear explanation from Dr Smerdon as to why he chose to proceed with his sexual misconduct in the circumstances or how he had developed meaningful insight in this regard. He submitted that the Tribunal concluded that there was a risk of repetition and that a finding of impairment was required in respect of all three limbs of the over-arching objective.

8. Mr Taylor submitted that consideration of the mitigating factors set out by Ms Tanchel was a matter for the Tribunal, but that they should be given limited weight in this case owing to the gravity of the findings.

9. Mr Taylor submitted that the aggravating features of this case were that it involved an abuse of position in respect of sexual misconduct towards vulnerable patients.

10. Mr Taylor submitted that this was not a case in which there were exceptional circumstances which could justifying taking no action and that to do so would be wholly inadequate. He also submitted that the facts of this case were far too serious for conditions to be an appropriate or proportionate sanction.

11. Mr Taylor told the Tribunal that no written undertakings had been agreed between the parties.

12. Mr Taylor submitted that in considering the applicable paragraphs of the Sanctions Guidance (2024) ('the SG'), suspension would not be appropriate or proportionate, reflect the seriousness of the findings made or uphold the statutory over-arching objective. He submitted that the misconduct in this case was so serious that complete removal from the Medical Register was in the public interest and was the only means of protecting the public. He submitted that Dr Smerdon's behaviour is fundamentally incompatible with continued registration and that erasure is the appropriate and proportionate sanction in this case.

13. Mr Taylor submitted that this case involves sexual misconduct committed against two vulnerable young female patients in 2012/2013 and 2019 whilst Dr Smerdon was working in an XXX and in Medical Centre D respectively, and that erasure was required both because Dr Smerdon presents an ongoing risk to patient safety, and because such action was necessary to maintain public confidence in the profession.

On behalf of Dr Smerdon

14. On behalf of Dr Smerdon, Ms Tanchel submitted that a period of suspension for 12 months with a review was the proportionate and sufficient sanction in the circumstances of this case.

15. Ms Tanchel submitted that it was accepted that sexual misconduct towards a patient is treated as being among the most serious categories of misconduct a doctor can commit, because it involves a fundamental breach of trust at the heart of the doctor-patient relationship and is inherently damaging to public confidence in the profession. She also accepted that misconduct of this kind, because it goes to personal integrity and the reputation of the profession rather than clinical competence, is generally harder to remediate through training or supervision than a clinical performance concern, and that evidence of remediation is correspondingly given more limited weight than it would be in a pure competence case. However, it is not the case that sexual misconduct automatically or invariably results in erasure irrespective of the individual circumstances.

16. Ms Tanchel submitted that abuse of professional position and sexual misconduct are properly to be treated as aggravating factors but that this (sexual misconduct) should not be *"double counted"* as it is the essence of the offence itself.

17. Ms Tanchel submitted that while personal mitigation is afforded limited weight in cases of this kind, and cannot outweigh the public interest in maintaining confidence in the profession, it remained relevant to the Tribunal's assessment of risk, insight and the proportionate outcome. She submitted that the following were mitigating factors:

a. full engagement with the regulatory process;
b. a recognised course addressing professional boundaries;
c. clinical competence;
d. personal circumstances at the time advanced not as an excuse but as context relevant to risk assessment; the impact of the finding and publicity already suffered; and,
e. the lapse of time.

18. Ms Tanchel submitted that a period of suspension was the sanction that most accurately reflected the seriousness of the conduct while remaining proportionate to the mitigation and insight now demonstrated.

19. Ms Tanchel submitted that a defined period of suspension would mark the Tribunal's serious disapproval, protect patients and public confidence for its duration, and would allow Dr Smerdon's insight, remediation and any risk assessment to be tested afresh by a differently constituted tribunal at a review hearing before any return to practice was contemplated. She submitted that this would be sufficient to meet the over-arching objective.

20. Ms Tanchel submitted that Dr Smerdon took steps to remediate long before this hearing and demonstrated the timely development of insight during the investigation, during the hearing and has repeatedly apologised and expressed his regrets. She submitted that there does not have to be a finality in respect of insight and remediation, which is a journey requiring time and reflection.

21. In terms of the risk of repetition, Ms Tanchel submitted that Dr Smerdon has undergone three investigations which have given him a salutary lesson, as have the context of these proceedings, the duration of these proceedings, the delay in these proceedings, and the entirety of the impact on him. She submitted that the risk of repetition is not just low but at a minimum, and therefore, there is no fundamental incompatibility with continued registration.

22. Ms Tanchel submitted that any sanction restricting a doctor's ability to practise engages Article 8 of the European Convention on Human Rights (right to respect for private life, encompassing the right to pursue a profession) and, in the case of erasure, is a substantial interference with that right. She submitted that the sanction imposed must therefore be the least restrictive that would meet the over-arching objective.

23. Ms Tanchel submitted that sexual misconduct is one of the most serious allegations a doctor can face but that the GMC had failed to identify a spectrum of behaviour and a gradation of the seriousness. She asked the question rhetorically what the GMC submission would be if a doctor raped a patient and submitted that based on Mr Taylor's submissions, somebody coming in and observing this from the outside would be forgiven for thinking that Dr Smerdon had either murdered the patient or raped them and that nowhere did Mr Taylor

set out for the Tribunal any scale of offending or leave room for offences or behaviour which could be significantly more serious than this.

24. Ms Tanchel submitted that the Tribunal should consider both the impact of erasure to Dr Smerdon, and the public - namely the shortage of supply of clinicians in his area of practice (general practice).

The Tribunal's Determination on Sanction

25. The Legally Qualified Chair provided legal advice to the Tribunal at the sanction stage which was accepted by the Tribunal and is a matter of record.

26. The Tribunal's decision as to the appropriate sanction to impose on Dr Smerdon's registration, if any, was a matter for the Tribunal exercising its independent judgment. In reaching its decision, the Tribunal took account of the SG and the over-arching objective, namely to protect the health, safety, and wellbeing of the public, maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for the members of the profession.

27. In making its decision, the Tribunal had regard to the principle of proportionality, and it weighed Dr Smerdon's interests with those of the public. Throughout its deliberations the Tribunal bore in mind that the purpose of sanctions is not to punish doctors although they may have a punitive effect.

28. The Tribunal has also borne in mind that in deciding what sanction, if any, to impose, it should consider all the sanctions available, starting with the least restrictive and then consider each sanction in ascending order.

29. In reaching its decision, The Tribunal considered whether there were any mitigating factors present in the case. In doing so, it had regard to paragraph 24 of the SG, which states:

> ***24*** *The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions. The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.*

30. The Tribunal acknowledged the mitigating factors set out by Ms Tanchel in her submissions, namely: that Dr Smerdon has fully engaged with the regulatory process; he has attended a recognised course addressing professional boundaries; his clinical competence has not come under question; his personal circumstances at the time of the events are context relevant to risk assessment; the impact on Dr Smerdon of the findings already made and the publicity; and, the lapse of time since the events.

31. Whilst the Tribunal accepted that these mitigating factors were present, it did not attribute them significant weight when assessing what sanction, if any, to impose due to the seriousness of the concerns and its findings at the earlier stages, as indicated by the SG.

32. The Tribunal also considered whether there were any features of the case which indicated that more serious action was likely to be required. In doing so it had regard to the following paragraphs of the SG under the heading *Cases that indicate more serious action is likely to be required*:

> *'Abuse of professional position*
>
> ***142*** *Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 86 of Good medical practice and in the more detailed guidance Maintaining personal and professional boundaries and Ending your professional relationship with a patient.*
>
> ***143*** *Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*
>
> *Vulnerable patients*
>
> ***145*** *Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:*
>
> > ***a*** *presence of mental health issues …*
>
> ***146*** *Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.*

Sexual misconduct

149 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others.

150 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.'

33. The Tribunal determined that the above paragraphs of the SG were applicable and that these features (abuse of professional position, vulnerable patients, sexual misconduct) were all present in this case, indicating that more serious action was likely to be required.

No action

34. The Tribunal first considered whether to conclude the case by taking no action.

35. The Tribunal determined that there were no exceptional circumstances which would justify the taking of no action, particularly in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be proportionate, or sufficient to protect the public and would fail to uphold the statutory over-arching objective.

Conditions

36. The Tribunal next considered whether a period of conditions would be the appropriate and proportionate sanction in the circumstances. In doing so, it reminded itself that where conditions are put in place, they should be appropriate, proportionate, workable and measurable.

37. The Tribunal took into account that neither party had suggested that the imposition of conditions would be appropriate or that any particular condition might be suitable.

38. The Tribunal determined that owing to the seriousness of its findings, amounting to sexually motivated conduct towards two vulnerable patients, conditions would not be appropriate or proportionate and would fail to uphold the statutory over-arching objective.

Suspension

39. The Tribunal then went on to consider whether to impose a period of suspension on Dr Smerdon's registration. In doing so it reminded itself of its findings at the impairment stage, as set out below.

> *'44. The Tribunal bore in mind that the authority Yeong v GMC [2009] EWHC 1923 (Admin) indicated that sexual misconduct is not easily remediable.*
>
> *45. The Tribunal found that Dr Smerdon's knew that Patient A and Patient B were vulnerable at the time, and was aware that what he was doing was a breach of standards as demonstrated by his messages and comments to Patient A and Patient B. Nonetheless, he chose to deliberately disregard these standards and the expectations upon him with two separate vulnerable patients approximately seven years apart. The Tribunal was of the opinion that this intentional disregard and repetition indicated a deep-seated or attitudinal component to Dr Smerdon's misconduct.*
>
> *46. The Tribunal therefore concluded that whilst potentially remediable, Dr Smerdon's misconduct was difficult to remediate.*
>
> *…*
>
> *55. The Tribunal considered that Dr Smerdon had failed to acknowledge the specific findings made against him, particularly in relation to Patient B and sought to minimise his misconduct and its impact. In his reflections, as set out above, he described the impact to himself in far more concrete terms than for either Patient A or Patient B, which he framed as potential or theoretical. Similarly, the Tribunal considered that his written reflections minimised or did not fully acknowledge the impact his actions had on the wider profession and public confidence.*
>
> *…*

58. The Tribunal concluded that whilst Dr Smerdon had taken steps to remediate and demonstrate insight, his insight remained limited. His development and restoration plan, though detailed, appeared to focus on reducing stressors in his life that could lead to his 'threshold being lowered' or him behaving in an impulsive or irrational fashion, but the Tribunal considered that such stresses or personal challenges could reoccur and Dr Smerdon had not explained how he would avoid acting in a similar fashion were this to happen. Dr Smerdon stated that he had not had any specific training on maintaining professional boundaries at the time of the events but, in the view of the Tribunal, it should be obvious that such behaviour is inappropriate, and the evidence demonstrates that Dr Smerdon knew this. The Tribunal did not receive any clear explanation from Dr Smerdon as to why he chose to proceed with his sexual misconduct in the circumstances or how he had developed meaningful insight in this regard.

…

63. … the absence of meaningful insight and Dr Smerdon's propensity to behave in such a manner, when considered with the fact that he had repeated similar behaviour with two patients, seven years apart. Accordingly, the Tribunal attributed the passage of time since the events little weight in terms of reducing the risk of repetition.

…

67. In its decision-making on impairment, in the interests of fairness to Dr Smerdon, the Tribunal, notwithstanding Mr Taylor's submissions, gave no weight to any "rejected defence" of Dr Smerdon as indicating lack of insight.

68. Overall, the Tribunal concluded that given the absence of meaningful insight and incomplete remediation, there remained a risk of repetition.'

40. The Tribunal then considered the relevant paragraphs of the SG, in particular paragraphs 92, 93 and 97(a), (e), (f) and (g), as set out below.

'92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for

which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 *Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.*

97 *Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*

> ***a*** *A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*
>
> *…*
>
> ***e*** *No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> ***f*** *No evidence of repetition of similar behaviour since incident.*
>
> ***g*** *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

41. The Tribunal found that whilst Dr Smerdon had demonstrated his willingness to engage, he had minimised his misconduct and its impact, demonstrated limited insight and that a risk of repetition remained. Whilst the Tribunal did not quantify that risk, it was not satisfied that, on the basis of its earlier findings and the evidence, the behaviour could be said to be 'unlikely' to be repeated. The Tribunal acknowledged that there had been no repetition, but due to the passage of time that it noted as having passed between Dr Smerdon's sexual misconduct in respect of Patient A and Patient B, it had attributed the passage of time since the events little weight in terms of reducing the risk of repetition. The Tribunal noted the submission of Ms Tanchel that these proceedings will have had a salutary

effect on Dr Smerdon but did not accept that this could be attributed any significant weight in assessing the risk of repetition.

42. Although the Tribunal found that Dr Smerdon's insight was limited, it did not consider it fair to say that he demonstrated a *persistent* lack of insight, and so did not accept the GMC's submission in this regard. However, of concern to the Tribunal was that Dr Smerdon had awareness (and, in a sense, therefore, insight) into his behaviour at the time of events themselves, in that he knew that Patient A and Patient B were vulnerable and that his actions were inappropriate. Despite this awareness, he chose to proceed. As set out in its impairment determination, the Tribunal concluded that it was and had been obvious to Dr Smerdon at the time that his actions were inappropriate, and so it also did not attribute any significant weight to the fact that his actions in respect of Patient A occurred early in his career.

43. The Tribunal considered that Dr Smerdon's actions, whereby he engaged in sexually motivated conduct towards two young, vulnerable, female patients was particularly serious. These actions were carried out in the course of his practice as a doctor and were repeated over an extended period of time, constituting sexual harassment in the case of Patient B. Dr Smerdon knew at the time that his actions were inappropriate and unacceptable and that he *"could get into serious trouble and be struck off"* and demonstrated a reckless disregard for the standards expected and core tenets of the medical profession.

44. The Tribunal was of the opinion that owing to the serious, repeated and deliberate nature, compounded by Dr Smerdon's limited insight and the risk of repetition, these actions were fundamentally incompatible with continued registration. As such, it determined that a period of suspension would fail to uphold each of the three limbs of the over-arching objective, all of which it found to be applicable in this case, and that it was neither an appropriate nor a proportionate sanction.

45. Although the Tribunal, in its decision-making, went up the ladder of sanctions, the Tribunal did not make its final decision until it had considered all options.

Erasure

46. The Tribunal then went on to consider whether to erase Dr Smerdon's name from the Medical Register. In doing so it had regard to paragraphs 109(a), (b), (c), (d), (e) and (i) of the SG, as set out below.

'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.
b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.
c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.
d Abuse of position/trust (see Good medical practice, paragraph 81: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').
e Violation of a patient's rights/exploiting vulnerable people
…
i Putting their own interests before those of their patients (see Good medical practice introduction on page 7 'Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients your first concern, and meet the standards expected of you in all four domains.' and paragraphs 94–97 regarding conflicts of interest).
…'

47. For the reasons set out previously, the Tribunal determined that all the above paragraphs indicating erasure was the appropriate and proportionate sanction. They were applicable in the circumstances of this case, particularly in light of the established features indicating that more serious action was likely to be required.

48. The Tribunal considered that whilst there were more serious examples of sexual misconduct, such as rape, as submitted by Ms Tanchel, Dr Smerdon's misconduct was so serious that it passed the threshold of being fundamentally incompatible with continued registration. It will always be possible to think of other cases that would be more extreme.

49. In reaching its decision, the Tribunal reiterated its finding that all three limbs of the over-arching objective were engaged. It was of the opinion that even if there was little risk of repetition and the first limb of the over-arching objective to protect the health, safety, and wellbeing of the public was not engaged, the sanction of erasure would be necessary in order

to maintain the second and third limbs, namely to maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for the members of the profession.

50. In reaching this decision, the Tribunal had regard to paragraph 108 of the SG, which states:

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.'*

51. As it had at the impairment stage, the Tribunal considered the positive testimonials provided on Dr Smerdon's behalf, which spoke of his good character and demonstrated that he is a highly regarded practitioner. However, given the seriousness of its findings and that the testimonials did not specifically address the sexual misconduct in this case, the Tribunal attributed them little weight.

52. In reaching its decision, the Tribunal acknowledged the impact erasure would have on Dr Smerdon in terms of both his career and personal circumstances, but balanced this against paragraph 17 of the SG which states:

> *'Maintaining public confidence in the profession*
>
> *17 Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.'*

53. The Tribunal also considered the submission by Ms Tanchel that the profession would be deprived of a competent GP, but considered that, because of the seriousness of its findings, this should not detract from the necessity of erasing Dr Smerdon's name from the Medical Register in order to uphold the statutory over-arching objective. The Tribunal considered that a member of the public in possession of all of the facts of the case would be

appalled were Dr Smerdon allowed to continue to practise as a GP in light of the findings made against him.

54. The Tribunal therefore determined that Dr Smerdon's name be erased from the Medical Register.

Determination on Immediate Order - 21/08/2026

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

2. Having determined that Dr Smerdon's name be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Smerdon's registration should be subject to an immediate order.

Submissions

3. On behalf of the GMC, Mr Taylor submitted that an immediate order of suspension should be imposed in this case.

4. Mr Taylor submitted that the Sanctions Guidance (2024) ("the SG") sets out that an immediate order may be imposed where it is necessary to protect members of the public or is otherwise in the public interest. He submitted that, as set out in the SG, an immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, where the doctor has abused a doctor's special position of trust or where immediate action must be taken to protect public confidence in the medical profession.

5. Mr Taylor submitted that the Tribunal found that there remains a risk to patient safety and that this was a case in which Dr Smerdon abused his position of trust. He submitted that immediate action needs to be taken to protect public confidence in the medical profession during the 28-day period or pending any appeal.

6. Mr Taylor submitted that, in light of the findings that the Tribunal had made and in light of the direction for erasure, it would be wholly inappropriate for Dr Smerdon to practise without restriction on his registration during any appeal period and so an immediate order should be imposed.

7. On behalf of Dr Smerdon, Ms Tanchel advised that she did not have any submissions to make in respect of an immediate order.

The Tribunal's Determination

8. The Tribunal accepted the legal advice provided by the LQC, which was not commented on by either representative.

9. The Tribunal has also taken account of the submissions made, the statutory overarching objective and the relevant paragraphs of the SG, in particular paragraphs 172, 173 and 178 as set out below:

> *'172 The tribunal may impose an immediate order if it determines that 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. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

10. The Tribunal concluded that it would be inappropriate not to impose an immediate order in this case given its findings. It found that all three limbs of the overarching objective

were engaged and that Dr Smerdon's conduct fell seriously below the standards set out in Good Medical Practice (2013) ('GMP')

11. The Tribunal also found that there was a risk to patient safety, an abuse of the position of trust and that a risk of repetition remained.

12. The Tribunal determined that public confidence in the profession would be undermined and that it would be failing to uphold the statutory overarching objective if an immediate order were not imposed in this case and Dr Smerdon were allowed to practise unrestricted during the appeal period or for the duration of any appeal.

13. Accordingly, the Tribunal determined that an immediate order of suspension was required in the public interest.

14. This means that Dr Smerdon's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, 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.

15. The interim order is hereby revoked.

ANNEX A – 21/10/2025

Application for the Tribunal to recuse itself

1. On 20 October 2025, the Legally Qualified Chair (LQC) brought to the attention of parties that he had noticed differences between the two versions of the Police Statement of Patient B dated 26 November 2019 at pages 49 and 50 (redacted) and pages 206 and 208 (unredacted) of the GMC documents bundle.

2. Ms Tanchel, on behalf of Dr Smerdon made an application for the Tribunal to recuse itself. She submitted that pages 206 and 208 of the GMC documents bundle should have been redacted.

3. Ms Tanchel referred the Tribunal to the case of *Porter v McGill [2002]* 2AC 357. She said that the test is whether a fair-minded and informed observer, after considering the facts, would conclude that there is a real possibility that the judge was biased. In the context of recusal, a judge must step down if there is a real possibility of bias, as determined by this objective standard.

4. Ms Tanchel referred the Tribunal to the case of *Lawal v Northern Spirit Ltd [2003]* UKHL 35, in particular paragraph 14. She also referred to *Mahfouz v The Professional Conduct Committee of the General Medical Council [2004]* EWCA Civ 233, 2004 WL 343900, R. *(on the application of Short) v Police misconduct Tribunal [2020] EWHC 385 (Admin)* and *Dr. Ramachandran Subramanian v The GMC [2002] WL 31676255.*

5. In summary, Ms Tanchel said the jurisprudence was absolutely plain, the issue is not just whether there is actual bias but that the Tribunal needs to satisfy itself, the public and Dr Smerdon that there is no perceived bias.

6. Ms Tanchel stated that a MPT preliminary hearing had taken place early October 2025, which covered a number of matters including redactions to the bundles and anonymity. She said the material on page 206 that the Tribunal has now seen erroneously had been the subject of a hotly contested application.

7. Ms Tanchel stated that the preliminary Tribunal had made the decision that the words at page 206 were inadmissible. It had also been agreed between the parties that page 208 would be redacted as this was hearsay evidence and prejudicial. She said that it had been

unfortunate that the determination of the preliminary Tribunal did not set out every single redaction as it was canvassed.

8. Ms Tanchel submitted that it was not open to this Tribunal to go behind those decisions. She submitted that this Tribunal should not have seen the prejudicial material which has already been ruled on or agreed to be removed.

9. Ms Tanchel said that there were two complainants in this case; if there had been a single complainant, Dr Smerdon's position may have been different. However, she said that as this case is presented as two complaints, albeit separate and separated by a significant number of years, the unredacted comment on page 206 and the reference to conduct on page 208 could create a subconscious thought in this Tribunal's mind of a pattern of behaviour.

10. Ms Tanchel said that in respect of the unredacted comment on page 208, this was third or fourth hand hearsay and ought to carry no weight for any Tribunal of fact whatsoever. She submitted it risks Dr Smerdon being exposed to a risk or perception of risk of bias or subconscious bias.

11. Ms Tanchel submitted that this tribunal cannot be perceived to be able to fairly hear the case against Dr Smerdon.

12. The GMC opposed the application. On behalf of the GMC, Mr Taylor submitted that the Tribunal was effectively being asked to recuse itself on the basis of two sentences which it could be said were irrelevant. Furthermore, he was not going to refer the Tribunal to them again because individual Tribunal members may not be that familiar with what this material is and if the Tribunal is not familiar with it, then it would be easier to put it to one side.

13. Mr Taylor submitted that recusal would be a wholly disproportionate and unnecessary response to the issue raised. He said that this was an expert Tribunal and as such could be trusted not to attach weight to irrelevant information put before it. In fact, the information was not put before the Tribunal, it was information which happened to be contained at the end of a bundle which the Tribunal does not need to look at again.

14. Mr Taylor submitted that the Tribunal is well placed to identify and ignore inadmissible materials.

16. The parties also referred to the following cases: *AB, a barrister v Bar Standards Board* [2020] EWHC 3285 (Admin) and *Murphy v General Teaching Council for Scotland* 1997 SLT 1152.

The Relevant Legal Principles

17. The LQC has given legal advice as follows:

18. There are two overlapping areas of law that apply. One is the law relating to recusal and the other is the specific law relating to the inclusion of irrelevant material (prejudicial effect of inadmissible material on an otherwise impartial tribunal).

19. They come from different starting points, but they both have the same underlying concern, which is with the proceedings being fair and being seen to be fair.

20. In the case of *R v Sussex Justices Ex parte McCarthy* [1924] 1 KB 256 (9 November 1923), Lord Hewart said (page 259):

> *'justice should not only be done, but should manifestly and undoubtedly be seen to be done'*

21. In considering the issue of recusal, the test is one of apparent bias. The leading case on apparent bias is:

> *Porter v Magill* [2001] UKHL 67; [2002] 2 AC 357 (13 December 2001) in which Lord Hope said, at paragraph 130:
>
> *"The question is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased."*
>
> We can call that the "*Porter* test".

22. In the Court of Appeal decision of *In re Medicaments and Related Classes of Goods (No 2)* [2001] 1 WLR 700 (21 December 2000), Lord Phillips MR, said at paragraphs 85 to 86:

> *"…The court must first ascertain all the circumstances which have a bearing on the suggestion that the judge was biased. It must then ask whether those circumstances would lead a fair-minded and informed observer to conclude that there was a real possibility, or a real danger, the two being the same, that the tribunal was biased.*
>
> *[86] The material circumstances will include any explanation given by the judge under review as to his knowledge or appreciation of those circumstances."*

23. People who are invited to recuse themselves are allowed to give an explanation to the parties, and parties are allowed to make submissions (or further submissions) on the application, having heard their explanation.

24. In accordance with *In re Medicaments*, the chair gave the following explanation:

> *"I saw the 13 words on page 206 of the GMC Documents Bundle and the 17 words on page 208, on Tuesday 14 October 2025 (which was 6 days ago), and noticed the differences between the two versions of the Police Statement of Patient B dated 26 November 2019. I have thought about them every day since then, not least because I thought I might need to give legal advice on recusal (which I am now doing)."*

25. In the case of *Bubbles & Wine Ltd v Lusha* [2018] EWCA Civ 468 (14 March 2018), Lord Justice Leggatt gave a definition of bias at paragraph 17:

> … Bias means a prejudice against one party or its case for reasons unconnected with the legal or factual merits of the case: see *Flaherty v National Greyhound Racing Club Ltd* [2005] EWCA Civ 1117, paragraph 28; *Secretary of State for the Home Department v AF (No2)* [2008] EWCA Civ 117; [2008] 1 WLR 2528, paragraph 53.

26. If a piece of information has specially been excluded from being in evidence (whether by agreement between the parties, or by a previous direction made by a Case Manager, or otherwise), that information is then not part of the "factual merits of the case", and so having regard to it in making a decision in the case would be improper.

27. In the case of *Lawal v Northern Spirit* [2003] UKHL 35 (19 June 2003), the House of Lords said, at paragraph [2] that, in applying the *Porter* test of the "real possibility of bias", bias includes *subconscious* bias. This was confirmed in the Court of Appeal decision In the

case of *Resolution Chemicals Ltd v H Lundbeck A/S* [2013] EWCA Civ 1515; [2014] 1 WLR 1943 (25 November 2013) in which Sir Terence Etherton C said, at paragraph 36 (italics added):

> … The test is "a real possibility" of bias, *whether subconscious or otherwise*.

28. In the case of *Morrison v AWG Group Ltd* [2006] EWCA Civ 6 (20 January 2006), which dealt with an allegation of apparent bias, Lord Justice Mummery said, at paragraph 29:

> *"… while I fully understand the judge's concerns … about the prejudicial effect that his withdrawal from the trial would have on the parties and on the administration of justice, those concerns are totally irrelevant to the crucial question of the real possibility of bias and automatic disqualification of the judge. In terms of time, cost and listing it might well be more efficient and convenient to proceed with the trial, but efficiency and convenience are not the determinative legal values: the paramount concern of the legal system is to administer justice, which must be, and must be seen by the litigants and fair-minded members of the public to be, fair and impartial. Anything less is not worth having."*

29. As regards if there is doubt one way or the other, In the case of Locabail (UK) Ltd v Bayfield Properties Ltd [2000] QB 451 (17 November 1999), the Court of Appeal said, at paragraph 25:

> *"In most cases, we think, the answer, one way or the other, will be obvious. But if in any case there is real ground for doubt, that doubt should be resolved in favour of recusal."*

30. The law on recusal has been applied in medical practitioners tribunals. As regards the law relating to the inclusion of irrelevant material:

> The law of "inclusion of irrelevant material" has a different history from recusal coming from cases involving jury trials where there has been adverse publicity (such as *Montgomery v. HM Advocate*, in which the question was the effect of pre-trial publicity on the minds of a jury dealing with a charge of murder). In such cases the remedy being sought is often a permanent stay of the proceedings (as it appears to have been in *Montgomery v. HM Advocate* [2003] 1 AC 641 at pages 656 and 657), which would effectively stop the proceedings (pages 647, 656, 678).

31. The MPTS Appeals Circular A06/25 says:

> *"There is no absolute rule that knowledge of prejudicial information is fatal to the fairness of proceedings. Rather, the test is whether the risk of prejudice is so grave that no direction [by the trial judge] could reasonably be expected to remove it*
>
> *Montgomery v. HM Advocate [2003] 1 AC 641*
> *R (Mahfouz) v. General Medical Council [2004] EWCA Civ 233, at [22]).*
> *Moodliar v General Medical Council [2025] EWHC 913 (Admin)"*

32. The case *R. (on the application of Short) v Police Misconduct Tribunal* [2020] EWHC 385 (Admin), which was an application for permission for judicial review, said that, even when it was obvious that a tribunal had seen prejudicial material, there is no absolute rule that such material is fatal to the fairness of the proceedings, referring to the cases R (Mahfouz) v. Professional Conduct Committee of the GMC [2004] EWCA Civ 233 and Subramanian v. General Medical Council [2002] UKPC 64."

The Tribunal's Determination

33. The application, made on behalf of the registrant is for the Tribunal (as a whole) to recuse itself. The Tribunal accepted the chair's legal advice.

34. The material that is the focus of the application is 13 words on page 206 of the GMC documents bundle (after the words ' *"YOU HAVE MADE MY DAY, IT WAS REALLY NICE TO MEET YOU."* ') and 17 words on page 208 (after the words ' *"SEEN THE GOOD LOOKING DOCTOR AGAIN AND HE WAS FLIRTY WITH ME"* 'and Patient B's friend's redacted name).

35. It is unfortunate that pages 206 and 208 of the GMC documents bundle were not redacted fully (as compared with pages 48 and 50 of the same police statement), as this has led to time being taken up at the beginning of this hearing. Nevertheless, the Tribunal considers the application to have been properly made.

36. Following *Morrison v AWG Group Ltd*, the Tribunal considered irrelevant to its decision-making on the application the inconvenience and disruption a re-listing would cause. Similarly, the Tribunal disregarded Mr Taylor's submission that recusal would not be proportionate, to the extent that that submission may imply a balancing act in which the

effect of recusal on the participants (parties, witnesses, the MPTS, etc.) is weighed against any issue arising from the unredacted material.

37. The Tribunal is able to put the material out of its mind. Bearing in mind the professional composition and experience of the Tribunal, in the view of the Tribunal the fair-minded and informed observer could be confident in the Tribunal's ability to put the material out of its mind.

38. The Tribunal does not consider that the history of how pages 206 and 208 were not redacted fully would have any effect on its decision.

39. The Tribunal applied the *Porter* test. In the view of the Tribunal, the fair-minded and informed observer, having considered all the facts, would not conclude that there was a real possibility that the tribunal was biased.

40. In the view of the Tribunal, the fair-minded and informed observer, having considered all the facts, would not, if the Tribunal did not recuse itself, conclude that there was a real possibility that the current proceedings are unfair.

41. In light of the above, the Tribunal decided not to recuse itself. Therefore, the application is refused.

42. The Tribunal will put out of its mind the material referred to in this application.

ANNEX B – 24/12/2025

The Tribunal's Directions

Background

1. Patient A was affirmed and began to give evidence before this MPT on Wednesday 22 October 2025 at approximately 11:46am.

2. Patient A is currently (as at Friday 24 October 2025) on affirmation and is in the middle of being cross-examined by Ms Tanchel, Counsel on behalf of Dr Smerdon.

3. At about the same time as Patient A began to give evidence, Ms E "received a call from Ms L, Trainee Solicitor at the GMC to discuss whether she was able to give evidence tomorrow afternoon" (source: supplemental witness statement of Ms E, dated 23 October 2023, paragraph 2). In due course that led to the Tribunal receiving the supplemental witness statement of Ms E, dated 23 October 2023 with three exhibits attached, which amount to 47 pages in total.

4. Under rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), the Tribunal decided to admit into evidence in this case the 47 pages, on the grounds that the Tribunal considers that the material is relevant to matters in issue in the case, and that it is fair to admit it into evidence. The tribunal has given the 47 pages the exhibit number C3.

5. The 47 pages comprise: pages C3-1 to C3-7 are the witness statement, which runs to 13 paragraphs; page C3-8 is the exhibit cover sheet of exhibit Ms E 1; pages C3-9 to C3-37 are 29 pages of copies of written electronic communications; page C3-38 is the exhibit cover sheet of exhibit Ms E 2; pages C3-39 and C3-40 are 2 pages of copies of written electronic communications; page C3-41 is the exhibit cover sheet of exhibit Ms E 3; pages C3-42 to C3-47 are 6 pages of copies of written electronic communications.

6. There are, therefore, 37 pages of written electronic communications (pages C3-9 to C3-37, C3-39, C3-40 and C3-42 to C3-47).

Submissions

7. Ms Tanchel said that the Tribunal had now seen the supplemental statement of Ms E and the text message exhibits. She said that Ms E provided these text messages to Patient A on several occasions, most recently on 21 October 2025. Ms Tanchel said that in any event, they are Patient A's messages that have been in her possession since 2022 when Ms E provided them to her. Therefore, there was no prospect of an ambush of Patient A.

8. Ms Tanchel submitted that the proper way to proceed is for the witness to be cross examined about the new material. The fair way of doing this would be to provide the text message exhibits to Patient A only after she had asked a cross-examination question about them.

9. Ms Tanchel said that seeking a supplemental witness statement from Patient A would not only be inappropriate but would cause grave concern. She said the GMC presents their witnesses as witnesses of truth. Therefore, there would be a real risk that the GMC would be cross examining their own witnesses by taking a supplemental witness statement because of the nature of the questions asked by the witness statement taker.

10. Mr Taylor said the GMC's principal concern remains that there is an attempt to ambush Patient A. He said that it was quite normal for a witness to be provided with documentation that they are then going to be asked about.

11. Mr Taylor said that even if Patient A has the text message exhibits or was sent them days ago, she does not know what she will be asked about during cross examination by Ms Tanchel on behalf of Dr Smerdon.

12. Mr Taylor said that Patient A should be sent the text message exhibits in advance and then she will not be surprised and there is no attempt to disconcert or discombobulate the witness by asking her about material which she has not been put on notice about being asked about. He said that it did not matter that Patient A had had these text message exhibits before.

13. Mr Taylor said that he was not asking for a supplemental witness statement to be taken from Patient A. He reiterated that the primary concern was that Patient A was provided with the text message exhibits which she going to be asked about. In fact, he said it would have been perfectly proper, as had previously been discussed, for the GMC, having been provided with the text messages to have gone back to Patient A and asked her to exhibit them or to comment on them.

14. Mr Taylor said that Patient A has been deemed a vulnerable witness and it is important that she is not ambushed by being asked about something that she has not been provided with and is going to be asked about.

The current situation

15. Ordinarily, disclosure of documents and the writing of witness statements should happen in good time before the beginning of an MPT hearing, and before any witnesses give oral evidence. The Tribunal has to decide how best to deal with the situation that has arisen as a result of events that have occurred during the hearing.

Power to make directions

16. Rule 16 of the 2004 Rules gives a case manager the power to give directions in proceedings under the rules. By virtue of Rule 16(1A)(b), an MPT has the power to give directions.

17. Rule 16(6) provides:

> 'Directions issued by the Case Manager may include, but are not limited to …

The words "but are not limited to" indicates that the list in rule 16(6) is not exclusive.'

18. Rule 16(6)(g) provides:

> '(g) a direction that a particular witness of fact should be treated as a vulnerable witness, and directions as to how the evidence of such a witness should be obtained or presented to the Medical Practitioners Tribunal;'

19. Rule 36(2) provides:

> '(2) Upon hearing representations from the parties, the Committee or Tribunal shall adopt such measures as it considers desirable to enable it to receive evidence from a vulnerable witness.'

20. Patient A is being treated as a vulnerable witness under rule 36(1)(b) and 36(1)(e) (source: direction 1 of case manager dated 29 September 2025).

21. Interpreting rule 16(6)(g) broadly (and 36(2) very broadly), directions about how the current situation should be dealt with could be considered to be concerning how the evidence of Patient A is obtained or presented to, or received by, the MPT, because the directions relate to how Patient A's evidence is elicited under cross-examination. In any event, the catch-all "but are not limited to" in rule 16(6) is broad enough to enable the Tribunal to make directions governing the current situation.

22. Rule 16(7A) provides:

'(7A) Directions issued by the Case Manager shall be binding on the parties and on any subsequent Tribunal considering the case, unless the Tribunal considers that—

(a) there has been a material change in circumstances; or

…'

23. If directions the Tribunal is now making are considered to be deviating in any way from any previous direction made, the Tribunal considers there to have been a material change in circumstances, namely the receipt by the GMC of the documents and witness statement from Ms E, and the receipt by the Tribunal of exhibit C3 from the GMC.

Factors to have regard to in decision-making

The over-arching objective

24. Section 1 of the Medical Act 1983 provides:

'1 The General Medical Council

…

(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.

(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—

(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession.'

25. This definition of "over-arching objective" applies throughout the Medical Act 1983 (section 55(1A)).

26. An MPT is a statutory committee of the GMC (Medical Act 1983, section 1(3)(h) & 1(3A)).

27. Section 35E(3A) of the Medical Act 1983 provides:

(3A) In exercising a function under section 35D, a Medical Practitioners Tribunal must have regard to the over-arching objective.

The overriding objective

28. Paragraph 1(1A) of Schedule 4 to the Medical Act 1983 provides:

'Procedure of and evidence before the Investigation Committee, Medical Practitioners Tribunals and Interim Orders Tribunals

1

…

(1A) The overriding objective of the General Council in making rules under this Schedule with respect to the procedure to be followed in proceedings before a Medical Practitioners Tribunal … is to secure that the Tribunal … deals with cases fairly and justly.'

29. The GMC (Fitness to Practice) Rules 2004 were made in the exercise of powers under (amongst other provisions) Schedule 4 to the Medical Act 1983.

30. Technically, the requirement to meet the overriding objective is a requirement on the GMC alone, and only when it is making the procedural and evidential rules for MPTs to follow, not on an MPT when applying those rules (or even on the Privy Council when modifying and approving rules under paragraph 1(8)). However, it is reasonable to conclude that paragraph 1(1A) creates an expectation that an MPT will, when making procedural and evidential decisions (such as a case management decision) under the rules, do so in such a way as to deal with the case before it fairly and justly. This is the approach adopted in cases that have considered paragraph 1(1A):

- *R (British Medical Association) v GMC* [2016] EWHC 1015 (Admin); [2016] 4 WLR 89; (2016) 151 BMLR 143; [2016] 5 WLUK 20 (4 May 2016) at paragraphs [6], [13], [22] and [120]. This case is the subject of MPTS Appeals Circular A11/21 (16 September 2021).
- *Ramaswamy v GMC* [2021] EWHC 1619 (Admin); [2021] 6 WLUK 170 (15 June 2021) at paragraphs [6], [13], [22] and [120]. This case is the subject of MPTS Appeals Circular A11/21 (16 September 2021)

The Tribunal's Decision

31. The Tribunal has had regard to the over-arching objective, and is seeking, in making this decision, to ensure that the case is dealt with fairly and justly.

32. The Tribunal considers that the primary purpose of oral testimony in an MPT at "Stage 1" (under rule 17(2)(f) and (h)) is to adduce evidence that will be of assistance to the Tribunal in fact-finding.

33. The Tribunal wishes to avoid any vulnerable witness (and, in relation to the current decision, Patient A), from being taken by surprise while giving oral evidence.

34. At the same time, the Tribunal wishes to minimise the risk of any witness (and, in relation to the current decision, Patient A), from acting in a way that might undermine the integrity of the proceedings (through collusion or otherwise) and wishes to minimise the risk of the perception or suspicion of such activity.

35. The Tribunal wishes to regulate the circumstances in which any vulnerable witness (and, in relation to the current decision, Patient A), gives oral evidence without unduly restricting the ability of the representatives of each party to present their client's case as they see fit.

36. Bearing in mind these considerations, the Tribunal concludes that the over-arching objective and the overriding objective can best be satisfied by the Tribunal making the following three directions.

The Tribunal's Direction

37. The Tribunal directs that:

1. The GMC shall extract from exhibit C3 the 37 pages of written electronic communications to form a new exhibit (which the tribunal will give the exhibit number C4), with pages numbered from 1 to 37, which the participants in the hearing will refer to as C4-1 to C4-37.

2. The GMC shall supply exhibit C4 to Patient A as close as possible to one hour before she is next scheduled to continue to give oral evidence.

3. The cross-examination of Patient A shall then resume as close as possible to one hour after Patient A receives exhibit C4.

ANNEX C – 03/11/2025

Application to amend the Allegation

The application

1. On 30 October 2025, Mr Taylor, on behalf of the GMC, applied for the Tribunal to exercise its power under rule 17(6) of the Fitness to Practice Rules 2024 to amend the Allegation (set out in the notice served under rule 15) to omit the words "While working" at the beginning of Paragraph 2 of the Allegation, so that instead of reading "While working at Hospital C…" it reads "At Hospital C…".

The parties' submissions

2. Mr Taylor submitted that the gravamen of the stem of paragraph 2 of the Allegation was that the things set out in paragraph 2 were said and happened at Hospital C during the period to 5 January 2013 and so paragraph 2 is not tied to Dr Smerdon specifically performing work when those things were said, or when those things were done. Therefore, Mr Taylor submitted, it clarifies the Allegation by not including that Dr Smerdon was 'working' at all points that are referenced in paragraph 2.

3. Mr Taylor submitted that the amendment could be made without injustice to Dr Smerdon because it did not change the case that is alleged against him. For instance, Dr Smerdon accepts that he kissed Patient A. Mr Taylor said that it simply removes any linking between all of the actions or words and whatever interpretations may be given to the word 'working'. He said the amendment removes any insinuation or inference that Dr Smerdon was actually performing work or not at the time these things happened.

4. Mr Taylor referred the Tribunal to the authority of *Ahmedsowida v General Medical Council* [2021] EWHC 3466 (Admin), [2021] 12 WLUK 313. In that case the Tribunal made its own amendments and Mr Justice Kerr said that there was nothing wrong with that because the doctor knew the charges he had to meet, which was clear both before and after the amendments.

5. Ms Tanchel, on behalf of Dr Smerdon, opposed the application. She said that the suggestion that the amendment does not change the case, or that it was a minor amendment was incorrect.

6. Ms Tanchel gave the Tribunal the chronology from when the Allegation was first drafted. She said that the GMC has had plenty of opportunity to formulate the Allegation, and indeed, it is incumbent on it to ensure that the case is properly drafted.

7. Ms Tanchel said it cannot be the case that when the GMC's own witnesses do not 'come up to proof' that the GMC is then entitled to change the case to encapsulate different evidence. She submitted that it was material in this case because of the wholly different set of circumstances of whether Dr Smerdon was at work or not.

8. Ms Tanchel said that Dr Smerdon was served with a draft Rule 15 notice as early as 2 June 2025 (and the subsequent Rule 15 notice was identical) and he then set out in his witness statement what his position was. She said that if the GMC thought that that created difficulty for it proving the case that they advanced at the start, then they should have made the amendment then.

9. Ms Tanchel said that amending the Allegation was not an opportunity to shift the case because one of the purposes of the statutory regime, was to entitle a defendant registrant to know the case that they face and to prepare a defence accordingly. She reiterated that this was simply not a minor amendment and plainly made a difference. If it was merely a minor amendment, the GMC application would not have been made.

10. Ms Tanchel said the authority of *Ahmedsowida* the Tribunal had been directed to was of no use to its deliberations on the application because it was not comparable. She said that it notes that there are occasions when a Tribunal can make amendments which is already reflected in the Rules and does not give guidance to a Tribunal as to when it would be appropriate or otherwise to amend an Allegation.

11. Ms Tanchel said that these were procedural and evidential issues. She reminded the Tribunal of the over-arching objective and that these proceedings were also subject to Article 6 of the European Convention on Human Rights (the right to a fair hearing). Ms Tanchel said that Dr Smerdon was entitled to a fair hearing which includes fair process, and that is not overridden by the Medical Act 1983. Therefore, she said that any submission that contends

that the threshold for fairness was lower in these proceedings than in any other jurisdiction in England or Wales was simply erroneous.

12. Ms Tanchel said that there was no identifiable reason why the GMC seeks to amend the Allegation against Dr Smerdon apart from the fact that its witnesses did not say what it thought they might say, and they did not 'come up to proof'. Furthermore, if there was a reason, the GMC would have made an application at the start of the hearing. She submitted that the GMC had shifted its case.

13. In response to Ms Tanchel, Mr Taylor said that the statutory over-arching objective was something that was taken into account at every stage of these proceedings. He said that these were regulatory proceedings which are different from other jurisdictions.

14. Mr Taylor said that the application had not been made sooner because the GMC had anticipated more admissions based on Dr Smerdon's witness statement, but these had not been made as Ms Tanchel had remained cautious (to which he made no criticism).

15. Mr Taylor said that it was not accepted that the application had anything to do with witness evidence. He reiterated that the amendment does not affect the essence of this case and would make clear that it was 'at' the hospital between those dates in paragraph 2 of the Allegation.

Legal Advice

16. The Chair advised the Tribunal that:

> Rule 17(6) says:
>
> (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.
>
> The power to amend under rule 17(6) exists where both 17(6)(a) and 17(6)(b) are satisfied, that is:

it appears to the Medical Practitioners Tribunal that the Allegation … should be amended

AND

it appears to the Medical Practitioners Tribunal that the amendment can be made without injustice

Even where the power arises, the word "may" indicates that the Tribunal does not have to exercise the power it has to make an amendment.

Decision

17. The Tribunal refuses the application.

Reasons

18. In the current case, the Tribunal does not consider that the Allegation should be amended (in the manner applied for), and so the test in Rule 17(6)(a) is not satisfied, and so the power to amend under Rule 17(6) does not arise. In any event (bearing in mind the word "may"), the Tribunal would not wish to exercise any power that it had to amend the Allegation (in the manner applied for).

19. The Tribunal considers that it is unnecessary for the Allegation to be amended as they do not accept that the wording "While working at Hospital C" should be restricted to the interpretation "Whilst in the act of performing a clinical task at Hospital C" or other similarly narrow meaning.

ANNEX D – 07/11/2025

Tribunal Directions

1. The Tribunal makes the following directions under rule 16:

- The next hearing after today will (subject to the approval of an MPTS Case Manager) be listed to reconvene on 23 February 2026 to 6 March 2026, with the first week (23 to 27 February 2026) to take place in person at St James's Buildings, and the second week (2 to 6 March 2026) to be conducted virtually.

- Subsequently (i.e. after 6 March 2026), the case shall (subject to the approval of an MPTS Case Manager) be listed to reconvene on 16 and 17 April 2026, and 17 to 26 June 2026, both to be conducted virtually.

2. If the parties need further directions between the end of today's hearing and the beginning of the next hearing on 23 February 2026, they should contact the MPTS so that a Case Manager can exercise their continuing power under rule 16.

3. In relation to the possible hearsay application on behalf of Dr Smerdon, Ms Tanchel indicated that if the Case Manager refers the application to the Tribunal, she will file with the MPTS a written skeleton argument in advance of the next hearing.