PUBLIC RECORD

Dates: 06/06/2022 - 14/06/2022

Medical Practitioner's name:	Dr Eckhard VOLLE
GMC reference number:	7031723
Primary medical qualification:	State Exam Med 1983 Freie Universität Berlin

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

Summary of outcome

Suspension, 4 months, no immediate order, no IOT to revoke

Tribunal:

Legally Qualified Chair	Miss Anya Lewis
Lay Tribunal Member:	Mrs Ann Bishop
Medical Tribunal Member:	Dr Helen Grote

Tribunal Clerk:	Miss Hinna Safdar

Attendance and Representation:

Medical Practitioner:	Not present and represented (Day 1-3)
Medical Practitioner's Representative:	Mr Patrick Cassidy, Counsel, instructed by BMA
GMC Representative:	Mr Alan Taylor

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.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) 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 Impairment - 13/06/2022

Background

1. Dr Volle qualified in 1983 from Freie Universität Berlin. From July 2015 to March 2017 Dr Volle was working as a consultant radiologist for Medica Reporting. In May 2018 Dr Volle started working for South Tees Hospitals NHS Foundation Trust ("South Tees Trust") as a diagnostic radiologist.

2. On 28th October 2016, whilst Dr Volle was working for Medica Reporting, a Clinical Governance Committee had commissioned an urgent review into Dr Volle's reporting because of concerns that he was not working at the required standard of a neuroradiologist. Restrictions were put on Dr Volle's practice in November 2016 and then January 2017. In March 2017 Dr Volle left Medica Reporting. Dr Volle was referred to the GMC by his Responsible Officer, Mr A, of Medica Reporting, in June 2017. Concerns were raised regarding Dr Volle's knowledge, skills and performance. Mr A was concerned that Dr Volle had left Medica Reporting with unresolved concerns and he was not confident that alternative safeguards were in place.

3. In relation to Patient A, Dr Volle failed to identify acute small carotid infarcts in a head MRI scan on 26 September 2016. In relation to Patient B, Dr Volle failed to identify a fracture of the left inferior facet of C5 with subluxation of the left C5/6 facet joint on a CT cervical spine scan on 1 October 2016.

4. In May 2019, the GMC received a referral from South Tees Trust in relation to Patient C. Patient C, who was then four-months old, underwent a CT scan of the brain on 19 June

2018 which was reported by Dr Volle. The clinical history provided to Dr Volle was that Patient C had multiple seizure episodes, presented with abnormal posturing, a high pitched cry, and eyes rolling. Patient C's head circumference was noted as over the 99.6th centile. Dr Volle failed to identify that extra cerebral fluid collections on the scan were not of CSF density, but were clearly subdural, and that there was local mass effect with effacement of sulci overlying the cerebral convexities. He did raise the possiblty that the extracerebral fluid collections might represent subdural hygromas. He did, further, recommend an MRI scan which was performed the next day, on 20 June 2018.

5. Dr Volle reported on the MRI scan of 20 June 2018. He failed to recognise that it was signficantly degraded and he failed to recommend a further MRI be undertaken with sedation or anaesthetic. He failed to describe whether the extra axial fluid collections were due to subdural or subarachnoid fluid or that the predominant feature of the scan was subdural fluid which was not of CSF signal.

6. In relation to both scans, Dr Volle failed to mention the possiblity of non-accidental injury either in his reports or in a clinical discussion with the treating consultant paediatrician on 21 June 2018.

7. Patient C had, in fact, first been brought to hospital in an ambulance on 17 May 2018 with a history of an unresponsive episode. On that occasion a lumbar puncture had been attempted but was unsuccessful. No scans were undertaken. Patient C was treated for presumed sepsis and discharged with a diagnosis of cow's milk protein allergy. There is no suggestion in the evidence before us that Dr Volle was aware of Patient C's attendance in May 2018 when he reported on the scans in June 2018.

8. On 24 September 2018, Patient C was seen in clinic by two consultant neurosurgeons who considered that the imaging from June 2018 demonstrated subdural haematomas. Patient C was subsequently the subject of Family Court proceedings in which Patient C's

mother accepted shaking Patient C, prior to Patient C's presentation at hospital on 17 May 2018.

The Allegation and the Doctor's Response

9. The Allegation made against Dr Volle is as follows:

That being registered under the Medical Act 1983:

1. On 26 September 2016 you performed a head MRI scan on Patient A and you:
    a. failed to:
        i. identify multiple acute small carotid infarcts;

        Admitted and found proved

        ii. report multiple acute small carotid infarcts;

        Admitted and found proved

    b. reported that diffusion weighted imaging did not show any areas of acutely restricted diffusion which was inaccurate because there were multiple foci of restricted diffusion in the cerebral cortex of both fronto-parietal lobes.

    Admitted and found proved

2. On 1 October 2016 you performed a CT cervical spine scan on Patient B and you failed to:
    a. identify a fracture of the left inferior facet of C5 with subluxation of the left C5/6 facet joint;

    Admitted and found proved

b. report the fracture of the left inferior facet of C5 with subluxation of the left C5/6 facet joint.

Admitted and found proved

3. On 19 June 2018 you performed a head CT scan on Patient C and you failed to:

a. identify that the extra cerebral fluid collections were clearly subdural collections and not of CSF density;

Admitted and found proved

b. identify local mass effect on the surface of the sulci of the brain;

Admitted and found proved

c. adequately consider:

i. that subdural collections could have multiple potential causes;

Admitted and found proved

ii. the possibility of non-accidental injury in light of Patient C's clinical history of:

1. being four months old; Admitted and found proved
2. suspected multiple seizure episodes; Admitted and found proved
3. abnormal posturing; Admitted and found proved
4. a high pitch cry; Admitted and found proved
5. his eyes rolling; Admitted and found proved

6. his head circumferences above the 99.6th centile; **Admitted and found proved**

d. recommend clinical correlation in order to exclude a:

1. history of infection; **Admitted and found proved**
2. clotting disorder; **Admitted and found proved**
3. metabolic disorder such as glutaric aciduria type 1 and Menkes; **Admitted and found proved**
4. history of witnessed accidental trauma; **Admitted and found proved**

e. report:

i. that the extra cerebral fluid collections were clearly subdural collections and not of CSF density; **Admitted and found proved**

ii. the local mass effect on the surface of the sulci of the brain; **Admitted and found proved**

f. record having undertaken the action as outlined at paragraphs:

i. 3c; **Admitted and found proved**

ii. 3d. **Admitted and found proved**

4. On 20 June 2018 you performed an MRI head scan on Patient C and you failed to:

a. identify bilateral subdural fluid collections; **Admitted and found proved**

b. identify whether the extra axial fluid collection was due to subdural or subarachnoid fluid; **Admitted and found proved**

c. identify that the mass effect and the predominant feature of the scan was due to subdural fluid which was not of CSF signal; **Admitted and found proved**

d. adequately consider that the MRI study was significantly degraded by movement; **Admitted and found proved**

e. adequately consider non-accidental injury in light of Patient C's clinical history of:

   i. being four months old; **Admitted and found proved**

   ii. suspected multiple seizure episodes; **Admitted and found proved**

   iii. abnormal posturing; **Admitted and found proved**

   iv. a high pitch cry; **Admitted and found proved**

   v. his eyes rolling; **Admitted and found proved**

   vi. his head circumferences above the 99.6th centile; **Admitted and found proved**

f. recommend and expedite a repeat MRI scan with sedation or anaesthetic support:

   i. to produce a complete and properly interpretable study to include imaging of the head and whole spine; **Admitted and found proved**

   ii. as soon as anaesthetic support was available during working hours; **Admitted and found proved**

g. report:

   i. bilateral subdural fluid collections; **Admitted and found proved**

ii. that the extra axial fluid collection was due to subdural or subarachnoid fluid; Admitted and found proved

iii. that the mass effect and the predominant feature of the scan was due to subdural fluid which was not of CSF signal; Admitted and found proved

iv. that the MRI study was significantly degraded by movement; Admitted and found proved

h. record having undertaken the actions as outlined at paragraphs:

i. 4d; Admitted and found proved

ii. 4e; Admitted and found proved

iii. 4f. Admitted and found proved

5. On 21 June 2018, during your discussion with Consultant Paediatrician Dr D, you failed to:

a. discuss the possibility that the imaging features on the scans of 19 June 2018 and 20 June 2018 could be consistent with non-accidental injury; Admitted and found proved

b. record having undertaken the action as outlined at paragraph 5a. Admitted and found proved

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

The Outcome of Applications

10. The Tribunal refused an application made on behalf of Dr Volle, pursuant to Rule 29 of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘*the Rules’*), to adjourn the hearing on the basis of Dr Volle’s absence and his wish to instruct an expert

witness. Annex A was produced in relation to this. Dr Volle has not availed himself of the opportunity to attend by video-link, XXX, to enable him to participate.

11. The relevant family court records were subsequently identified by Mr Cassidy, counsel for Dr Volle, and their admissibility was agreed by Mr Taylor, on behalf of the GMC. Copies of the relevant records were provided to Dr D who then produced a supplementary report.

The Admitted Facts

12. On day 3 of the hearing, prior to the facts being opened, Dr Volle admitted, through his counsel, the facts of the Allegation in its entirety, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced the facts of the Allegation as admitted and found proved in full.

13. Subsequently, upon being asked by the Tribunal, Mr Cassidy stated that Dr Volle's admission included an admission that he was impaired because of his misconduct.

14. At this point, Mr Cassidy further advised the Tribunal that he had been instructed by Dr Volle to withdraw due to Dr Volle having insufficient funds to continue to instruct him and he would no longer be representing him, albeit his instructing solicitor would remain on the record.

Documentary Evidence

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

- Index referral from Medica Reporting attaching internal correspondence and audit data, dated 9 June 2017 (heavily redacted)
- Expert Report from Dr B,, dated 3 September 2019
- Supplementary Expert Report from Dr B, dated 1 October 2019

- Second Supplementary Expert Report from Dr B, dated 11 May 2020
- Rule 7 response from Dr Volle regarding Patient A and B, dated 20 February 2020
- Email from Dr Volle to the GMC in response to new allegations regarding Patient C, dated 8 July 2019
- Rule 7 response from Dr Volle regarding Patient C, dated September 2019
- Correspondence from South Tees Hospitals NHS Trust, dated 5 July 2019 (letter from four consultant neurosurgeons at South Tees Hospital)
- Independent review of gross negligence manslaughter and culpable homicide, submitted by Dr Volle
- Extract of Dr Volle's journal article: MRI examination and monitoring of paediatric patients under sedation
- Patient A medical records
- Patient B medical records
- Expert Report from Dr D regarding Patient C, dated December 2019
- Letter from Dr D, dated 6 June 2022
- Supplementary Medico-Legal Report from Dr D, dated 7 June 2022
- Bundle of documents relating to postponement application
- Letters from Dr C, dated 6 June 2022 and 7 June 2022
- Family Court documents dated 1 October 2018
- Further comments from Dr Volle bundle including letter dated 23rd July 2021

Determination on Impairment

16. 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 above, Dr Volle's fitness to practise is impaired by reason of misconduct.

The Evidence

17. 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 which included but was not limited to:

- Dr Volle's CV
- CPD Certificates
- Summary of Dr Volle's reporting (2016)
- Audit templates suggested by Medica, dated 27 November 2015
- Email from Mr E to Dr Volle, dated 13 February 2017
- References from:
    - Dr F, dated 17 November 2017
    - Dr G, dated 16 November 2017
    - Dr H, dated 16 November 2017
    - Dr I, dated 30 August 2017
    - Dr J, dated 13 December 2017
- Email from Mr R to the GMC attaching supporting evidence from:
    - Mr K, dated 2 July 2018
    - Dr L, dated 3 July 2018
    - Mr M, dated 3 July 2018
    - Dr N, dated 5 July 2018
    - Dr O, dated 4 July 2018
    - Mr P, dated 5 July 2018
    - Dr Q
- Telephone call note from Dr R to the GMC with positive feedback for Dr Volle, dated 11 July 2018
- Email from Mr S at Remedy Locums to the GMC in support of Dr Volle and attaching a communication skills course attended by Dr Volle, dated 7 March 2018
- Email from Mr S at Remedy Locums to the GMC in support of Dr Volle and attaching a communication skills course attended by Dr Volle, dated 7 March 2018
- Joint letter of support from Dr T, Dr U, and Dr V, dated 26 July 2019

- CPD Certificate, and course programme: Royal College of Radiologists 19, dated 15 October 2019

18. The Tribunal also received a number of testimonials, all of which it has read.

Submissions

19. Mr Taylor submitted that Dr Volle's fitness to practise is impaired by reason of misconduct. He reminded the Tribunal of the overarching objective and of the two-stage process when considering misconduct. He referred the Tribunal to the relevant case law which he submitted was engaged in this case.

20. The cases cited by Mr Taylor included *Meadows v General Medical Council (2007) Q.B. 466; Nandi v General Medical Council | [2004] EWHC 2317 (Admin); Martin v GMC [2011] EWHC 3204 (Admin); R (on the application of Remedy UK Ltd) v General Medical Council [2010] EWHC 1245 (Admin), Yeong v GMC (2009) EWHC 1923 (Admin)* and *Council for Healthcare Regulatory Excellence v. NMC and Paula Grant [2011] EWHC 927 (Admin).*

21. Mr Taylor submitted that Dr Volle brought the medical profession into disrepute by making serious fundamental errors and that all three limbs of the over-arching objective were engaged.

22. Mr Taylor submitted that this was not an isolated case, rather, 3 separate cases, involving 3 separate patients over the span of a 21-month period from September 2016- June 2018. He submitted that Dr Volle made serious errors that put patients at an unwarranted risk of harm. Mr Taylor referred to Dr B's report, in relation to Patients A and B, in which he said, '*the omissions could have led to significant patient harm.'*

23. Mr Taylor submitted in relation to Patient C, that Dr Volle's failings meant that the child was returned to a potentially dangerous, abusive environment for 3 months until matters came to light.

24. Mr Taylor submitted that both Dr B and Dr D had expressed that the overall standard of care was seriously below the standard expected of a consultant radiologist. The errors, failures and deficiencies relate to core fundamental skills and could easily repeat themselves in other contexts unless they were reasonably addressed.

25. Mr Taylor submitted that individually each case is serious, but cumulatively, these are very serious. He stated that there can be no doubt that Dr Volle's actions amount to serious misconduct and invited the Tribunal to find that all of this amounted to misconduct that was serious. He stated that Dr Volle had brought the medical profession into disrepute and patients expect and deserve better.

26. Mr Taylor went on to submit that, although remedial actions may be relevant in clinical errors, there are some cases where the public confidence would be undermined if a finding of impairment was not made. He stated that, in this case, in relation to lack of insight and the inability to be able to conclude that Dr Volle has remediated, the Tribunal cannot find that the risk of repetition is low. Mr Taylor stated that Dr Volle continues to present a risk to members of the public in his current role and the need to uphold proper professional standards and confidence in the profession would be undermined if a finding of impairment was not made.

27. Mr Taylor submitted that admissions were made on Dr Volle's behalf very late in the day. Further, the Tribunal has no recent or meaningful evidence of any reflection and no detailed understanding from Dr Volle relating to insight into the concerns raised. In terms of remediation, Mr Taylor submitted that the Tribunal does not have up-to-date evidence of remediation, no witness statement from Dr Volle was prepared for the purposes of these

proceedings, there is insufficient evidence that the concerns have been remediated, and ultimately the Tribunal cannot be satisfied that there is no risk of repetition.

28. Mr Taylor invited the Tribunal to consider that Dr Volle's misconduct had breached following paragraphs of Good Medical Practice *("GMP"):*

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> *15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*
> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*
>
> *19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *21 Clinical records should include:*
> *a relevant clinical findings*
> *b the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c the information given to patients*
> *d any drugs prescribed or other investigation or treatment*
> *e who is making the record and when.'*

29. Mr Taylor concluded that Dr Volle had accepted impairment through his representative. He stated that Dr Volle's actions demonstrated a serious departure from what is expected of doctors. In all circumstances, Mr Taylor submitted that the Tribunal should find that Dr Volle's fitness to practise is currently impaired.

The Relevant Legal Principles

30. 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.

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

32. 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 could lead to a finding of impairment.

33. In relation to the question of misconduct, the Tribunal had regard to the case of *Calhaem v GMC [2007] EWHC 2606 (Admin)* where it was said that the word "misconduct" does not mean any breach of the duty owed by a doctor to his or her patient; it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.

34. The Tribunal further considered *Roylance v General Medical Council (No.2) [2000] 1 AC 311* in which it was held:

> *"Misconduct' is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may*

often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'

35. The Tribunal further considered *Nandi v GMC [2004] EWHC (Admin)* where Collins J emphasized the need to give the adjective serious proper weight observing that in other contexts it has been referred to as "conduct that would be regarded as deplorable by fellow practitioners".

36. The Tribunal had regard to the case of *Cohen v GMC [2008] EWHC 581 (Admin)* in which Mr Justice Silber states:

'It must be highly relevant in determining if a doctor's fitness to practise is impaired that; first his or her conduct which led to the charge is easily remedied, second that it has been remedied and third that it is highly unlikely to be repeated.'

37. The Tribunal bore in mind paragraph 76 of the judgment in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*, in which Cox J set out the approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Shipman Report, Dame Janet identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.

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

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or…

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

38. The Tribunal also had regard to the overarching objective as to whether any of the three limbs were engaged.

'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.'

The Tribunal's Determination on Impairment

Misconduct

39. The Tribunal first considered whether the facts found proved in the Allegation are a sufficiently serious departure from the standards of conduct reasonably expected of Dr Volle as a registered medical practitioner to amount to misconduct which was serious.

40. The Tribunal acknowledged that Dr Volle, through his counsel, had admitted misconduct and conceded impairment but was aware that the decision on misconduct and impairment was for the Tribunal to determine.

41. The Tribunal noted that the clinical errors had occurred over a period of time from September 2016 to June 2018.

Patient A

42. The Tribunal first considered whether the facts admitted and found proved in relation to Patient A, namely that Dr Volle had missed multiple acute small carotid infarcts in a head MRI scan on 26th September 2016, amounted to serious misconduct.

43. The Tribunal noted the opinion of Dr B in his first report, dated 3 September 2019, in which he said that Dr Volle's *"omission of the infarcts was seriously below the standard expected of a reasonably competent consultant as these infarcts were obvious on the diffusion sequences. Furthermore, it potentially would have delayed treatment and further investigations".*

44. The Tribunal noted that Dr Volle had stated in his Rule 7 response that:

"I was not provided with the full set of images in the Night shift on 26.9.2016. With my experience it is nearly impossible to miss in MRI Brain the multiple acute small cerebral infarcts because they are so obvious. Indeed, I reported a "Diffusion weighted imaging which does not show any areas of acutely restricted diffusion", but what I saw in reality was the first line images used not for clinical diagnosis assuming that the right images were send to me.

In my current position as a senior radiologist, I reflect on my MRI reporting to make sure that all DWI sources, including an Apparent Diffusion Coefficient (ADC) map, that all required sequences are in order and ready for analyzing and reporting. I make sure with the radiographer that all this is done before the patients data go to the work station for reporting."

45. Dr B provided a response to Dr Volle's submission in his second supplemental report, dated 11th May 2020. Dr B said:

"A competent radiologist has an obligation to ensure that the quality of the examination and supply of images are both sufficient to issue a report. It would

appear from Dr Volle's submission that he mistook the "first line localiser images from the diffusion weighted images". It is entirely possible that any radiologist can make such an error by mistaking one set of images for another. My opinion on the standard of care is unchanged."

46. The Tribunal noted that Mr Taylor had indicated that the GMC could not go behind the submission of Dr Volle in his Rule 7 response and invited the Tribunal to approach the admitted facts on the basis of Dr Volle's submission.

47. The Tribunal further noted that in the Stage 2 and 3 Impairment and Sanction Bundle (D5) Dr Volle states in a reflective document that:

"*I was working the night shift remotely for Medica Ltd on 26.09.2016 when I was forwarded Patient A's MRI scan of the brain to report…. Providing remote neuroradiology service to a wide catchment area, one comes across images from a variety of MRI scanners ranging from the highly sophisticated state of art MRI scanner which send the images automatically including the complete set of diffusion DWI sequences to the older generation MRI scanners. In which the images are sent separately, with often a time delay due to post processing…"*

48. The Tribunal noted that this information did not appear to have been provided to Dr B.

49. The Tribunal concluded that the behaviour of Dr Volle in mistaking the first line localiser images for the diffusion weighted images fell short of the standards of conduct expected among medical practioners but that it did not fall sufficiently short of those standards to amount to misconduct that was serious.

50. In coming to this conclusion, the Tribunal gave appropriate weight to the unchallenged opinion of Dr B that the behaviour fell seriously below the standard to be

expected of a competent doctor. The Tribunal noted, however, that Dr B also expressed the opinion that, "*it is entirely possible that any radiologist can make such an error by mistaking one set of images for another*". The Tribunal concluded that in their judgement, in light of the opinion of Dr B as to the nature of the error made and in light of the fact that Dr Volle was working at night, for a wide catchment area coming across images from a variety of MRI scanners, his failure did not amount to serious misconduct. The Tribunal noted that the error was not one of clinical judgement but a mistake as to the type of scan being looked at and it was a mistake that Dr B stated in his report it was entirely possible for any radiologist to make. In those circumstances the Tribunal did not consider that the behaviour was so seriously below the standard of care that it could in any context be described as deplorable by fellow practitioners or that it amounted to serious misconduct.

Patient B

51. The Tribunal considered whether the facts admitted and found proved in relation to Patient B, that Dr Volle failed to identify and report a fracture of the left inferior facet of C5 with subluxation of the left C5/6 facet joint, amount to serious misconduct. The Tribunal noted that Dr Volle had failed to identify the fracture/subluxation in the CT scan on 1 October 2016 and that it was subsequently identified on MRI imaging on 5 October 2016.

52. The Tribunal noted the opinion of Dr B in his first report where he said that the failure was seriously below the standard expected of a reasonably competent consultant in diagnostic radiology. He stated that it was an unstable neck injury representing a significant missed lesion which could lead to significant patient harm specifically cord damage. The subsequent MRI imaging showed deterioration with more anterior slip of C5 on C6.

53. The Tribunal noted that Dr Volle had stated in his Rule 7 response that:

> *"The CT used on 1.10.2016 was of an older generation, a low quality CT, that means that the reconstruction technique was not available to me at the time of reporting. In*

the night shift I was provided with an axial CT raw data of the head and an axial CT of the C-spine. The reconstruction on the image using the raw data which gave the midsagittal image, were done by the radiographer subsequently on the next day (1.10.2016). I did not see this image at all, since after my night shift I am obliged to rest. The extreme difficulty in this case is that Medica Ltd. due to unknown reason they deleted this images which have been sent to my work station. This is very unusual…. I recommended in my report, to arrange an urgent MRI head and the C-spine in case the symptoms would aggravate."

54. Dr B in his second supplemental report states, having considered Dr Volle Rule 7 response that:

"Whilst the supply of images may have been suboptimal, a finalised report should not be issued without seeing all images including any reconstructed images, which may be generated by the radiographers or by manipulating the raw data on the radiologist's workstation. The image quality is degraded by patient movement particularly near the fracture. This is difficult to see on the axial cuts (although is definitely present) and would have been easier to pick up on the sagittal images. A competent radiologist has an obligation to ensure that the quality of the examination and supply of images are both sufficient to issue a report. Alternatively, a warning should appear on the report that the study is non-diagnostic with management advice, if appropriate. My opinion on the standard of care is unchanged."

55. The Tribunal noted the further information provided by Dr Volle in the Stage 2 and 3 Impairment and Sanction Bundle (D5) and in particular that the Dr accepted that:

"Reporting remotely for Medica Ltd at night, I only had access to the axial images of the C spine while furnishing the report. The sagittal and coronal reformats were done the following morning. In my day to day hospital practice, I would liaise with the CT radiographers and expedite the reformats before issuing the report, this was however not possible working remotely under constraints to issue a timely report.

This was a omission on my behalf. Unavailability of timely reformats and the remote nature of work at odd hours of night were significant contributory factors. I realized I should have qualified the unavailability of sagittal and coronal reformats in my report and addend (sic) my report after reviewing the reformats."

56. The Tribunal concluded that Dr Volle's issuing of a final report, without either seeing all the images or giving a warning that all the images had not been viewed, was behaviour which fell so far below the standard of a competent consultant radiologist that it amounted to serious misconduct.

Patient C

57. The Tribunal considered whether the facts admitted and found proved in relation to Patient C amounted to serious misconduct.

58. The Tribunal were of the view that Dr Volle's reporting of the scans on 19 and 20 June 2002 amount to misconduct. In particular, in relation to the scans, he

(i) did not clearly describe bilateral subdural collections and did not state that there was local mass effect on the surface of the sulci of the brain in relation to the CT scan of 19 June; and

(ii) did not clearly describe in his report whether the extra axial fluid collection was due to subdural or subarachnoid fluid and did not state that the mass effect and the predominant feature of the scan was due to subdural fluid which is not of CSF signal in relation to the MRI scan of 20 June.

59. The Tribunal accepted the opinion of Dr D, in his supplementary report, dated 7th June 2022, that the standard of care provided by Dr Volle in the reporting of the two scans was below the standard expected of a reasonably competent Consultant Neuroradiologist. The Tribunal did not consider, taking into account the opinion of Dr D, that the reporting of the scans was so far below the standards expected so as to amount to serious misconduct. In

particular, in this regard, they were of the view that had Dr Volle identified, as he should have done, that non-accidental injury should be investigated, it is unlikely that any concerns would have been raised about the reporting of the scans themselves. They further took into account the fact that it was acknowledged by Dr D that Dr Volle did raise the possibility that the extra cerebral fluid collections might represent subdural hygromas in his CT scan report and did recommend that an MRI scan should be performed to further evaluate the abnormalities on the scan. Further Dr D stated that the mass effect on the surface of the brain was subtle and would not have led to surgical intervention.

60. The Tribunal was of the view that Dr Volle's conduct in relation to Patient C was serious misconduct in two regards. Firstly, Dr Volle's failure to specifically mention the possibility of non-accidental injury in his review of either the CT scan on 19 June 2018 or the MRI scan on 20 June 2018 or in his clinical discussion with the Consultant Paediatrician on 21 June 2018 was serious misconduct. Dr Volle had been given the clinical information as to Patient C's age, suspected multiple seizure episodes, abnormal posturing, a high pitch cry, eye rolling and a head circumference above the 99.6th centile. The Tribunal found that there was no evidence before them that Dr Volle had been told about Patient C's previous admission on 17 May 2018. The Tribunal accepted the unchallenged evidence of Dr D that the behaviour fell seriously below the overall standard of care expected of a reasonably competent Consultant Neuroradiologist in that he did not raise the possibility of non-accidental injury and the consequences were serious in that the child was returned to parental care at that time without proper investigations being undertaken.

61. Secondly the tribunal were of the view that the failure to recommend that a repeat MRI scan be conducted under sedation in light of the level of degradation in the MRI of 20 June 2018 also amounted to serious misconduct particularly in the context of his failure to raise the possibility of non-accidental head injury.

62. In terms of the facts admitted and found proved, and for the avoidance of doubt, the Tribunal found that paragraphs 3(a)(b)(d)(e) and (f)(ii), 4(a)(b)(c) and (g)(i)(ii)(iii) amount to misconduct.

63. The Tribunal found that paragraphs 3(c)and f(i); 4(d)(e)(f)(g)(iv) and(h)(i)(ii)(iii) and 5 amount to misconduct that is serious.

Impairment

64. The Tribunal went on to consider whether the serious misconduct found in relation to Patient B and C led to Dr Volle's fitness to practise being impaired.

65. In terms of remediation and insight, the Tribunal noted that the Dr Volle had indicated his intention to accept the facts in relation to Patient B in advance of the hearing. His acceptance of the facts in relation to Patient C was indicated on the third day of the hearing through his representative.

66. In relation to Patient B, the Tribunal had regard to Dr Volle's Rule 7 response, dated February 2020, as well as his reflective practice documents, provided in July 2021, which included proof of a relevant course attended on 15 October 2019.

67. The Tribunal noted that in his reflective document of July 2021 Dr Volle clearly accepted that the error in regard to Patient B was an omission on his behalf. He showed an understanding of the errors he had made and identified the steps he needed to take to ensure this would not happen again. Since 2016 Dr Volle had ceased carrying out any remote reporting and had decided no longer to undertake any night shifts. This was of his own volition, as GMC counsel accepted. The Tribunal determined that this demonstrated a good level of remediation and insight in relation to Patient B.

68. In relation to Patient C, the Tribunal had regard to Dr Volle's Rule 7 response dated September 2020 and reflective documents dated 3 July 2021 along with a further letter dated 23rd July 2021 from Dr Volle to the GMC (provided in Bundle D4).

69. The Tribunal found that whilst Dr Volle, in his letter of 23 July 2021, was not accepting responsibility for his errors in relation to Patient C, there was an indication that he had accepted the feedback of Dr D. The Tribunal noted, however, that Dr Volle had made comment in his reflective document of same date, that in relation to what he had learned as a result of the activity '*I take the GMC experts criticism for not organising a repeat MRI scan under General Anaesthetic with a pinch of salt.'* The Tribunal noted that Dr Volle had, again of his own volition, stopped reporting paediatric neuro radiology scans. However, it considered that there was no detailed evidence of reflection and, as already indicated, nothing that demonstrated his acceptance of responsibility. The Tribunal considered that Dr Volle's repeated references to the family court ruling in his various documents and correspondence demonstrated a complete lack of understanding of the concerns about his failings. The Tribunal further noted the absence of any reflective document from Dr Volle subsequent to his acceptance of responsibility in relation to Patient C. The Tribunal concluded that the level of remediation and insight demonstrated by Dr Volle in relation to Patient C was very low.

70. The Tribunal noted that it had no information as to Dr Volle's current work, other than the fact he was working full time as a radiologist. It also had no up-to-date testimonials, no information regarding Dr Volle's recent CPD engagement or attendance at his discrepancy meetings, and his last appraisal had not been provided.

71. The Tribunal had had sight of numerous CPD certificates, all but one which were dated from 2016 and 2017. The testimonials put before the Tribunal were considered to be of little relevance at this stage, particularly in light of the fact there was no up-to-date testimonial evidence.

72. The Tribunal referred to Dr B's supplemental report, in which he considered the telereporting statistics provided by Dr B in relation to 2016:

> *'The fact that Dr Volle has made two errors with potentially serious consequences does not make him an incompetent radiologist. All radiologists are entirely capable of making such errors and in fact all radiologists have an error rate. In Dr Volle's submission, he lists discrepancies in 14 out of 8433 reports in 2016 giving a calculated reported discrepancy rate of 0.166%. I must make clear that the judgement I have applied to the standard of his reporting in the two cases listed above remains seriously below the standard expected of a reasonably competent Consultant in diagnostic radiology. It should be acknowledged that, in the round, Dr Volle's recorded error rate, as shown in his submission, is very low.'*

73. The Tribunal considered that, notwithstanding the material provided by Dr Volle in relation to Patient B, and the views of Dr B in the paragraph above and the Tribunal's conclusions as to his remediation and insight in relation to Patient B, looked at in the round, and taking into account the Tribunal's findings in relation to Patient A, Dr Volle's fitness to practise was impaired.

74. The Tribunal was clear that Dr Volle had acted in the past so as to put patients at risk and in so doing had acted to bring the medical profession into disrepute. Whilst it considered that his misconduct was remediable it did not consider, particularly in relation to Patient C, that the behaviour had been remediated and so concluded that at this stage there was a risk of the conduct being repeated.

75. The Tribunal accepted Mr Taylor's submission that all three limbs of the overarching objective are engaged and a finding of impairment was required in order to 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. Failure to make such a

finding, the Tribunal concluded, would undermine public confidence in the profession and in the regulatory process.

76. The Tribunal therefore determined that Dr Volle's fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 14/06/2022

The Outcome of Applications Made during the Sanction Stage

77. The Tribunal proposed an amendment to the Allegation under Rule 17(6) of the *General Medical Council (Fitness to Practise Rules) 2004 as amended* ('the Rules'), to replace the word '*performed*' with the word '*reported*' as this more accurately reflects Dr Volle's role in relation to the respective scans. Mr Taylor indicated that he was neutral in relation to the proposed amendment. The Tribunal were of the view that the amendment could be made without injustice and so amended the Allegation.

Evidence

78. The Tribunal received 3 documents from Dr Volle during the deliberation stage on sanctions. Mr Taylor indicated he had no objection to the Tribunal receiving and considering the documents at this stage. The documents received and considered were:

- Colleagues feedback 2021 (this was a duplicate of a document included in Dr Volle's Stage 2 Bundle which the Tribunal had already seen)
- Appraisal Certificate 2021
- Appraisal Certificate 2022

Submissions

79. Mr Taylor submitted that the decision as to the appropriate sanction was a matter for the Tribunal exercising its own independent judgement. The primary purpose of a sanction is to uphold the overarching objective. Sanctions are not designed to punish a doctor but may have a punitive effect. Sanctions must be proportionate.

80. Mr Taylor invited the Tribunal to consider the following mitigating factors: Dr Volle had not had any previous GMC history; the lapse of time since the events referred to in the allegation and that there had been no repetition of the misconduct. Mr Taylor submitted that the Tribunal must balance the mitigating factors with the aggravating factors of the case. Mr Taylor submitted that the main aggravating factor in the case was that Dr Volle lacked any meaningful insight in relation to Patient C. He submitted that this was paticularly worrying in a case in which a patients' safety had been put at risk. Mr Taylor submitted that it was of particular concern that Dr Volle had not provided the Tribunal with a witness statement and submitted that he had completely disengaged from the regulatory proceedings.

81. Mr Taylor submitted that this could ordinarily have been a case where conditions might have been appropriate in light of paragraph 80 of the Sanctions Guidance (16 November 2020) ('the SG'), however, he submitted the low level of remediation and insight found in relation to Patient C meant that conditions would not be workable.

82. Mr Taylor submitted that the appropriate sanction in this case would be one of suspension. He submitted that suspension is appropriate when a breach of *Good Medical Practice* (GMP) is serious but is not fundamentally incompatible with continued registration.

83. Mr Taylor referred to SG paragraphs 92, 93 and 97. In relation to paragraph 97 he submitted that the Tribunal should have particular regard to 97(a), (f) and (g):

> '*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…*
>
> *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 breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

…

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'.

84. Mr Taylor submitted that the length of the suspension was a matter for the Tribunal.

The Relevant Legal Principles

85. This stage of the proceedings is governed by Rule 17(2)m of the Rules and the Tribunal's task now is to decide what sanction, if any, should be imposed upon Dr Volle's registration.

86. When considering sanction, the Tribunal had particular regard to the statutory overarching objective:

a. To protect, promote and maintain the health, safety and wellbeing of the public;

b. To promote and maintain public confidence in the medical profession;

c. To promote and maintain proper professional standards and conduct for members of that profession.

87. In reaching its decision, the Tribunal took into account the SG. The Tribunal considered that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although the sanction may have a punitive effect.

88. The Tribunal took into account that its decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgement, taking account of the SG. It considered the least restrictive sanction first and then the other sanctions, in ascending order, taking into account the submissions made. The Tribunal considered its determination on impairment and took its findings at the impairment stage into account during its deliberations on sanction.

89. The public interest, which was at the forefront of the Tribunal's mind, includes the public interest in enabling a suitable doctor to return to safe practice, but also the wider public interest of the protection of patients, the maintenance of confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Tribunal's Determination on Sanction

Aggravating and Mitigating Factors

90. The Tribunal considered and balanced the aggravating and mitigating factors in this case, before considering what action, in any, to take in respects of Dr Volle's registration.

91. The Tribunal first considered the aggravating factors. The Tribunal agreed with the submission of Mr Taylor that Dr Volle's lack of insight in relation to Patient C was a significant aggravating factor in the case. The was no material before it on which the Tribunal could conclude that Dr Volle showed an understanding of, and remorse for, the potential harm that could have occurred to Patient C from his failings. The Tribunal noted that in the documents Dr Volle had presented to them there were repeated references to the family court findings. It appeared to the Tribunal that, up until the point of Dr Volle making admissions to paragraphs 3 and 4 of the Allegation, on day 3 of the hearing, he had failed to recognise that one of his key failings in relation to Patient C was to identity that the extra cerebral fluid of non-CSF density or signal on Patient C's scans should have alerted Dr Volle to the possibility of differential diagnoses including previous non-accidental head injury. Dr Volle had not presented to the Tribunal any reflective statements subsequent to his admissions in relation to Patient C.

92. The Tribunal did note however, considering paragraph 51 of the sanction guidance, *"…The tribunal must be assured that this approach adequately protects patients, in that the doctor has recognised the steps they need to take to limit their practice to remediate",* that despite the low level of insight shown by Dr Volle, he had stopped reporting on paediatric neuro radiology scans in September 2018.

93. The Tribunal did not identify any further aggravating factors.

94. The Tribunal then considered the mitigating factors in the case recognising that the Tribunal is less able to take mitigating factors into account when the concern is about patient safety.

95. The Tribunal considered that, in relation to Patient B, there was evidence that Dr Volle understood the problem, had insight and had taken steps to remediate. Whilst, as discussed above, Dr Volle had not provided evidence of similar insight in relation to Patient C, the Tribunal did take into account that he had admitted paragraphs 3 and 4 of the Allegation

in relation to Patient C and, as stated above, had stopped reporting on paediatric neuroradiology scans.

96. The Tribunal took into account that Dr Volle was of good character and had no previous findings of impairment. They also considered that the incident in relation to Patient B dated back to 2016 and the incident in relation to Patient C dated back to June 2018 and there had been no recurrence in that time.

97. The Tribunal took the view that Dr Volle had remediated his failings in relation to Patient B. Given the evidence of remediation in relation to Patient B, and the information provided on Dr Volle in the numerous references, the Tribunal were firmly of the view that Dr Volle's actions were remediable in relation to Patient C, albeit that the level of remediation was low at the moment. The Tribunal noted that Dr Volle had attended a 1 day course in 2019 which included an afternoon teaching session on non-accidental injury and noted some level of remediation in the reflective comments made by Dr Volle in his July 2021 documents. The Tribunal were, however concerned, that they had not been provided with any evidence of recent CPD albeit it had received two certificates confirming a satisfactory appraisal in 2021 and 2022, at a late stage in the proceedings.

98. The Tribunal considered the large number of testimonials and references placed before it, noting that they covered the period from April 2012 to November 2021. The Tribunal considered the SG, in particular paragraph 39, and concluded more weight could be attached to some references than others and placed more weight on those references where the authors had more experience of Dr Volle. The Tribunal noted that it was far from clear that all referees were aware of the allegations and some of the references appeared to be in support of job applications. The Tribunal took the view, however, that, certainly in relation to the references from towards the end of Dr Volle's times at James Cook Hospital, the authors of the references would have been aware of the incident involving Patient C because of its serious nature and consequently were able to place more weight on those references.

99. The Tribunal took the view that taking the references together they showed that Dr Volle had good standing in the medical profession and that they were supportive of his clinical skills. The references from other members of MDT showed that Dr Volle had wide support from other clinicians and allied health care professionals. The Tribunal noted that, albeit none of the references directly addressed the allegations, there were references which dealt with the quality of Dr Volle's reporting, the fact Dr Volle had improved protocols and Dr Volle's approach to communicating. The Tribunal were concerned, however, given that it was told that Dr Volle was working at the time of the hearing, that there were no further references since the end of 2021. The Tribunal in general were concerned by the lack of information as to Dr Volle's current employment with virtually no information having been provided to them in relation to Dr Volle's professional life in 2022 (the Tribunal were simply told that Dr Volle was working and was provided with an appraisal certificate dated March 2022).

The Tribunal's decision on Sanction

100. The Tribunal next turned to consider the possible sanctions in this case. The Tribunal reminded itself of the statutory overarching objective and the importance of ensuring that any sanction they imposed was proportionate.

No action

101. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

102. The Tribunal next considered whether the overarching objective would be met by imposing conditions on Dr Volle's registration. The Tribunal agreed with the submission of Mr Taylor that this might have been a case in which conditions were appropriate as, in accordance with paragraph 81, issues around Dr Volle's performance were involved and there was evidence of shortcoming in specific areas of Dr Volle's practice.

103. The Tribunal considered whether conditions were likely to be workable. Despite the lack of engagement of Dr Volle in the hearing, the Tribunal was satisfied that Dr Volle would comply with any conditions placed on his practice. The Tribunal took into account Dr Volle's engagement with the regulatory process prior to this hearing, his remediation in relation to Patient B, the steps he himself had taken to stop reporting on paediatric neuroradiology cases and the information in the references and concluded that Dr Volle did have the potential to respond to remediation and supervision. However, the Tribunal was concerned that a period of retraining and/or supervision would not be workable in a case where Dr Volle's insight was currently so low. The Tribunal further considered that a period of retraining and/or supervision would not meet the overarching statutory objective in a case where the doctor had such limited insight and was not the most appropriate way of addressing the findings in this case. The Tribunal was concerned that it did not have current evidence in relation to Dr Volle's practice.

Suspension

104. The Tribunal then went on to consider whether suspending Dr Volle's registration would be appropriate and proportionate. In this regard, The Tribunal considered paragraphs 92, 93 and 97 (a), (e), (f) and (g) of SG to be relevant (set out above).

105. The Tribunal took the view that Dr Volle's conduct was serious but fell short of being fundamentally incompatible with continued registration. The Tribunal were concerned that given the low level of insight there is currently a risk to patient safety but were of the view that Dr Volle does not pose a *significant* risk of repeating behaviour. In the Tribunal's view,

Dr Volle has demonstrated potential for remediation and there is no evidence that demonstrates remediation is unlikely to be successful.

106. The Tribunal concluded that a period of suspension would reflect the gravity of the misconduct and meet the public interest of maintaining public safety and promoting public confidence in the medical profession and maintain proper professional standards. Dr Volle would have the time and opportunity to continue to develop insight into his failings and to remediate.

Length of suspension

107. In terms of the length of suspension, the Tribunal took into account that, whilst its findings were serious, the nature of the facts admitted and found proved were such that they might have been addressed by conditions being imposed on Dr Volle had there been evidence of further insight into his failings with regard to Patient C. The Tribunal concluded that the appropriate level of suspension was one of 4 months. They considered that this should be sufficient time for Dr Volle to reflect on his failings in relation to Patient C and demonstrate insight and remediation.

108. This suspension will uphold the over-arching objective to protect the public, maintain public confidence in the profession and uphold proper professional standards.

Review

109. The Tribunal determined to direct a review of Dr Volle's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review was sought.

110. At the review hearing, the onus will be on Dr Volle to demonstrate how he has developed insight and remediated his conduct. Any future Tribunal may be assisted if Dr Volle provides:

- A reflective statement considering the potential harm to Patient C as a result of Dr Volle's failure to raise the possibility of non-accidental injury and to address the failure to recognise that the MRI on 20 June 2018 was significantly degraded
- Evidence of relevant CPD courses in the areas of safeguarding and non-accidental head injury
- Evidence of relevant reading in relation to radiological standards in the area of suspected non-accidental head injury
- Up-to-date references and testimonials
- Information as to Dr Volle's work since November 2021 and future work plans

Determination on Immediate Order - 14/06/2022

111. Having determined to suspend Dr Volle's registration for a period of 4 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

112. On behalf of the GMC, Mr Taylor submitted that he made no application for an immediate order to be imposed. He stated that it was not necessary for an immediate suspension to be imposed, given the circumstances of the case, given the substantive sanction of suspension that the Tribunal has made as this met the public interest, maintained the public confidence in the profession, and maintained and upheld the standards of the profession.

The Tribunal's Determination

113. The Tribunal had regard to paragraphs 172 and 178 of the SG. It took account the guidance, the submissions of GMC Counsel and the specific basis upon which the Tribunal reached its determination on sanction.

114. It determined that the substantive order upholds the overarching objective in maintaining public confidence in the profession and met the Tribunal's concerns about patient safety. An immediate order would not be necessary in this case.

115. This means that Dr Volle's registration will be suspended from the Medical Register 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Volle does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

116. There is no interim order to revoke.

117. That concludes the case.

ANNEX A – 08/06/2022

118. On 6 June 2022, Mr Cassidy, counsel on behalf of Dr Volle, made an application to adjourn the hearing pursuant to Rule 29(2) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

Summary of submissions on behalf of Dr Volle

119. Mr Cassidy, firstly, submitted that Dr Volle was absent XXX and the Tribunal, in fairness to him, should adjourn in order to enable him to attend at a future hearing. The Tribunal was told that Dr Volle had indicated in a conference with counsel on Tuesday 31 May 2022 XXX (6 June 2022, Day 1 of the scheduled hearing). He eventually presented to the Tribunal two letters obtained that day from Dr C, XXX.

120. Secondly, Mr Cassidy reminded the Tribunal that there had been an application to adjourn this hearing previously based on the fact that Dr Volle, having obtained legal representation late in the day, now wished to instruct an expert. That application, which was refused, was renewed before the Tribunal.

121. Mr Cassidy submitted that this case is complex and Dr Volle should have the ability to obtain an independent expert opinion to address the same issues that were being addressed by Dr D, an expert instructed on behalf of the GMC. He highlighted the importance of expert evidence to the issues in the case.

122. Further, Mr Cassidy submitted that, in the likely position that was unfolding that Dr Volle did not attend the hearing, Dr Volle would be left in the position of having no one who can provide a comment on the evidence of Dr D.

123. Mr Cassidy submitted that the Case Manager failed to put significant weight on the natural disadvantage that Dr Volle has if this hearing was to go ahead and instead prioritised the inconvenience if this hearing was adjourned.

124. Mr Cassidy concluded by stating that the Tribunal should consider that the proper decision to adjourn was not the attractive decision however, it was more attractive than the decision to proceed and that natural justice required an adjournment.

Summary of submissions on behalf of the GMC

125. On behalf of the GMC, Mr Taylor submitted that the Tribunal should refuse the application made on behalf of Dr Volle to adjourn the hearing.

126. Mr Taylor submitted that the GMC remains amenable to agreeing that family court documents can be put before the Tribunal. The Tribunal also had sight of the Case Management bundle, responding to the application to postpone the hearing. Mr Taylor

submitted that it would be proper to have the expert witness read over and comment on the relevant family court documents.

127. Mr Taylor submitted that the Case Manager, who had managed the case throughout, was not satisfied that Dr Volle had insufficient time to prepare his case before the Tribunal and that was the reason why his initial postponement application had been refused.

128. In relation to the XXX side of the adjournment application, Mr Taylor stated that XXX letter is *'thin'*. There is no indication that Dr Volle is not fit to participate in the hearing and participation is not the same as attendance. There is no explanation or reference to Dr Volle attending remotely.

129. Mr Taylor submitted that XXX. XXX, he is currently working. Dr Volle is represented and he can give his representative instructions. XXX.

130. Mr Taylor submitted that there was no indication in February 2022, at the pre-hearing meeting, that there would be any difficulty in Dr Volle attending XXX. He submitted that the Tribunal only knew of this from Mr Cassidy who informed it that Dr Volle had been unwell since Tuesday 31 May 2022.

131. Mr Taylor submitted that there needs to be cogent and compelling evidence as to why a Tribunal cannot go ahead with a hearing and the Tribunal has not been presented it. Mr Taylor concluded that reasonable adjustments can be made. Dr Volle can attend via video link XXX. Further, Dr Volle is represented and the expert witness can be cross-examined by Mr Cassidy.

The Relevant Legal Principles

132. The Tribunal considered the submissions by both counsel and the provisions of Rule 29(2) of the Rules:

> ***29.*** *(2) Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.*

133. The Tribunal considered the guidance in *R v Jones 2001 EWCA Crim 168* and *Adeogba v GMC [2016] EWCA Civ 162* where it was said that *R v Jones* provided a useful starting point but it is important to bear in mind that a disciplinary hearing must also be guided by the overarching objective and that the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance. Fairness

encompasses, as prime importance, fairness to the medical practitioner, but it also involves fairness to the GMC.

134. The Tribunal further considered the guidance of the Court of Appeal in *Lovett v HCPC [2018] EWHC 1024 (Admin)* included that proceedings could continue even if a practitioner was absent for health reasons and/or lacked capacity, as long as it was fair to do so.

135. The Tribunal also considered the guidance in *GMC v Hayat [2018] EWCA Civ 2796* in relation to the approach to medical evidence provided in support of an adjournment application.

The Tribunal's Decision

136. When considering whether to adjourn these proceedings, the Tribunal had regard throughout to the overarching objective. The Tribunal was also aware of a need to strike a balance in terms of fairness to Dr Volle and to the GMC and the need to take into account the wider public interest.

137. The Tribunal considered that, in terms of Dr Volle's absence, the application had been made at the last minute, despite that fact it appeared to relate to longstanding and ongoing issues with Dr Volle's health. Ill-health had not formed part of the application to adjourn dated 10th May 2022.

138. XXX was put before the Tribunal during the course of the hearing. It was clear from the letter that Dr Volle had not presented to Dr C that morning with XXX. XXX. The letter said,

> "*He tells me that he would be unable to attend a hearing*".

A further letter from Dr C was received later in the day with a single line stating :

> *"XXX".*

139. The Tribunal considered that this evidence was unsatisfactory on a number of levels. Firstly, XXX, it was far from clear why these issues were raised so late in the day XXX. Secondly, neither letter from Dr C XXX. There was no suggestion of XXX. Thirdly, and crucially, the letter did not address XXX. The Tribunal determined that the implication of this appears to be that in fact he could attend by video link were it not for his hearing problems.

140. The Tribunal heard from both parties that Dr Volle is currently working. On being asked, Mr Cassidy informed the Tribunal that, as of Tuesday 31st May 2022, Dr Volle was working full time as a radiologist in a hospital. The Tribunal considered it signifcant that XXX had not prevented him from working full-time.

141. Weighing up all the full circumstances and balancing the interests of Dr Volle alongside the overarching objective, the Tribunal took the view that it was not satisfied that there was an evidential basis for finding that Dr Volle was unable to participate in the hearing, should he choose to do so. The evidence presented to the Tribunal was late and unsatisfactory for the reasons identified above. The Tribunal determined that reasonable adjustments could be made to enable Dr Volle's participation via a video link, through the use of both the real-time captions and the live transcript on Microsoft Teams. The Tribunal further considered that Dr Volle could take regular breaks, both to enable him to speak with his representative XXX.

142. The Tribunal went on to consider whether proceedings should adjourn in order to enable Dr Volle to obtain his own expert opinion.

143. The Tribunal noted that Dr Volle had applied to adjourn the hearing on 10th May 2022 and that decision had been refused by his Case Manager on 26th May 2022. The Tribunal was also aware that Dr Volle had only sought legal representation recently and had previously indicated that he did not intend to be represented. Dr Volle had been aware of the date of the hearing and the timescales for the preparation of his case by late August 2021. The Tribunal further noted that his representative had not initially sought an expert witness, but instead had been content to rely on material from the family court, changing tack only when it was unclear whether the GMC would agree to this.

144. The Tribunal was concerned that the need to instruct an expert witness had been identified at a very late stage. The Tribunal was informed that a Dr W had been contacted on either 10 or 11 May and had been subsequently asked about his timetabling. He had not yet been formally instructed and counsel were unable to advise the Tribunal when a report could be prepared by. There was no suggestion that any preliminary view had been sought from him. No explanation had been provided to the Tribunal as to why the report had not been expedited.

145. The Tribunal took into account that, despite the pre-hearing meeting in February 2022, Dr Volle had still not provided a witness statement, not even after obtaining legal representation.

146. The Tribunal was concerned that, despite the reasoning of the Case Manager refusing the application to adjourn, that fairness could be ensured by the inclusion of the helpful material from the family proceedings "providing Dr Volle's representatives identify those parts relied upon", no attempts had been made by his representative to identify relevant material to the GMC.

147. The Tribunal took the view that the issues in dispute were relatively narrow in this case and it shared the view of the Case Manager that any potential unfairness to Dr Volle could be mitigated by the admission of the relevant material from the family court proceedings. The Tribunal therefore determined to refuse the application to adjourn.