NHS England

Ms Helen Rimmer
HM Assistant Coroner
Liverpool and Wrral
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[redacted]

Primary Care Medical Director
NHS England
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11 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Eleanor Hazel Aldred-Owen who died on 2 October 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 18 December 2024 concerning the death of Eleanor Hazel Aldred-Owen on 2 October 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Eleanor's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Eleanor's care have been listened to and reflected upon.

Your Report raises concerns about the Standard Operating Procedure (SOP) for radiographers, and whether this includes provision for radiographers to escalate care and put out an urgent arrest call when there are clear signs of imminent danger to life.

Diagnostic radiographers are registered professionals under the Health and Care Professions Council (HCPC). Under the HCPC standards, it is expected that all registered diagnostic radiographers will be able to:

- distinguish between normal and abnormal appearances on images (standard 12.16)
- appraise image information for clinical manifestations and technical accuracy, and take further action as required (standard 13.17)
- distinguish disease trauma and urgent and unexpected findings as they manifest on diagnostic images, and take direct and timely action to assist the referrer (standard 13.40)

In Eleanor's case, the radiographer would have been expected to recognise the clinical urgency shown on the X-ray image and immediately alert the referring doctor, or in the absence of the referring doctor, the medical or nursing staff on the ward of this critical finding. This expectation is in line with the standards of proficiency for diagnostic radiographers.

In October 2022, the Academy of Medical Royal Colleges published the Alerts and notification of imaging reports recommendations which included the expectation that in time critical events, the radiologist or the diagnostic radiographer may notify the

referrer verbally before the examination is formally reported. The recommendation includes that this verbal notification should be recorded in the patient record, radiology information system or on the radiology report.

The Royal College of Radiologists' Quality Standard for Imaging (QSI) supports improving standards of imaging services. It is expected that all providers of imaging services will work towards this QSI, or equivalent quality standard, to ensure their services are managed effectively and are safe for all users. In the QSI, all imaging services that work under this quality standard are required to have protocols in place to manage unexpected diagnoses and indications of potential medical emergencies.

To ensure all radiographers are aware of their responsibilities under the HCPC standards of proficiency, national communication is shared through the professional body for diagnostic radiographers – The Society of Radiographers. In addition, NHS England will share the link to the HCPC proficiency standards for radiographers on the NHS Futures internet pages, which is a collaboration platform available to anyone working in or for health and social care. This will support dissemination and remind all diagnostic radiographers of their responsibilities in clinical practice as state registered healthcare professionals.

NHS England's North West regional colleagues have also engaged with NHS Cheshire and Merseyside ICB on the concerns raised. We are advised that Alder Hey Children's NHS Foundation Trust had already amended their SOP to address the learning required from this particular case, and they presented this evidence during the inquest. They are disseminating this change through all of their quality and/or contract meetings with relevant providers and to their Patient Safety Specialist Community of Practice in February 2025 to support further discussion and awareness.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Eleanor, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted], MBBS, DRCOG, MRCGP
Primary Care Medical Director