NHS England

Steve Eccleston
Assistant Coroner for the West Yorkshire area
HM Coroner's Court
Cater Building
1 Cater Street
Bradford
BD1 5AS

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

24 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Gemma Suzanne Marshall who died on 15 March 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 January 2025 concerning the death of Gemma Suzanne Marshall on 15 March 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Gemma's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Gemma's care have been listened to and reflected upon.

Your Report raises concerns about the interpretation of a CT scan, which showed that Gemma's gastric band had slipped and was out of position. You reported that the slippage was not commented on or subsequently reported by the radiologist and noted that this was due to lack of familiarity with how slipped bands present, compounded by the increasing rarity of the procedure as well as the CT scan having been reviewed by an outsourced third-party radiologist without the relevant specialism in abdominal or bariatric issues. You considered that the knowledge gap around the presentation of slipped bands is an issue of concern nationally.

My response to your concerns has been informed by the Imaging and Transformation Programme Team at NHS England. Teleradiology is the transmission of images and associated data between locations for the purpose of primary interpretation or consultation and clinical review. Such processes include the sharing of patient identifiable information within and among organisations and across international boundaries. Teleradiology reporting is widely used across the NHS for out of hours emergency reporting of CT examinations and other modalities, where clinically required to support urgent patient care. In addition, teleradiology reporting can also be outsourced to companies to deliver routine reporting where there is a local requirement to support the expected report turnaround times within imaging services.

To ensure the reporting clinician working in the imaging department has appropriate clinical information to formally report on examinations, it is essential that all referrers requesting imaging examinations provide clear, concise, and relevant clinical information to justify the examination, including any medical history that is relevant to the clinical examination requested. Trusts that outsource imaging reports to

teleradiology providers should ensure the teleradiology provider has access to the same patient referral form as reporting staff working within the imaging department.

All NHS Trusts that outsource reporting of imaging examinations to teleradiology companies remain responsible for the patient. Trusts should have robust contract arrangements in place to ensure the teleradiology service meets the Trust's clinical and governance standards, overseen by regular performance and management meetings between the teleradiology company and the Trust, to ensure that the Trust's standards are delivered.

In order to learn from reporting discrepancies or clinical incidents, all reporting discrepancies should be reviewed at the Trust's Radiology Events and Learning Meeting (REALM) or equivalent forum. The REALM should include any relevant teleradiology cases, with feedback given to the teleradiology provider on the outcome of the case, to ensure learning is shared with the original reporter.

In 2019, the Healthcare Safety Investigation Branch (HSIB), now the Health Services Safety Investigations Body (HSSIB), issued an investigation into 'Failures in communication or follow-up of unexpected significant radiological findings'. This identified a series of safety recommendations, which included that the Royal College of Radiologists, working with the Society of Radiographers and other relevant specialties through the Academy of Medical Royal Colleges, developed:

- principles upon which findings should be reported as 'unexpected significant', 'critical' and 'urgent' (safety recommendation 1)
- a simplified national framework for the coding of alerts on radiology reports (safety recommendation 2)
- a list of conditions for which an alert should always be triggered, where appropriate and feasible to do so (safety recommendation 3).

The contents of the HSIB's investigation report were considered by NHS England's Imaging Transformation Team, as part of a working group overseeing NHS England's response to the Parliamentary & Health Service Ombudsman (PHSO) Unlocking Solutions in Imaging: working together to learn from failings in the NHS 2021 report into imaging within the NHS. To support this work, significant investment has been made to improve IT and digital infrastructures within imaging services and additional funding will be allocated in 2025/26.

In response to the PHSO report, the Academy of Medical Royal Colleges published the report 'Alerts and notification of imaging reports: Recommendations' in October 2022 to support critical and unexpected findings.

All Trusts should ensure that they are following these published recommendations and that they work with their teleradiology company to embed their local alerting processes into the teleradiology workflow. On 31 January 2023, NHS England issued a Patient Safety Update to notify Trusts that the Academy of Medical Royal Colleges' 'Alerts and Notification' paper had been published.

The Quality Standard for Imaging (QSI) launched in July 2024 in collaboration with the College of Radiographers, 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.

With a few exceptions, the reporting of emergency CT scans out of hours is considered to be a core competency and is routinely delivered by radiologists with other specialist interests, both across the NHS and teleradiology companies.

NHS England will work with key partners, including the Royal College of Radiologists, and via the 22 imaging networks operating across the NHS, to support the governance of teleradiology contracts going forwards.

NHS England's North East and Yorkshire regional colleagues have also engaged with West Yorkshire Integrated Care Board (ICB) on the concerns raised in your Report. We have been advised that Calderdale and Huddersfield NHS Foundation Trust have conducted an After Action Review, and the findings and learnings from the investigation have been shared with staff involved in the incident, as well as all relevant areas across the organisation. The Trust have also undertaken a REALM teaching session, which included a case study and learning around gastric band functioning, positioning, complications (including band erosion) as well as how these should be radiologically managed in conjunction with the treating team. In addition, the Trust have confirmed that discrepancies in the radiological reporting have been shared with the relevant external reporting provider who reported on the CT scan, who will undertake their own investigation. Discrepancies, alongside other performance markers, are routinely discussed with the external reporting provider as part of their contracting agreement.

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 Gemma, 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]
National Medical Director