



**Doncaster and Bassetlaw  
Teaching Hospitals**  
NHS Foundation Trust

██████████ Interim Executive Medical Director  
██████████ Medical Director – Operations  
██████████ Interim Medical Director - Workforce  
██████████ Associate Medical Director – Clinical Safety  
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20 May 2025

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**STRICTLY CONFIDENTIAL – ADDRESSEE ONLY**

Mrs S L Slater  
Area Coroner for South Yorkshire East  
Coroner's Court and Office  
Crown Court  
College Road  
Doncaster DN1 3HS

Dear Mrs Slater

**Khadija Kerri (deceased)**

I write to you with respect to the Regulations 28 Report originally issued on the 25 February 2025 to the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust following the Inquest into the death of Khadija Kerri concluded on the 5 July 2024. I understand that your initial notification was inadvertently missed; for which we extend our sincere apologies, and a follow up call to your office confirmed that the submission date of our response would be extended to 29 May 2025.

The report was received by the Chief Executive's office and forwarded to me in order to provide a response.

I have been assisted in constructing this response by ██████████ Associate Medical Director for Clinical Safety and ██████████ Head of Service in Radiology.

I would respond to the matters of concern referred to within the PFDR as follows:

- 1. There is no clear internal policy/procedure within Doncaster Royal Infirmary for disseminating either an addendum report and/or the information contained within the addendum report from the external third party radiology service to the treating clinical team. If this is not addressed there is potential for similar delays and incorrect management of patient care**

I would like to take this opportunity of assuring you and Ms Kerri's family that the Trust has undertaken a full review of the Failsafe Alert for Radiological Findings (Communication Protocol) PAT/T 38 v.5 and this is scheduled to be duly approved through the Local Clinical Governance processes by the 4 June 2025. Our Radiology department communicated with Everlight Radiology to ensure their full agreement with

amendments. The Protocol has been placed on the Trust's Patient Safety Review Group agenda scheduled for 6 June 2025 for ratification.

Once fully approved and ratified, the protocol will be uploaded onto the Trust's intranet within the Policies & Procedures section which is accessible by all staff. It is important to note this is a Trust-wide Policy which provides further enhancement to the safety of our patients on all hospital sites.

A key amendment to the Failsafe Protocol addresses your concern in terms of the Radiology Departmental procedures for communication of failsafe alerts. The procedure clearly defines that *"out of hours" (tele-radiology reported) critical findings will be telephoned directly from the tele-radiology reporting radiologist directly to the referrer on site ("responsible person") and a record of the conversation will be added as an addendum to the report issued.*

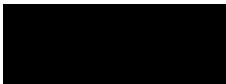
In accordance with the Trust's approved policy procedure, the Failsafe protocol will be audited within 3 months of implementation to ensure all "Failsafe notifications" are communicated and managed appropriately.

Whilst it is recognised that this revision is essential to ensure patient safety, it is acknowledged that the safety net contained within the protocol **does not** replace the Referrer's responsibility to read and act upon radiology reports. This is in line with national guidance *"Recommendations on Alerts and Notification of Imaging Reports"*, published by the Academy of Medical Royal Colleges October 2022.



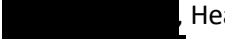

This clinical responsibility will be further highlighted through Trust communications and it is the Trust's responsibility to ensure this is actively communicated on a regular basis through governance processes.

I trust that this will reassure you that the communication alert processes contained with the revised protocol provides an enhanced safety net to undoubtedly make it safer for patients.

Yours sincerely



Acting Executive Medical Director

Cc:  Chief Executive  
 Associate Medical Director for Clinical Safety  
 Head of Service, Radiology  
 Trust solicitor