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Executive Office of the Chair & Chief Executive

Chair : [redacted]
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For the attention of Mrs Louise Hunt
Senior Coroner for Birmingham and Solihull

Sent by way of email only: [redacted]

Dear Mrs Hunt

Inquest touching the death of Mark Villers
Response to Regulation 28 Report to prevent future deaths.

I am writing in response to the Regulation 28 notice issued following the conclusion of the Inquest on 3 June 2025 touching the death of Mr Villers who died on 21 May 2024 at Good Hope Hospital (part of University Hospitals Birmingham NHS Foundation Trust (UHB)).

We note your concerns are that at the time of Mr Villers' presentation to Good Hope Hospital on 18 May 2024 there were insufficient radiologists to report the large number of CT scans undertaken over the weekend period. This was one of the root causes of the very subtle abnormality indicating aortic dissection being missed when the scan was reported. The inquest heard evidence that whilst the situation had improved the number of radiologists was still not in accordance with Royal College of Radiology guidelines, thus creating a risk of future deaths.

We have carefully considered your concerns and would respond as follows.

Following the incident and starting from 1st of September 2024, the provision of out of hours radiology reporting over weekends at Heartlands, Good Hope and Solihull Hospitals, part of UHB Trust, has been reconfigured to increase capacity and reduce the workload for individual radiologists. Previously the On-Call resident and radiologist were responsible for reporting all cross-sectional scans for both the Emergency Department (ED) and inpatients and the workload, which fluctuates, would often exceed safe reporting levels.

The reconfiguration was facilitated by separating the ED reporting from inpatient reporting. Both are now managed across all three hospital sites.

1- Emergency Department Reporting:

   a. All CT scans and urgent MRI scans from ED at Heartlands and Good Hope Hospitals are reported by two resident doctors working from 9am to 5pm and from 1pm to 9pm, overlapping and doubling up between 1pm and 5pm, which is the busiest period.

b. Overnight reporting 9pm to 9am is undertaken by three resident doctors centralised at the Queen Elizabeth Hospital covering all UHB sites.
c. All resident doctor reports are issued to the clinical team pending further review by the On-Call consultant.
d. The On-Call consultant is available from 9am to 9am the next day. They are responsible for reviewing scans undertaken from 11pm the night before to 11pm on the night of their on call.
e. On average the On-Call consultant would review 120 scans during the day of their on call. These are all scans that have been previously reported so would take less time than reporting the scan themselves. The majority of radiologists find that by working for 2-3 hours in the morning, afternoon, and late evening with breaks in between, the number of scans to review is manageable and without undue stress.
f. The On-Call team are not reporting any inpatient scans unless they have been escalated by the clinical team as requiring an immediate report.

2- Inpatient Reporting:

a. Three consultant reporting sessions have been provisioned for Saturdays, Sundays and bank holidays, provided by two different radiologists - one for the AM/PM and one for the evening to reduce the intensity.
b. Each session includes reporting an average of 18 CT and MRI scans which is within most radiologists' ability to do without undue stress.
c. Sub specialist MRI reporting is offered to other radiologists who are not on call as additional work to be carried out as a waiting list initiative (WLI) to cover their specialist areas.
d. We are currently in the process of establishing outsourcing of subspecialist MRI reporting which will provide an additional resource to review any subspecialist MRI scans which the radiologists covering the sessions have been unable to complete during their session.

The majority of our resident doctors and radiologists, who are part of this on call / acute reporting rota, have found the reconfigured system has improved their workload making it much more manageable.

The Royal College of Radiologists (RCR) produced a guidance document to assist with departmental planning.

(https://www.rcr.ac.uk/our-services/all-our-publications/clinical-radiology-publications/radiology-reporting-figures-for-service-planning-2022/)

The RCR guidance provides the headline figure of 14 single body part MRI or 16 single body part CT scans to be reported during each 4-hour session. There is no specific mention of how long reviewing a previously reported scan would take.

The RCR guidance was published to be used for service planning as an average of radiologist performance across the year and the department. As quoted from the document linked above: "*The focus of this guidance is solely on departmental*

planning rather than the individuals, and it should not be used for individual performance management or medico-legally."

We do use this guidance as a benchmark to plan our service and provision it appropriately, but it is recognised that there will be significant variation between individual radiologists and in different reporting sessions and in particular during acute reporting sessions which service busy emergency departments where it is not unreasonable for radiologists to work at a higher intensity. This would be similar to an emergency department consultant managing patients that present themselves and this is something that cannot be controlled.

In addition to the reconfiguration we have undertaken, we have also discussed the case at our Radiology Events and Learning (REAL) meeting, which was held on 6 March 2025. We have also delivered an educational session around aortic dissection.

While we recognise that the intensity and volume of work undertaken by the radiologist on the day of this particular incident and that this could have contributed to the error, the abnormality on the scan was very subtle. The consensus of the body of radiologists who attended the REAL meeting when the case was discussed was that it would have been very difficult to identify the subtle abnormality regardless of the setting.

The Radiology team is very sorry that we let down the family of Mr Villers, and we apologise for this incident.

I would like to assure you that the concerns raised within the Regulation 28 notice have been taken extremely seriously, which I hope is demonstrated in the steps that we have taken following Mr Villers' death.

Yours sincerely

[redacted]

[redacted]
Deputy CEO and Chief Medical Officer