Barking, Havering and Redbridge
University Hospitals
NHS Trust

PRIVATE AND CONFIDENTIAL
Ms Nadia Persaud
HM Area Coroner
Walthamstow Coroner's Court
Queens Road
London

Legal Services
Queen's Hospital
Rom Valley Way, Romford, RM7 0AG
[redacted]

Date: 20 November 2025

Regulation 28 Report on the death of Mr Matthew Goldsmith – [redacted]

Dear Ms Persaud,

Thank you for your Regulation 28 Report issued on 9 October 2025 in relation to the death of Mr Matthew Goldsmith. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) has carefully considered the matters of concern raised by the Coroner, acknowledges these findings, and has implemented an action plan to reduce the risk of a recurrence of missed radiological findings. The Trust also extends its sincere condolences to Mr Goldsmith's family.

The matters of concern identified in the Regulation 28 Report and the Trust's responses are set out below.

Missed Abnormal Findings on CT Scans and the Coroner noted the absence of a formal peer review system for Radiology reporting, as required by the Royal College of Radiologists RCR).

The full concerns were:

1. Abnormal findings in the abdominal vascular system were apparent on 3 CT scans from January 2020 to October 2024 but not reported by the reviewing radiologists.
2. In January 2020 a CT trauma scan was carried out following a road traffic collision. This scan showed an occluded right common iliac artery and origin of inferior mesenteric artery. Whilst these findings were not relevant to the clinical condition at the time, they should have been reported.
3. In April 2024 the CT scan of the chest showed occlusion of the infrarenal aorta, bilateral common iliac artery and right external iliac artery. There was severe stenosis of the superior mesenteric artery in its mid segment. The

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latter finding was of direct clinical interest. None of these findings were reported.

4. On 10 October 2024 an abdominal CT scan showed occlusion of the superior mesenteric artery mid segment. This was directly relevant to the clinical condition and it was not reported.
5. The Royal College of Radiologists Guidance requires peer review of 5-10% of reported radiology cases as part of a Trust's quality assurance process. At the date of the inquest, Barking Havering & Redbridge NHS Trust does not have such a peer review system in place.
6. In light of the number of missed radiological findings in this case, by 3 separate radiologists, it is of concern that the peer review process is not taking place at the trust.

Trust Response

Following receipt of the Regulation 28 Report on 9 October 2025, a multidisciplinary review meeting was convened on 15 October 2025. This meeting included senior clinical and managerial representatives from Radiology, Nursing, Governance, Legal Services, and the Medical Directorate to review the findings and develop a comprehensive action plan.

The Trust recognises that the missed findings represent a serious quality concern and accepts the Coroner's recommendations in full. The following actions are being implemented:

The Radiology senior team are in the process of outlining a Radiology Governance Framework (project plan) by aligning workstreams, responsible leads and measuring key outputs by each of the governance domains and fundamentally ensuring that this links back to the SEIPS plan (Systems Engineering Initiative for Patient Safety) methodology. This is a working plan which in the coming months will be discussed with clinical and non-clinical staff for oversight and approval. Within this plan there are essential domains which responds to the coroner's concerns and will be standalone items to ensure that they are progressed without delay and detailed below including an action plan. With the framework there will be enhanced oversight and assurance through the Corporate Quality & Safety Team, Radiology Governance Forum, and Legal Services.

- Introduction of a SEIPS-based project to identify and address human and system factors contributing to reporting discrepancies.

- Development and implementation of a peer review process for Radiology in alignment with RCR guidance, ensuring systematic case review and feedback mechanisms.

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Action Plan

Action Area	Specific Actions	Outputs	Timeline/lead
1.A project plan to be developed to outline implementation of a rapid review of discrepancies using SEIPS methodology 2. The review of the wider Radiology Governance framework and the establishment of workstreams	Implement dual-track PSIRF (SEIPS + Systems Thinking) for discrepancy learning. Action plan developed for workstreams	≥90% discrepancy reviews completed monthly using SEIPS process. Addresses external factors learning from diagnostic errors and reduces recurrence risk whilst also maintaining principles of Radiology events and Learning meeting (REALM)	12 December 2025 – Feb 2026 Radiology Professional Lead, Consultant Radiologist and Service Development Manager
Clinical & Governance Lead consultants in Radiology to introduce Peer Review Process and required assurances	Introduce a peer review process within Radiology to further identify, discuss, and learn from interpretation discrepancies in addition to REALM. Radiology will conduct 3% each month rising to 5% from June 2026	Monthly peer reviews completed; learning outcomes presented in governance meetings; summary dashboard produced showing learning and outcomes and themes identified. Supports quality improvement, PSIRF learning culture and professional development	12 December 2025 Radiology Governance Lead And Radiology Clinical Lead

The specific actions arising from Patient Safety Incident Investigation (PSII) have been included for assurance:

1. A grand round teaching session will be delivered on 11 December 2025 by the Surgical Clinical Group around acute and chronic presentation of mesenteric arterial occlusion. The Grand round is a regular learning session led by the Director of Medical Education to review incidents where learning has been established. At this grand round colleagues from the upper Gastrointestinal and Vascular teams were present.

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2. The case was presented at the BHRUT Patient Safety Summit (PSS) on 23 July 2025 for Trust wide learning. The PSS is a monthly Trust wide open forum for staff to attend and learn about incidents that have significant learning outcomes. This embeds shared learning for all and is also available on the intranet for staff that are unable to join.
3. BHRUT has implemented Electronic Patient Record (EPR) system from week commencing 08 November 2025 which will enable Radiologists and referring clinician's to record real-time decisions and clinical advice directly into the patients record.

Plain Film Peer Review

Within Radiology, the plain film x-ray specialty has already commenced peer reviews which has been in place for over 12 months and from July 2025, the specialty has managed to peer review 5% of cases and is being led by the Radiology Specialty lead. A Standard operating procedure was created and will be replicated to the other modality/specialty areas. A shared governance file stores all reviewed cases.

Teleradiology Governance

BHRUT use Everlight outside of normal working hours to ensure 24 hour imaging cover.

Should there be a discrepancy the imaging/report is reviewed at REALM, letters to Radiologists are produced where needed, and uploaded to Everlight's Governance Portal for action. Everlight then conducts a peer review and produces a governance report (confidential).Everlight operates a structured clinical governance system, which includes:

- A blame-free learning culture with rigorous peer review.
- 2–10% of all Radiology reports subject to structured internal peer review.
- Review of all Level 1 and 2 discrepancies by the Medical Leadership Council (MLC)
- Personal reflection learning forms for Radiologists involved in significant discrepancies.
- Regular Clinical Governance Everlearning webinars are held, open to all Everlight Radiologists, where cases identified via the peer review process are shared and learning points reinforced. These webinars are also recorded and made available offline for review. Everlight Radiologists are required to attend or view the majority of these meetings
- Learning is also shared via monthly Everlearning Bulletins which contains details of interesting cases and learning points, and regular email newsletter to all Radiologists
- Use of discrepancy data to identify trends and drive system improvement. These processes are widely recognised as more rigorous than standard NHS governance models and BHRUT Radiology aims to mirror best practice for peer reviews and discrepancies to Everlight's process.

The Trust takes the Coroner's findings extremely seriously and is committed to ensuring that the learning from this case translates into measurable and sustained improvements in radiological practice.

We thank the Coroner for highlighting these critical issues. The Trust is fully committed to completing all actions within the specified timelines, with progress rigorously monitored through established governance processes. We will ensure that these measures are fully implemented and embedded into routine practice, driving sustained improvements in patient safety and the quality of radiological care.

I would be happy to meet with you to discuss this response if that would be helpful.

Yours sincerely,

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Chief Executive
Barking, Havering and Redbridge University Hospital.