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23 December 2025

Ms Lorraine Harris
East Riding and Hull Coroner Service

[REDACTED]
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Dear Ms Harris

Re: Regulation 28 Report to Prevent Future Deaths – Mr Raymond Leake (Deceased)

I write in response to the Regulation 28 Report dated 28 October 2025, issued following the inquest into the death of Mr Raymond Leake. I write on behalf of Hull University Teaching Hospitals NHS Trust to provide our formal response.

Firstly, I wish to again express our sincere condolences to Mr Leake's family. We recognise the distress caused not only by his death but by the delays in imaging and communication identified during the inquest.

Coroner's Concern

The Coroner raised concern that although changes to radiology processes were introduced in March 2025, these had not been audited by the time of the inquest. As a result, there was insufficient assurance that urgent CT head scans, particularly for in-patients who had fallen while on anticoagulation, would not be missed or delayed in future.

Actions Taken Since the Inquest

1. Review of Policy and Compliance with National Guidance

The Trust confirms that it has a robust Falls Prevention and Management Policy and CT referral guidance aligned with NICE Head Injury Guideline NG232 and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). These policies clearly state that 'Patients on anticoagulation who sustain a head injury should receive a CT head scan within 8 hours of the injury.'

2. Immediate Process Changes Implemented (March 2025)

Following identification of the delayed scan in February 2025, the Radiology Department implemented the following controls in March 2025:

- Automatic Porter Dispatch - Where wards do not answer booking calls, porters are now dispatched directly without further delay

- Radiology Information System (RIS) Flagging - A “Schedule ASAP” flag was introduced at the vetting stage for urgent CT head scans

These actions were communicated to all CT Radiographers and Radiologists by Trust-wide email.

Audit Findings

In direct response to the Coroner’s concern, the Trust has now completed a formal audit and detailed data analysis of CT head scanning performance for in-patients who sustained a fall while receiving anticoagulation. The analysis considered two comparative time periods: April – September 2024 and April – September 2025. Performance was measured against the 8-hour standard, noting that due to limitations in documentation, time of request rather than time of fall was used.

Results were as follows:

2024	2025
228 eligible patients	274 eligible patients
48 scans exceeded 8 hours	49 scans exceeded 8 hours
79% compliance	82% compliance

The audit shows a modest improvement in performance against the 8-hour standard, with compliance increasing from 79% in 2024 to 82% in 2025, including an increase in the number of eligible patients. Despite this, further improvement is required.

The analysis demonstrated that delays that did occur were multifactorial rather than attributable to a single point of failure. Contributing factors included ward availability and shortages of suitable escorts, limited trolley availability on medically fit for discharge wards, patients being temporarily unavailable or moved between wards, and delays at the vetting stage or failure to consistently document the reasons for delay. This analysis has enabled the Trust to understand where delays are occurring across the pathway and to target improvement actions accordingly.

Further actions

The following further improvement actions are now underway:

- Mandatory visual prompts at point of booking – Posters have been implemented at CT booking desks to reinforce the 8-hour requirement for in-patients who sustain a head injury while receiving anticoagulation.
- Reinforced porter escalation process – Radiology staff have been re-briefed to dispatch porters immediately where urgent scans are required, without delaying escalation through attempts to contact wards.
- Strengthened oversight at vetting stage – Lead Radiographers will undertake regular monitoring of vetting lists to ensure head injury CT scans are appropriately vetted and prioritised in a timely manner.
- Clear escalation routes for nursing staff – Nursing teams are being explicitly encouraged to escalate directly to Radiology where urgent scans appear delayed, supporting shared ownership of timely imaging.
- Review of escort and trolley availability – Operational reviews are underway to address delays arising from escort shortages and limited availability of appropriate transfer equipment.
- Improved quality of CT requests – The CT requesting process is being revised to require documentation of the time and location of the fall, supporting accurate prioritisation and improved audit quality.

The findings of this audit and the associated action plan are now overseen through Divisional Governance and escalated to the Trust's Quality and Safety Committee, ensuring executive oversight and organisational accountability for delivery.

Planned follow-up

Once the above actions are embedded, a repeat audit will be undertaken to assess improvement and to provide assurance that urgent CT head scans are delivered reliably and in accordance with required timeframes. The Trust expects to undertake this audit in March/April 2026 and would be pleased to share the findings with the Coroner on completion.

Conclusion

Whilst it is acknowledged that earlier identification of Mr Leake's injury would not have altered the ultimate clinical outcome, the Trust fully accepts the Coroner's finding that the failures identified must be addressed in order to reduce future risk. We are committed to learning from this case and to strengthening our systems to support timely investigation and the delivery of safer care for our patients.

Yours sincerely

A large black rectangular redaction box covering the signature of the Group Director of Patient Safety and Quality Governance.

Group Director of Patient Safety and Quality Governance