The Royal College of Radiologists

Assistant Coroner R Brittain
Manor House Drive
Coventry
CV1 2ND

30/01/2026

[redacted]

Dear Dr Brittain,

RCR Response to Regulation 28: Prevention of Future Deaths report issued on 5 December 2025 in relation to the death of Man Yin 'Anita' Ng.

I was very sorry to read about the death of Man Yin 'Anita' Ng and I would like to express my deepest condolences to Anita's family.

We take the matters raised in your report very seriously and I hope this reply will be helpful in outlining how we are committed to learning from them and supporting our members and Fellows to develop and maintain excellent medical care.

The Royal College of Radiologists (RCR) is a charity which works with our members and Fellows to improve medical care across the specialties of Clinical Radiology and Clinical Oncology. The RCR does not commission, fund, manage, or directly deliver clinical services. Responsibility for the organisation, resourcing, and operational delivery of emergency and specialist services lies with NHS providers, commissioners, and national bodies. However, the RCR has an important role in setting professional standards, providing guidance, supporting workforce development, and advocating for system-level change where patient safety and service sustainability are at risk.

In preparing this response, we sought input from our specialty interest groups most closely aligned with this area of practice to ensure that our comments reflect the breadth of relevant expertise within the specialty. The British Society of Interventional Radiology feedback has been incorporated into the general observations set out below.

We recognise and share your concerns regarding delays to investigation and treatment, variation in access to specialist neurointerventional procedures, and the challenges arising from fragmented clinical ownership across specialties. These issues reflect wider, longstanding system pressures within the NHS, including workforce shortages, constrained critical care and interventional capacity, and increasing demand for time-critical specialist radiological interventions.

Your report highlights the complexity of care pathways where responsibility for admission and ongoing inpatient management may sit with one specialty, while definitive treatment is delivered by another. This model, which is common across Interventional Radiology (IR) can lead to ambiguity in clinical ownership, delays in decision-making, and difficulties in coordinating urgent care, particularly when services are under significant pressure. These

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challenges are not confined to neurointerventional practice alone but are seen across multiple IR emergency and urgent care pathways, including vascular, hepatobiliary, and haemorrhage control services. As demand for minimally invasive, image-guided interventions has grown rapidly, the development of supporting infrastructure, workforce, and governance arrangements has not always kept pace.

The RCR acknowledges the particular concern raised regarding the lack of admitting rights for interventional radiologists. Where interventional radiologists are responsible for delivering definitive, time-critical treatment but do not have admitting rights or direct access to inpatient beds, there can be a misalignment between procedural responsibility and overall clinical accountability. Evidence in the literature (T. Bryant, R. Ahmad, A. Diamantopoulos *et al*, 2023) has highlighted that admitting rights and involvement in ward-based care are important for patient safety, continuity of care, and the long-term sustainability of IR services. The RCR supports collaborative models that enable appropriate admitting rights and shared inpatient responsibility, tailored to local service configurations.

We also recognise the pressures created by the rapid expansion of neurointerventional thrombectomy and aneurysm services over recent years. While these advances have delivered significant benefits for patients, their growth has often occurred in the context of limited workforce expansion and insufficient critical care, theatre, and interventional suite capacity. This has contributed to variability in service availability and resilience, particularly outside normal working hours.

While the RCR cannot mandate service reconfiguration or staffing levels, we will continue to work with partner organisations, including specialist societies and national bodies, to advocate for sustainable workforce planning, clearer clinical governance arrangements, and equitable access to specialist interventional services. We will also continue to develop and update professional guidance and standards that support timely access to care and clarify roles and responsibilities within complex, multidisciplinary pathways.

I am grateful to you for bringing these matters of concern to our attention and for giving us the opportunity to respond. Once again, I express my deepest condolences to Anita's family and loved ones.

Yours sincerely,

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RCR President