[redacted]
Date: 26 May 2026

[redacted]
Chief Medical Officer
Trust Headquarters and Medical Education Centre
Aberford Road
Wakefield
WF1 4DG
[redacted]

Address:
[redacted]

Dear Ms Keighley,

Regulation 28 Report to Prevent Future Deaths
Re: Raisa Cristina Iordan (Deceased)

Thank you for your Regulation 28 Report dated 31 March 2026.

On behalf of Mid Yorkshire Teaching NHS Trust, I would like to express our sincere condolences to the family of Raisa Cristina Iordan.

The Trust acknowledges the findings of the inquest, namely that Raisa died of natural causes and that there were missed opportunities to escalate care despite clinical concerns being raised.

Following this incident and the subsequent investigation, the Trust has undertaken a review and taken improvement actions across paediatric, emergency, anaesthetic and radiology services. This has included internal investigation, system-wide learning, and engagement with external professional bodies. As a result, the Trust has implemented a range of actions aimed at strengthening the recognition and management of deteriorating children, improving escalation processes, enhancing workforce resilience, and increasing the reliability of stabilisation and transfer arrangements.

These actions include: standardisation of paediatric equipment across clinical areas; expansion of multidisciplinary simulation and interfacility transfer training; strengthening of governance structures for deteriorating patients, including regular multidisciplinary review forums; improved communication with families regarding appropriate service access; and progression of workforce initiatives across paediatrics, emergency medicine and anaesthetics.

In parallel, the Trust has undertaken broader system engagement to improve coordination with ambulance and retrieval services.

This letter constitutes the Trust's response pursuant to Regulation 29 of the Coroners (Investigations) Regulations 2013. It addresses each of the matters of concern identified in your report and sets out further specific actions taken and planned to mitigate the risk of future deaths.

Context
The Trust operates a hub-and-spoke model for paediatric services, whereby Dewsbury District Hospital (DDH) provides assessment and stabilisation, with inpatient and critical care services delivered at Pinderfields General Hospital.
The Trust recognises that the management of acutely deteriorating children at DDH, particularly out of hours, represents a low-frequency but high-impact risk requiring effective systems of early recognition, escalation, stabilisation and transfer.
The Trust accepts that, in this case, elements of those systems did not operate to the expected standard.

Response to Matters of Concern

1. Escalation of Clinical Concerns
The Trust accepts the concern that clinical observations and concerns raised by junior and other clinicians were not escalated or acted upon appropriately.
In response, the Trust has implemented the following measures:

- Revision of the Management of the Deteriorating Child Out of hours at DDH Standard Operating Procedure, including clearer escalation triggers and requirements for senior clinical review
- Establishment of a monthly Deteriorating Patient Governance Group to review cases and escalation performance
- Strengthening of significant event review processes, with multidisciplinary participation including system partners
- Implementation of regular multidisciplinary simulation training focused on escalation, communication and management of deteriorating paediatric patients
- Reinforcement of professional expectations regarding escalation of concerns and clinical challenge, including in situations of disagreement

Further actions include the introduction of an enhanced out-of-hours paediatric rapid response model, for which recruitment is currently underway.

Compliance with escalation processes is subject to ongoing audit through established governance structures.

2. Radiology Reporting
The Trust notes the concern regarding the reporting of out-of-hours CT imaging.
The Trust recognises that, in this case, the radiology report did not identify significant intracranial pathology. This case has been reviewed through internal quality assurance processes, and engagement has taken place with the external reporting provider.
Overnight radiology outsourcing is established practice within the NHS. TMC is the largest such provider of outsourcing Radiology reporting in Europe and has contracts

with over 50 UK hospitals. Its radiologists are all trained to the same standard as NHS consultant radiologists, with equivalent qualifications, and their reporting quality is audited, with a minimum of 5% of their reports peer-reviewed. Routine access to subspecialist paediatric radiology reporting overnight is not available within West Yorkshire. The Trust is aware that TMC have also been sent the regulation 28 and will issue a response.

Actions taken include:

- Formal review of the case with the external provider.
- Reinforcement of the requirement for clinical decision-making to reflect the overall clinical presentation, rather than reliance solely on imaging reports.
- Ongoing audit and peer review of radiology reporting, including externally provided reports.

In addition, processes supporting direct communication between clinicians and reporting radiologists in complex cases have been reinforced.

These measures are subject to ongoing review.

3. Delays in CT Imaging

The Trust acknowledges the concern regarding delays in obtaining CT imaging. An audit of overnight CT activity indicates that median time from request to scan is comparable to other Trust sites. However, the Trust recognises that delays in time-critical cases require continued mitigation.

Actions undertaken include:

- Audit and review of overnight CT response times.
- Review of the workforce model supporting CT provision at DDH.

Further work is in progress to move towards an on-site overnight radiographer model, subject to workforce availability, alongside continued monitoring of response times and prioritisation of critically unwell patients.

4. Anaesthetic Support and Delays in Intubation.

The Trust acknowledges the concern relating to delays in securing appropriate anaesthetic support.

Out-of-hours anaesthetic provision has been identified as a critical dependency in the management of deteriorating children, and the following actions have been taken:

- Approval of a business case for a dedicated DDH anaesthetic consultant on-call rota.
- Expansion of multidisciplinary simulation training, including paediatric airway management scenarios.
- Standardisation of paediatric airway equipment and transfer compatibility.

- Requirement for appropriate paediatric life support training for anaesthetic clinicians.

Further actions include implementation of the anaesthetic rota, subject to recruitment

System-Level Actions
In addition to the above, the Trust is undertaking a programme of system-level improvement, including:

- A strategic review of paediatric service configuration to ensure long-term safety and sustainability

Conclusion
The Trust acknowledges the concerns identified in your report and has taken, and continues to take, action to address them.
Whilst recognising that risk cannot be entirely eliminated in the management of uncommon and rapidly evolving paediatric conditions, the Trust is committed to strengthening escalation processes, workforce resilience and system reliability, and will continue to monitor the effectiveness of these measures through its governance arrangements.

Please get in touch if there are any further queries.

Yours sincerely,

Chief Medical Officer