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NHS Partner for
Sub-specialist Radiology
Since 2004

HM Assistant Coroner Charlotte Keighley
West Yorkshire Coroner's Court (Western Area)
Inquest: Raissa Cristina Iordan (concluded 23 October 2025)
Responding Organisation: Telemedicine clinic limited (TMC)

Response to Regulation 28 Report

Introduction

We write in response to the Prevention of Future Deaths Report dated 31 March 2026.

Telemedicine Clinic Limited (TMC) wishes to express its sincere condolences to the family of Raissa Cristina Iordan for their tragic and devastating loss. We recognise the profound distress experienced by Raissa's family and all those involved in her care. We have sought to approach this response in a factual and sensitive manner.

TMC has carefully considered the Coroner's findings and the Regulation 28 Report. While the Coroner concluded that the death was due to natural causes and that the outcome would not have been altered, TMC acknowledges the concerns raised in relation to out-of-hours paediatric neuro-imaging interpretation and the associated risk of future harm. TMC recognises that CT brain interpretation in infants requires heightened vigilance, structured escalation, and robust quality assurance and is highly committed to learning from this incident and to strengthening safeguards within its services.

National context

TMC considers it important to place its response within the wider national context, which was also highlighted during the inquest. There is a recognised national challenge in accessing subspecialist paediatric neuro-radiology expertise, particularly outside normal working hours, even in tertiary paediatric centers. As a result, emergency paediatric imaging services across the UK NHS are commonly delivered by general consultant radiologists, supported by clinical governance frameworks and escalation pathways. This model is explicitly recognised by the Royal College of Radiologists (RCR) as appropriate where such safeguards are in place.

This context does not diminish the seriousness of the issues identified but explains why national risk reduction strategies in this area focus on mitigation and system safeguards rather than complete elimination of risk.

Radiologists providing the TMC UK Emergency Radiology service are tested in their competency and have extensive experience in reporting emergency neuro radiology and can be considered subspecialist emergency radiology reporters.

TMC notes that paediatric cases constitute a small proportion of its UK emergency workload (approximately 1–2%) but acknowledges that the potential consequences of error in this cohort are disproportionate. For this reason, TMC has already taken certain actions and more actions are underway.

Actions taken

Following this adverse incident, TMC has implemented and reinforced the following measures:

1) All paediatric examinations are explicitly flagged within TMC systems as a distinct high-risk cohort. Paediatric scans (including CT brain examinations) are prioritised on emergency reporting worklists. The turnaround time for issuing a completed report in the emergency setting is a maximum of sixty (60) minutes from when the last image is received. Prioritisation of paediatric examinations ensures that sufficient time is available for review and, where appropriate, consultation with a second radiologist, while still meeting required reporting timeframes.

2) A senior radiologist is rostered on every emergency shift to provide immediate peer consultation, second opinions, and clinical discussion. Reporting radiologists are actively encouraged to escalate equivocal or concerning paediatric findings without hesitation.

3) The use of structured standard reports for CT Head examinations is strongly encouraged within TMC. These standard reports serve as cognitive aids, supporting systematic assessment of grey–white differentiation, ventricular size, basal cisterns, mass effect and herniation—features recognised as challenging in infants.

4) 100% of paediatric CT examinations are selected for retrospective second reading by a senior consultant radiologist, within the same shift. This process is documented within TMC's quality management system and is subject to capacity constraints which are actively monitored.

5) TMC has implemented prospective double reading service on all paediatric CT scans for children aged between 0-5 years. A TMC service available to all clients.

6) This case has been reviewed through TMC's Serious Adverse Event and governance processes. Learning points have been shared within the Emergency Radiology service, with emphasis on the limitations of CT in infants and the importance of explicit escalation advice where uncertainty exists.

Actions in progress and planned improvements

TMC recognises that actions it has already taken may not fully mitigate risk in time-critical paediatric cases. Accordingly, further actions are underway:

1) TMC commits to progressively increasing, prospective second reading for high-risk paediatric CT brain examinations, particularly in children under 5 years with neurological symptoms, infection or safeguarding concerns.

2) TMC will engage with its client to better understand their individual service needs and any challenges they may be facing, and to discuss whether the introduction or expansion of prospective double reading would be of benefit to them.

3) Scope-of-practice limitations are formally recognised, and radiologists will be encouraged to clearly state when subspecialist review or further imaging (e.g. MRI) is recommended.

4) Paediatric emergency imaging already forms part of TMC's rolling audit programme. Effectiveness of second-reading processes and escalation pathways will be reviewed during 2026, with findings reported through clinical governance structures.

Closing statement

TMC respectfully assures the Coroner that it has carefully reflected on this case and the concerns raised. Within the context of a nationally limited paediatric neuroradiology workforce, TMC has further strengthened safeguards, formalised escalation processes, and remains committed to ongoing quality improvement.

TMC trusts that the actions outlined above demonstrate its commitment to addressing the concerns raised in the Regulation 28 Report and to reducing the risk of future harm.

Yours sincerely,

[redacted]

Medical Director UK
Telemedicine Clinic Limited