Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Mid Yorkshire Teaching Hospital NHS Trust** **2 Telemedicine Clinic Limited**
1	**CORONER** I am Charlotte KEIGHLEY, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 13 December 2023 I commenced an investigation into the death of Raisa Cristina Iordan aged 19 months. The investigation concluded at the end of the inquest on 23 October 2025. The conclusion of the inquest was that Raisa died of natural causes however there were missed opportunities to escalate Raisa's care at Dewsbury District Hospital, despite concerns being raised by a Junior Doctor and other clinicians involved in Raisa's care. When imaging was undertaken, this was reported by an external general radiologist with no experience in paediatric radiology who incorrectly reported that the images showed no acute pathology.
4	**CIRCUMSTANCES OF THE DEATH** At around 2130 hours on the 12th November 2023, Raisa Cristina Iordan returned to Dewsbury District Hospital having presented earlier that afternoon with a suspected viral illness. In the period following her initial discharge, it was noted that Raisa had become less responsive and during the journey to hospital she was seen to be shaking and became less responsive. On arrival at Hospital Raisa was assessed by a speciality doctor who considered that she was experiencing febrile convulsions and needed to be transferred to a different hospital. The junior doctor assessing Raisa had also noted that she appeared to be making abnormal movements on one side and was exhibiting new neurological symptoms which was a significant cause for concern leading her to seek advice from the Consultant Paediatrician on call. On arrival, the consultant shared the concerns raised by the junior doctor and noted that Raisa was experiencing a seizure. Medication was given to stop the seizures and a CT scan was performed. The images were sent to an external agency for interpretation where they were considered by a general radiologist who incorrectly reported that the images showed no acute pathology. When the imaging was re-reported, it was determined that the imaging was consistent with meningo-encephalitis, with brain swelling and downward displacement of parts of Raisa's brain, an exceedingly rare and rapid progression of a rare condition. Irrespective of the imaging, it was clear to the treating team that Raisa was very unwell and needed to be transferred to a specialist paediatric unit as soon as possible. Raisa was

	intubated and ventilated and then transferred to Sheffield Children's Hospital where it was noted that her pupils were fixed and dilated, indicating severe brain swelling. Throughout the admission she remained ventilated, sedated and muscle relaxed. In the period which followed, despite extensive attempts to treat and support Raisa, there was no improvement in her condition, with further imaging demonstrating catastrophic and irreversible downward brain herniation and spinal cord abnormality. Raisa's case was discussed with other specialist paediatric intensive care teams with the conclusion being that Raisa would not survive. Her death was confirmed at 1456 hours on the 30th November 2023.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) In the course of the Inquest I heard evidence which raised the following concerns:- 1) Concerns were raised by a Junior Doctor in respect of Raisa's presenting symptoms, which were ignored by the more Senior Doctor in charge, whose assessment of Raisa was limited and of poor quality. The more Senior Doctor formed a view that Raisa was experiencing febrile convulsions and they were unwilling to consider the views, observations or concerns raised by not only the Junior Doctor but by other clinicians who had been caring for Raisa during the course of her admission. 2) Since September 2021, the standard practice across the Mid Yorkshire Teaching NHS Trust has been that the interpretation of out of hours radiology is provided by an external agency, Telemedicine Clinic Limited ("TMC"). The company provides radiology reporting services to a large number of hospitals, providing, amongst other things, acute on call radiology reporting services. Although TMC has a number of radiologists available from a variety of subspecialties to provide reports, their expertise are limited to that of adult radiology, rather than paediatric radiology. At the time the scan was undertaken, the radiographer raised concerns that the imaging appeared abnormal and contacted TMC to ensure that no further imaging was required and in the course of that conversation, concerns were raised in respect of raised intracranial pressure. When the images were reported by TMC, it was said that there was no convincing evidence of acute intracranial pathology, but when Raisa's imaging was reviewed at Sheffield Children's Hospital, it was noted that there was obvious brain herniation which had not been identified by the general radiologist at TMC. 3) There were delays in obtaining a scan for Raisa as there was only one on call anaesthetist at Dewsbury and one on call radiographer. The scan was required prior to Raisa being transferred as the treating clinicians needed to ensure that not only was it safe for Raisa to be transferred but also that she was being transferred to a Hospital that was able to provide appropriate care, there being no paediatric intensive care unit at Pinderfields Hospital. 4) There were delays in Raisa being intubated as there was no support for the on call anaesthetist, with no Operating Department Practitioner or other trained member of staff to help manage a critically ill paediatric patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 26, 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] I have also sent it to **Sheffield Children's NHS Foundation Trust** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 31/03/2026** [redacted] **Charlotte KEIGHLEY** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**