Mary Hollands

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Bwrdd Iechyd Prifysgol
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Ysbyty Gwynedd, Penrhosgarnedd, Bangor,
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PRIVATE & CONFIDENTIAL

Mr John Gittins
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Dyddiad / Date: 29 February 2016

Dear Mr Gittins

Re: Regulation 28: report to prevent future deaths

BCU Health Board is grateful to the Assistant Coroner for her report, and is taking the findings extremely seriously in order to prevent deaths or serious harm in the future.

The matters of concern relate to the process of review of radiographic images in the Emergency Department at the time the patient attended and the review procedure following the receipt of the formal report produced by the Radiology Department.

It is well recognised that even with the "red dot" process in place to help Emergency Department clinicians identify injuries there will be a number that are picked up subsequently by the radiology department during formal reporting. The Emergency Departments have safety net systems in place to review the radiology reports against the clinical outcomes to try to prevent failures to act.

During the summer of 2015 a task and finish group was established to look at the issues related to failure to act for all diagnostic test results and agree standards that clinical teams should work too. From this piece of work a procedure has been developed that is in its final stages of production and consultation. This work highlighted previous messages from the Medical Director reminding staff who refer for diagnostic tests of their professional responsibility to ensure results are reviewed and acted upon. In the case of diagnostic imaging the Ionising Radiation (Medical Exposure) Regulations 2000 places a duty on the referrer to ensure there is a documented outcome for each examination requested.

Matters of concern paragraph 3. The suggestion is for a coding system to be in place. However, as the radiologists do not have the full clinical picture of the care given to the patient following their imaging it would be difficult to develop such a system.

Matters of concern paragraph 4. In accordance with the Welsh Medical Imaging Sub-Committee standards for unexpected findings a radiologist would communicate directly by phone or in person if an emergency or life threatening condition was

detected. This would not be practical for every examination reported due to the volume of reports performed.

There is currently no electronic system available to highlight results and confirm that they have been received by the referrer. However the Radiology and Emergency departments are working together to develop an interim solution to ensure the results are communicated and received by the referring department.

Matters of concern paragraph 5. The health board will consider what integration of the Radiology and Emergency Department IT systems can be undertaken to support the communication process.

Please see the enclosed action plan in support of the review. This action plan will be monitored by the Health Board's Quality and Safety Committee (which reports direct to the Board) and local committees on each site. We will provide you with detailed evidence of long term actions detailed within the action plan as soon as possible and with an update report before the end of May 2016.

Yours sincerely

pp MR CHRIS WRIGHT
Director of Corporate Services on behalf of the Chief Executive

Enc Action Plan