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Ms Alison Mutch OBE
Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Further information, regarding concerns raised in the following the Inquest touching upon the death of Mr Joseph Brindley

I am writing to you in response to the regulation 28 report which was received on 22nd December 2020. In the report you raised areas matters of concern that fractures were not identified on x-rays despite having been carefully examined.

In concluding the course of the inquest, you requested a letter from the Trust providing reassurance as to the system of audit of radiology reporting and discrepancies. We submitted these prior to the Regulation 28 being issued and thank you for allowing us an opportunity to clarify the steps that have been taken by the Trust to minimise the occurrences where staff miss similar injuries in the future, and alleviate your concerns. I also note a meeting is being arranged with you, myself and our team to discuss your concerns.

During an internal review of the incident it was identified that on 11th March when presenting to ED and on all subsequent chest x-rays until 1st April, the rib fractures were not visible. This is due to the extensive pleural effusion on

the right side of the chest. Following removal of the drain, a chest x-ray was performed on 1st April and for the first time the fractures are clearly visible affecting the lower right ribs. This image did not receive a formal radiological report as the patient was an inpatient.

It is the role of the team requesting the diagnostic test to review the imaging performed to inform plans for the ongoing care and clinical management.

On the chest x-ray performed on 4th April the rib fractures were somewhat visible, although not as clearly as on the post drain chest x-ray. This was not appreciated by the Reporting Advanced Practitioner however there was no suggestion of trauma on the history given and the chest x-ray was to rule out re-effusion. The fractures became less visible still on the chest x-ray performed on the 26th April stating pneumonia, to rule out Covid-19 as the clinical history with no mention of previous trauma. Had the fractured ribs been realised at the start of Mr Brindley's journey it is unlikely that it would have altered the course of his clinical treatment, but we acknowledge that there were multiple rib fractures which could have been identified on 1st April 2020. It is acknowledged that the fractures of the rib which were not diagnosed were not contributory to the cause in death in this instance.

System of Peer Review

As you are aware, diagnostic interpretation errors are considered to be an inevitable occurrence in radiology and whilst technology has made enormous progress over the years, human factors remain. The Royal College of Radiologists and Society and College of Radiographers advise that consistent audit of image reporting is essential to ensuring service and the most effective and constructive way to carry this out is via a system of peer review.

Prior to independent reporting, all appropriately qualified reporting Radiographers must successfully pass a robust formal audit process (preceptorship), which has its own documented requirements. This expectation matches that expected of a consultant Radiologist. As a result, the Trust have implemented Peer Review in relation to reporting by Advanced Practitioner Radiographers, which has been embedded within X-ray (plain film imaging) since 2017.

Whilst Radiologists have a more varied scope of practice and job plan, under current Royal College of Radiologist guidelines they are also required to have a peer review practice. For simplicity, this process is the same for the Radiologist as that of the process of Radiographer peer review.

Audit Schedule and Process

Under the Trusts' current audit process, 10 examinations are randomly collected for each reporter per week from the Trust Clinical Radiology Information System (CRIS). For those reporting on chest and abdominal x-rays, an additional 10 reports per week will also be selected and audited.

Peer review focuses on reporting quality and follows guidance set out in the Royal College of Radiologists *Standards for Interpretation and Reporting of Imaging Investigations*. This requires the reviewers to assess whether the reporter has answered the clinical question posed by the Referrer (with a target of 100%), provides (where appropriate) a tentative differential diagnosis when an abnormality is described and provides appropriate advice on the next step (this will not always be required but where advice is given should be appropriate).

Results are recorded, with the Lead Advanced Practitioner (for Radiographers) and the Radiology event and learning meeting (REALM) Lead (for Radiologists) arbitrating any discrepancies identified and providing feedback to the individuals as appropriate.

Standards

In terms of accuracy, the Royal College of Radiologists chooses not to put a precise figure on minimum accuracy percentages required. Instead, the guidance is to learn from any discrepancies that are found in order to avoid similar errors in future. However, the Trust Radiology Preceptorship Policy for newly qualified reporting radiographers requires that they demonstrate a minimum 95% accuracy and these results and accuracy levels are monitored with any extra learning/mentorship/actions at the discretion of the Lead Advanced Practitioner or REALM lead. If the reporter is found to be falling short of the expected level of accuracy, there is a period of remedial mentorship with double reporting and an action plan for improvement agreed. The mentee would be expected to have their practice re-audited on a continual basis until such a time as they meet the required 95% accuracy and the mentor is happy that there has been sufficient development and improvement to allow them to practice independently again.

Radiology event and learning meeting (REALM)

Cases identified for learning are also discussed at the Radiology event and learning meeting (REALM), a group meeting to aid discussion and learning. This is held monthly. This forum presents a robust process for both Consultant Radiologist and Advance Practicioner Radiographers to refer and discuss cases in relation to discrepancies identified during reporting of imaging or

identified by the multi-disciplinary teams external to Radiology. The case in question was discussed with the individuals concerned and also discussed at the REALM on 4th December 2020 and the learning points shared within the department.

Departmental transformation plans

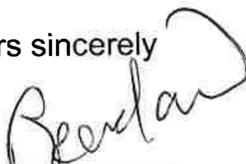
I would like to take this opportunity to make you aware of steps taken by the organisation to strengthen both the clinical and managerial teams within Radiology. In 2019, the division of clinical support services was established and encompasses, diagnostics including Radiology. This was intended to provide coordinated leadership, oversight and governance.

Since this time, investment has been made to increase the clinical workforce, increasing the number of substantive Radiologist from three to five with a further two undertaking their CESR qualification (Certificate of Eligibility for Specialist Registration), there are also 3 locum consultants bringing a total establishment to 8.5 whole time equivalent. This is an increase of 3.5 in the last 18 months. In addition to this we also have a Consultant Sonographer and 5 Advance Practice Reporting Radiographers.

The Royal College of Radiographers have offered advanced practice qualifications since 1994, in order to obtain this qualification Radiographers must complete postgraduate training to develop Clinical practice and/or undertake independent reporting of imaging. They must develop their knowledge and understanding of anatomy, physiology and pathology relating to their particular area of practice and once the training is completed there is a further 6 months minimum preceptorship under the supervision of a Consultant Radiologist where all reports are double reported. During this entire process they must achieve levels of accuracy and clinical competency in line with expectations outlined by the Royal College of Radiologists, measured at an equal level to that of a Consultant Radiologist; the main difference being that their scope of practice is less extensive.

I hope that this demonstrates our commitment to Radiology safety and look forward to discussing this with you in the near future.

Yours sincerely



Medical Director