Medica Reporting Ltd.
Sixth Floor, One Priory Square
Hastings, East Sussex, TN34 1EA

[redacted]
medica.co.uk

FAO Jason Wells
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Date: 4th June 2021

Dear Mr Wells,

I write in response to the Regulation 28: Report to Prevent Future Deaths issued to Medica Reporting Limited (Medica), and Liverpool Heart and Chest Hospital (LHCH) dated 12th May 2021.

I would like to express condolences on behalf of Medica to the family on the loss of Mrs Mary Anne Mellor.

This response is related to the involvement of Medica Reporting Limited in this case. A timeline of Medica's knowledge of the case is presented below.

This information was not requested and hence unavailable at the time that the Regulation 28 notice was drafted. Whilst I understand that it is not your practice to amend or rescind a Regulation 28 notice once it has been issued, our aim is to clarify our position and in the event that the notice cannot be amended to consider the detail set out below. We would request that our response is placed on file. Please note that a copy of this letter has also been sent to our client, LHCH.

Sequence of events

21/09/2019: CT angiogram scan of the deceased undertaken at LHCH to monitor a known thoracic aortic aneurysm repair.

26/09/2019: The CT scan is reported by a Medica radiology consultant specialising in vascular and interventional radiology.

26/10/2020: Medica were made aware of a discrepancy related to the reporting of a CT angiogram study of the deceased.

26/10/2020: The discrepancy was reviewed and agreed by the reporter as demonstrating a Type 1b endoleak at the distal end of the thoracic endovascular repair (TEVAR) stent. The leak was more evident in the coronal plane.

24/11/2020: An arbitrating radiologist reviewed the study and agreed with the discrepancy. The arbitrating radiologist also commented that the leak was more evident in the coronal plane in multiplanar (MPR) reformats. He also commented that the leak was in retrospect present but much smaller on a scan dated July 2018 and larger on a subsequent scan in September 2020. For clarity, an arbitrating radiologist is asked for an opinion on any discrepancy raised by a Client as part of Medica's governance system. The arbitrating radiologist graded the discrepancy as a Grade 2 observational error (Subtle – a number of reporters would not identify this abnormality). There was no interpretation error or communication error. The risk to the patient at the time of reporting the study was given a Score of 3 (Risk of harm low).

04/05/2021: Medica were first made aware of the Coroner's involvement in this case following the inquest held 4th May 2021.

05/05/2021: Microsoft (MS) Teams meeting between LHCH investigation team and Medica Clinical Governance. Agreed sharing of information. LHCH gave a synopsis of the Coroner's Inquest.

06/05/2021: Medica received an email copy of the LHCH Root Cause Analysis (RCA) dated 27/11/2020 pertaining to this case.

19/05/2021: Second meeting between LHCH and Medica by MS Teams. LHCH made Medica aware of involvement of CQC and that a response was required by 20/05/2020.

Medica were not made aware of LHCH undertaking an RCA investigation or of involvement of the Care Quality Commission (CQC) in this case or of the Coroner's inquest.

Section 5 (2) of the Regulation 28 Report states "*However, as of the date of the inquest, LHCH had received no response from Medica and could not assure me that Medica are using 3D reconstruction to report this type of scan and/or intend to do so in the future*". It has been acknowledged by LHCH in a meeting between Medica and LHCH held on 19/05/2021, following receipt of the Regulation 28 notice, that LHCH had not raised additional queries with Medica in respect of the use of '3D reconstructions'. LHCH were not awaiting a response on any matter pertaining to this case from Medica at the time of the Inquest.

In response to The Matters of Concern in Section 5 of the Report, Medica offers the following response:

1. Thank you for raising this important case with Medica.

2. Medica routinely trains reporters in the use of the Radiology image viewing system (Medica Insignia PACS system) including the use of Multiplanar Reformatting (MPR) for the interpretation and reporting of all cross-sectional imaging (CT and some MRI). MPR is a term used to describe the type of 3D reconstruction that would be used in the case of the deceased.

3. The reporter in this case has documented training PACS including the use of MPR (Attachment 1.1 Checklist and DSE PDF of training).

4. The Medica Reporter Handbook refers to expected reporting standards and the use of MPRs in reporting studies (Attachment 1.2 Consultant Radiologist Handbook). The reporting radiologist received this Handbook at the time of training 31/07/2017.

5. In September 2020 Medica prepared an in-house training video which includes a section on MPR (3D) technique. This was notified to all reporting radiologists and placed in the online learning folder There is a training video and Radiology Reporting Process Guide for post training reference available to reporters at all times (Attachments 1.3 Screenshots from training video and 1.4 Radiology Reporting Process Guide).

6. The use of radiology viewing systems and MPR for reporting cross sectional imaging is a fundamental part of core radiological training as stipulated by the RCR. All radiologists are required to demonstrate competence prior to award of a Certificate of Specialist Training (or equivalent). This happens prior to Consultant appointment.

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7. Medica commissioned an internal refresh of the training video referenced in point 5 to further highlight the functionality in PACS of MPRs in April 2021, prior to our notification of this case. This has been published to all Medica Reporting radiologists on 12/05/2021.

8. Medica continually audits radiologist reporting (5% sample of this type of work for each radiologist) and provides opportunities for learning from error. Medica provides feedback to individual Medica radiologists on a case-by-case basis where errors have been made and will highlight the use of good MPR technique for analysis. Medica regularly highlights areas of opportunity to improve observation and interpretation for reporters. Cases of interest are shared with all reporting radiologists in a monthly review. This case will be shared with our radiologists as an action of the Medica RCA for this case (initiated and completed following notification of the inquest, attachment 1.5).

9. Where Medica identifies a radiologist with a specific training need for MPR, steps are taken to provide refresher training for reporting radiologists.

10. Medica will continue to highlight to reporters the importance of the use of MPR tools in reporting (as described at 7 and 8 above).

11. It is not possible to monitor/measure the use of MPR tools in a simple or meaningful way but experienced analysis of reporting discrepancies can lead the reviewer to highlight this to reporting radiologists when the reviewer considers that this may be a contributory factor. Medica will as a result of this notice, remind case reviewers of the importance of the use of MPRs.

The above items evidence the importance that Medica places upon MPR functionality in CT reporting. The reporter in this case uses MPR in their normal workflow. It is therefore possible that it was employed at the time of reporting this study, but the endoleak was not recognised by the reporter. This is termed an observational error and is a recognised error in radiology. Medica places great importance on informing reporters of errors made by others to maximise learning opportunities and reduce error in the future as much as possible. We will be sharing the learning from this case with our reporters.

I hope that this assures the Coroner of the ongoing commitment to clinical governance and the recommendations to use MPR in reports issued by our reporters.

Yours sincerely

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Chief Executive Officer