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Reviewing the Results of Radiological Imaging

Two Rule 43's have been issued from HM Coroner as a result of the deaths of two patients where radiological (pulmonary embolus and intracranial haemorrhage) findings were not acted on as early as they should have been.

Whilst it is always the requesting clinician that has the responsibility to review the results, HM Coroner in this recent statement has made it clear the reporting radiologist has a responsibility to ensure serious radiological findings are communicated to the clinician.

Previously the process of communicating the results of radiological imaging came under scrutiny as a result of the NPSA Safer Practice Notice No 16 issued in February 2007. This made a number of recommendations for healthcare organisations providing or commissioning radiological imaging services, a significant number of which were directed at individual clinical and radiology staff. These were to

1 **Ensure that the radiological imaging reports of all patients are communicated to, and received by, the appropriate registered health professional and, where necessary, action is taken in a manner appropriate to their clinical urgency;**

2 **Ensure registered health professionals design 'safety net' procedures for their specialty;**

3 **Make it clear to patients how and when they should expect to receive the results of a diagnostic test;**

4 **Review relevant policies and procedures in line with the safer practice recommendations outlined in this safer practice notice.**

In order to minimise the risk of overlooking a serious finding identified on imaging senior teams within the ED should review their processes to ensure there are processes that enable

1. The requesting clinician reviews the results of tests they have requested or ensures the need to review an image is handed over to a colleague.

2. All new radiological images are reviewed on the ward rounds by a senior doctor.

3. Senior teams within the ED work with their radiology colleagues to establish a process by which ED staff are alerted to all serious findings and this alert is acted upon within the ED, 7 days a week.

4. Patients understand how they will receive their results, even if discharged from the ED,

Rule 43:

HM Coroner may use rule 43 to prevention future deaths

43. (1) Where—
(a) a coroner is holding an inquest into a person's death;
(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and
(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner may report the circumstances to a person who the coroner believes may have power to take such action.
(2) A report under paragraph (1) may not be made until all the evidence has been heard except where a coroner, having adjourned an inquest under section 16 or 17A of the 1988 Act, does not resume it.
(3) A coroner who intends to make a report under paragraph (1) must announce this intention before the end of the inquest, but failure to do so will not prevent a report being made.
(4) The coroner making the report under paragraph (1)—
(a) must send a copy of the report to—
(i) the Lord Chancellor; and
(ii) any person who has been served with a notice under rule 19; and
(b) may send a copy of the report to any person who the coroner believes may find it useful or of interest.
(5) On receipt of a report under paragraph (4)(a)(i), the Lord Chancellor may—
(a) publish a copy of the report, or a summary of it, in such manner as the Lord Chancellor thinks fit; and
(b) send a copy of the report to any person who the Lord Chancellor believes may find it useful or of interest (other than a person who has been sent a copy of the report under paragraph (4)(b)).