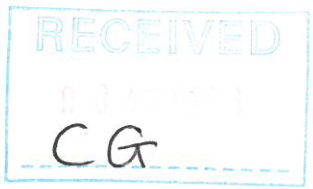
Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust



Medical Director's Office

[redacted]**Medical Director (3630)**
Mr R J Cuschieri, Deputy Medical Director – Clinical Standards (4714)
Dr R Harris, Deputy Medical Director – Professional Standards (3376 or 75 2275)
Karen Humphries, Clinical & Professional Standards Co-ordinator (3637)
Jacqueline Ford, Executive PA to Medical Director (3183)

Our Ref RJC/jj

1 April 2016

Dr E Didcock
HM Assistant Coroner for Nottinghamshire
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Dr Didcock

I write with respect to the concluded inquest on Douglas Kay and the Regulation 28 report dated 5 February 2016 where concerns have been highlighted with respect to arrangements for the management and transfer of patients with gastrointestinal bleeding (GI Bleed) at Bassetlaw Hospital.

The report was addressed to the Chief Executive of the Doncaster & Bassetlaw Hospitals NHS Foundation Trust and I have been tasked with addressing the issues identified in your report.

I have been assisted in the course of this by [redacted] Consultant Gastroenterologist and clinical lead for GI bleeding with contributions from Dr Gurgit Singh, Consultant Gastroenterologist, Bassetlaw Hospital and Dr Vinesh Vincent, Consultant Anaesthetist/Intensivist at the same hospital.

I attach two documents with respect to the concerns highlighted. Document 1 is the standard GI bleed pathway for any patient presenting with a gastro-intestinal bleed to the Doncaster & Bassetlaw Hospitals NHS Foundation Trust. The 2nd document and the one

which is particularly relevant in this case is the Upper GI Bleed Transfer Policy at Bassetlaw Hospital for those patients who require to be referred to Doncaster for further management of their upper GI bleeding. This policy has been developed after consultation between the anaesthetic and the medical teams.

All staff will be made aware of this specific transfer policy at Bassetlaw through the Clinical Site Manager and Matron at Bassetlaw.

The policy will also be ratified at the next meeting of the Patient Safety Review Group and this will ensure wider dissemination throughout the Trust.

I trust that this will provide the assurance you require that appropriate action has been taken following the death of Douglas Kay. The implementation will continue to be monitored by the Emergency Care Group Clinical Governance Team through the Datix incident system.

May I take this opportunity to invite you to revert back to me should you feel it necessary to do so.

Yours sincerely

Mr R. J. Cuschieri MD. ChM. M.Ed FRCS
Deputy Medical Director - Clinical Standards

Cc Mr M Pinkerton, Chief Executive, DBHFT
Mr S Singh, Medical Director, DBHFT
[redacted] Deputy Director of Quality & Gvernance
[redacted], Consultant Gastroenterologist/GI Clinical Lead
[redacted] Assistant Care Group Director, Surgery
[redacted] Care Group Director, Emergency Medicine
[redacted] Consultant Gastroenterologist, Bassetlaw
[redacted] Consultant Gastroenterologist, Bassetlaw
[redacted] Clinical Lead Accident & Emergency Services
[redacted] Consultant Anaesthetics/Intensivist
[redacted] Matron Emergency Services, Doncaster
[redacted], Matron, Emergency Services, Basetlaw