York and Scarborough
Teaching Hospitals
NHS Foundation Trust

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Chief Executive Office
York Hospital
Wigginton Road
York
YO31 8HE
Simon Morritt, Chief Executive
Direct Line: 01904 725075
Email: s.morritt@nhs.net
Cheryl.gaynor.1@nhs.net

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Ms G Kane
HM Assistant Coroner for York & North Yorkshire
By email: coronersadmin@northyorks.gov.uk

Dear Madam

Thank you for raising your concerns following the inquest surrounding the death of Ms Joanne Stones following her admission to York District Hospital. York & Scarborough Teaching Hospitals NHS Foundation Trust (the Trust) recognises the seriousness of your concerns outlined at Section 5 of the Report to Prevent Future Deaths (PFD). I write to outline the actions we have taken to address these. These measures are intended to reduce the risk of recurrence and improve the quality and safety of care provided to our service users.

I will address your specific concerns as follows:

1a. Pre-alert of the ambulance crew

Ambulance service pre-alerts are a tool used daily in both Trust Emergency Departments. They are key to ensuring the hospital is prepared for the arrival of patients who are critically injured or ill. The mechanism of pre-alerts is a phone call from the treating ambulance crew to a senior member of the nursing or medical team in the Emergency Department (ED). The decision of where to place the patient is determined by the ED team at the time and will take into account availability of physical space, staffing and how unwell the patient is.

At the time of Ms Stones attendance at Scarborough the resuscitation room was full. This sometimes occurs at times of pressure and the “overflow” to the resuscitation room is the First Assessment area. Medical care that is provided in the resuscitation room can be provided to the same level in the First Assessment area, with the exception of airway management and anaesthesia (breathing for the patient if required). Ms Stones did not have a requirement for breathing support at time of arrival in the hospital. Therefore, although the resuscitation room

would have been preferable, treatment in the First Assessment area was a reasonable alternative at that time.

In terms of potential risk for future patients, the Emergency Department at Scarborough now occupies a new Urgent and Emergency Care Centre which has been designed with 4 resuscitation room spaces, rather than the 3 that were available in the old department. In addition, the First Assessment space has been expanded to 8 bays from 5 bays in the old build. This significantly reduces the risks of delays to initial assessment and treatment of patients arriving in the department from the ambulance service.

1b. Alerting clinicians to the presence of a critically ill patient

There were two main ways in which the ED clinicians should have been alerted to Ms Stones previous medical diagnoses; antiphospholipid syndrome (APD) and Addison's disease (AD): the Medic-alert bracelet on her wrist and the system of alerts on the hospital patient record (computer) system CPD.

The only time that Ms Stones' medical history was referenced in the clinical notes was in the nursing notes when she was referred to the Emergency Assessment Unit for further investigation of her chest (which was subsequently identified as abdominal) pain. The assumption therefore is that the bracelet wasn't seen, or if it was, its importance wasn't recognised. The CPD system is designed to remove the computer AD/steroid treatment alert if a patient dies (because of the need to remove the individual from the locality steroid register) and so can't be seen on CPD at present. However, we are confident that the alert was present and visible when Ms Stones presented at the time, but unfortunately not noted by the treating clinicians. The alerts on CPD are not as obvious as they could be (they are displayed on a tab at the top of the screen in a light blue colour).

The action that we will take to resolve these issues going forward is two-fold: we have reminded all staff of the importance of checking alerts on CPD and medic-alert bracelets on the patient by means of our "learning on a postcard" system. In addition, we are in the process of implementing a new electronic patient record system (known as Nervecentre) and we will ensure that the alerts on this system have improved visibility, in order to maximise the chance of clinicians seeing and acting on these alerts.

In addition, the subject of alerts is discussed in detail in the ED two-day departmental induction.

1c. Interaction with Rheumatology regarding ongoing care of Ms Stones

It has been identified that there would have been benefit of liaising with Ms Stones' parent clinical team in Rheumatology (including Dr Moverley) in order to guide her ongoing treatment. Although that would not have been achievable when she presented at the weekend, or at the time of her final attendance on the following weekend (because there is not an out of hours Rheumatology service within the Trust), it would have been possible to get Rheumatology input into Ms Stones' care during the week. The proposed completed action was to add this to the "learning on a postcard" general message to clinical staff as a prompt to contact other relevant clinicians for advice in complex cases.

2. There was delay in Joanne receiving fluids, which led to hypoglycaemia which was then not treated promptly.

Regarding giving fluids, adherence to the Trust Sepsis guidance will ensure that fluids are prioritised in unwell patients such as Ms Stones.

It was identified in the Serious Incident Investigation report that the failure to identify Ms Stones' hypoglycaemia was a significant failing when she presented acutely on her final attendance. The Trust has already implemented two actions designed to reduce the risk of a low blood sugar being missed/not actioned in future patients. These actions are to:

a) The results from a point of care testing (POCT) machine now automatically transfer into the CPD system. This ensures that the blood sugar from the venous blood gas test appears on the Emergency Department electronic white board adjacent to the lactate level.

b) Change the order of the results from the blood gas test listed on the paper print out, to ensure that the blood sugar is higher up the list in the expectation that a low blood sugar is more easily identified.

3. It was not clear from the medical notes that staff treating Joanne had considered the relevance of her Anti Phospholipid Syndrome (APS) and Addison's Disease (AD) in her treatment plan.

The notes did not clearly identify that Ms Stones' existing conditions (APS and AD) had been identified by the clinical teams who saw her (with the exception of the Emergency Assessment Unit nursing notes). The actions specified in point 1 above are designed to ensure that the alerting systems are present and visible as well as the 'learning on a postcard' prompting clinicians to act on this information. Addison's disease and long-term steroid usage are medical conditions where there is an awareness amongst the medical team that action (in terms of adding in or increasing steroid dosage) is required to ensure that the patient does not suffer an adverse outcome.

Conclusion

We hope that this information provides you with assurance that the Trust has learned from this incident and refined our processes as a result. This will continue to be monitored carefully through our governance and assurance structures.

Yours sincerely

Simon Morritt
Chief Executive