Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

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[redacted] Medical Director – Operations
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23 September 2025

STRICTLY CONFIDENTIAL – ADDRESSEE ONLY
Mr S Tait
Assistant Coroner for South Yorkshire East
Coroner's Court and Office
Crown Court
College Road
Doncaster DN1 3HS

Dear Mr Tait

John Bell (deceased)

I write to you with respect to the Regulations 28 Report issued on the 6 August 2025 to [redacted] Chief Executive of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust following the Inquest into the death of John Bell concluded on the 30 July 2025.

The report was received by the Chief Executive's office and forwarded to me in order to provide a response.

I have been assisted in constructing this response by [redacted], Associate Medical Director for Clinical Safety; [redacted], Associate Chief Nurse for Patient Safety & Quality; [redacted], Consultant Orthopaedic Surgeon & Divisional Director; and [redacted], Divisional Nurse for Surgery.

I would respond to the matters of concern referred to within the PFDR as follows:

1. **Renal investigations were undertaken following a fast track cancer referral in September 2024. Investigations were undertaken and on 16 October 2024, a renal MDT reviewed CT scans and recommended that Mr Bell be considered for left nephrectomy to treat a renal tumour. Although the MDT note was apparently in the electronic records, the spinal Surgeons were not aware of the renal findings at the time of the spinal surgery on 25 October 2024. Had they been aware, spinal surgery would not have been undertaken at this stage with renal surgery being prioritised.**

   I am concerned that critical clinical information was not available to and/or considered by, the spinal surgeons before the spinal surgery took place.

I would like to take this opportunity of assuring you and Mr Bell's family that the Trust has undertaken a full review of this case as part of a thematic analysis. The prolonged waiting times and lack of standardised pre-operative processes raised concerns around patient safety, pathway efficiency, and equity of access.

Immediate safety actions agreed - all patients with a TCI ("to come 'in' date") now have a clinically appropriate pre-operative assessment, within a reasonable timescale, and the patient is reviewed by both the operating surgeon and anaesthetist on the day of surgery to establish if there has been any deterioration/change that would necessitate a change in clinical plan. This is documented in the patient's notes, team brief and operation notes.

The longer term plan is to formulate a comprehensive action plan to address the following:

i) Pathway & Process Improvements

- Review how patients are listed and allocated for surgery.
- Define timeframes for additional investigations.
- Standardise referral into pre-operative assessment and high-risk anaesthetic clinics (template/letter).
- Introduce electronic referral forms (ICE or similar) to replace yellow waiting list forms.
- Ensure compliance with the national clinical prioritisation programme, so that all patients have a clinical prioritisation code recorded on the Patient Tracking List (PTL), that the clinical prioritisation code is in line with FSSA guidance (Federation of Surgical Specialty Association) and that clinical reviews are undertaken at the required intervals for each clinical prioritisation code
- Review the theatre booking and scheduling processes to ensure this is in line with national best practice
- Ensure robust PTL management processes are in place, in line with best practice

i) Pre-operative Optimisation

- Review and enhance pre-habilitation offerings.
- Improve timeliness and mechanisms for referring into pre-operative assessment.
- Introduce a morbidity scale for orthopaedic surgery risk stratification.

ii) Consent and Safety

- Review consent processes (digital consent, EIDO) with Consent Lead.
- Explore Venous Thrombosis Embolism (VTE) prescribing integration via VTE forum.
- Strengthen Surgical Site Infection (SSI) reporting and culture appropriateness with Infection Prevention & Control (IPC).

iii) Governance & Oversight

- Review Mortality & Morbidity (M&M) processes across the division.
- Maintain oversight of prioritisation work within orthopaedics through Divisional Leadership Team.

2. **The issue in the previous paragraph came to light shortly after the spinal surgery in October 2024. However, no investigation of the incident was undertaken by the Trust. At the time of the Inquest, no DATIX report had been submitted. The witnesses accepted at Inquest that a DATIX would have been good practice.**

   I am concerned that some 8 months after the incident no formal investigation had taken place and no consideration of any learning had occurred.

I can confirm that a DATIX incident form was completed on 30 July 2025, and the investigation remains ongoing as part of a broader thematic analysis. A comprehensive thematic review and associated actions are currently being drafted for presentation to the Executive Team.

While the patient safety culture within the Trust is strong, it is recognised that incident reporting for learning purposes is predominantly undertaken by nursing colleagues. Significant work is underway across the Trust – through clinical governance meetings and patient safety events – to enhance incident reporting by medical staff.

Further awareness has also been raised through the World Patient Safety programme, with a dedicated session held on 17 September 2025.

Conclusion

By implementing the proposed recommendations, the Trust has an opportunity to standardise care, enhance pre-operative optimisation, and strengthen governance oversight. A coordinated, multidisciplinary approach will be essential to ensure that patients are not only listed appropriately but also supported to "wait well" and undergo surgery safely and effectively.

I trust this information provides reassurance that learning from Mr Bell's case, along with other cases identified in the thematic review, will lead to improvements in pathways and processes, ultimately strengthening patient safety.

Yours sincerely

[redacted]

[redacted]
Acting Executive Medical Director

Cc: [redacted], Chief Executive
[redacted], Associate Medical Director for Clinical Safety
[redacted] Associate Chief Nurse for Patient Safety & Quality
[redacted], Consultant Orthopaedic Surgeon & Divisional Director for Surgery
[redacted], Divisional Nurse for Surgery