Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

[redacted] Acting Executive Medical Director
[redacted] Medical Director – Operations
[redacted] Interim Medical Director - Workforce
[redacted] Associate Medical Director – Clinical Safety
[redacted] Associate Medical Director – Professional Standards
[redacted] Clinical Governance & Professional Standards Co-ordinator [redacted]

Doncaster Royal Infirmary
Armthorpe Road, Doncaster
South Yorkshire DN2 5LT

[redacted]

www.dbh.nhs.uk

14 October 2025

STRICTLY CONFIDENTIAL – ADDRESSEE ONLY
Miss L Slater
Area Coroner for South Yorkshire East
Coroner's Court and Office
Crown Court
College Road
Doncaster DN1 3HS

Dear Miss Slater

Lee James Stammers (deceased)

I write to you with respect to the Regulations 28 Report issued on the 22 August 2025 to Mr Richard Parker, Chief Executive of Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust following the Inquest into the death of Lee James Stammers concluded on the 22 August 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; Marie Hardacre, Associate Chief Nurse for Patient Safety & Quality and [redacted] Divisional Nurse for Urgent & Emergency Care (UEC).

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

1. **There were no clear communication, documentation, or systems in place, to identify if investigations had been performed as requested. For example, the medical records indicated blood had been obtained and collected by the laboratory and the result was awaited. When blood had not been obtained.**

Inaccurate information in the medical records and poor communication, led to a failure of urgent tests being undertaken. A comparable situation occurred, in relation to confusion regarding the performance of the electrocardiogram.

Poor communication, documentation, and systems allowed tests/actions to be cancelled by student nurses, temporary staff and locum clinicians, who can also access the system and cancel tests without any rationale, accountability or identifying themselves in the records. These individuals were referred to as "unknown" at the Inquest and have not been identified.

Finally, there was clear and consistent evidence of poor documentation throughout the medical records, from admission to the emergency department continuing through to the resuscitation attempts

Mr Stammers' case was formally presented to the Learning from Patient Safety Events (LFPSE) Panel with the declaration of a Patient Safety Incident Investigation (PSII). During this meeting, Immediate Safety Actions were identified and shared with the relevant division to ensure prompt implementation.

In relation to Mr Stammers' case, the panel noted several Immediate Safety Actions, particularly concerning communication and documentation practices. These actions were communicated to the division to support timely improvements and mitigate the risk of recurrence.

In response to the concerns raised, the Emergency Department promptly implemented the identified Immediate Safety Actions. The majority of these actions were overseen by a named senior doctor within Emergency Medicine, ensuring accountability and compliance with the require safety improvement.

I can confirm that the Patient Safety Incident Investigation (PSII) Report is now complete and scheduled for review and approval at the next Trust Executive Patient Safety Oversight Group. Once approved, this report will be shared with Mr Stammers' family.

Safety Recommendation 1 - The Emergency Department (ED) should review their departmental procedure regarding the frequency of Monitoring Observations and Escalation of Care in the Emergency Department and ensure this is clearly communicated to all staff. Once implemented, audit the effectiveness of the procedure.

Part 1 of the recommendation was completed June 2025. Part 2 of the recommendation is targeted for completion by October 2025.

Safety Recommendation 2 - The ED should develop Standing Operating Procedure (SOP) to ensure standardised care within the ED when patients present with chest pain. This should include expectations of the clinical assessment and investigation required. Once implemented, this should be followed by education and training for all ED staff.

This will be discussed in Divisional Clinical Governance and is targeted for completion and implementation by 30 November 2025.

Safety Recommendation 3 - Symphony user access to be reviewed and permissions changed to prevent user changes to prescribed care errors. Urgent & Emergency Care to consider how locum access can be strengthened to ensure traceability and an audit trail.

Recommendation completed in respect of restrictions in place for all student nurses. Locum doctors must enter their full name and GMC number upon first login to Symphony – this step is mandatory.

Safety Recommendation 4 – The ED to introduce a local quality improvement initiative focusing on enhancing communication and contemporaneous documentation in both emergency and non-emergency situations.

Target date for recommendation 4 is 1 December 2025.

I trust that the above information reassures you that learning from Mr Stammers' case will improve communication and documentation in the Trust's Emergency Department to enhanced 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] Divisional Nurse for UEC