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Date: 22 August 2025

Case: NJM / 28445208

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Doncaster Royal Infirmary

CORONER

1 I am Louise Slater, Area Coroner for South Yorkshire East

CORONER'S LEGAL POWERS

2 I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 12 March 2025 I commenced an investigation into the death of Lee James STAMMERS. The investigation concluded at the end of the inquest on the 22nd August 2025. The medical cause of death was :

3 1a Acute Cardiac Event

1b Lung Infection, Myocardial Ischaemia, Pericardial Effusion

II Haemorrhage from punctured right and left ventricles from pericardiocentesis

The inquest concluded with a narrative conclusion as follows:-

Mr Lee Stammers died as a result of an acute cardiac event which developed due to the combined effects of infection, myocardial ischaemia, and pericardial effusion, and occurred on a background of recognised complications of pericardiocentesis during resuscitation efforts.

CIRCUMSTANCES OF THE DEATH

4 Mr Lee Stammers, 47 year old, attended Doncaster Royal Infirmary at 12:06 hours on the 10th February 2025 with chest pain, shortness of breath and nausea. He was treated for infection, with intravenous fluids and antibiotics. At 19:15 hours, Lee suffered a cardiorespiratory arrest and despite prolonged resuscitation attempts he was pronounced deceased at 20:00 hours.

During Mr Stammers admission, there were missed opportunities for the myocardial ischemia

to be identified prior to his collapse. Electrocardiography was incomplete, not reported, or repeated. Blood tests were not performed as requested. If these actions had occurred, his clinical management would have been different.

Although, it is not possible to determine if the cardiac arrest would have been avoided and/or the ultimate outcome would have been different, if his cardiac ischaemia had been identified earlier and managed sooner but it would have given Mr Stammers the best possible chance of survival.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) Poor documentation, Communication, and systems–

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
5 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.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you [redacted] have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 17th October 2025. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted], Secretary of State Health.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

22 August 2025

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Signature

Louise Slater Area Coroner for South Yorkshire East