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4 August 2026

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Mrs S L Slater
Area Coroner
South Yorkshire (East District)
Coroner's Court and Office
Crown Court
College Road
Doncaster
DN1 3HS

[redacted]

Dear Mrs Slater

Inquest Touching the Death Barbara Joan Cope: Regulation 28 Preventing Future Deaths Report

I write further to your letter dated 8 June 2026.

I understand that following review of the evidence heard at the Inquest dealing with the circumstances of Barbara Joan Cope's death, a number of matters were raised that were of sufficient concern to invoke your statutory duty under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

I was disappointed to hear that the evidence heard at the Inquest did not provide you with the level of assurance you required in relation to the timely review and escalation of abnormal blood results. As an organisation we take your concerns seriously and are committed to ensuring that the learning arising from this matter is fully considered and acted upon.

For ease of reference I have addressed each of the concerns set out in your report in the order in which they are presented. My response is intended to provide clear assurance regarding actions taken, further work underway, and the governance arrangements in place to oversee delivery and sustained improvement.

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Chief Executive, The Rotherham NHS Foundation Trust
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1. Although the blood sample was collected and tested in a timely manner, there was no evidence of communication and/or follow up of the abnormal result, therefore time critical medication was not commenced until 19 hours later.

Over the years, the Trust has undertaken a programme of quality improvement work, led by the Deputy Medical Director and Chief Clinical Information Officer to strengthen our responsiveness to abnormal results. This has included ensuring that all abnormal results are flagged within MEDITECH (our electronic patient record). In addition, a Standard Operating Procedure setting out the required actions for managing investigation results was introduced and communicated Trust wide.

Since Mrs Cope's death we have reviewed and updated the Standard Operating Procedure for the Management of Critically Abnormal Pathology Results in Clinical Areas and I attach a copy of the same for your reference.

The aforementioned Standard Operating Procedure aims to standardise the actions required across the Trust when a critically abnormal pathology result has been identified and subsequently transmitted to the clinical area. The result must be escalated immediately to the appropriate member of staff to enable any treatment/management to be implemented in a timely manner. The results must be documented in the patient's medical and nursing records and the effect of any actions to correct the results noted.

Section 5 of the Standard Operating Procedure sets out the process laboratory medicine staff are required to follow when an abnormal result has been noted which provides an electronic trail of the date, time and details of the escalation. Laboratory Medicine staff are expected to use the situation, background, assessment, recommendation (SBAR) communication tool to communicate results which fall outside of laboratory critical limits. Once the results have been communicated to the clinical area, laboratory staff will ask the receiver to repeat key information to ensure understanding, take their full name and designation and record the details of the results transmission in the Laboratory Information Management System (LIMS). This is in accordance with the Pathology Policy for the Transmission of Results by Telephone (QPL-PQ-004).

If the result has been given to a Registered Nurse, the laboratory staff will inform them that they need to escalate the information to a clinician within 30 minutes. The Registered Nurse must document the name of the clinician they have informed and if no action has been taken within 60 minutes, the Registered Nurse must escalate to the Senior Nurse on Duty.

In the event laboratory staff are unable to contact the clinical area, Section 5.2 of the Standard Operating Procedure sets out a clear escalation process of contacting the Specialist Registrar in the first instance, secondly the Consultant and finally the Clinical Site Management Team.

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Chief Executive, The Rotherham NHS Foundation Trust
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An audit has been conducted by Pathology to check that the documentation for time critical results telephoned to clinical areas complies with the Standard Operating Procedure with a finding that results audited had been communicated in a timely manner. An additional audit of 50 results is currently underway focusing on whether time critical results have been documented and acted on appropriately. The result of this audit is expected by the end of August 2026.

In addition, the Trust has developed a Power BI module to monitor acknowledgement of results which continues to show an improvement in clinicians' responsiveness to the management of test results.

2. Even when the patient clinically deteriorated overnight and required two separate clinical reviews, the blood results were not reviewed and/or acted upon. If clinical records and recent investigation results are not reviewed then appropriate medical management will be delayed or will not occur.

I was concerned to hear that Mrs Cope deteriorated overnight, requiring two separate clinical reviews and despite this, her blood results were not reviewed. The Trust has a clear handover process in place whereby medical staff working in hours, handover tasks for follow up to the out of hours team at the face-to-face handover meetings. In addition to this, we will imminently launch a pilot within our Urgent and Emergency Care Centre of the use of the 'alertive bleep' system which flags critical blood results on the bleep system.

3. This patient was transferred from the emergency department to the care of Surgery. A referral was then made for Gastroenterology input, they then requested a blood test for paracetamol levels. This was not followed up for 17 hours. There needs to be clear communication, understanding and record keeping of who is responsible for the patient and the ongoing follow up and care in these circumstances.

Mrs Cope was admitted under a surgical Consultant, remained on the surgical ward and therefore under the care of the surgical team who were responsible for her care.

The Deputy Chief Nurse in conjunction with colleagues from the learning from deaths programme, clinical effectiveness team and the quality governance team will include the learning from this incident in the Quality Newsletter focusing on the importance of acting upon time critical blood results.

In relation to your concern that staff do not have a clear understanding of who is responsible for the ongoing care and follow up of patients, our electronic patient record clearly states the name of the admitting Consultant and any tasks relating to that particular

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Chief Executive, The Rotherham NHS Foundation Trust
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patient will be under that admitting Consultant until such time that the care is transferred to a different Consultant and this is amended on the system.

I hope the above provides you with the assurance that the Trust has taken your concerns seriously and please do not hesitate to contact me in the event I can be of further assistance to you at this time.

Yours sincerely

Chief Executive

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Chief Executive, The Rotherham NHS Foundation Trust

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