West Suffolk
NHS Foundation Trust

15 June 2026

West Suffolk NHS Foundation Trust
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[redacted]
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Darren Stewart
HM Area Coroner for Suffolk
Ipswich Coroner's Court
Beacon House
Whitehouse Road
Ipswich
Suffolk
IP1 5PB

[redacted]

Dear HM Coroner,

WSFT information relating to Regulation 28 Report into the death of David Abbott

I write further to the Regulation 28 Report dated 2 April 2026 issued following your inquest into the death of David Abbott. West Suffolk NHS Foundation Trust (WSFT) acknowledges HM Coroner's concerns and is grateful for the opportunity to outline the actions taken and those ongoing to reduce the risk of future deaths.

In advance of responding to the specific concerns raised in your Report, we would like to express our deep condolences to Mr Abbott's family and loved ones. WSFT are keen to assure the family, and HM Coroner, that the concerns raised have been listened to and reflected upon.

Please find below details of the ongoing work to address your concerns, which we hope is of some small comfort to Mr Abbott's family and friends.

1. The wrong advice has been provided to a patient on discharge which has exposed them to increased risk.

We acknowledge the concern regarding the provision of incorrect or potentially misleading discharge advice, specifically the distinction between "avoiding heavy lifting" and "avoiding weight bearing/mobilisation."

This case has been formally discussed at the Urology Governance Afternoon, ensuring dissemination of learning across the team and reinforcing the importance of clear and accurate discharge advice.

Since 2024, a standardised discharge summary process has been implemented within the Trust. This utilises #tag functionality, allowing clinicians to insert pre-approved, standardised advice directly into discharge documentation.

This replaces previous practice where advice may have been manually copied and pasted from ward notes. The use of standardised text reduces variability and the risk of misinterpreted, incorrect or inconsistent instructions.

Junior doctors receive training on the use of #tags during their induction, ensuring early awareness and consistent application in clinical practice.

Patients undergoing TURP procedures receive written information leaflets at pre-assessment, which includes guidance on post-operative activity. This information leaflet gives the following guidance: *"You should avoid heavy lifting or strenuous exercise for about a month"*.

The #tag functionality in the discharge letter provides the following information to supplement the information leaflet given at pre-assessment*:*

> *"Following your general anaesthetic: for 48 hours - do not drive a car / motorbike, ride a bicycle, operate power tools or heavy machinery. Do not make vital decisions or sign legal documents. Do not stand up quickly as you may become light-headed. Do not smoke, drink alcohol, take recreational drugs or sleeping tablets. You may feel sick or vomit.*
>
> *It is normal to see some blood and debris in the urine for the next few weeks. Drink 2-3 litres of watery fluid / day, for the next 48 hours, to flush this out (unless you have been recommended to be fluid restricted for other reasons).*
>
> *You may notice some burning, increased urinary frequency and pain in the lower abdomen, but this usually settles over the next few days, and pain can be treated with Paracetamol.*
>
> *Some loss of control is common in the early days, so it is helpful to start pelvic floor exercises as soon as possible; these can improve your control when you get home. The symptoms of an overactive bladder (frequent & urgent urination) can take up to three months to settle, whereas the flow of urine is usually improved immediately.*
>
> *If bleeding is heavy, you see blood clots in the urine, you have temperature above 37.5 degrees Celsius, your urine is cloudy / smelly, or you are unable to pass urine, please return to A&E for review.*
>
> *If your work involves heavy lifting or manual work you should ask for a sick note or altered duties for 4 weeks to avoid heavy exertion and reduce the risk of further bleeding.*
>
> *If you are discharged with a catheter, we will arrange for this to be removed at the Johanna Finn Unit.*
>
> *Your tissue samples will be analysed routinely in the laboratory, and your surgeon will contact you with the results of this.*
>
> *You will be contacted by the Urology Specialist nurses over the telephone, around 3 months after your surgery. If you have further questions before then please contact your GP or the Urology Specialist nurses on* [redacted]*."*

2. Inadequate record keeping has resulted in inaccurate records being maintained in relation to important advice provided to patients on discharge. If this is the scenario, there would appear to be no assurance mechanism in place to identify and remedy any error.

This incident has reinforced the importance of clear verbal and written communication at discharge. Improving the quality of discharge letters has been a project over the last 18 months led by the Associate Medical Director [redacted]. This has focussed on initially identifying the barriers and the work to address them.

Through this project the barriers identified: -

- Usability of software
- Lack of workstations
- Lack of instructions
- Need for dedicated time

To address this, consultants have been requested to take ownership of the discharge process and provide check and challenge where appropriate of draft discharge letters.

The digital team have now rectified the digital barriers and have tried to implement the enablers. We have also put in place methods to ensure compliance can be monitored by Clinical Directors and Clinical Leads. It is advised that this data should be discussed at departmental and divisional governance meetings.

This is to enable staff to recognise the importance of discharge letters and rectify issues that lead to incomplete discharge letters.

Recently, as a continuation of this project, WSFT is exploring how best it can utilise the "write to me rather than about me" paradigm. This has been advocated by the Academy of Medical Royal Colleges since 2018 and has just been updated. A link to the further guidance can be found here: https://www.aomrc.org.uk/wp-content/uploads/2026/02/Please_write_to_me_0226.pdf

The "write to me" concept has been extensively discussed at senior medical leadership over the past few years, especially in the concept of recording shared decision making. We are now exploring ways to role this out more widely across the Trust.

3. I am further concerned that the communication processes at West Suffolk Hospital between patients and hospital staff (including treating clinicians) are ineffective in affording patients and their families with adequate opportunity to engage with and inform clinical decisions around their care and treatment.

As reported previously, we would like to highlight the continued work introducing the national 'call for concern' and Martha's rule programme. Since Mr Abbott's death on 29 November 2023, the Trust has adopted the national Call 4 Concern / Martha's Rule programme. As part of this initiative, it introduces a daily structured patient-wellness question, enabling both doctors and nurses to engage proactively with patients regarding their condition and any emerging concerns.

The programme provides a standardised response matrix that supports staff to escalate concerns consistently and ensures patients and families are afforded regular opportunities to contribute to decisions about their care. After a successful pilot on wards F7 and G4, demonstrating measurable improvement in patient–staff communication and early identification of deterioration, Martha's Rule/Call for Concern, was implemented at West Suffolk Hospital on 1 May 2024 across all inpatient areas. This initiative provides patients, relatives, carers and staff with a direct route to request an

independent clinical review if they are worried about a patient's clinical deterioration and feel their concerns have not been adequately addressed by the ward team.

The Critical Care Outreach Team (CCOT) is responsible for delivering this service. Their responsibilities include:

- Receiving all calls.
- Conducting an initial triage to assess the nature and urgency of the concern.
- Attending the relevant ward/inpatient area to speak with the individuals raising the concern.
- Liaising with the ward team to review the situation collaboratively and ensure appropriate clinical action is taken.
- Referrals to different specialities, including intensive care if deemed necessary.
- If required, organising/facilitating multidisciplinary teams (MDT) meetings.

In addition to the above, since April 2026 WSFT has extended its visiting hours from 10am to 8pm. This will support improved communication with relatives and patients, as the next of kin can be present during ward rounds and thus increasing the opportunity for face-to-face communication with consultant teams.

This process aims to strengthen patient safety, support open communication and provides an additional safeguard for patients experiencing clinical deterioration. I am sorry that it was not in place at the time of Mr Abbott's care.

Learning from this case has been shared within the department to increase awareness and improve clinical communication practices. Furthermore, an inquest learning bulletin will be shared to disseminate learning further through our Mortality Oversight Group and the Medical Director's Bulletin.

Thank you for bringing this important patient safety issue to our attention. We hope this information assists to address your concerns and please do not hesitate to contact us should you need any further information.

Yours sincerely,

Chief Executive Officer