Mid and South Essex NHS Foundation Trust

H.M Area Coroner
Ms Sonia Hayes
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

[redacted]

[redacted]
Date:23 July 2026

Dear Ms Hayes,

Regulation 28 Report to Prevent Future Deaths – Miss Lacey Carol Anne Heath

I write further to your Prevention of Future Deaths Report, dated 28 May 2026, following the conclusion of the Inquest touching on the death of Miss Heath.

We have considered your concerns and now set out our formal response to each matter using your numbering as follows.

Matters of Concern

1. **Ms Heath was noted to be warfarin resistant and alternative medication regimes were not successful in keeping Ms Heath within a therapeutic range for her required lifelong requirement to have anticoagulation to prevent a significant risk of death. The GP and hospital clinicians trailed different combinations of appropriate therapy which included additional injections when required. This was not considered to be clinically appropriate long-term.**

   We recognise the importance of clinically appropriate plans being in place for our patients. Therefore, we are implementing a high-risk anticoagulation pathway for patients with persistent sub-therapeutic INR, suspected warfarin resistance, complex anticoagulation requirements or repeated instability despite appropriate dose adjustment.

   The pathway will define criteria for senior clinical review, frequency of INR testing, escalation thresholds and documentation requirements. This is due for completion by the end of July 2026.

   Patients with prolonged sub-therapeutic INR or complex anticoagulation needs will be identified promptly and receive documented senior review. There will be an approved pathway, staff communication, sample audit of high-risk cases and evidence of escalation decisions recorded in the clinical record.

To maintain oversight and sustainability, the divisional governance team will undertake a monthly audit of high-risk anticoagulation cases for the first three months following implementation; thereafter there will be a quarterly audit.

Any issues detected in the audits will be reported through Pathology Governance group and Broomfield Quality and Safety Hospital Group. Exception reporting at the site level feeds up directly into trust-wide board ensuring oversight at a Senior Leadership Level.

2. **Due to the complexity of her case, Ms Heath's anticoagulation was under the care of the acute hospital team. Alternative anticoagulation medication had resulted in high INR readings and significant risks associated with bleeding.**

By the end of August 2026, we will have conducted a complete review of the anticoagulation service escalation process for complex patients under hospital care.

We plan to introduce a documented requirement for complex cases including high INR readings, bleeding risk, recurrent instability or failed alternative regimes to be reviewed by a senior clinician and, where appropriate, haematology. This will establish a clear escalation route for complex anticoagulation patients.

An updated standard operating procedure will be devised to reflect this approach, which will include clearly defined senior review criteria.

Communication of the new process will be undertaken will all anticoagulation staff. There will be a quarterly governance audit of complex anticoagulation cases and escalation of any compliance concerns.

Any audit exceptions will be reviewed through the hospital site governance assurance groups, and appropriate actions will be assigned where documentation or escalation is incomplete or below the expected standard.

3. **Ms Heath's experienced clinical team did not consider that there had been a sufficient trial of Warfarin and recommended at-home monitoring to permit daily readings to be taken to manage the significant risks associated with anticoagulation and to find an individualised dose for Ms Heath. Clinicians were not concerned about medication non-compliance and that the difficulties were clinical.**

By the end of September 2026, a robust process for home INR monitoring will be in place. Prior to home monitoring proceeding, we will conduct a detailed assessment of patient suitability, any training needs, equipment requirement, general support and governance, and follow-up arrangements as necessary. This new process will ensure that decisions to recommend, decline or defer self-testing are clearly recorded with the rationale, and always discussed with the patient and, if possible, their family or carers.

4. **Ms Heath could not afford to fund the at home monitor as this was financially prohibitive for her being on a low income. The monitor was expensive and there is no obligation for General Practitioners to fund the testing strips and incidentals required to facilitate testing. As this would be a lifelong commitment for a woman who was only 34 years-old, Ms Heath was not able to take the advice of her expert clinical team and was compelled to have alternative prescribing that was not successful in keeping her INR within therapeutic range.**

   By the end of September 2026 we will have a process for escalating cases where recommended anticoagulation monitoring equipment or consumables may be clinically required but financial barriers are identified. This will include signposting to available funding routes, individual funding consideration, charitable support or commissioner discussion where applicable.

   Where financial barriers for clinically recommended monitoring are identified, they will be escalated and documented. We plan to introduce funding and escalation guidance that will be communicated to relevant staff. To ensure the new process is working effectively, we plan to complete audits of funding applications.

5. **No application for funding was made on behalf of Ms Heath by the Trust nor was this explained to Ms Heath who a very quiet, shy lady who always relied on her very loving family to assist her with appointments and could not advocate for herself. There was no consideration if Ms Heath had any learning difficulties and it was noted that there was developmental delay in her medical records. Evidence at the inquest was Ms Heath experienced this as clinicians not caring about her and she became very despondent about the failure to achieve a therapeutic range.**

   By the end of October 2026, we plan to introduce a prompt within the high-risk anticoagulation pathway requiring clinicians to consider whether the patient may need additional communication support, family/carer involvement, reasonable adjustments or advocacy where records or presentation suggest vulnerability, developmental delay, difficulty self-advocating or reduced understanding of risk.

   This will ensure that patients who may have additional communication or support needs are recognised and supported in risk discussions and decision-making. This will be by way of a pathway prompt, staff briefing, audit of high-risk cases for documentation of support needs, family/carer involvement and agreed follow-up plans.

   The effectiveness of this prompt and pathway will be monitored by the Patient Experience and Learning Disability teams and reported to the Pathology Governance group.

6. **Ms Heath did not manage to achieve a therapeutic INR for a protracted period of time putting her at increased risk of developing complications and did not have a medical review or a haematology referral.**

   A defined trigger will be set for medical review and/or haematology referral when a patient INR remains outside therapeutic range for a prolonged period; when repeated appointments are not attended during a high-risk period; or when treatment instability persists despite appropriate intervention. This will include a requirement for documented clinical rationale where referral is not made.

   This will allow patients with prolonged poor INR control to receive timely medical review and specialist input where indicated.

   The referral and escalation criteria will be updated along with a referral log, clinical record audit and governance review of any cases breaching trigger thresholds.

7. **There was an absence of appropriate medical records recorded for Ms Heath to understand her clinical presentation other than very basic information on the INR platform on INR results and medication dose. Evidence was these records are not compliant with the requirements of healthcare regulators and led to a lack of appreciation of Ms Heath's concerns and the complexity of her case. One entry stated Ms Heath had been "unwell" with no clarification or further information on what the problem was and/or how this may have impacted on her condition.**

   We are reviewing documentation standards within the anticoagulation service, and we will implement a structured clinical note template for contacts, missed appointments, patient-reported symptoms such as "unwell", risk discussions, escalation decisions, advice given and follow-up plan by the end of October 2026. This will explore system functionality for persistent alerts or pinned critical risk information.

   Clinical records will show clear evidence of the patient's presentation, risks, advice, escalation and follow-up. Critical risk information will then remain visible to staff reviewing the case. There will be an approved note template, staff briefing, sample documentation audit and outcome of clinical system review.

   Monthly documentation audits will be undertaken for the first three months after implementation, followed by quarterly intervals. Results and improvement actions will be monitored through the Pathology Governance group and included in service quality reports.

   We are currently in the process of introducing a new single electronic patient record ('EPR') system across our trust. This EPR will replace/integrate with current systems services in all areas and will be for all our hospital sites.

This system will provide real-time and accurate information on a patient's history to support clinical decision making. Clinicians will have the ability to add and access information to support quicker and personalised care for our patients, reducing the need for paper-based processes and multiple systems.

The system is currently in its testing stage, expected to run through the remainder of the year. As per current timelines, the system is expected to go live in June 2027.

Once established, the addition of the new EPR will be twofold:

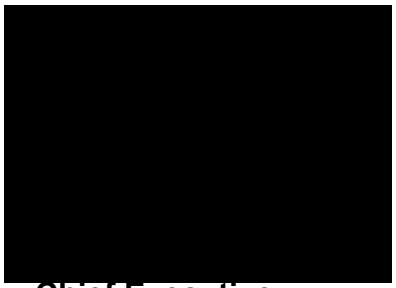
1. The observations will be in the new EPR for all encounters across the trust from the date it goes live
2. All new electronic notes will be visible within the notes

In the interim we will use our current INR monitoring system, INRstar, to conduct INR checks.

Following implementation of the new EPR there will be further consideration as to its use and its suitability and combability.

If I can assist any further with these matters, please do not hesitate to contact me.

Yours sincerely,



Chief Executive
Mid and South Essex NHS Foundation Trust