Trust Executive Office
Ground Floor
Pathology and Pharmacy Building
The Royal London Hospital
80 Newark Street
London E1 2ES

[redacted]

www.bartshealth.nhs.uk

Private & Confidential
Adrian Farrow
Assistant Coroner, Greater Manchester South
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Farrow,

Re: Regulation 28 Prevention of Future Deaths Report: Monica Wood

I write in response to the Regulation 28 report dated 23 July 2026, issued following the inquest held on 21 and 22 July 2026.

We are very sorry that Mrs Monica Wood died following her transfer from the Royal London Hospital to Stepping Hill Hospital on 19 November 2025. We accept the Coroner's concerns that there was no reliable mechanism to ensure that her fitness for a long-distance transfer, and the suitability of the transport and crew, were reassured after the transfer had been delayed and her clinical condition had changed.

Since the receipt of your concerns, we have reviewed our discharge policy (approved June 2026) and our patient transfer policy (approved April 2025).

The purpose our discharge policy and associated procedures is to ensure that there is a consistent approach to all aspects of the discharge process, and that risks associated with discharge are recognised and minimised through effective planning, with the patient at the centre, and through partnership working with the multidisciplinary team within Barts Health and with partner agencies. The policy aims to ensure that relevant staff understand the significance of their role in the discharge process and adhere to common practices according to the type of discharge that is being arranged. This policy does include a section explaining steps to be taken where repatriation to another hospital is delayed, however this is focused on the operational management of the process. We have identified that it does not refer to the process for the clinical review to reconfirm suitability to transfer on the day

of transfer or the oversight of any changes in a patient's condition and steps to be taken should their status change during the wait.

Our patient transfer policy provides a framework for the safe clinical transfer of patients either within the Trust or to other external organisations. The policy focuses on the 3 distinct phases of transfer; preparation for transfer, the actual transfer and the handover of care. This is a process that, as a major trauma centre, the Royal London Hospital utilises regularly but typically this is for local transfers in the London and the South-East region. We note that your report explains Mrs Wood experienced a 7-hour journey in non-emergency transport without medically trained staff. While these journeys are rare, on reflection of her experience, it is evident that our policy does not refer explicitly to long distance transfers where there are likely to be additional considerations including the length of time in the transport, whether this changes the requirements of an escort in comparison to a local journey and privacy & dignity aspects that may arise during a long journey such as access to personal care.

In light of Mrs Wood's experience and the gaps this has flagged in our policies, the trust has commenced amendments to the Discharge Policy and Patient Transfer Policy. The revised requirements will mandate a documented clinical reassessment before departure where a transfer has been delayed, where there has been any material change in clinical condition, or where the planned journey presents additional risk because of its duration or distance. Pending formal policy approval, an immediate Trust-wide safety notice has been issued. This requires the responsible clinical team to complete and document a fresh assessment on the day of transfer, and to reassess the transport type, crew and escort requirement before the patient is handed over.

In the time leading up to the inquest, we corresponded with Mrs Wood's family regarding other matters associated with her time as an inpatient in the Royal London Hospital. The discussions through the inquest and this PFD have led us to reflect further on our part in the events on and after 19 November 2025. As such, the Royal London Hospital has now raised your feedback through the incident process so that the events of her discharge and transfer can be looked at using the Patient Safety Learning Response Framework (PSIRF). We will use this as an opportunity to identify any further learning from the experience of both Mrs Wood's and her family. We would be happy to communicate again directly with her family should they wish to know more about this in the future.

I hope this provides you with the assurance that we have taken the events in Mrs Wood's care very seriously, but I would be very happy to discuss or clarify any of the above points if you wished.

Yours sincerely

[redacted]

Group Chief Medical Officer