REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Adrian Farrow, Assistant Coroner, for the coroner area of Greater Manchester South.
2.	**DATE OF REPORT** **23rd July 2026**
3.	**CORONER'S LEGAL POWERS** 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.
3.	**THIS REPORT IS BEING SENT TO** Chief Executive, Barts Health NHS Foundation Trust, The Royal London Hospital, Whitechapel Road, London, E1 1FR. You are under a duty to respond to this report within 56 days of the date of this report, namely by **17th September 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** **The absence of a review of the fitness of a patient for transfer and the suitability of the method of transport from the Royal London Hospital to a hospital in Greater Manchester in circumstances where the anticipated transfer is delayed.**
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 28th November 2025, an investigation was commenced into the death of Monica Wood, aged 66 years. The inquest was held on 21st and 22nd July 2026.

	The medical cause of death was: 1a) Acute heart failure 1b) Multi-organ failure of the liver, kidneys and lungs 1c) Sepsis from hospital acquired pneumonia II) Vascular dementia, peripheral vascular disease, hypertension, ischaemic heart disease, traumatic brain injury. **How, when and where:** Monica Wood died at Stepping Hill Hospital, Stockport on 20th November 2025. She was transferred to Stepping Hill Hospital on 19th November 2025 from the Royal London Hospital, London where she had been admitted following an accidental fall on 4th November 2025 in which she sustained a bleed to her brain, which was being managed conservatively. Whilst waiting at the Royal London Hospital for transfer to a hospital closer to her home, Mrs Wood contracted a chest infection which was not recognised and which developed into sepsis coincident in time with the journey between hospitals on 19th November 2025. The hospital transport did not have any medically trained crew to undertake monitoring of her condition during the journey and on arrival at Stepping Hill Hospital, Mrs Wood had developed multi-organ failure which her underlying medical conditions and the effects of the recent brain injury left her unable to overcome. **Conclusion:** **Died from the consequences of overwhelming infection contracted in hospital whilst recovering from a brain injury sustained in an accidental fall.**
8.	**CIRCUMSTANCES OF DEATH** Mrs Wood sustained a traumatic brain injury in an accidental fall on 4th November 2025. The injury was treated conservatively at the Royal London Hospital. She remained stable, aside from a urinary tract infection which was treated, until 18th November 2025 when her condition began to deteriorate. The anticipated repatriation to her local hospital was delayed for over 4 days from 14th to 19th November 2025 due to the unavailability of a suitable bed. Notwithstanding the deterioration in her condition, there was no review of her condition and her fitness for transfer to a distant hospital on the day of her transfer on 19th November 2025, when the inquest found that she had begun to develop pneumonia. The suitability of the non-emergency patient transport was not reviewed in the light of the changes to her condition with the result that there was no nursing or clinical observation or monitoring of her condition for a period of over 7 hours at a time when she had raised NEWS 2 scores and a chest infection. She was medically frail with several co-morbidities including dementia and vascular disease and on arrival at Stepping Hill Hospital in Stockport, she had developed sepsis which led to multi-organ failure, which brought about her death
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could 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. There appears to have been no provision or mechanism to review the fitness of a patient for travel where the transfer from the Royal London Hospital to another hospital had been delayed by a number of days. 2. There appears to have been no mechanism to review the suitability of the chosen transport and crew for a patient whose condition has materially changed from the point of booking to the point of transfer.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should

	receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. The Family of Monica Wood 2. The Associate Director of Transport, Barts Health NHS Foundation Trust, The Royal London Hospital, Whitechapel Road, London, E1 1FR. I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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