Heath Westerman
H.M. Assistant Coroner for Shropshire,
Telford & Wrekin
H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
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SY3 8HQ

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

12 December 2025

[redacted]

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lynn Silcock who died on 10th July 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 23rd October 2025 concerning the death of Lynn Silcock on 10th July 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lynn's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Lynn's care have been listened to and reflected upon.

You raised concerns that Lynn was discharged by the gastroenterology team at The Royal Shrewsbury Hospital in September 2022, without referral to the cardiology team or a plan to be referred later, and that no investigation had taken place by Shrewsbury and Telford Hospital NHS Trust ('SATH') as to why this had occurred and what had gone wrong.

The concerns raised in your Report will be dealt with by SATH, to whom your Report has also been addressed to, and there is no action for NHS England to take in regard to this matter as the issues fall outside of NHS England's role and remit as a commissioner of certain healthcare services. However, the following information may be useful to the Coroner as background.

NHS England has long recognised that omissions in information-sharing within or between healthcare organisations can contribute to poor continuity of care and lead to poor health outcomes. In 2021, NHS England developed and rolled out a national 'Frontline Digitisation' (FD) Programme, which aimed to support NHS Trusts in England with the procurement and deployment of Electronic Patient Record (EPR) systems. The aim of this was to support increased digital maturity of organisations and improve information sharing within and between organisations. Beyond facilitating the procurement of EPR systems, the FD Programme also provided guidance and support to ensure safe and effective deployments.

As part of this initiative, SATH secured a multi-year funding to implement a replacement Patient Administration System (PAS) and Emergency Department (ED) solution. Subsequently, in April 2024, SATH deployed the 'System C CareFlow EPR'. EPR systems typically include locally configurable functionality to ensure that NHS Trusts can adapt them to meet their service needs. These systems can include capabilities for creating discharge summaries, patient search functions and the creation of referrals.

However, despite EPR systems being able to enhance information sharing and referrals, these processes continue to rely on the user taking the correct action and there remains a risk of oversight, which may result in incomplete discharge summaries and/or referrals not being created or sent.

To mitigate this risk, NHS Trusts should ensure that discharge and referral processes are streamlined and aligned with clinical workflows, and that these are formalised within local Standard Operating Protocols (SOPs). These workflows should be configured in a way that supports staff and should be rigorously tested, incorporated into training programmes and clearly communicated to clinical staff for them to facilitate workflows in the most efficient and effective way possible.

NHS England has requested to be included in SATH's response to the concerns raised in your Report, and will review it to determine whether any further action is necessary.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Lynn, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted]
National Medical Director
NHS England