The Shrewsbury and Telford Hospital
NHS Trust

Royal Shrewsbury Hospital

Mytton Oak Road
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SY3 8XQ

[redacted]

Mr Heath Westerman, Assistant Coroner

HM Coroners Service

Shirehall

Abbey Foregate

Shrewsbury

Shropshire SY2 6ND

Dear Mr Westerman,

Thank you for your letter dated 23rd of October 2025 issued under Regulation 28: Report to prevent future deaths, in relation to the risks you identified examining the death of the late Lynn Silcock.

I write to provide details of the steps that we have taken and plan to address the issues highlighted in your letter. These issues were outlined as:

1. *Discharged by the gastroenterology team without referral to the cardiology team as to whether the discharge was appropriate.*

2. *Discharged without a cardiology clinic appointment or plan to be later rereferred.*

3. *There was no document exchange or communication between the gastroenterology team and the cardiology team meaning that Ms Silcock was then forgotten about.*

4. *No investigation by Shrewsbury and Telford NHS Trust as to what went wrong and why between the treating teams and their respective administration teams.*

I have taken these points slightly out of order to provide appropriate context to then outline the actions we are taking to reduce the risk of a similar incident.

4. No investigation by Shrewsbury and Telford NHS Trust as to what went wrong and why between the treating teams and their respective administration teams.

The case of Mrs Silcock has been raised as a Patient Safety Investigation (PSII) under the Patient Safety Incident Response framework and some of the initial work of that investigation has been used to inform the response outlined in this letter.

The PSII was raised following communication between the coroner's office and the Trust's legal team following the issuing of Ms Silcock's cause of death in July 2025. The legal team put in a Datix incident report which led to a review of the issues relating to Ms Silcock's care. This led to the raising of the PSII via the Trust Executive chaired incident review group on the 4th of November 2025.

Before the point in July when Ms Silcock sadly died and had a post-mortem investigation there was no indication for the Trust that an incident had occurred as the Cardiology referral had not been received and so there was no tracking on the intended pathway.

A detailed review of the circumstances around the lack of referral to Cardiology has been unable to determine the exact mechanism whereby the intended referral from the medical team to Cardiology failed to occur. On this basis, the PSII has been commissioned to further understand the current risks in inpatient to outpatient referrals across SaTH clinical specialties. Further to this the PSII will also explore the likely optimum system to reduce risk of referrals being lost to help inform in the longer term the tools (likely to be digital) which can support a safe referral system which reduces risk to the lowest level reasonably practicable.

1. Discharged by the gastroenterology team without referral to the cardiology team as to whether the discharge was appropriate.

2. Discharged without a cardiology clinic appointment or plan to be later rereferred.

3. There was no document exchange or communication between the gastroenterology team and the cardiology team meaning that Ms Silcock was then forgotten about.

Ms Silcock was admitted to SaTH in 2022 with shortness of breath. Initial blood test investigation indicated she had a low haemoglobin (ie she was anaemic). A cardiac echo investigation was undertaken which reported severe aortic stenosis.

The investigation results outlined above led to discussions with gastroenterology and cardiology teams regarding ongoing investigations and care. This resulted in the decision based on the specialist's advice to refer Ms Silcock for outpatient upper and lower gastrointestinal (GI) endoscopy to investigate potential bleeding or malignancy in the GI tract. The medical team would also refer to the outpatient service of the cardiology team for further follow up and investigation of Ms Silcock's aortic stenosis.

The possibility of bleeding or malignancy led to the endoscopy investigations being prioritised with cardiology advising these should be completed first then cardiology would continue the process to investigate the aortic stenosis. On review it is clear there was no expectation that the gastroenterology team would be responsible for following up the referral to cardiology once Ms Silcock's endoscopy investigations were completed.

The decision to refer to the cardiology team as an outpatient is documented in the discharge letter and notes and should have occurred formally at the point of Ms Silcock's discharge from the medical inpatient team in 2022. The process failed at the point of discharge and the referral to cardiology was lost in the system. It has not been possible despite in depth review to explain exactly where the issue arose that mean this referral was lost. It is possible to postulate a number of potential scenarios, but we do not know the precise issue that led to the missed opportunity to further investigate Ms Silcock's stenosis.

Based on the initial review of the issues around Ms Silcock's care and the information gathered as part of the PSII we can say broadly:

- There is variation across the inpatient specialties in the Trust in terms of the process of referral to other specialties on an inpatient to outpatient basis.

- Not all specialties have a defined standard operating procedure (SOP) for these referrals which can lead to variation and potentially increase risk of referrals becoming lost.

- There is currently no standardised tool available to teams digitally which enables referrals to be made and tracked or audited to ensure follow up appointments are made. The current process of referral is largely paper based, which can increase risk.

On the basis of these initial insights we have proposed two courses of action to address risk and reduce the likelihood of a similar incident occurring. One course of action is aimed at the short to medium term and the other looking for a longer term and sustainable solution to this challenge.

Actions in the short to medium term:

In the short to medium term the Trust's Medical Director and Deputy Medical Director are tasking the leadership teams of our clinical divisions to ensure each inpatient specialty has a clear standard operating procedure (SOP) for inpatient to outpatient referrals. This will be documented and shared across the team with clear direction on process, roles, and responsibilities in ensuring referrals are made and a system of safety netting is in place to ensure decisions to refer to other specialties are followed through and actioned.

There will be a single referral email for each speciality for referral for outpatient follow-up, the referrals within the team will then be managed in the standard way all referrals are with appropriate triage. This process will be developed over the next 3 months with SOPs developed and appropriate communications cascaded.

Actions in the long term:

The Trust has an ongoing programme of digital development to implement digital systems to support clinical teams to work effectively and safely.

A project feasibility request has already been raised to assess the need for a digital solution to support referral management. This is the route whereby needs are reviewed and scoped to develop proposals and business cases to place the need on the Trusts 'digital roadmap' (the overall programme of work to mature the Trusts digital systems).

There are several potential existing systems available which may support referral processes and reduce the risk which has been highlighted by this incident. The ongoing PSII, which is likely to be completed by February, will engage clinical teams in outlining a robust and reliable referral process. This work will be used to evaluate what system is best suited to support management of referrals.

It is difficult at this stage to give an indication of the timescale for development of any digital solution given the need to scope the process and available systems as well as the prioritisation of funding and scheduling such work.

Thank you for bringing your concerns to my attention. I hope that you are assured that I have taken them seriously, we are investigating them appropriately and we are putting in place systems and processes to reduce future harm. If I can provide any further information, please do not hesitate to contact me at the above address.

Yours sincerely,

[redacted]

[redacted]
Executive Medical Director

On behalf of [redacted], Group Chief Executive