HEATH WESTERMAN
H.M. ASSISTANT CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
Shropshire SY3 8HQ

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England, Wellington House, 133-155 Waterloo Road, London SE1 8UG [redacted] 2. Chief Executive of Shrewsbury and Telford NHS Hospital Trust, Royal Shrewsbury Hospital, Mytton Oak Way, Shrewsbury, Shropshire
1	**CORONER** I am Heath Westerman, H.M. Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin.
2	**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	**INVESTIGATION and INQUEST** On 14 July 2025 I commenced an investigation into the death of Lynn SILCOCK The inquest was opened on 28 August 2025 and adjourned to the 21 October 2025. On 21 October 2025 the inquest was adjourned for further investigations and the issue of this Prevention of Future Deaths Report
4	**CIRCUMSTANCES OF THE DEATH** Ms Silcock was admitted to The Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire on 12 September 2022 with a history of lethargy, breathlessness, fatigue and loss of appetite over the preceding 6 weeks. She was 62 years old. On 13 September 2022 on ward 11 a differential diagnosis was made of congestive cardiac failure, aortic stenosis, severe anaemia and angiodysplasia and she was referred to the cardiology team. On 14 September 2022 it was decided to treat the anaemia first and then transfer to cardiology ward for management of her aortic stenosis. Later that day an endoscopy and CT virtual colonoscopy was discussed and she was kept on ward 11. She was discharged on 16 September 2022 to the care f her GP with a view to then be seen as an outpatient in the endoscopy clinic on the 2 week rule pathway and then be referred to the cardiology team for treatment of the aortic stenosis. A gastroscopy report was received on 30 September 2022 but no referral to cardiology was made and consequently she was lost in the system. She died at her home address on 10 July 2025. A postmortem examination conducted on 16 July

	2025 gave a cause of death as: 1a. Aortic stenosis (on a background of bicuspid aortic value). 2. Myocardial fibrosis. Had Ms Silcock have been referred in an appropriate and timely matter, more likely than not her death would have been prevented.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 December 2025. I, the coroner, may extend the period. 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.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	[redacted] Heath Westerman H.M. Assistant Coroner Shropshire, Telford & Wrekin 23 October 2025

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