The Shrewsbury and Telford Hospital
NHS Trust

Royal Shrewsbury Hospital

Mytton Oak Road
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Shropshire
SY3 8XQ

[redacted]

Mr John Ellery, H.M Senior Coroner

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

12th March 2026

Dear Mr Ellery,

Thank you for your letter dated 15th January 2026 issued under Regulation 28: Report to prevent future deaths, in relation to the risks you identified examining the death of the late Margaret Elizabeth Grimsley.

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. *The apparent absence of or use of an upper alarm setting on a bedside oxygen meter. The evidence indicated that a lower scale alarm was set, but not an upper alarm which required manual observations as and when a nurse or healthcare assistant was carrying out observations. The risk is that over-oxygenation could take place without medical attention being sought.*
2. *The evidence of a Consultant Respiratory Physician did not reflect the response from SaTH in a letter to the deceased daughter of the 30 May 2024 at page 10.*
3. *It is not clear whether an upper alarm can be set and/or whether it is practice to do so.*

I have taken these points slightly out of order in my response.

1. The apparent absence of or use of an upper alarm setting on a bedside oxygen meter. The evidence indicated that a lower scale alarm was set, but not an upper alarm which required manual observations as and when a nurse or healthcare assistant was carrying out observations. The risk is that over-oxygenation could take place without medical attention being sought.

3. It is not clear whether an upper alarm can be set and/or whether it is practice to do so.

The wall mounted patient monitors (not the portable monitors) have the functionality to provide an upper oxygen alarm however none of the respiratory consultants have ever worked in a hospital where this functionality is used in a ward environment. We have also enquired about common practice across the region; we are not aware of any other hospital that uses upper limit alarms in the ward setting.

When interpretating the measured oxygen concentration using the oxygen saturation, the levels do not reliably correlate well with the blood oxygen levels when measured invasively by blood testing. The oxygen saturation measure is the essential measurement to monitor to ensure that the tissues are receiving enough oxygen, however in patients who are extremely unwell the relationship between the two readings can correlate poorly.

The upper alarm is not used as the greatest risk to the patient is low blood oxygen levels. Using the lower alarm in patients with severe lung disease to keep oxygen levels within the required tight range is extremely challenging, and will often require frequent adjustment by the nursing staff to keep the oxygen levels high enough. When considering the poor correlation between oxygen saturations and actual blood levels as well as the higher risk of low oxygen levels, the focus on the ward is the lower alarms with regular monitoring to minimise higher results.

1. The evidence of a Consultant Respiratory Physician did not reflect the response from SaTH in a letter to the deceased daughter of the 30 May 2024 at page 10.

I apologise that the responses of the consultant and the complaint letter were not consistent. The drafting of the response letter was compiled from the feedback of numerous team members. On reflection the response to the question about setting an upper limit should have been reviewed by the medical team to ensure it was accurate. This was not done. Given the reasons for not using the upper limits as outlined above, I can confirm that the complaint response letter was not accurate. However, the information given to the inquest by the consultant was correct and in keeping with the explanation provided in this response. I am very sorry for the upset and difficulty that this error in the original complaint response has caused. Our review of the complaint response letter failed to pick up this error before it was submitted.

I hope that you are assured by the information I have been able to provide and that I have explained the differences in evidence that you reviewed at the inquest. If I can provide any further information, please do not hesitate to contact me at the above address.

Yours sincerely,

Executive Medical Director

On behalf of [redacted] Group Chief Executive