JOHN ELLERY
H.M. SENIOR CORONER

FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive – [redacted] Shrewsbury & Telford Hospital Trust (SaTH) Royal Shrewsbury Hospital Mytton Oak Road Shrewsbury SY3 8XQ
1	**CORONER** I am John Ellery, H.M. Senior 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 3 February 2025 I commenced an investigation into the death of Margaret Elizabeth GRIMSLEY The investigation concluded at the end of the inquest on 6 January 2026 The conclusion of the inquest was a natural cause being Ia) frailty and advanced chronic obstructive pulmonary disease II) right sided heart failure
4	**CIRCUMSTANCES OF THE DEATH** Margaret Elizabeth Grimsley was admitted to the Royal Shrewsbury Hospital on the 16 December 2024 following a fall at home. Mrs Grimsley had comorbidities and was seriously ill. Sadly, she did not recover and following an infection in the last 24 to 48 hours of her life, she died while still at the hospital on the 22 January 2025.

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) 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 12 March 2026. 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 family of the late Mrs Grimsley. 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] John Ellery H.M. Senior Coroner Shropshire, Telford & Wrekin 15 January 2026

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