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Date : 18 September 2026

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Dear Dr Didcock,

Inquest touching the death of Shiree Routledge

Thank you for providing us with a copy of the Regulation 28 Report to Prevent Future Deaths. This letter is the response from United Lincolnshire Teaching Hospitals NHS Trust.

At the outset, the Trust would like to express our heartfelt condolences to Miss Routledge's family and friends for their loss.

Response to issues raised by the Report

We acknowledge the concerns raised regarding seizure monitoring, the timely implementation of specialist neurosurgical advice, and the identification of implanted shunt devices. We recognise the importance of addressing these concerns through clear clinical responsibilities, reliable documentation and timely escalation.

1. Inadequate monitoring of seizure frequency on the Medical Assessment Unit and medical ward

We acknowledge that the recognition, monitoring and documentation of suspected seizures require improvement on the Medical Assessment Unit and medical wards. Events suggestive of seizures may have several possible causes. This diagnostic uncertainty reinforces the need for accurate observation and documentation so that the treating team and specialist neurologist can assess the events appropriately. Staff should record what they observe without being expected to establish a definitive neurological diagnosis.

The proposed improvement measures are:

- **A standardised seizure observation chart:** Review and approve the existing draft for use in relevant inpatient areas. This should capture the timing, frequency, duration and observed features of each event, the patient's responsiveness, recovery, treatment administered and escalation undertaken. Documentation should distinguish between "no events observed or reported" and an absence of completed observations.
- **Targeted staff education:** Provide training for nursing and medical staff on recognising and describing suspected seizures, common alternative presentations, immediate management and indications for urgent escalation.
- **Daily clinical review:** Include a documented review of suspected seizure activity and the observation chart during the daily ward round, with timely communication with the neurologist providing advice for the patient. Urgent concerns should be escalated immediately rather than deferred to the next ward round.
- **Witness accounts:** Actively seek and document relevant accounts from the patient, relatives, carers or other witnesses, particularly where events have not been observed by ward staff.
- **Implementation and assurance:** Establish joint medical and nursing responsibility for implementation, supported by Neurology. Audit should assess chart use, completeness of documentation, clinical review and appropriate escalation, with findings reviewed through the relevant governance forum.

2. Failure to follow urgent neurosurgical advice from Queen's Medical Centre, Nottingham

We acknowledge the concern that urgent advice from the regional neurosurgical service was not acted upon promptly. In relation to the advice described, fundoscopy and/or ophthalmological assessment should have been arranged with the urgency advised, with any difficulty in obtaining that assessment escalated promptly.

The absence of papilloedema does not reliably exclude raised intracranial pressure or shunt malfunction. This limitation does not reduce the importance of completing the assessment requested by the neurosurgical team.

The proposed improvement is to establish a clear process for documenting and tracking urgent specialist advice. The clinical record should identify the advice received, its urgency, the clinician responsible for implementing it and whether the requested action has been completed.

Where advice cannot be implemented within the required timeframe, or there is uncertainty about the appropriate next step, the treating team should promptly re-contact the specialist service and escalate to the responsible consultant. Any alternative plan should be agreed and documented. Outstanding actions should be explicitly included in clinical handover.

3. Delay in obtaining shunt information required for safe MRI scanning

We acknowledge that the information required to establish the shunt type and its MRI conditions should have been sought promptly.

Early contact with the on-call neurosurgical team at Queen's Medical Centre could have helped identify the appropriate source of the implant information. However, it cannot be

assumed that a single telephone call would necessarily have provided all the information required to authorise safe scanning.

The proposed improvement is a defined escalation process involving the treating team, Radiology and the implanting neurosurgical centre. This should identify responsibility for obtaining and documenting the device details and confirming the applicable MRI safety conditions. For programmable devices, any required arrangements for checking and, where necessary, restoring valve settings should also be established.

Where device information cannot be obtained promptly, the responsible consultant should discuss the urgency of investigation with Radiology and Neurosurgery, agree an appropriate interim investigation or management plan, and document the decision. This should ensure that uncertainty about MRI safety results in active clinical escalation and an agreed plan.

The above actions and learning will be implemented over a six-month period under the leadership of the Neurology and Acute Medicine departments.

We hope that this response is satisfactory and addresses the concerns you have outlined.

Yours sincerely,

A black rectangular box redacting the signature of the Group Chief Medical Officer.

Group Chief Medical Officer
Lincolnshire Community and Hospitals NHS Group