

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Dr Elizabeth Didcock, HM Assistant Coroner, for the coroner area of Nottingham City and Nottinghamshire
2.	DATE OF REPORT 29.6.26
3.	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.
4.	THIS REPORT IS BEING SENT TO 1. [REDACTED], Chief Executive, United Lincolnshire Hospitals NHS Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 24.8.2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	SUMMARY OF CORONER'S CONCERN 1. Inadequate monitoring of seizure frequency on the Medical Assessment Unit and medical ward 2. The lack of following of urgent Neurosurgical advice from the Regional Centre at Queens Medical Centre, Nottingham 3. The delay in obtaining key information about a shunt type to allow safe MRI scanning
7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 21.10.2025, I commenced an investigation into the death of Shiree Routledge, aged 33. The investigation concluded at the end of the inquest on the 22.5.2026. The conclusion of the inquest was a Narrative as follows: Shiree died from diffuse hypoxic cortical brain injury secondary to a complex combination of causes as follows- she had chronic hydrocephalus caused by an intraventricular haemorrhage as a neonate, with then shunt blockage and shunt infection, both recognised complications, occurring in August 2025. Whilst this was managed appropriately with antibiotics and shunt material removal and a temporary External Ventricular Drain placed, there were issues of care at Queens Medical Centre on 25.9.25, specifically that of not responding appropriately to the drain malfunction that led to an acute rise in intracranial pressure and a seizure on that day. This rise in intracranial pressure, with possibly reduced mean arterial blood pressure during the drain replacement on the evening of 25.9.25, together with chronic hydrocephalus and chronic shunt infection all led to the unexpected development of hypoxic ischemic brain injury, that led to her death.
9.	CIRCUMSTANCES OF DEATH

Shiree died at Queens Medical Centre (QMC) in Nottingham on 14/10/25 from a diffuse hypoxic ischemic brain injury. The hypoxic event likely occurred during the evening of 25.9.25 during a procedure to replace her non functioning external ventricular drain, with a further drain. Shiree had longstanding hydrocephalus, requiring a shunt to drain her Cerebrospinal fluid (CSF).

The shunt became blocked in August 2025 likely secondary to a slowly developing chronic shunt infection. The shunt malfunction was not recognised initially at Lincoln County hospital on admission on 30.8.25 There were issues of care at Lincoln County hospital, that of:

1) Inadequate monitoring and recording of her absence seizures, and inadequate monitoring and recording of her headache symptoms. Both of these issues were worsening on admission, and clearly required detailed monitoring to guide management.

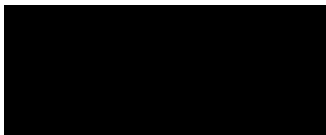
2) The medical team not following neurosurgical advice provided on 1.9.25, to obtain an urgent ophthalmology review to look for papilloedema, a key and necessary investigation as part of establishing whether or not there was a shunt malfunction. These issues together with the delay in obtaining an MRI brain scan led to a delay in Shiree's transfer to Queens Medical Centre for definitive management of her shunt malfunction, likely of the order of five to seven days (noting that Shiree's Glasgow Coma Scale (GCS) remained stable over this period, and that she was not critically unwell, requiring urgent transfer).

Shiree was transferred to QMC on 13.9.25. Whilst the delay in transfer is serious, it is unlikely to be causal or more than minimally contributory to Shiree's death, as following transfer the necessary exploration of her shunt, and External Ventricular Drain (EVD) insertion occurred promptly, with good recovery following it.

Shiree was managed appropriately at Queens medical centre following transfer, with her shunt malfunction and infection diagnosed and treated promptly with antibiotics and removal of shunt material in a planned and staged way on the 14th and 18th of September 2025. The EVD ceased to function from approximately 9:00 AM on 25.9.25. This was escalated by the nursing team to the neurosurgical doctors, but the drain was not reviewed by a senior doctor, as it should have been by midday that day. Shiree's intracranial pressure rose, as she was not receiving necessary CSF drainage. It is possible, though it cannot be said probable, that had the drain review occurred by midday the issue of the drain not functioning may have been resolved .

Shiree had a seizure at approximately 1815 hours on 25.9.25, likely secondary to a number of causes, but principally the rise in intracranial pressure, caused by the drain malfunction on a background of chronic hydrocephalus and chronic shunt infection. The blockage or displacement of the drain was then

	recognised promptly following the seizure and a necessary procedure to replace it followed. Shiree developed hypoxic ischemic brain injury over the subsequent hours likely caused by a combination of factors- the underlying chronic hydrocephalus and ongoing infection, together with acutely raised intracranial pressure over the 25.9,25, (only relieved once the drain was in place). Additionally, insufficient mean arterial blood pressure for perfusion of cortical cells, during the procedure also possibly made a contribution to the development of the hypoxic ischemic brain injury.
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as set out in Box 6 above. Shiree had a shunt to manage her longstanding hydrocephalus and presented to Lincoln County Hospital on 30th August 2025, with headache and increased absence seizures. Neurosurgical advice was sought on 1.9.25 but not followed. No urgent eye assessment to look for papilloedema (swelling of the optic discs caused by raised intracranial pressure) was requested as advised. There was no recording of headache frequency or severity, and very limited recording of seizures to help guide urgency of management. These issues all led to a delay in recognising that Shiree had persistent raised intracranial pressure, due to a shunt blockage, such that there was a delay in transfer to Queens Medical Centre, which did not occur until 13.9.25.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> • FAMILY • Nottingham University Hospitals NHS Trust

	I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Dr Elizabeth Didcock HM Assistant Coroner Nottinghamshire