	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Lancashire Hospitals NHS Trust Medical Director and Legal Services Department** **Care Quality Commission** **Gillian McKinlay's family**
1	**CORONER** I am Dr James Adeley Senior Coroner for **Lancashire & Blackburn with Darwen**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Gillian McKinlay, 68 years of age, was admitted to the Accident & Emergency Department of Royal Blackburn Hospital on 23 April 2018. The provisional diagnosis was of small bowel obstruction and both the A & E and Surgical Registrars requested siting of a nasogastric tube to decompress the bowel. The NG tube was not sited prior to Mrs McKinley's death four hours later, which in the Coroner's view, contributed to the death. Despite Early Warning Score indications that there should have been a significant review of Mrs McKinlay's condition in the 2 ½ hours before she arrested, there is no evidence that any such review took place. A copy of the summing up is attached to this document for further information.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. For patients remaining for a considerable period of time in the Accident and Emergency Department there is no clear indication or understanding as to who is responsible for the overall patient's clinical care. 2. EWS scores indicated that a clinical review was mandated for which there is no evidence in the medical records that any such review took place by A & E medical staff or that the matter was referred to any of the other clinical teams. 3. When the NG tube was unable to be sited and no obvious clinical review in response to the EWS scores had occurred, there is no evidence of escalation by the nursing staff either through the nursing hierarchy or the medical hierarchy. 4. The Trust's Serious Incident Review to identify the root causes of the incident raises the following concerns concerning the adequacy of the Trust's investigation and measures taken: a. NG tube not sited - the Trust's response does not address why there was a failure of escalation or referral back to the requesting teams and the updated action plan that "training on insertion should shorten time taken to decompress" is inadequate; b. that the EWS score mandated review by the acute care team (whoever that may

	be for these purposes-see first point), there is no evidence in the medical records apart from a blood gas that any such review took place or that any treatment occurred; c. the investigating consultant had informal conversations during the investigation with a middle grade doctor who had performed the arterial blood gas but was unable to state who this was, why no medical records were created and why no action was taken d. the report states that there was a "*correct escalation of the EWS at every stage*" for which no evidence has been provided and appears to be factually incorrect e. medical records created by the surgical registrar were in accurate as they were completed by a junior doctor and not checked f. that no audit has taken place to ascertain whether the Trust's measures have had the appropriate effect.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report before **Friday, 28 May 2021**. The period for your response has been extended due to the Covid 19 pandemic. 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, namely East Lancashire Hospitals NHS Trust Medical Director and Legal Services Department and Gillian McKinlay's family I have also sent it to the Care Quality Commission 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	Dated  Signature for **Lancashire & Blackburn with Darwen**