	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], CEO MHRA via [redacted]
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** The inquest into Sybil Morgan-Gray's death was opened on 22 August 2023 and concluded on 2 May 2025. I reached a narrative conclusion that her death was caused by recognised complications of a necessary surgical procedure
4	**CIRCUMSTANCES OF THE DEATH** Ms Morgan-Gray was admitted to hospital when concerns were raised regarding the vascular supply in her lower limbs. She underwent surgical procedures to address this. However, she was later admitted to Intensive Care after developing Stercoral Colitis, for which she required a total colectomy. She had previously been diagnosed with diabetes mellitus and suffered episodes of hypoglycaemia whilst in hospital. She was noted to have suffered another episode of hypoglycaemia on 24 April 2022, which was addressed. However, she did not have further blood glucose results analysed until after 3am the next morning (despite entries in the records, which were seemingly falsified). Two results were obtained via blood gas analysis within minutes of each other. Both showed an unrecordably low glucose but subsequent action was not taken, based on these results. I heard evidence that most medical staff are aware that blood gas analysers show an unrecordably low glucose as '- - -↓' but that this can be interpreted as meaning that the sample was not analysable. Ms Morgan-Gray's hypoglycaemia was not recognised for several hours, by which time she had suffered a consequential brain injury. This condition contributed to her death but the direct cause was an infection arising from her earlier abdominal surgery. She died on 15 May 2022.
5	**<u>CORONER'S CONCERNS</u>** During the course of this 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** following the inquest into Ms Morgan-Gray's death were as follows: 1. A concern regarding the interpretation of blood gas machine readings. Specifically, when blood glucose levels are unrecordably low, the machines report this as '- - -↓'. This display can be misinterpreted as indicating the sample is unanalysable, rather than accurately reflecting an extremely low glucose level. This misinterpretation could lead to delayed or inappropriate clinical responses, potentially resulting in future deaths. It was unclear why the results are not recorded as 'Low' or similar. As the regulator of medical devices, I made the decision to write this report to you, rather than an individual manufacturer, as I believe you have the power to direct all manufacturers of such devices to ensure they provide clear and easily interpretable results.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee 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 31 June 2025. 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, Ms Morgan-Gray's family, the hospital Trust and the CQC. 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. She may send a copy of this report to any person who she 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	7 May 2025  **Assistant Coroner R Brittain**