REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England**
1	**CORONER** I am Miss Sarah Middleton, Assistant Coroner, for the Coroner Area of Northumberland.
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 2nd July 2025 an investigation was commenced into the death of Ellen Victoria Floyd Taylor aged 69 years. The investigation concluded at the end of the inquest on 29th January 2026. The narrative conclusion of the inquest was: Ms Taylor died from acute peritonitis, an infection that occurred due to her small intestine being perforated by the insertion of a nasogastric tube. Although the nasogastric tube was inserted appropriately the lack of knowledge of her altered anatomy and her previous surgery meant a perforation was not recognised until the peritonitis had developed.
4	**CIRCUMSTANCES OF THE DEATH** Ellen Victoria Floyd Taylor, aged 69 years, had previously undergone gastric bypass surgery and as a result her oesophagus was attached to her small bowel. She had a history of strokes and was admitted to Northumbria Specialist Emergency Care Hospital on 25th June 2025 where she was found to have suffered another stroke. The fact that she has previous gastric surgery was not known by the treating professionals. A nasogastric feeding tube was inserted on 25th June 2025 as there was a clinical need for this. Over the next few days Ms Floyd Taylor suffered abdominal pain. A CT scan of her abdomen on 29th June 2025 showed the nasogastric tube had perforated her small intestine. This was due to her altered anatomy from the previous bypass surgery. The nasogastric tube could not be placed in her stomach and over the days she has had it inserted it has caused the perforation. Due to the perforation acute peritonitis had developed. She was not a candidate for surgery and so was

	managed conservatively and died on 1st July 2025 at Northumbria Specialist Emergency Care Hospital, Northumbria Way, Cramlington, Northumberland.
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) Ms Taylor underwent gastric/bariatric surgery in 2009. As a result of this her oesophagus was not attached to her stomach but instead attached to her small bowel. On 25th June 2025 she was admitted to hospital having suffered a stroke and was deemed to require a nasogastric tube. The fact that she has previous surgery and her anatomy was therefore altered was not obvious from her notes. As such when complications began this was not something that was considered and investigations about potential perforation were not undertaken initially. (2) I heard evidence that the time there were no guidelines about insertion of nasogastric tubes in circumstances where someone had had previous gastric surgery. The Northumbria Healthcare NHS Foundation Trust identified areas of learning as a result of the circumstances of Ms Taylor's death. The key finding from the After Action Review was that the previous gastric surgery was not recognised at the time of the nasogastric tube insertion. Previous surgery was not a routine consideration and not included within the nasogastric tube guideline. Local guidelines have now changed and consultation with on-call surgical team for guidance about insertion of the tube in these circumstances is now included in the process. Training has taken place and a clinical safety message circulated to increase awareness. Whilst the local NHS Traut have taken and implemented these steps my concern is that there is a wider risk, and these are circumstances that are relevant to every NHS trust nationally and there is a risk future deaths will occur unless action is taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action by ensuring thorough safeguarding reviews take place and all parties are notified of the conclusion and involved fully in the process.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th May 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 following Interested Persons; the family of Ellen Victoria Floyd Taylor, and Northumbria Healthcare NHS Trust. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 9th February 2026** [redacted] Sarah Middleton HM Assistant Coroner for Northumberland