



Department
of Health &
Social Care

*From Maria Caulfield MP
Parliamentary Under Secretary of State
Department of Health and Social Care*

*39 Victoria Street
London
SW1H 0EU*

Jonathan Stevens
Assistant Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Tuesday 29th November 2022

Dear Mr Stevens,

Thank you for your letter of 22 February 2022 about the death of Mr Van Thai Tuyen. I am replying as Minister with responsibility for Health and Secondary Care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Tuyen's death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC).

Since NHS England issued the 2016 Patient safety alert 'Nasogastric tube misplacement: continuing risk of death and severe harm' and accompanying resources, they have worked with partners across the healthcare system to provide additional support for local implementation of this guidance. This includes funding the Royal College of Radiologists to provide eLearning in x-ray interpretation of nasogastric tube placement, working with the British Association for Parenteral and Enteral Nutrition who published an easy reference version of key nasogastric safety checks, and working with the Nursing and Midwifery Council who added nasogastric placement to its core standards of proficiency for registered nurses.

In October 2019, the Healthcare Safety Investigation Branch (HSIB) launched an investigation into nasogastric tubes and how previously identified safety improvements for the placement of these tubes are put into practice. HSIB published their report in December 2020, which included a recommendation that NHS England and the Department of Health and Social Care identify the process by which the NHS can commission necessary research to support improvements in patient safety, including research to confirm nasogastric tube placement. Implementation of the learning and advice from the HSIB report within the health system is ongoing.

To support this, and following an open competition, the Department has awarded £25 million of funding over the next five years via the National Institute for Health and Care Research (NIHR) for research on patient safety to improve the safe delivery of health and care. The funding is for six NIHR Patient Safety Research Collaborations (PSRCs) across England to help improve understanding and resolution of patient safety challenges. The PSRCs will



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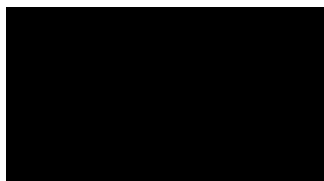
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undertake high-quality translational, applied and health services research on patient safety that addresses strategic patient safety challenges within the health and care system, aligned with NHS England's National Patient Safety Strategic Research Needs 2022/23. Crucially, the PSRCs' work will include research into the reduction of never events.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Kind regards,



MARIA CAULFIELD