NHS Improvement and NHS England
National Medical Directorate
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80 London Road
London SE1 6LH

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

Email: **england.coronersr28@nhs.net**

Dear Mr Stevens,

20th April 2022

Re: Regulation 28 Report to Prevent Future Deaths – Mr Van Thai Tuyen who died on 25 August 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 22 February 2022 concerning the death of Mr Van Thai Tuyen on 25 August 2021.

I would firstly like to express my deep condolences to Mr Tuyen's family.

Following the inquest, you raised concerns in your Report regarding the misplacement of nasogastric tubes to administer fluids or medication.

NHS England and NHS Improvement provided extensive resources alongside the 2016 Alert that support a more unified approach to the prevention of avoidable deaths from nasogastric placement. Local adoption of the national approach is key and we understand that after Mr Tuyen's death, Barts NHS Trust are urgently updating their local policies and staff training to align with the guidance set out in the 2016 Alert and associated resources.

The Resource set can be found here – it is a 54 page document that outlines key areas to support safer initial placement of nasogastric and orogastric tubes including the recommended way for checking placement.

We agree that we need to continue to make efforts to eliminate death from feeding via misplaced nasogastric tubes, and believe the most effective route to improve the safety of patients with nasogastric tubes is the consistent implementation of established safety practices, rather than issue new national guidance.
Our NHS Patient Safety Strategy provides a range of support for Trusts and other healthcare providers to act on safety-critical issues across their organisation. These include a network of Patient Safety Specialists in every Trust. Between December

2021 and February 2022 we took our network of over 700 Patient Safety Specialists through an exercise to look back at their response to the requirements of the 2016 nasogastric Alert, including checking that their policies and training materials include the nasogastric safety advice in the resource set. We also encouraged Trusts with successful implementation approaches to share their experiences to help others.

Unfortunately we are unable to nationally standardise the groups of staff, that Trusts decide are best placed to develop the skills in the confirmation of initial placement of nasogastric tubes (via x-ray or pH strips), as Trusts will differ in staff groups available across the days and hours of the week. However, we have encouraged the sharing of different local approaches to ensure that only staff with the right skills and assessed competencies undertake these crucial checks.

Since we issued the 2016 Alert, we have worked with partners to provide additional support for local implementation. The Nursing and Midwifery Council has added nasogastric placement within its core standards of proficiency for registered nurses.

The direct link to the relevant section is future-nurse-proficiencies.pdf (nmc.org.uk)

During the early stages of the COVID-19 pandemic we worked with the British Association for Parenteral and Enteral Nutrition who published easy reference versions of key nasogastric safety checks.

We have funded the Royal College of Radiologists to provide an eLearning course in x-ray interpretation of nasogastric tube placement that will be completed during 2022.

The Department of Health and Social Care, via the National Institute for Healthcare Research, is commissioning Patient Safety Research Collaborations and we have emphasised the need for research into new technical solutions for all Never Events, alongside research to help us further improve the culture and systems within healthcare providers that support adoption of national safety advice.

We hope this information provides reassurance to you and Mr Tuyen's family that our teams, and many other national bodies and professional organisations, continue to work to reduce the risk of this reoccurring.

Thank you for bringing this important patient safety issue to my attention and please do not hesitate to contact me should you need any further information.

Yours Sincerely,

[redacted]

Medical Director for Professional Leadership and Medical Workforce
NHS England & NHS Improvement
[redacted]