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[redacted]

Chief Medical Officer
[redacted]

www.bartshealth.nhs.uk

Date: 12th April 2022

Private & Confidential
Mr Jonathon Stevens
Assistant Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

Dear Mr Stevens,

RE: Regulation 28 Prevention of Future Deaths Report

I write in response to your Regulation 28: Report to Prevent Future Deaths, dated 22nd February 2022. Your concern was related to Mr Van Thai Tuyen, whose death was a consequence of a failure to identify that a nasogastric tube (NGT) had been misplaced before commencing feeding.

The specific concerns that you raised at inquest were:

1. Using a misplaced nasogastric tube is recognised as a 'never event', namely an event which is wholly preventable and should never happen
2. The court heard evidence at the inquest that an NHS Improvement patient safety alert issued in 2016 identified that between 2011-2016 there had been 95 incidents of misplaced nasogastric tubes used to administer fluids or medication, 32 of which resulted in death
3. The court heard that there had been Barts NHS Trust had had at least 7 incidents relating to misplaced nasogastric tube since 2012
4. The court heard that the use of misplaced nasogastric tubes to administer liquids or medication continues to take place in Trusts across the country
5. The court heard that there is no unified approach to address the on-going issue of avoidable deaths caused by using misplaced nasogastric tubes

As noted within your report, this is a national matter of concerns but the trust is in a position to take action to prevent future deaths of patients within tour care. I would like to take this opportunity to provide an update on the steps Barts Health NHS Trust has taken locally.

Policy Updates

The Nasogastric and Orogastric tube policy is under review; it is currently in draft and the consultation on it is in finalisation. For information, the national guidelines from NHS Improvement are being considered as part of this review. The NHS Improvement national guidelines for nasogastric and orogastric tubes clarify and expand on the issues related to oro/nasogastric tube Never events and provide direction for organisations in the NHS. The policy review will also include an e-learning module to increase the frequency of training for all staff and a competency framework.

This project is being led by the trusts Director of Quality Governance and will be implemented at all the hospitals across the trust. The policy is due for presentation for finalisation at our Policy Committee on the 30th May 2022.

Safety Check Documentation

The safety checks for completion prior to use are completed electronically on the patients electronic records. The trust started rolling out electronic record keeping in in 2019 and as part of this progressive project, the safety check documentation moved from paper to the electronic records. Whilst there were no omissions in the documentation for this gentleman as part of our work to reduce the risk of harm from misplaced NGT's, we have updated the posters that are displayed on our wards detailing the checking process to ensure it aligns with up to date practice both for completing the checks and for documenting them. These posters are available for display at adult bed where an NGT is or may be used.

Thank you for bringing your concerns to my attention. I trust that you are assured that I have taken them seriously. I am very happy to discuss or clarify any of the above points.

Yours sincerely

[redacted]

[redacted] – Deputy Chief Medical Officer
On Behalf Of:
[redacted] - Chief Medical Officer