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Surrey HM Coroner's Court
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National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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[redacted] [redacted]

27 December 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Reginald Edwin Bourn who died on 24 February 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 August 2023 concerning the death of Reginald Edwin Bourn on 24 February 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Reginald's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Reginald's care have been listened to and reflected upon.

In your Report, some of your concerns related to the lack of instructions, national guidance, and protocols/training on the insertion of nasogastric decompression tubes. I will address these within the realms of NHS England's statutory powers, roles and responsibilities. Where I am unable to assist, I hope to provide you with some direction on either where such information can be obtained or from what organisation.

Whilst NHS England would not routinely provide national guidance on the insertion of nasogastric decompression tubes, there is existing national guidance in the form of the Royal Marsden Manual, who have particular expertise in this area. The manual has a section on 'Insertion of a nasogastric drainage tube' which contains background information and specific procedural guidance for the insertion and removal of these tubes, including around pH testing. This is aimed at clinical nursing staff who would routinely be the staff responsible for placing nasogastric tubes in patients. The Manual is a well-known guide for nurses to deliver clinically effective, patient-focused, and evidence-based care.

You raised concern about some nasogastric tubes having product instructions and others not. Product instructions for the use of nasogastric decompression/drainage tubes would not sit within the remit of NHS England. The Coroner may wish to refer this concern to the Medicines and Healthcare products Regulatory Agency (MHRA) as they would be the organisation responsible for issuing the relevant instructions. NHS England will be happy to support the MHRA with the dissemination of any new instructions/guidance to relevant healthcare professionals.

In your Report, you also raised the concern that a Healthcare Safety Investigation Branch independent report 12019/006 found that the use of pH strips is potentially unreliable and incorrect X-ray confirmation and interpretation is the most common

cause of nasogastric tube misplacement incidents. It recommended national standardised competency-based training for nasogastric tube placement and confirmation by pH testing.

The National Institute of Health and Care Excellence (NICE) are the statutory body who lead on developing and disseminating clinical guidance and I note that you have also sent your Report to them. NHS England will carefully consider NICE's response to you and any actions that may be required from us as a result.

As to national training provisions around insertion of nasogastric tubes, I asked my colleagues from the national Workforce, Training and Education (WTE) Directorate at NHS England to consider your Report and the concerns raised. They advised that such a training programme would not come under NHS England's remit. Individual NHS Trusts are responsible for the implementation of locally recommended practice and protocols, including the staffing and availability of workforce. You may wish to engage with Frimley Health NHS Foundation Trust for further information on their specific practice and protocols regarding placement of nasogastric tubes.

What is clear from your Report is that there does appear to be some inconsistency of understanding and awareness around instructions or guidance on the insertion of nasogastric decompression tubes. Considering this, NHS England has asked regional colleagues to ensure that they raise awareness of what happened in Reginald's care, the concerns raised in your Repot and the learnings with their regional Integrated Care Boards (ICBs). ICBs are responsible for planning and commissioning health services for their local populations and will be able to engage with their respective local NHS Trusts and NHS providers on this matter to ensure that there is understanding of guidance and information available.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

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

Yours sincerely,

[redacted]
National Medical Director