	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive, Health Education England** **2. [redacted], Chief Executive, National Institute for Health and Care Excellence**
1	**CORONER** I am Caroline Topping assistant coroner, for the coroner area of Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An inquest into the death of Mr Reginald Edwin Bourn was opened on the 12th May 2022 and on the 19th June 2023. The inquest was concluded on the 27th June 2023. Reginald Bourn died at Frimley Park Hospital on the 24th February 2022. The cause of death was: I a Aspiration of Gastrointestinal Content I b Small Bowel Obstruction caused by either a Peritoneal Adhesion or Incarceration of an Inguinal Hernia (Resolved) The narrative conclusion was: Reginald Bourn was admitted to Frimley Park Hospital with acute abdominal pain and a distended stomach. Investigations revealed prominent small bowel loops but no transition point. He began to vomit. He was treated conservatively, and a nasogastric tube was used to decompress his stomach. On the 24th February 2022 the tube had fallen out by 4.30 by which time he no longer felt nauseous. He began to vomit again, and staff were advised to reinsert the nasogastric tube at 7.02. He was seen at a surgical ward round at 9.45 by which time the tube had not been reinserted. The plan remained for conservative treatment and decompression with a nasogastric tube. He was admitted to a surgical ward with a NEWS score of 3 at 10.20. Insertion of the nasogastric tube was effected by 11.40. The tube was misplaced into his left lung. Prior to 12.00 he suffered an acute event resulting in the aspiration of one and a half litres of stomach content into his lungs. His condition significantly worsened, his

	NEWS score was 10 and his blood oxygen level deteriorated to 88%. He died from the aspiration of gastrointestinal content. The misplacement of the nasogastric tube more than minimally contributed to the death. Misplacement of nasogastric tubes into the lungs is a known complication of a necessary medical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bourn had an intestinal blockage on admission to hospital which required the placement of a nasogastric draining tube to decompress his stomach. The first tube came out and a second one was placed by an experienced nurse. Shortly thereafter he suffered an acute event and aspirated one and a half litres of gastrointestinal content into his left lung. A chest X ray was taken. He died shortly thereafter. When read the X ray revealed that the tube had been misplaced in the left lung. He died as a consequence of the aspiration of gastrointestinal content which was in part attributable to the fact that the misplaced tube enabled ingress to the lung of the aspirate, and in part because the stomach content had not been drained.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. The expert and clinical evidence was that the insertion of any nasogastric tube is complicated and misplacement into a lung can occur because of the proximity of the trachea to the oesophagus. 2. Examples of nasogastric decompression tubes and nasogastric feeding tubes were provided in evidence. The feeding tubes have instructions both as to how to insert them and as to how to ensure that they are correctly placed. The decompression tubes have neither. 3. The expert evidence was that there is national guidance in relation to the placement of nasogastric feeding tubes but not nasogastric decompression tubes. However, as exemplified by this case, misplacement of either can prove fatal. 4. The clinicians who investigated the death could not find any nationally recognised protocols dealing with the use of, and training on the insertion of, nasogastric decompression tubes nor for checking whether they are appropriately placed. 5. The Healthcare Safety Investigation Branch independent report 12019/006 made recommendations in December 2020 on the placement of feeding nasogastric tubes. It found that the use of pH strips is potentially unreliable and incorrect X ray confirmation and interpretation is the most common cause of misplacement incidents.

	6. One of the recommendations made was for a national standardised competency-based training programme for nasogastric tube placement and confirmation by pH testing. 7. It appears that there is no suggested training nor national guidance in relation the placement of nasogastric decompression tubes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you[AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd October 2023. 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: Mr Bourn's Family Frimley Park Hospital I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful 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 usefulor of interest. You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response.
9	**Caroline Topping, 8th August 2023**