05 March 2025

[redacted]
Chief Executive Officer
Oxford University Hospitals
NHS Foundation Trust
Trust Headquarters, Level 3
John Radcliffe Hospital
Headley Way
Oxford OX3 9DU

Your ref: [redacted]

Mr Michael Walsh

HM Assistant Coroner for Oxfordshire

Sent via email only to: [redacted]

Dear Mr Walsh

Regulation 28 Report/Prevention of Future Deaths

Inquest into the Death of Mr David Vincent Tighe

Following the death of Mr David Vincent Tighe, and subsequent inquest hearing from Wednesday 11 December - Friday 13 December 2024 and Monday 16 December – Wednesday 18 December 2024, I write as CEO of Oxford University Hospitals NHS Foundation Trust (OUH), to provide a response to your Regulation 28 Report dated 9 January 2025.

I would like to start by expressing to Mr Tighe's family how sorry I am for their loss.

Mr Tighe had been diagnosed with adenocarcinoma of the gastro-oesophageal junction in November 2022. He commenced chemotherapy treatment with a life expectancy of at least a year, and subsequently suffered chemotherapy-induced enterocolitis, which was a known complication of his treatment and related symptoms requiring admission to the Oncology Ward, Churchill Hospital on 2 February 2023.

You recorded a narrative conclusion on 18 December 2024 as follows: "David (Tighe) died due to complications of treatment for chemotherapy-induced enterocolitis; contributed to by Neglect."

The medical cause of death was confirmed after hearing evidence from OUH clinicians and external nursing expert by you to be:

1a Sepsis due to Bronchopneumonia
1b Enterocolitis with Paralytic Ileus
1c Metastatic Adenocarcinoma of Oesophagus treated with Chemotherapy
2) Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease

In your conclusion you set out two areas of concern, and for each I can provide the following additional information:

1. **Absence of a Ryles Tube Policy**

There is no nationally recognised policy for wide bore nasogastric (Ryles) tubes for aspiration drainage. The existing OUH policy is for nasogastric (NG) tubes when used for feeding. Current practice for insertion of a wide bore tube is based on the Royal Marsden manual of clinical and cancer nursing procedures. Only one of the 9 similar Trusts who we approached has a policy which is virtually identical to the Royal Marsden manual.

The Oncology Matron has set up a working group to review current practice, evaluate external resources and produce a Trust wide policy. The policy will set out the Trust standards for managing patients with Ryles Tubes for aspiration drainage. The working group includes nursing and medical staff across the organisation including anaesthetics, surgery, oncology and gastroenterology representatives. The first meeting was held on 3 February 2025. The policy will be presented to the OUH Clinical Policy Group by April 2025 and a Trust wide safety message will be communicated to all staff which will include the link to this policy. The publication of the policy will be followed by training of the appropriate staff through ward-based learning delivered by clinical educators.

2. **Use of a narrowly focussed Structured Review by a treating clinician**

The Trust has a robust process for training clinicians in performing Structured Judgement Reviews (SJRs). The training highlights the need to review the whole case record including the nursing records. It directs the reviewer to contact any individual or team if there are concerns about the quality of care provided. There is no limit put on the length of time to undertake an SJR. Over 230 clinicians within OUH have been trained to date.

Since this case we have strengthened our mortality review processes in two ways. Firstly, we have formalised the process for feeding back family concerns to the clinical team and incorporating these into the mortality review. The Medical Examiner Officers speak to every bereaved family of a patient who dies in OUH and feed back, in a structured format, any concerns from the family about the care of the deceased. This feedback is directed to the Divisional governance team and responsible clinical team who must then address this within the mortality review.

Secondly, we have modified the SJR template to ask the author if they have any concerns about the scope or focus of the review, giving them an explicit opportunity to raise any concerns which can then be addressed proactively by the Trust through providing additional support. Prior to completing the review, the reviewer will also be asked to confirm whether they have any conflict of interest such as having been involved in the care of the patient. This will provide stronger assurance that all reviews investigate deaths without restriction in scope, time pressure or appearance of conflict or bias.

In addition to the actions above, the learning from this case will be presented on 5 March at Oncology Clinical Governance meeting and will also be presented at the OUH Clinical Governance Committee and the OUH Mortality Review Group over the next 2 months.

I hope that this response will reassure you that we have taken your concerns very seriously and implemented appropriate actions following this inquest.

Yours sincerely

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[redacted]

Chief Executive Officer
Oxford University Hospitals NHS Foundation Trust