THE OXFORDSHIRE CORONER'S COURT

IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF

DAVID VINCENT TIGHE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Oxford University Hospitals NHS Foundation Trust
1	**CORONER** I am Michael Walsh, HM Assistant Coroner, for the coroner area of Oxfordshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** The inquest into the death of Mr David Vincent Tighe, aged 59, was opened on 26th April 2023. The investigation concluded at the end of the inquest on 20th December 2024. The medical cause of death was: Ia Sepsis due to Bronchopneumonia Ib Enterocolitis with Paralytic Ileus Ic Metastatic Adenocarcinoma of Oesophagus Treated with Chemotherapy II Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease The Narrative conclusion to the inquest was: David died due to complications of treatment for chemotherapy-induced enterocolitis; contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** David was a 59-year-old man who had been diagnosed with adenocarcinoma of the gastro-oesophageal junction in November 2022. With chemotherapy treatment his prognosis was at least a year, and he was being treated with the intention of prolonging his life. He subsequently suffered chemotherapy-induced enterocolitis, which was a known complication of his treatment, and related symptoms required his admission to Churchill hospital on 02.02.2023. During treatment in hospital, David suffered three instances of aspiration of bile into his lungs when he was laid flat, that should have been avoided. The Ryles tube being used to drain bile from his stomach, and the amount of bile being drained, were insufficiently monitored, and the Ryles tube became displaced following an episode of vomiting, on 08.02.2023, causing ineffective and/or partial drainage over

	several hours. He was also noted to have bile in his mouth on the morning of 09.02.2023. There was no discrete policy in place for the management of Ryles tubes, and no repeat position check forms were used, although they were said to exist. Had displacement been recognised in a timely manner and/or had the presence of bile in David's mouth been escalated in a timely manner, all events of aspiration should have been avoided, by virtue of the Ryles tube being repositioned or replaced to provide effective drainage; and/or by virtue of advice being given not to lay David flat, or to do so with particular caution. Instead, no particular caution was taken when laying David flat and he suffered aspiration which contributed in a more than minimal way to bronchopneumonia and sepsis from which David died on 11.02.2023.
5	**CORONER'S CONCERNS** 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. – **Concerns directed to Oxford University Hospitals NHS Foundation Trust** CONCERNS Absence of a Ryles tube policy: 1. At the time of David's death there was no separate policy for Ryles tubes, and clinicians were required to apply the modest Royal Marsden Manual guidance, and/or note that the practice consideration and care requirements for Ryles tubes were not dissimilar to that for nasogastric tubes used for enteral administration, as per the Trust's "*Insertion, Use and Care of Nasogastric Feeding Tubes in Adults: Policy and Procedure*", October 2018 ('NG feeding tube policy'), which provided limited advice. Evidence was given that a Ryles tube policy was required and that there was motivation at the Trust to provide one, albeit none has been forthcoming in the 20 months since David's death. Evidence was also given that an NG tube "Position Record" for recording "Repeat Position Checks" was in use for Ryles tubes (similar to the "*Nasogastric Feeding Tubes Position Record - Repeat Position Checks*" document at Appendix 11 / page 53 of 55 of the Trust's NG feeding tube policy), but several staff were unaware of such a document existing for Ryles tubes, and no such Ryles Tubes records were ever disclosed. Expert evidence was given that it was suboptimal care not to have a specific policy for the management of Ryles tubes given the risks associated with such an invasive procedure that required ongoing monitoring. At the time of the inquest, the Trust's expressed intention was to provide a Ryles tube policy, and assistance was said to have been requested from the Shelford Group (an external body), although conversations about such a policy were said to have started within the Trust itself, as early as April or May of 2023. It is therefore unclear whether a Ryles tube policy would ever be produced notwithstanding one appears to be accepted as being required. The absence of policy where a need has been identified creates an obvious risk of death to future patients, due to the absence of guidance and procedure to assist clinicians undertaking such an invasive procedure. Use of a narrowly focussed structured review by a treating clinician: 2. On 18.03.2023 the Trust undertook a Structured Review to consider learning from David's death. Evidence was given that the Structured Review was intended to be narrow in focus, as opposed to a more comprehensive serious incident report. As a result, it did not involve taking information from staff, but was a 2-hour review of the

	medical records across five different areas, undertaken in a highly pressured environment. The Structured Review consequently overlooked considering several issues including: (i) missing bile drainage entries. (ii) missing clinical observations contrary to Trust policy ("*Recognising the Acutely Ill and Deteriorating Adult Patient (RAID) Policy*, April 2021). (iii) the absence of Repeat Position Checks for the Ryles tube. (iv) the absence of any written record of family concerns that were raised with a ward sister. Evidence was given by an author of the Structured Review that he considered its scope was in fact too limited, and in future, he would advise suspending such a narrow review. That author was also a clinician involved with David's care in spite of the potential for conflict being correctly raised with the Trust in advance. Any inability to adequately investigate such incidents, without undue restriction in scope, without time pressure, and without any appearance of conflict or bias, creates a risk of death to future patients, as oversights or omissions in care, policy or procedure that may be missed by a narrow review, may remain unidentified and unremedied.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action in relation to the concerns above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th March 2025. 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: 1. David's family 2. Oxford University Hospitals NHS Foundation Trust I am also under a duty to send the Chief Coroner a copy of your response. 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 useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**9th January 2025**  **Michael Walsh** HM Assistant Coroner Oxfordshire Coroner's Court