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Dartford and Gravesham
NHS Trust

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THIS RESPONSE IS BEING SENT TO:

Jyoti Gill, Assistant Coroner for Kent and Medway in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an inquest into the death of Thomas FENNEY that concluded on 28 May 2026.

1. RESPONDENT

In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, Dartford & Gravesham NHS Trust provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.

2. DATE OF RESPONSE

1 October 2026.

3. CONFIRMATION OF CORONER'S MATTERS OF CONCERN

The **MATTERS OF CONCERN** were identified in the report are as follows:

There is concern that Mr Fenney's previous gastric-bypass surgery was not consistently documented or recognised, resulting in feeding decisions being made without full consideration of his altered gastrointestinal anatomy. This highlights a wider risk that other trusts may also lack robust systems to ensure significant surgical history is clearly flagged for multidisciplinary review. In addition, the current NG Care Bundle contains no guidance for patients with prior gastric surgery, creating uncertainty for clinicians regarding whether nasogastric or nasojejunal feeding is the safer and more appropriate route. The PSII noted that gastric surgery may be an indication for NJ tube feeding but is not a contraindication for NG feeding, and that there is insufficient literature to guide decision making. This absence of national guidance may lead to inappropriate feeding decisions in similar cases.

A further concern relates to the management of malpositioned NG tubes identified on portable chest X-rays. Evidence confirmed that when malposition is detected on X-rays performed within the radiology department, tubes are removed immediately and clinical teams are notified, preventing unsafe use.

However, this safeguard does not exist for portable imaging, as demonstrated in Mr Fenney's case where an NG tube reported as "unsafe to use for feeding" was not removed promptly. This creates a systemic risk of continued unsafe feeding and potential aspiration, particularly in vulnerable patients.

Taken together, these issues indicate potential national variation in documentation practices, feeding-route decision making for patients with prior gastric surgery, and safety procedures for NG tube management following portable imaging.

4. DETAILS OF ACTION TAKEN

The Trust has carefully reviewed the concerns raised and undertaken a multidisciplinary review involving Radiology, Patient Safety, Nursing and Medical teams. We acknowledge the concern that, whilst there is a robust safeguard in place when patients attend the main Radiology Department for NG tube position confirmation, there is potential for delay in removal of an unsafe tube following portable ward-based imaging if communication and escalation processes are not consistently followed.

Existing Process

The Trust's current Standard Operating Procedure for CXR following placement of NG tube (RAD035 Adult Nasogastric Tube SOP) was published March 2025, and is due for review March 2027. It is easily available on the Trust's intranet.

It includes the following specific to portable CXR:

- All portable CXR's must be annotated with the radiographic position and time of imaging. On return to the department, the examination should be processed to allow formal reporting. The Radiographer should inform the Duty Radiologist or a Chest Reporting Radiographer that an CXR for review of positioning of an NG tube has been performed.
- Approved NG tubes which are not in the correct position must be flagged in the final report as ***URGENT*** by the reporter and highlighted as a critical finding on SECTRA.
- A formal radiology report is issued within 2 hours documenting that the tube is unsafe for use.
- The clinical ward is contacted immediately by telephone to ensure prompt awareness of the findings.
- The clinical team is informed that the tube should not be used and should be removed or re-sited before any feed, fluids or medications are administered.
- The name of the individual receiving the communication and the time of the communication are documented within the radiology reporting system (SECTRA), either within the report itself or as an addendum.

The SOP also makes clear that the NG tube must not be used until a formal radiology report has been issued.

This process differs from that used when patients attend the main Radiology Department. In those circumstances, where an NG tube is identified as unsafe, the tube will ordinarily be removed or repositioned before the patient returns to the ward. This is possible because the patient remains under the direct care of the Radiology Department at the time the imaging findings are identified, allowing the risk to be controlled immediately at source.

For portable examinations performed on inpatient wards, the patient remains under the care of the treating clinical team and Radiology does not have the same direct governance or physical control of

the patient or tube once the image has been acquired. Consequently, responsibility for removal or repositioning of the tube rests with the clinical team, supported by timely communication of the radiological findings.

Review and Learning

Following the incident that gave rise to this Prevention of Future Deaths Report, the Trust has reviewed compliance with the existing SOP and identified the need to strengthen assurance that communication and escalation processes are consistently followed and clearly documented.
The Trust notes that the current reporting workflow was previously reviewed when consideration was given to becoming an early adopter site for the Royal College of Radiologists (RCR) and GIRFT nasogastric tube pathway. That review concluded that the Trust's established process provided a robust alternative model, with formal radiology reporting during core hours and separate established arrangements for intensive care and high dependency areas outside of core hours.
However, we recognise that even a robust process depends upon reliable communication, documentation and prompt action by all involved teams.

Actions taken

In response to the Coroner's concerns, the Trust has undertaken the following actions:

1. **Reinforcement of the Existing SOP**

    - The requirements for urgent verbal communication of unsafe NG tube findings have been re-emphasised with all radiology reporting staff.
    - Staff have been reminded of the requirement to document the recipient and timing of all communications within the radiology reporting system.

2. **Clarification of Clinical Responsibilities**

    - Clinical areas have been reminded that responsibility for removing or repositioning an NG tube following portable imaging rests with the responsible clinical team once the radiology findings have been communicated.
    - Further guidance has been provided regarding the prohibition on using a tube until radiological confirmation of safe positioning has been obtained.

3. **Audit and Compliance Monitoring**

    - The Radiology Reporting Lead has commenced an audit of compliance with the SOP.

    - The audit will review a number of components of the pathway, including:

        - Verification and reporting processes.
        - Use of urgent communication flags.
        - Documentation of verbal communications.
        - Use of standardised reporting text.
        - Timeliness of reporting and escalation.
        - Differences in practice between departmental and portable imaging pathways.

    - Findings from this audit will be reviewed through the Trust's governance framework and any additional actions identified will be implemented.

Organisational Learning

- Learning from this incident has been shared through relevant governance and patient safety forums. The case was discussed on the Trust Wide Learning from Deaths Group on 25th August, 2026, and at the Patient Safety Group on 7th September 2026.

- Ongoing monitoring will be undertaken to ensure compliance with the SOP and to provide assurance that unsafe NG tubes identified on portable imaging are escalated appropriately and acted upon without delay.

5. CONCLUSION

The Trust acknowledges the concerns raised by the Coroner and is committed to learning from the circumstances identified during the inquest. The Trust believes that its existing SOP contains appropriate safeguards for the management of poorly positioned NG tubes identified on portable imaging. However, this case has highlighted the importance of ensuring that communication, documentation and escalation requirements are adhered to consistently.

The actions described above are intended to strengthen assurance around compliance with the established process and reduce the risk of any recurrence.

The Trust remains committed to learning from this incident and continually improving patient safety systems.

Yours sincerely

[redacted]

Interim Chief Executive Officer
Dartford & Gravesham NHS Trust