REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1. CORONER

I am Jyoti Gill, Assistant Coroner for Kent and Medway.

2. DATE OF REPORT

3 August 2026

3. 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.

3. THIS REPORT IS BEING SENT TO

1. Chief Exceutive of Darent Valley Hospital

2. NHS England

You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 September 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary

5. SUMMARY OF CORONER'S CONCERN

There are concerns that Mr Fenney's previous gastric bypass surgery was not clearly or consistently documented, meaning this important history was not considered when feeding was initiated; that the NG Care Bundle provides no guidance for patients with prior gastric surgery, creating uncertainty about whether Nasogastric (NG) or Nasojejunal (NJ) feeding is safest; and that although malpositioned NG tubes are removed immediately when identified on X-rays performed in the radiology department, this safeguard does not exist for portable chest X-rays, as seen in Mr Fenney's case where the tube was not removed despite being reported as unsafe. Together, these issues highlight wider risks that other trusts may also lack clear documentation systems, specific feeding guidance for post-gastric surgery patients, and robust procedures to ensure prompt removal of unsafe NG tubes identified on portable imaging.

6. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

7. INVESTIGATION and INQUEST

On 25 June 2025 I commenced an investigation into the death of Thomas FENNEY, aged 77 Years.

The investigation concluded at the end of the inquest on 28 May 2026**.** The conclusion of the inquest was that Mr Fenney died as a result of post stroke complications causing aspiration pneumonia on the background of a recent discharge from hospital following surgery which required the withholding of anticoagulation medication.

Thomas Fenney underwent right sided inguinal hernia repair at Medway hospital on 23 May 2025 and was discharged on 30 May 2025. Mr Fenney was admitted to Darent Valley Hospital on 31 May 2025 following a fall at home with slurred speech and left sided leg and arm weakness. Mr Fenney had several comorbidities. He suffered a large right hemispheric Total Anterior Circulation Ischaemic stroke (TACI) and developed post stroke complications of aspiration pneumonia. Whilst in hospital Mr Fenney developed acute worsening of chronic heart failure, pneumonia, scrotal cellulitis and Type 1 respiratory failure. Mr Fenney was also unable to eat or drink, and a Nasogastric tube was inserted for feeding and administering medications. An X ray on 16 June 2025 revealed that the Nasogastric tube was unsafe for feeding but the radiology report contained a spelling error and a doctor assumed it was safe and so Nasogastric feeding commenced. The report from the radiologist also advised urgent removal of the tube. Unfortunately, Mr Fenney's condition deteriorated on the evening of 16 June 2025, and a decision was made to keep him comfortable. Sadly, Mr Fenney passed away on the 19 June 2025 at Darent Valley Hospital.

1a Aspiration Pneumonia

1b Stroke

1c

1d

II Chronic Kidney Disease, Hypertension, Diabetes Mellitus, Gastric Bypass , Nasogastric Feed

8. CIRCUMSTANCES OF THE DEATH

[Please explain the relevant circumstances of the individual’s death, ideally this should be in no more than 500 words]

Mr Fenney was admitted to Darent Valley Hospital on 31 May 2025 with slurred speech and left-sided weakness, against a background of multiple comorbidities including hypertension, type 2 diabetes, CKD, atrial fibrillation, previous MI and SMV thrombosis. Initial CT imaging was significantly degraded by motion artefact but suggested chronic ischaemic changes, occlusion of the right common and internal carotid arteries, and possible acute-on-chronic infarction, with MRI recommended. He was not eligible for thrombolysis due to apixaban use, was started on aspirin, and an NG tube was inserted due to unsafe swallow. By 1 June, repeat CT confirmed an extensive right MCA territory stroke. He developed a wet cough and was treated for aspiration pneumonia, with antibiotics escalated over subsequent days; he also developed scrotal cellulitis. His respiratory status worsened with periodic apnoeic episodes, pulmonary oedema on CXR, and reduced ejection fraction on echocardiogram. On 13 June he deteriorated into type 1 respiratory failure, prompting a MET call; CTPA showed no pulmonary

embolism but significant cardiac enlargement, bronchial thickening and severe anasarca. Despite further antibiotic changes and respiratory support including Optiflow and later CPAP, his condition continued to decline. A CXR on 16 June showed the NG tube was malpositioned and unsafe for feeding. He developed worsening bilateral consolidation and persistent respiratory failure, leading to escalation to tazocin. With ongoing deterioration, a palliative approach was agreed, and Mr Fenney sadly died on 19 June 2025.

9. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].

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.

10. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:
[please do not use individual's names, but instead roles/titles]

1. Mr Fenney's Family
2. Chief Executive of Darent Valley Hospital
3. NHS England

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026) Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

Signature 

Chief Coroner

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.