NHS
South Warwickshire
NHS Foundation Trust

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PRIVATE AND CONFIDENTIAL
Senior Coroner S McGovern
Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
Warwickshire
CV32 4EL

3 February 2020

Dear Mr McGovern Sean,

Thank you for your Regulation 28 report, dated 19 December 2019, relating to the inquest of Mr Colin Beaumont. I was sorry to read of your outstanding concerns at the conclusion of the inquest and hope that the following information will provide you with further reassurance.

Following receipt of your report, the Trust convened a working group to review and critically reappraise the care and decision-making related to Mr Beaumont. That Group included our Medical Director, Director of Nursing, Head of Governance, Legal Service Co-ordinator, Clinical Nutrition Nursing Team, Consultant Stroke Physician and Matron for Elderly care Directorate. The Group explored, and reflected upon, several points relating to Mr Beaumont's care and I have outlined these below with the conclusions reached by the Group.

Whether the Trust policy for Nasogastric Tube Insertion was appropriate and whether, as a result of this case, it should be amended in any way.

The Group heard that current Trust policy is appropriate and follows recognised best practice. However, as a result of this case, it will be amended to direct that if staff are unable to pass a nasogastric tube on two occasions, or if it is twice passed and then found to be misplaced, a review of alternative options for feeding should take place, together with a further discussion of risks with the patient and/or their family. This policy adaptation will be undertaken by the end of March 2020.

Whether staff training in Nasogastric Insertion is appropriate.

Staff training was not believed to be a factor in the events surrounding Mr Beaumont because the staff involved were all deemed to be competent and had followed current policy. However, our nutritional nursing team have contacted other local Trusts to benchmark our training and found it to be broadly similar. We found one Trust who gave staff access to regular refresher training and we are now exploring the potential for sourcing an e-learning nasogastric tube refresher module with our learning and development team. We hope to source this by the end of July 2020.

Whether, in Mr Beaumont's case, passing a Nasogastric Tube was appropriate.

Interventions of this type are not undertaken lightly as there are recognised associated risks including that of pneumothorax, which Mr Beaumont unfortunately experienced Nasogastric feeding tubes are passed to prevent malnutrition and so help the patient recover from their illness. The inherent mortality risk of malnutrition is balanced against the, often lesser, risks associated with the inserting of a nasogastric tube. In this case Mr Beaumont's difficulty in swallowing was felt to be more likely a result of his infection from pneumonia rather than his stroke and so any feeding tube was likely to be short term in duration. Ensuring that Mr Beaumont had sufficient nutrition would also be essential in allowing him to fight the infection and recover to his previous level of health. In addition, the Group heard that clinical staff had discussions with Mr Beaumont before each insertion and he expressed a wish for the feeding to be attempted.

This discussion did bring up a number of medical, ethical and legal considerations and the Group felt that it would be useful for this discussion to be held with a wider group of Trust staff and so we have committed to discussing the above points at a future 'Grand Round' clinical meeting. Grand Rounds are a formal meeting at which senior clinicians discuss the clinical case of one or more patients. They are an integral component of medical education and highlight clinical problems in medicine by focusing on current or interesting cases and are also sometimes utilised for dissemination of new research information. Mr Beaumont's case will be used to share learning with other consultant colleagues and to allow discussion and debate of the broader principles around balancing clinical risks, communication of those risks with patients and the importance of appropriate, transparent and timely discussion with patients and carers around futility of treatment and withdrawing care. We will schedule this discussion onto the Grand round agenda in the next six months.

Whether staff were suitably trained and competent to undertake the Nasogastric Tube Insertion.

It was confirmed that the two members of staff that inserted the nasogastric tubes were trained and competent to perform that procedure and followed current policy correctly, therefore no further action is proposed related to this point.

In summary, we believe that Mr Beaumont underwent a clinically appropriate procedure performed by trained and competent staff. That procedure carried a small risk that the nasogastric tube could enter the lung which, in turn, carried a very small risk of pneumothorax Mr Beaumont unfortunately experienced that eventuality, and all involved in his care were deeply saddened by his death. Our initial, routine, review of Mr Beaumont's care following his death highlighted no fundamental care management concerns however I am grateful that your report has provided us with a further opportunity to improve our care to patients undergoing nasogastric tube insertion. The further review arising from your regulation 28 report has led to the actions above and I hope that they provide you with the assurance that you had been seeking when considering the regulation 28 report. If, however, having read this letter, you have outstanding concerns, please do not hesitate to contact me.

Yours sincerely

Glen Burley
Chief Executive