	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for the Department Health & Social Care, 39 Victoria Street Westminster, London SW1H 0EU 2. Chief Executive, Barts Health NHS Trust, Whitechapel Road, Whitechapel, London, E1 1FR 3. NHS England London, Skipton House, 80 London Road, London, SE1 6LH
	CORONER I am JONATHAN STEVENS, Assistant Coroner, for the coroner area of Inner North London
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.
3	**INVESTIGATION and INQUEST** On 31st August 2021 Assistant Coroner Stevens commenced an investigation into the death of VAN THAI TUYEN [age 96]. The investigation concluded at the end of the inquest on 2nd February 2022. The conclusion of the inquest was that death was a consequence of neglect namely a failure to identify that a nasogastric tube had been misplaced before commencing feeding. The medical cause of death was: 1 (a) cavitating necrotising pneumonia (b) misplaced nasogastric tube 2. Cerebrovascular disease, hypertension, diabetes mellitus, Parkinson's disease
(b)	**CIRCUMSTANCES OF THE DEATH** Mr Van Thai Tuyen was admitted to the Royal London Hospital on 1st August 2021 for treatment of a stroke. A nasogastric tube was inserted to administer medication and food, due Mr Tuyen being assessed as having an unsafe swallow. Despite an x-ray showing that the nasogastric tube had been misplaced into his right lung the tube was used to administer approximately 300ml of liquid feed. This caused the cavitating necrotising pneumonia from which he died.
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. – (1) Using a misplaced nasogastric tube is recognised as a 'never event', namely an event which is wholly preventable and should never happen. (2) The court heard evidence at the inquest that an NHS improvement patient safety alert issued in 2016 identified that between 2011-2016 there had been 95 incidents of misplaced nasogastric tubes used to administer fluids or medication, 32 of which resulted in death. (3) The court heard that there had been Barts NHS Trust had had at least 7 incidents relating to misplaced nasogastric tube since 2012. (4) The court heard that the use of misplaced nasogastric tubes to administer liquids or medications continues to take place in Trusts across the country (5) The court heard that there is no unified approach to address the on going issue of avoidable deaths caused by using misplaced nasogastric tubes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th April 2022. 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 [redacted], grandchildren of the deceased. I am also under a duty to send the Chief Coroner a copy of your response. I may also send a copy of your response to any other person who I believe may find it useful or of interest 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	**22nd February 2022 SIGNED**