Medicines & Healthcare products Regulatory Agency

DEVICE SAFETY INFORMATION (DSI)

NGPod pH testing device: quarantine and dispose of all devices (DSI/2026/009)

Specialisms: *GI, hepatology and pancreatic disorders, General Surgery, Nutrition and dietetics, Paediatrics and neonatology*

DEVICE DETAILS

NGPod handheld device and NGPod sensor

AFFECTED LOT SERIAL NUMBERS

All

MANUFACTURED BY

NGPod Global Limited

Summary

The NGPod handheld device and NGPod sensor, used to test pH to aid the placement of nasogastric tubes, is being withdrawn from the UK market. The manufacturer has ceased trading in the UK and cannot support continued use of the product. Users should quarantine all remaining stock and dispose of all NGPod devices.

While the cessation of trading is not directly related to a current safety concern, a Field Safety Corrective Action (FSCA) was initiated earlier this year, due to two UK adverse incident reports, including one with a fatal outcome. In these instances, the device provided a green result, indicating contact with acidic pH, suggesting that the nasogastric tube was correctly placed when, in fact, it was found in the lung.

The Field Safety Notice (FSN) provides further details and should be read in conjunction with this Device Safety Information (DSI).

Advice for Healthcare Professionals:

- stop use of the NGPod handheld device and sensor immediately
- identify, quarantine and dispose of all NGPod devices, as the manufacturer is unable to accept device returns

- return the FSN acknowledgement form to the manufacturer
- use alternate pH testing methods to inform placement of nasogastric tubes, in line with local and national guidelines. pH testing methods should be CE-marked and intended by the manufacturer to test human gastric aspirate
- review local stocks of alternative pH testing devices to ensure continuity of care
- report any suspected or actual adverse incidents involving these devices. There are specific reporting arrangements for healthcare professionals to follow in each region

Healthcare professionals should report incidents:

- in England and Wales to the Yellow Card scheme or via the Yellow Card app
- in Scotland to Incident Reporting & Investigation Centre (IRIC) and their local incident recording system
- in Northern Ireland to the Yellow Card website in accordance with your organisations medical device policies and procedures

Advice for Healthcare Professionals to Provide to Patients:

- there is no advice for healthcare professionals to provide to patients regarding this DSI as this DSI requires action by healthcare professionals only

Advice for Distributors:

- identify any NGPod devices within your possession or control
- cease further supply of NGPod devices immediately
- quarantine and dispose of all NGPod devices
- inform customers who may have received affected devices and the actions required

Explanation of identified safety issue

Following assessment of two adverse incident reports received in January 2026, the MHRA requested that NGPod Global initiate a FSCA. In both reports, the NGPod gave a green result, indicating it had detected pH<5.5, suggesting that the nasogastric tube was correctly placed when in fact the tube was located in the lung. One of these adverse incidents had a fatal outcome. Whilst multiple factors are thought to have contributed to this death, we cannot rule out a contributing role of the NGPod result in the clinical decision pathway.

In discussion with the MHRA, the manufacturer had made updates to their instructions for use (IFU) to include contraindications for use in patients with significant aspiration of gastric contents, conditions in which the respiratory tract may contain acidic secretions and situations where clinical assessment indicates radiographic confirmation is required. Other updates were made to the IFU to make it clear that the NGPod system alone does not determine anatomical tube location and does not independently confirm nasogastric tube placement. The MHRA have been informed that NGPod Global has ceased trading as of 20 July 2026.

Therefore, the manufacturer will no longer be able to support continued use of the medical device and has made the decision to recall the product from the market. Without appropriate oversight from the manufacturer, there is a risk of significant patient harm if the device continues to be used.

Reporting advice

Healthcare professionals should report incidents:

- in England and Wales to the Yellow Card website or via the Yellow Card app
- in Scotland to Incident Reporting & Investigation Centre (IRIC) and their local incident recording system
- in Northern Ireland to the Yellow Card website in accordance with your organisations medical device policies and procedures.

Additional information:

You can sign up to receive email updates on alerts and device safety information from the MHRA.

You can sign up to receive our monthly roundup of safety communications.

For any enquiries, please contact info@mhra.gov.uk

Stakeholder engagement:

- British Association for Parenteral and Enteral Nutrition (BAPEN)
- NHS England Patient Safety Team
- Devolved administrations