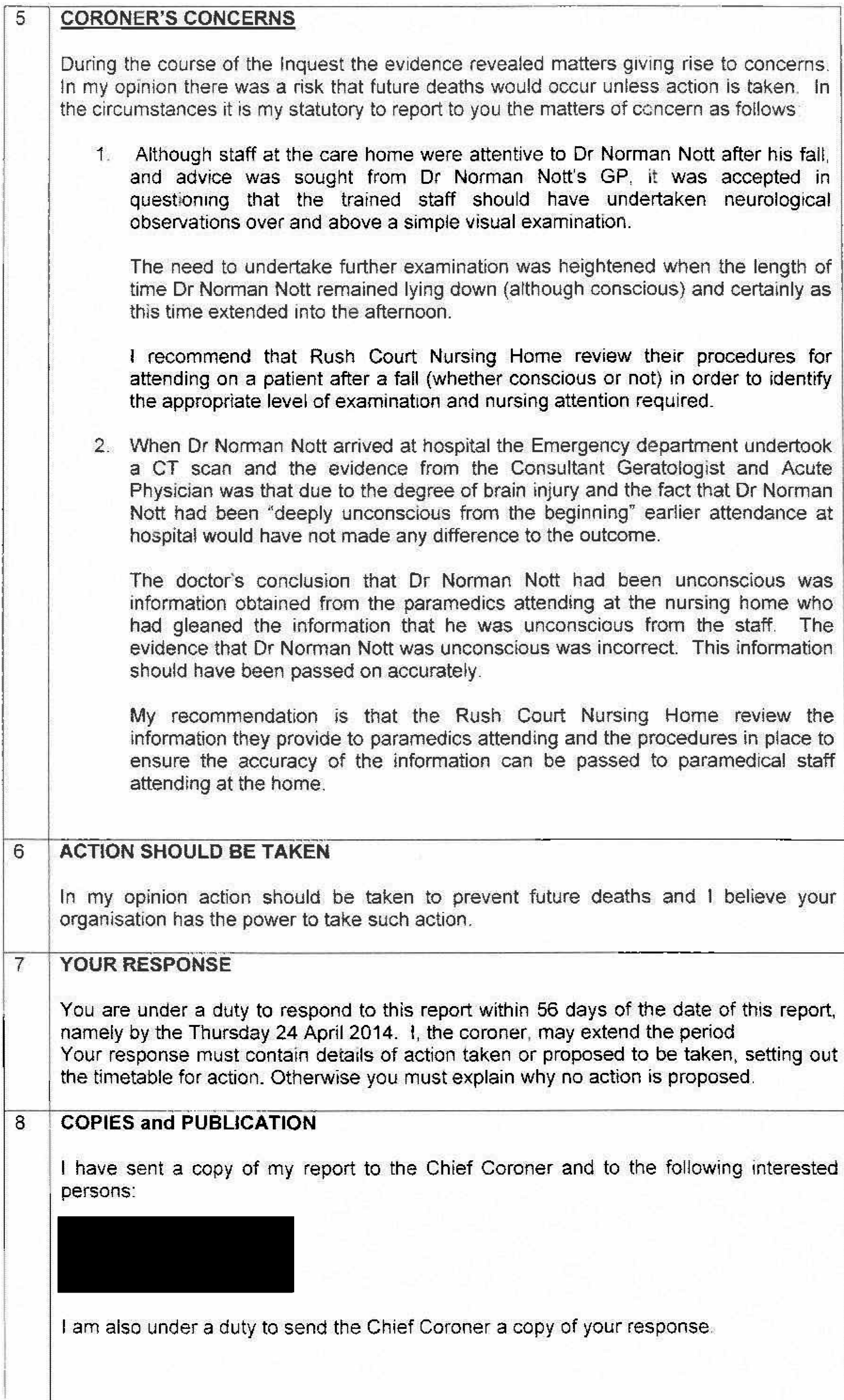
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Inquest into the death of Peter Norman NOTT

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rush Court Nursing Home, Shillingford Road, Wallingford, OXON**
1	**CORONER** I am Nicholas Graham, Assistant Coroner, for the Coroner area of Oxfordshire
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 9 September 2013 an investigation commenced into the death of Peter Norman Nott, who was 75 years old. The investigation concluded at the end of the inquest on 26 February 2014. A short form conclusion of accidental death was recorded. Dr Norman Nott had fallen in his room at Rush Court Nursing Home causing injury to his head. The fall occurred around 10:30 hours but he was not taken to the hospital until 18:57 hours that evening. He succumbed on 8 September 2013. The medical cause of death was recorded as: 1(a) Subdural haemorrhage 1(b) Parkinson's disease
4	**CIRCUMSTANCES OF THE DEATH** 1. Dr Peter Norman Nott had a complex medical history of Parkinson's decease with Shy-Drager syndrome (severe postural hypertension) with Dementia. He was assessed as being at very high risk of falls. 2. Although the nursing home had undertaken detailed assessments to address Dr Norman Nott's propensity for falling, there were numerous incidents of falls at the home. 3. As indicated, on the morning of 2 September 2013 Dr Norman Nott experienced an unwitnessed fall in his room at the nursing home. He was attended by nursing home staff and was conscious. He spent the next two hours lying down (which was not uncommon) until he was hoisted onto the bed where he remained and was nursed and regularly checked. Also the GP was called and suggested that he be closely monitored. 4. At 17:45 hours his condition deteriorated and an ambulance was called which took him to hospital at 18:57 hours 5. The hospital took a CT scan and in view of his condition considered that surgical intervention was futile. 6. He sadly passed away on 8 September 2013 at 20:00 hours.



5 CORONER'S CONCERNS

During the course of the Inquest the evidence revealed matters giving rise to concerns. In my opinion there was a risk that future deaths would occur unless action is taken. In the circumstances it is my statutory to report to you the matters of concern as follows:

1. Although staff at the care home were attentive to Dr Norman Nott after his fall, and advice was sought from Dr Norman Nott's GP, it was accepted in questioning that the trained staff should have undertaken neurological observations over and above a simple visual examination.

   The need to undertake further examination was heightened when the length of time Dr Norman Nott remained lying down (although conscious) and certainly as this time extended into the afternoon.

   I recommend that Rush Court Nursing Home review their procedures for attending on a patient after a fall (whether conscious or not) in order to identify the appropriate level of examination and nursing attention required.

2. When Dr Norman Nott arrived at hospital the Emergency department undertook a CT scan and the evidence from the Consultant Geratologist and Acute Physician was that due to the degree of brain injury and the fact that Dr Norman Nott had been "deeply unconscious from the beginning" earlier attendance at hospital would have not made any difference to the outcome.

   The doctor's conclusion that Dr Norman Nott had been unconscious was information obtained from the paramedics attending at the nursing home who had gleaned the information that he was unconscious from the staff. The evidence that Dr Norman Nott was unconscious was incorrect. This information should have been passed on accurately.

   My recommendation is that the Rush Court Nursing Home review the information they provide to paramedics attending and the procedures in place to ensure the accuracy of the information can be passed to paramedical staff attending at the home.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

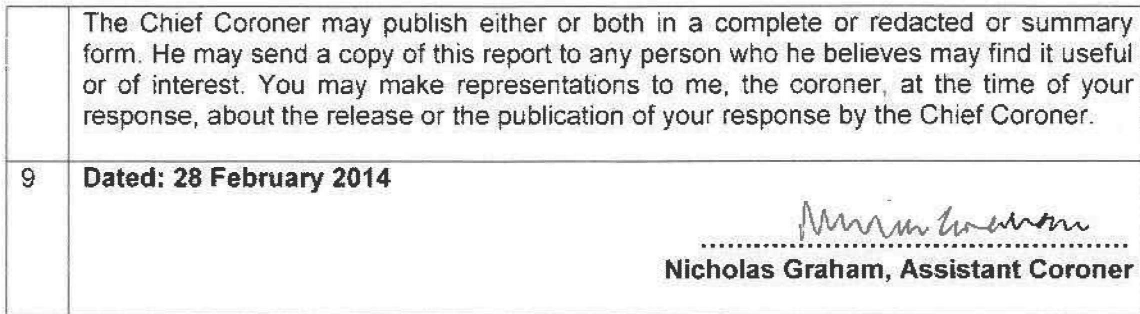
7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by the Thursday 24 April 2014. 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 persons:

I am also under a duty to send the Chief Coroner a copy of your response.



	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	**Dated: 28 February 2014** .... **Nicholas Graham, Assistant Coroner**