IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Frederick Davidson
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Epsom and St Helier University Hospitals NHS Trust Secretary of State for Health
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 28th December 2011 I opened the inquest into the death of Frederick Davidson, who at the date his death was 80 years old. The inquest was resumed and concluded on 23/9/13. I found that the cause of death to be: 1a – Aspiration pneumonia secondary to recurrent epileptic seizures complicated by misplacement of nasogastric tube 2 – Ischaemic heart disease mixed Alzheimer's and vascular dementia. I concluded with a narrative conclusion as follows: On 9/12/11 Frederick Davidson who had a history of advanced dementia and chronic seizures was admitted to Epsom General Hospital with aspiration pneumonia. It was subsequently discovered that he had developed a pneumothorax as a result of being fed via an unnoticed and incorrectly placed nasogastric tube, which on the balance of probabilities hastened his death on 20/12/11.

4	**CIRCUMSTANCES OF THE DEATH** Frederick Davidson was admitted to Epsom General Hospital on 9/12/11 upon referral by his consultant doctor, after he was found to have developed aspiration pneumonia. He had suffered two seizures the week before his admission. He was fed via a naso gastric tube which was misplaced and unnoticed for 24 hours notwithstanding several chest x rays taken. As a consequence he suffered a pneumothorax but despite treatment he succumbed and died on 20/12/11.
5	**<u>CORONER'S CONCERNS</u>** During the inquest [redacted] who conducted the SI Report provided very helpful evidence and the following concerns were highlighted: - • Staff's note keeping practices, in relation to the placement of the nasogastric tube, were inadequate. • The inappropriateness of the use of a naso gastric tube given Mr Davidson's known history of advanced dementia and seizures • Unexplained and important gaps in the clinical notes • Breakdown in communication between the junior doctor and consultant. • The lack of recognition of the pneumothorax on the x ray and the subsequent delayed medical treatment. • The junior Doctor authorised feeding by way of the naso gastric tube prior to full checks being made. There was no note of this authorisation. • Delay in the forwarding and receipt of x ray reports from radiology I would ask that you consider the guidelines on the urgency of x rays and staff training needs when a pneumothorax is suspected and/or concerns raised about the placing of a nasogastric tube.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Epsom and St Helier University Hospitals NHS Trust has the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** • [redacted] • [redacted] – Director • [redacted] • Chief Coroner
9	**Signed: Martin Fleming, HM Assistant Coroner for Surrey** **DATED this 14 day of October 2013**