NHS
Blackpool Teaching Hospitals
NHS Foundation Trust
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Telephone: 01253 956993
[redacted]

15 December 2017

Mr Alan Wilson
Senior Coroner for Blackpool & the Fylde
Municipal Buildings
Corporation Street
Blackpool
FY1 1GB

Dear Mr Wilson

Re: Regulation 28 Report to Prevent Future Deaths – Bernard Cosgrove

I write in response to your Regulation 28 report to prevent future deaths relating to the care of Mr Bernard Cosgrove. Having reviewed your Regulation 28 I initiated a review of the care which Mr Cosgrove received whilst an in-patient in the Trust.

You have raised three concerns which I shall address in turn.

1. **Despite an entry in the clinical records made by a doctor on 3rd March 2017 which refers to a rotating right leg, neither the issue he identifies nor his entry in the notes appear to have been appreciated by nursing staff who cared for Mr Cosgrove thereafter. A Sister who was a clear and helpful witness acknowledged in court that the issue identified by the doctor on 3rd March 2017 was not considered as part of his plan of care subsequently. This is despite the fact that between 3rd March 2017 and discharge from hospital he was seen regularly by staff with responsibility for physically rolling him with a view to providing pressure relief.**

   It is acknowledged that, sadly, the necessity to x-ray Mr Cosgrove's hip was not acted upon post the recommendation on the 3rd March 2017. The nursing staff continued with Mr Cosgrove's plan of care until his discharge on the 10th March 2017, this included a strict turning regime given his susceptibility to developing pressure damage, which for a patient like Mr Cosgrove could have been fatal. The Trust cannot, identify why, in Mr Cosgrove's case, there was no further record or action taken in terms of investigation into the potential findings from the 3rd March 2017 and for this we apologise. However, having undertaken an internal review of Mr Cosgrove's care, lessons have been learnt and are being implemented.

2. **Although from the evidence it is not known how the dislocation occurred the fact it does not appear to have been recognised over a period of 7 days is concerning and strongly suggests that staff paid insufficient regard to the patient's previous medical record entries. Patients such as Mr Cosgrove should not find themselves being discharged from hospital in such circumstances and at a time when the medical professionals looking after his welfare are unaware of such an issue.**

   A problem with his hip was suspected by the attending Physician who ordered an x-ray on 3 March 2017. Unfortunately this Physician was a locum who left on that date and the outstanding request for an x-ray investigation was not pursued by his successor who was also a locum. Since that time the Trust has introduced an electronic tracking system on every ward

where critical activities are flagged until they have been actioned. The hip x-ray would now be identified as a critical activity and I can assure you that such an oversight could not now occur.

3. **But for the fact he was discharged from hospital on 10th March 2017 and that this resulted in the dislocation problem being identified, had he spent a lengthier period in hospital the dislocation and developing infection may well have continued to go unrecognised which raises a concern about how effectively patients are being monitored and their medical records are being considered by staff who are subsequently involved in that patient's care. On this occasion once the dislocation issue was identified this did not substantially alter his care and he was treated conservatively, but in other circumstances not recognising the problem may have directly caused a death.**

   The Trust notes your concern in terms of other potential circumstances where not recognising issues or recording specific history within patient notes could lead to future problems and we are working hard to eradicate such problems. We work closely with our staff in terms of practice development and continued professional development through Ward based education, updates and reminders of their professional responsibility in terms of patient care and contemporaneous recording of observations and notes.

I hope the Trust's response assists you in addressing your concerns.

Yours sincerely

PROFESSOR MARK O'DONNELL
MEDICAL DIRECTOR