REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Acting Chief Executive** **Blackpool Teaching Hospitals NHS Foundation Trust** Blackpool Victoria Hospital Whinney Heys Rd Blackpool
1	**CORONER** I am Alan Wilson, Senior Coroner, for the area of Blackpool & Fylde
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** **The medical cause of death was recorded as follows:** **1 a Bronchopneumonia** **1 b Chronic obstructive pulmonary disease** **11 Severe coronary artery atheroma, Left ventricular hypertrophy, Pyelonephritis, Hip joint infection associated with dislocated hip prosthesis** Narrative conclusion: **In December 2016 Bernard Cosgrove lost his balance as he made his way to his front door at his home and suffered a fracture of his right neck of femur which was surgically repaired. On 28th February 2017 he was admitted to hospital after he had been observed to be unresponsive. By the time he was discharged back to the care of the nursing home on 10th March 2017 it had not been fully recognised that his right hip joint had become dislocated during that period of hospitalisation and had started to become infected. He died at 0730 hours on 21st March 2017 at the nursing home where he resided from the effects of bronchopneumonia which had developed after his discharge from hospital. A subsequent post mortem examination confirmed his death was contributed to by significant heart disease and the hip joint infection.**
4	**CIRCUMSTANCES OF THE DEATH** Please see Narrative conclusion in section 3 above.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

On 25th September 2017 I concluded this inquest by way of a narrative conclusion. I indicated at the end of the inquest that it was my intention to write a report due to a concern about future deaths. Mr Cosgrove found himself being discharged back to the nursing home from where he had originally been admitted to hospital at a time when seemingly unknown to the hospital staff - including a senior member of the nursing staff for the ward - he had a dislocated hip. The fact that there was a problem with the hip seems to have become quickly apparent to care home staff upon his return to that home and to a General Practitioner who visited him although once the dislocation was in fact recognised it was treated conservatively given the patient's co-morbidities.

The concerns are:

- **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.**
- **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.**
- **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.**

At the conclusion of the inquest, I indicated to the Properly Interested Persons that I proposed to write to the Trust by way of a report in accordance with the provisions of paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.

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 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 : • The family of Bernard Cosgrove. • The Manager of New Victoria Nursing Home. • Care Quality Commission. 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	A.A.Wilson **Alan Wilson** **Senior Coroner for Blackpool & The Fylde** **Dated: 10th October 2017**