Robin J. Balmain
H.M. SENIOR CORONER

Smethwick Council House
High Street
Smethwick
West Midlands
B66 3NT

Tel: 0845 352 7483
Fax: 0121 569 5384
E-mail:

BLACK COUNTRY CORONER'S DISTRICT
(SANDWELL • DUDLEY • WALSALL • WOLVERHAMPTON
Metropolitan Borough Councils)

Date: 02 April 2014 Our Ref: RJB Your Ref:

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO :
Medical Director,
Dudley Group of Hospitals
Russells Hall Hospital
Pensnett Road
Pensett
Dudley
DY1 2HQ

1. CORONER

I Andrew Paul Thompson am the Assistant Coroner for the Black Country Coroners Jurisdiction

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 26 March 2014 at Dudley Coroners Court I concluded the inquest into the circumstances surrounding the death of Mr John Dodd.

4. CIRCUMSTANCES OF THE DEATH

The Deceased died of a Retroperitoneal Haemorrhage at Russells Hall Hospital, on 21 April 2013, having been admitted 20 April 2013 through A&E. He had been seen in A&E at Russells Hall Hospital on 16 April 2013 a few days prior to his final admission and sent home.

5. CORONERS CONCERNS

The **MATTERS OF CONCERN** are as follows :-
The deceased was on Warfarin but the INR was not checked on 16 April 2013 despite the degree of pain and the history of fall.

There was a rise in temperature of nearly 1 degree on the afternoon of 16 April 2013 documented by the IMPACT team which was not reported to the medical staff. This was against a background of paracetamol being administered. It was the evidence of [redacted] that he would have wanted to know about this and would have wanted the patient reassessed medically prior to the actual discharge from the department. This did not happen, Mr. Dodd having been declared medically fit for discharge prior to the referral to the IMPACT team. There was a considerable delay on the night of the 20 April between the arrival of Mr. Dodd in A&E and his first assessment by a medically qualified member of staff vis: 20:44 - 00:23. It was the evidence of [redacted] that this was inappropriate, and clearly led to a delay in investigation and diagnosis.

6. **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you 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 the report, namely by **Wednesday 28th May 2014.**

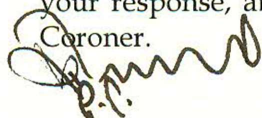
8. **COPIES and PUBLICATIONS**

I have sent a copy of my report to the Chief Coroner and to the following interested Persons :

None

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.



A. P. Thompson
Assistant Coroner
BAP