University Hospitals Birmingham
NHS Foundation Trust

Executive Office of the Chair & Chief Executive
[redacted]

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14th March 2024

Mrs Louise Hunt
HM Senior Coroner for Birmingham and Solihull

[redacted]

Dear Mrs Hunt

Inquest touching the death of Dorota Kuklinska
Response to Regulation 28 Report to prevent future deaths

I write in response to the Regulation 28 Report made by you following the Inquest touching the death of Ms Kuklinska which concluded on 29 January 2024. You will recall that Ms Kuklinska was not a patient of this Trust but we will endeavour to assist with the issues raised within the Regulation 28 Report.

University Hospitals Birmingham NHS Foundation Trust (the Trust) has carefully considered the concern raised within your report to prevent future deaths, which surrounds the guidance available to acute Trusts where there is strong clinical suspicion of an intracranial bleed due to cerebral aneurysm and when a referral should be made for specialist neurosurgical advice.

During the Inquest you heard evidence from [redacted], Consultant Neurosurgeon, that there were guidelines in place which indicate that patients should be referred via the NoRSE referral system when there is a strong clinical suspicion of a brain bleed and particularly where they have refused a lumbar puncture. To provide some context to [redacted] evidence, patients should be referred where there is a high index of suspicion of a bleed and specialist advice is required, but the Trust do not have specific guidelines for the particular scenario where a patient refuses lumbar puncture or any other assessment. It is therefore not the case that there are guidelines that exist which have not been provided to SWBH/other acute Trusts.

Guidance on the management of subarachnoid haemorrhage
Subarachnoid haemorrhage (SAH) is not a rare diagnosis and the capability to diagnose SAH, or to have a clinical awareness of the potential diagnosis to initiate and complete relevant investigations are within the expected capabilities of a physician managing patients presenting to an emergency department.

There is established national guidance (NICE guideline NG288) in place for clinicians when considering a possible diagnosis of SAH. A diagnosis of SAH should be considered in any patient with a severe and sudden onset or rapidly escalating headache. It has been established for many years that where SAH is suspected, there should be a CT scan of the head and if this is negative/inconclusive, a lumbar puncture should be performed. Both of these tests are ordinarily performed at a referring hospital.

[redacted]

Where a lumbar puncture is refused by the patient, it would not be practical or appropriate to refer all such patients to a specialist tertiary centre without further action at the referring hospital. Options available at the referring centre would include providing further advice to the patient to ensure that the risks were fully understood and consideration of further imaging, including CT angiography (CTA), which would detect an intracranial aneurysm and thereby assist in the diagnosis of SAH. It would not be reasonable, as a function of the specialist team, to re-assess imaging for patients solely on the basis of their refusal to permit a complete assessment whilst a patient is at the referring centre. However, if the treating team have a high level of suspicion that there is SAH, then a referral to a specialist centre should be made for advice on further management.

In Ms Kuklinska's case, unfortunately, the clinical team were falsely reassured by the initial CT report and therefore did not consider CT angiogram and/or referral to the neurosurgical team. Where there is a legitimate basis for neurosurgery referral (clinical suspicion of SAH), it is established practice for advice to be sought and scans to be shared with the specialist team for advice.

Action taken
The concerns raised have been considered and a detailed discussion has taken place at our neurosurgical governance day where the facts of this case were considered. The consensus reached was that there is long standing guidance in place for the management and referral of patients with a diagnosis of SAH. The scenario where the referring team had a high level of suspicion for SAH but there was a negative CT and LP was refused was also considered and in this scenario it was considered that the patient should be informed by the treating team of the clinical findings with a suggestion that a second opinion be obtained. A CTA should also be considered.

As referred to above, there are no specific Trust guidelines for the particular scenario where a patient refuses to follow medical advice/ best practice. Where clinicians remain concerned, our on-call neurosurgical team can be contacted for advice.

Whilst it is considered that there is well established guidance in place, having considered your concern, a letter will be circulated to all emergency departments in our catchment area to re-iterate the established pathway/ guidance and to highlight that, if there are concerns with particular cases, our on-call team can be contacted for advice. This letter will be circulated by 30 March 2024 and we would be happy to provide a copy to you.

We have also discussed this case with the patient safety team at SWBH and have shared our internal guideline for managing SAH with them to assist in review of their own guidelines. A meeting has also been arranged between [redacted], Hospital Medical Director QEH, and [redacted], Chief Medical Officer at SWBH to discuss any additional training/guidance that we can provide to support the clinical teams at SWBH.

I would like to assure you that we have taken the concerns raised within the Regulation 28 Report extremely seriously, which I hope is demonstrated in the steps we have taken, as set out above.

Yours sincerely

[redacted]

[redacted]
Chief Executive

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