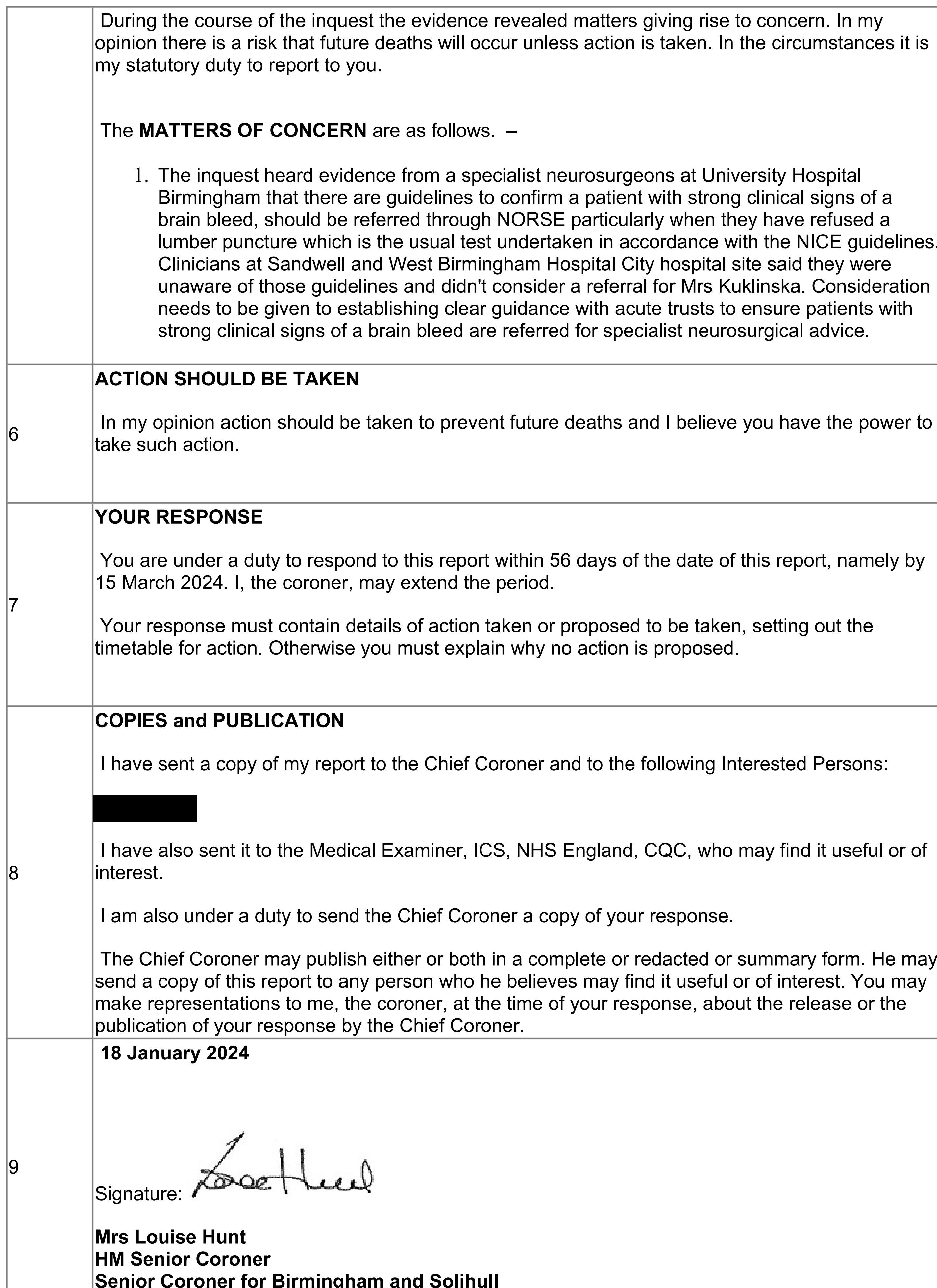
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Sandwell and West Birmingham Hospitals NHS Trust 2. University Hospitals Birmingham NHS Foundation Trust
1	**CORONER** I am Mrs Louise Hunt for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under 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 10 September 2023 I commenced an investigation into the death of Dorota Marta KUKLINSKA. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Died from a catastrophic brain bleed caused by a cerebral artery aneurysm due to a misreported CT scan and not referring to specialist neurosurgeons.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Kuklinska attend the City Hospital on 27/06/23 having woken at 05.00 am with a severe headache 10/10 in severity and radiating down the neck and eyes. The headache was associated with vomiting, fever, chills and light sensitivity. There was concern she had suffered a brain bleed so a CT scan was arranged which was misreported as normal as it was later found to show some subtle signs of cerebral swelling but no brain bleed. Had the CT scan been correctly reported it is likely a referral would have been made through NORSE to specialist neurosurgeons and the condition would have been identified and successfully treated. Clinicians advised that a lumber puncture was necessary to confirm or rule out a brain bleed. This was explained to Mrs Kuklinska who was advised of the risks and benefits of a lumber puncture and given an information leaflet but she declined a lumber puncture and self-discharged against medical advice. She was advised to see her GP about the high blood pressure which was identified at the hospital. Given the strong clinical signs of a brain bleed and refusal of lumber puncture a referral should have been made through NORSE to the specialist neurosurgeons which would on balance have identified the condition and successful treatment would have been provided. She attended her GP on 28/06/23 and was prescribed blood pressure medication. On 07/07/23 she advised the GP her headache had resolved as her blood pressure became normal. She collapsed at home on 20/07/23 and was readmitted to hospital where a CT scan confirmed an unsurvivable brain bleed caused by a right middle cerebral aneurysm. She died at the hospital on 21/07/23. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Spontaneous Intracerebral Bleed** **1b Right Middle Cerebral Aneurysm** **1c** **II**
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. – 1. The inquest heard evidence from a specialist neurosurgeons at University Hospital Birmingham that there are guidelines to confirm a patient with strong clinical signs of a brain bleed, should be referred through NORSE particularly when they have refused a lumber puncture which is the usual test undertaken in accordance with the NICE guidelines. Clinicians at Sandwell and West Birmingham Hospital City hospital site said they were unaware of those guidelines and didn't consider a referral for Mrs Kuklinska. Consideration needs to be given to establishing clear guidance with acute trusts to ensure patients with strong clinical signs of a brain bleed are referred for specialist neurosurgical advice.
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 this report, namely by 15 March 2024. 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: I have also sent it to the Medical Examiner, ICS, NHS England, CQC, who may find it useful or of interest. 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	**18 January 2024** Signature: **Mrs Louise Hunt** **HM Senior Coroner** **Senior Coroner for Birmingham and Solihull**