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H.M. CORONER

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

Date: 15 October 2013 Our Ref: RJB/BAP Your Ref:

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO :
National Institute for Health & Clinical Excellence,
Level One
City Tower
Piccadilly Plaza
Manchester
M1 4BD

1. CORONER

Robin John Balmain the Senior 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 19th June 2013 I commenced an investigation into the death of Lucy KILVERT. The investigation concluded at the end of the inquest on 16th October 2013. The conclusion of the inquest was that death was due to an accident.

4. CIRCUMSTANCES OF THE DEATH

The deceased was taken to hospital on 14th June 2013 having suffered a fall at home on 10th June 2013 and subsequently deteriorating. She had hit her head in the fall and was on blood thinning medication. She was aged 84 at the time.

5. CORONERS CONCERNS

The **MATTERS OF CONCERN** are as follows, namely that Mrs. Kilvert was not initially at the hospital given a CT scan of the head. It was not performed until about 8 hours after presentation at hospital and revealed an intracranial bleed. The medical cause of death was :-

1a) Intracranial bleed,
II Chronic Kidney Failure
Hypertension
Heart Valve Replacement.

As it turned out neurological intervention would not have been appropriate even if a brain bleed had been discovered immediately. I was told by the consultant in emergency medicine who gave evidence, that although the NICE Guidelines were considered, the clinical judgment of the senior house officer who saw her initially was that there was no reason to suspect a bleed, although the consultant said that his judgment may have been different. The consultant felt that the Guidelines possibly insufficiently emphasised the significance of blood thinning medication in elderly people who had had a fall when considering whether a CT scan of the head was necessary, albeit that eventually the matter was a question of clinical judgment.

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.

I would respectfully invite you to consider whether further consideration of the Guidelines is appropriate.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of the report, namely by 17th December 2013.

8. COPIES and PUBLICATIONS

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

(a) The Medical Director, Russells Hall Hospital.
(b) [redacted]

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.

R.J. Balmain
H.M. Senior Coroner