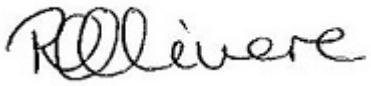
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Rebecca Ollivere, Assistant Coroner, for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 9 November 2023 I commenced an investigation into the death of James Patrick PEARSON. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Died as a result of complications of prolonged hospital admission, in combination with injuries sustained in a road traffic collision, and subsequent hypoxic brain injury, following cardiac arrest.

4	**CIRCUMSTANCES OF THE DEATH** On 14th June 2023, James Pearson was hit by a vehicle on A4540 Birmingham. He was assessed at the scene and his injuries did not appear to be serious. He was taken to Birmingham Heartlands Hospital where a CT scan showed an axonal brain injury, small bleed to the brain, and severe pelvic injuries with suspicion of an active bleed. Observations taken at 03.16 indicated that he was maintaining his blood pressure and the Consultant at the time did not feel he was actively bleeding. James went into peri-arrest, and subsequently suffered a cardiac arrest. After 12 minutes of CPR, a return of spontaneous circulation was achieved, however, James had suffered hypoxic brain injury as a result of the cardiac arrest. This, alongside the traumatic brain injury sustained in the road traffic collision resulted in a prolonged stay in hospital for James, who continued to decline, and developed hospital acquired pneumonia. He was transferred to St Catherine's Hospice in Preston on 12th October 2023 for end of life care, and he passed away there on 22nd October 2023. Whilst at Birmingham Heartlands Hospital an opportunity to provide fluids to James was missed, which, on the balance of probabilities would have prevented his cardiac arrest and subsequent hypoxic brain injury. Following a post mortem, the medical cause of death was determined to be: 1a Pneumonia 1b Diffuse axonal injury and hypoxic brain injury 1c Road traffic collision II Malnutrition

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. Having had a CT scan at Birmingham Heartlands Hospital on 14th June 2023, James Pearson was diagnosed with severe pelvic injuries, and the Radiologist reported findings which were consistent with an active pelvic bleed. 2. At 03.16, observations were taken, and the Doctor was satisfied that James was maintaining his blood pressure and therefore was not actively bleeding at that time. 3. During the inquest, I heard that James was attached to a monitor, which was taking his observations every 15 minutes. None of these observations, however, were documented. This is of concern, as it is not possible to know at what point James began to decline. I am concerned that lack of proper documented observations could lead to future deaths, as staff will not be able to follow the observation pattern and notice a decline in presentation. 4. At 04.20am, James became more agitated and nurses noted a drop in consciousness. At this point the Major Haemorrhage Protocol was activated at 04.23am, as there was now a suspicion of ongoing bleeding. 5. Whilst waiting for his blood products, James suffered a cardiac arrest at 04.25am 6. [redacted] told me in evidence that during the time since his last review by a Doctor at 03.16am, and his cardiac arrest at 04.25am, James was not seen by a Doctor, and only Nurses were available in the department. The only Doctor on shift at that time was dealing with another very unwell patient, who also required resuscitation. 7. [redacted] told me that at the point in time the deterioration in James was noted, sometime between 04.00-04.20am, James should have received fluids, and in his opinion, if he had done so, on the balance of probabilities, he would not have had a cardiac arrest. He added that this was beyond what he would expect a nurse to adduce, however, if the Doctor had been present, he believed this would have been done. 8. I am therefore concerned that there were not enough Doctors in the department at the time, meaning that there is no resilience to deal effectively with more than one very unwell patient at any given time. If this is not addressed, there is a risk of future deaths. 9. I further heard from [redacted] that the blood products at Birmingham Heartlands Hospital are not kept in the ED, and are kept some distance away, and could take up to 20 minutes to obtain after the major haemorrhage protocol is activated. Whilst this is unlikely to have affected the outcome for James, due to his sudden deterioration, I am concerned that a delay in obtaining blood products could lead to future deaths.
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 9th July 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:- [redacted], James' mother 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	**14 May 2024** Signature:  **Rebecca Ollivere** **Assistant Coroner for Birmingham and Solihull**