	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) NHS England** **2) The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust**
1	**CORONER** I am Mr Adam Hodson 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 December 2024 I commenced an investigation into the death of Peter Michael ANZANI. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** At 10.45am on 23 November 2024, Peter sadly died from a pulmonary embolism in Birmingham Heartlands Hospital. He had been admitted to hospital the day prior on 22 November 2024 and was receiving treatment for a community acquired pneumonia when he suddenly and unexpectedly collapsed, in keeping with a pulmonary embolism. Peter had previously suffered a number of falls at home in August and September 2021 and was subsequently diagnosed with suffering a spontaneous infection of the cervical vertebral canal which caused a complete spinal cord injury and left him tetraplegic. This made him more vulnerable to chest infections and pulmonary embolisms which he experienced in the years that followed. There is no evidence of any human intervention that rendered his death unnatural. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a Pulmonary Embolism 1b 1c 1d II Pneumonia Spinal cord injury resulting in Tetraplegia
5	**<u>CORONER'S CONCERNS</u>** 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. – • **<u>To The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust</u>** *1.* I considered evidence from a [redacted] who indicated at paragraphs 20-21 of his statement, *"I did not see any record of his pulse, blood pressure or oxygen saturation. The normal practice is to complete these observations, and I would expect this to be done,*

	especially with him presenting with chest issues. However, I am unable to comment why this was not recorded or confirm that these were carried out. (21) This is a learning point for the department, and I have taken steps to ensure this learning is taken forward by the Trust. I have alerted the Sister in charge of the Spinal Injuries Outpatients' Department and requested that adequate measures are taken to ensure that all observations made are recorded in the outpatient forms..." 2. It was unclear whether this was a single one-off event involving human error or indicative of a wider and systemic issue involving a lack of training. There was no evidence before the court that this "learning point" had been actioned or that any adequate steps had been taken to ensure proper and accurate recording of records by staff. 3. There is a real risk of future deaths occurring where staff do not have adequate training and that patient records are not being properly completed. • **<u>To NHS England / Department of Health and Social Care</u>** 1. I heard evidence that The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust ("The Trust") have been experiencing difficulties with patient waiting lists - due to both an increase in the quantity of patients being treated and staffing shortages - which has led to patients waiting longer than is reasonable or necessary for reviews and treatments. As part of the inquest, there was evidence that Peter Anzani himself had been waiting for nearly a year for a follow-up review, which should have been carried out after no more than 6 months. 2. I heard evidence from representatives of the Trust that they have repeatedly requested additional funds for workforce development and expansion to assist with cutting patient waiting lists and waiting times. I understand that an initial Workplace Funding Review was submitted in 2023 but was rejected by NHS England due to a funding shortage. I understand that a further Workplace Funding Review was submitted in the Autumn of 2024, but in February/March of this year, NHS England indicated that the same would again be rejected under a "no growth policy". 3. Whilst naturally I am aware of the pressures on the public purse and on the NHS generally, it is concerning to hear that the Trust do not appear to be being adequately supported financially by NHS England, and do not currently appear to be able to address their workplace staffing issues without additional financial support (which does not appear to be forthcoming). 4. It is obvious that where patients are waiting for longer than is reasonable or necessary for treatment or reviews, there is a real risk of deaths occurring. No patient should be waiting longer than absolutely necessary for treatment. 5. In light of HM Government's decision on 13 March 2025 to abolish NHS England and for its role to be subsumed within the Department of Health and Social Care, this report is being sent to both Agencies to consider, as it relates to issues of both a local and national significance.
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 26 June 2025. 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: 1) Peter Anzani's next of kin 2) University Hospitals Birmingham NHS Foundation Trust 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. She may send a copy of this report to any person who she 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	**1 May 2025**  Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**