Department of Health & Social Care

Karin Smyth MP
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

Our ref: PFD – 25-06-05 - BROOKS

HM Assistant Coroner Simon Brenchley
The Birmingham and Solihull Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ
0121 303 3228

By email: coroner@birmingham.gov.uk

28 August 2025

Dear Mr Brenchley,

Thank you for the Regulation 28 report of 29 June 2025 sent to the Secretary of State for Health and Social Care about the death of Colin Charles Brooks. I am replying as the Minister with responsibility for Secondary Care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Brooks' death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

The report raises concerns over an insufficient number of on-call perfusionists when Mr Brooks' emergency surgery took place. The out of hours surgery took place concurrently with an emergency lung transplant, with only two on-call perfusionists available on site. This fell short of the 2023 Society of Clinical Perfusion Scientists' guidance requiring a minimum of N+1 perfusionists to ensure safe cover for procedures requiring a cardiopulmonary bypass machine. It also found that Perfusionist 2, who was relatively junior, was unable to access immediate support when trying to identify the cause of Mr Brooks' hypotension, as the only other perfusionist was engaged in the other theatre. The Trust does follow N+1 during normal hours however they have stated resource constraints prevented this being met out of hours and while, as you noted, it is rare for two emergency operations requiring cardiopulmonary bypass machines to occur simultaneously out of hours, it is clear it can happen.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

I have carefully considered the situation. Individual NHS Trusts and other employers are responsible for determining staffing levels and workforce composition. They are best placed to understand their services and the needs of their patients in order to deliver safe and effective care. I would expect University Hospitals Birmingham NHS Foundation Trust and all other NHS Trusts to ensure that their staffing arrangements, including weekend and overnight cover, are appropriate following the tragic death of Mr Brooks.

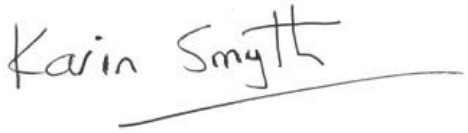
Trusts already have a duty through the Health and Social Care Act 2008 to regularly review the number of staff and range of skills needed to safely meet the needs of people using their services.

Mr Brooks' case was reviewed in a Mortality and Morbidity meeting, where shared learning was cascaded across the surgical team. Following this, both the Cardiac Surgery and Perfusionist Teams at University Hospitals Birmingham confirmed they have implemented several safety actions in response. A peer-reviewed perfusion checklist has been introduced, which is now embedded into routine practice for all cardiopulmonary bypass procedures. Additionally, they assessed the need for more centrifugal pumps, alongside other cardiac measures taken by the perfusionist team, to make sure this doesn't happen again.

In our 10 Year Health Plan, we committed to publishing a new 10 Year Workforce Plan later this year. This will ensure the NHS has the right people in the right places to deliver the best care for patients.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,



KARIN SMYTH

MINISTER OF STATE FOR HEALTH