Husband on Ventilator After Brain Injury: What “Slim Chances” Means

Families' FAQ: “Not brain dead, but slim chances. How can both be true?” | Quick tip for families in intensive care

A wife's husband slipped climbing down from a boat on land and struck the back of his head. He arrived at hospital conscious and talking, but on day four he went into an MRI talking and never responded again. Hours later he was intubated, and on day 13 a tracheostomy and PEG feeding tube are planned. Doctors say he is “not brain dead” but his chances of waking up are “slim”. Here is what families in this situation need to know.

Q. What happened clinically?

A blow to the back of the head can cause a traumatic brain injury (TBI): bruising, bleeding and swelling (cerebral oedema). Arriving conscious and talking is reassuring, but many TBI patients deteriorate over 24 to 72 hours as swelling builds, because the brain sits in a rigid skull and even a small increase raises the pressure inside the head (ICP) significantly. **What deserves much closer scrutiny is day four:** he went into the MRI talking and never spoke again, and was left snoring and unattended for several hours before staff realised he had lost consciousness.

Q. What could explain the sudden drop in consciousness after the MRI?

1. Sedation and airway obstruction: if he was sedated for the scan, lying flat could have partly blocked his airway (snoring is a classic sign). A sustained drop in oxygen can cause a second injury, a **hypoxic-ischaemic brain injury**, on top of the trauma. **2. A new event:** a seizure (including non-convulsive seizures, which can look like simply not waking up), a new bleed, or hydrocephalus (fluid build-up blocking cerebrospinal fluid flow). A secondary hypoxic injury on top of a TBI generally carries a more guarded prognosis, so it should be clearly documented, explained and factored into every conversation about his chances.

Q. How can he be “not brain dead” but have “slim chances”?

Both can be true. **Brain death** is a strict clinical and legal diagnosis: no brainstem function at all (no breathing drive, pupil response, gag or cough), confirmed by repeated formal tests. “Not brain dead” means the brainstem still works to some degree, but says nothing about awareness, thinking or communicating. Between full recovery and brain death is a spectrum: **coma**, then **Unresponsive Wakefulness Syndrome** (eyes open, sleep-wake cycles, no evidence of awareness), then **Minimally Conscious State** (inconsistent but reproducible awareness, such as occasionally following commands), then improving consciousness. “Slim chances” usually refers to meaningful recovery of awareness and function along this spectrum.

Q. How reliable is a “slim chances” prognosis this early?

Prognosis at two weeks, especially with possibly two injuries layered together, is notoriously unreliable. Many ICU and neuro-rehabilitation specialists hesitate to give a firm prognosis before about **four to six weeks**, because the first one to two weeks don't always predict the months that follow. Ask: **What is driving the “slim” assessment: clinical exam only, or repeat CT/MRI and an EEG? Has a secondary hypoxic injury been considered, and how?** Don't just “wait and hope”: ask for a clear written plan for reassessment, and don't treat any single conversation as the final word.

Q. Do a tracheostomy and PEG mean the team has given up?

No. They are standard for anyone needing ventilator support beyond one to two weeks. A **tracheostomy** is more comfortable and needs far less sedation, which matters because **you can't accurately assess consciousness while someone is heavily sedated**. It also makes suctioning easier, protects the vocal cords and opens the door to weaning trials and later a speaking valve. A **PEG** gives reliable nutrition directly into the stomach, since swallowing isn't safe with reduced consciousness (aspiration risk), supporting healing and any future rehabilitation.

Q. What else should be on the table right now?

Neurological monitoring: repeat assessments once sedation is reduced, repeat CT or MRI to track swelling, and an **EEG** if not yet done, to rule out treatable non-convulsive seizures. **Swelling and pressure management:** positioning, temperature control, ICP medications, or drainage if hydrocephalus has developed. **Early rehabilitation:** physiotherapy for joint range and chest clearance, plus an early neuro-rehabilitation referral even while in ICU, so rehab can start without delay when awareness improves.

Q. Which medical records do we need?

Request **in writing** full, continuous access to the actual charts, not a summary. For the period around the day-four MRI: nursing observation and neuro (GCS, Glasgow Coma Scale) charts for every hour before, during and after the scan; oxygen saturation and vital sign trends; the sedation and medication record (what was given, when, what dose); any rapid response (MET call) documentation; and radiology reports for the MRI and later imaging, side by side. This isn't about blame: if a period of low oxygen hasn't been identified and discussed, it is critical for his prognosis. You are also entitled to raise the unmonitored period as a formal clinical incident with the hospital's patient safety team, separately from his ongoing care.

Q. How can a consulting call help?

We go through the records with you, line by line if needed, help you prepare specific clinical questions that get specific answers, and help you advocate calmly and effectively for a second opinion, a clear reassessment timeline and everything clinically appropriate for your husband.

Q. What if he needs long-term ventilation?

A long ICU admission isn't the only option. **Intensive Care at Home**, Australia's only third-party accredited specialist home intensive care nursing service (ISO 9001:2015, NDIS registered, all states and territories), provides 24/7 Critical Care Registered Nurses for invasive or non-invasive ventilation, tracheostomy that can't be weaned in the short term, and palliative care at home. Ventilator-dependent care at home needs ICU-trained nurses, not support workers without ICU training. Families in the USA, Canada, UK, India and elsewhere can reach out too.

Q. What should we do right now?

1. Request full, continuous medical records, especially neuro observations, vital signs, sedation records and imaging from day four on. **2.** Ask which findings (exam, imaging, EEG) are behind the “slim chances” and whether a secondary hypoxic injury has been discussed. **3.** Ask for a written reassessment timeline. **4.** Ask about EEG monitoring. **5.** Ask about early neuro-rehabilitation. **6.** Consider a second opinion: it is entirely normal. **Hope and honesty aren't mutually exclusive.**

Need independent expert advocacy? Intensive Care Hotline can help.
Patrik Hutzel brings 25 years of critical care nursing experience. We review records line by line, help you prepare the right clinical questions and advocate for a second opinion. Book a **free 15-minute phone consultation**.
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