Department of Health

Office of the Chief Medical Officer
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T: [redacted]
E: [redacted]

W: www.gov.uk

Our reference: [redacted]

Your reference: [redacted]

Mrs A Pember
HM Senior Coroner Northamptonshire
110 Whitworth Road
Northampton
NN1 4HJ

Wednesday 30th August 2017

Dear Mrs Pember

Thank you for your letter of 14 June 2017 about the death of Mrs Dianne Macrae.

I was very saddened to read of the circumstances surrounding Mrs Macrae's death. Please pass my condolences to her family and loved ones.

I have noted very carefully the conclusion of the inquest and the areas of concern you have detailed. I can appreciate how distressing these circumstances must be for Mrs Macrae's family.

Your concern is that those involved in the management of patients undergoing similar elective spinal surgery are aware that internal haemorrhage is a rare but recognised complication.

You also issued your Report to the Royal College of Surgeons, the Royal College of Anaesthetists and the Nursing and Midwifery Council and I am advised that they have replied to you on this point. I hope their replies have been helpful.

I am advised that the Royal College of Surgeons has brought your concern to the attention of the Society for British Neurological Surgeons (SBNS) and the British Association of Spinal Surgeons (BASS), who have written to their members. The SBNS and BASS have recommended a number of learning points including increasing patient awareness of the risk of major vascular injury; educational learning for all staff involved in this area of surgery; and ensuring there are clear arrangements in place for access to urgent vascular imaging and acute services.

I am further advised that the Royal College of Anaesthetists is taking action to increase awareness of the possibility of concealed haemorrhage resulting from spinal surgery through patient safety bulletins, e-learning and other educational material.

I also understand that the Nursing and Midwifery Council has advised that the concerns you raise around complications of surgery will be taken into account as part of the consultation process it is currently undertaking to review the educational and pre-registration standards for nurses.

I hope these replies have provided assurance that action is being taken to learn from this incident and reduce the likelihood of a similar event occurring again.

In addition, I am advised that NHS England is assisting clinical commissioning groups (CCGs) to develop elective care pathways for people with musculoskeletal problems and is working with relevant bodies, such as the Royal College of Surgeons, to support the development of a patient decision aid tool to support shared decision making for people with lower back pain. If this is successful, NHS England hopes to make it more widely available by the end of 2018-19.

Finally, Departmental officials have made enquiries with the Care Quality Commission (CQC), as well as the Corby CCG to understand the system response to this incident. I am informed that the CQC and Corby CCG have taken steps to gain assurance that the provider has taken sufficient action to learn from Mrs Macrae's death.

While I understand most of the actions identified by the provider have been completed, I am advised that the CQC will continue to monitor progress at the Woodlands Hospital.

I hope this reply is helpful. Thank you for bringing the circumstances of Mrs Macrae's death to our attention.

Yours ever,

[redacted]

CHIEF MEDICAL OFFICER