	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: **Royal College of Anaesthetists** **Royal College of Surgeons** **Department of Health** **Nursing and Midwifery Council** **Kettering General Hospital** **Woodlands Hospital**
1	**CORONER** I am Anne Mary Christine Pember, Senior Coroner for the coroner area of Northampton.
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 23rd June 2016 an investigation was commenced into the death of Dianne Jane MACRAE. The investigation concluded by way of inquest on 17th and 18th May 2017. The medical cause of death was:- 1a) Multi organ failure b) Haemorrhage c) left common iliac trauma related to spinal surgery 11th June 2016 A narrative conclusion was given as follows:- Dianne Jane Macrae was admitted to the Woodlands Hospital Kettering on 11th June 2016 for elective spinal surgery. The surgery was uneventful. Whilst in recovery she had dips in her blood pressure. She was cared for and treated by attending anaesthetists. Her Consultant Spinal Surgeon was not contacted in a timely fashion and not asked to attend. Her haemoglobin level was not obtained. Those caring for Mrs Macrae did not consider internal haemorrhage as a cause for her instability. Her condition deteriorated. She was conveyed to Kettering General Hospital where she underwent further surgery. It was found she had suffered trauma to her left common iliac artery during the earlier surgical procedure. She was confirmed deceased at Kettering General Hospital on 13th June 2016 at 16.25 hours. She died as a consequence of a rare but recognised complication of surgery.