Ms Elizabeth Gray
HM Area Coroner
Cambridgeshire and
Peterborough Coroner's Service
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

2 May 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ameila Alexandra Anuszka Ridout who died on 16 June 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 11 February 2025 concerning the death of Amelia Alexandra Anuszka Ridout on 16 June 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Amelia's parents and family. NHS England are keen to assure the family and the Coroner that the concerns raised about Amelia's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Amelia's parents and family. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raises that there should be development and publication of national guidelines and a standard operating procedure (SOP) for the carrying out of Bone Marrow Aspirate (BMA) and trephine biopsy, and consideration of developing a database to record these procedures and outcomes.

It would not sit within the remit of NHS England to produce the relevant clinical guidelines or SOP for BMA and trephine biopsy, although we have engaged with the National Institute for Health and Care Excellence (NICE) and the British Society for Haematology (BSH) on the concerns raised in HM Coroner's Report and have been sighted on the responses from NICE and the BSH to the Coroner.

BMA and trephine biopsy are common diagnostic procedures, used for a variety of reasons. Our National Specialty Advisor for Blood and Marrow Transplantation (BMT) has considered your Report and confirmed that the procedures do not sit within the NHS England commissioned BMT pathway or within specialised children's services. It is therefore a service directly commissioned by Integrated Care Boards (ICBs), who would be expected to ensure that Hospital Trusts have the appropriate processes in place to deliver the procedure safely and effectively. The Coroner may wish to engage with the relevant ICB in this matter, although my regional Clinical Quality colleagues

for the East of England have been made aware of your Report and the circumstances that led to Amelia's death, and they can liaise with the local ICB directly.

Bleeding due to vascular injuries is recognised as a known, although adverse, risk of bone marrow biopsy and NHS England are aware of individual Trust Patient Information Leaflets (PILs) that outline the risks and details of the procedure, for example: Bone marrow biopsy | The Rotherham NHS Foundation Trust and pl-964.1-bone-marrow-biopsy.pdf.

NHS England have however communicated to the BSH that it would be supportive of them developing the relevant national guidance for clinicians. Our national Patient Safety Team have advised that they would consider issuing a National Patient Safety Alert (NatPSA) to support and raise awareness of key recommendations, although this would have to be weighed against the existing NatPSA criteria. We are aware that the BSH has already published a demonstration video on 'How to perform bone marrow aspiration and trephine biopsy'.

Regarding the development of a database to record BMA and trephine biopsy procedures and their outcomes, my colleagues with responsibility for national databases and registries have considered this, together with your Report. NHS England do not consider there is a need for us to develop a registry at this point, however we will undertake to:

1. Investigate further to understand the evidence in this area, to determine the potential root cause, for example, are there any training and / or supervision issues associated with this practice.
2. Review relevant national guidance and understand how this translates into local policies.

On review of the above and depending on the evidence, NHS England will take any necessary and proportionate steps to minimise potential future harm.

We also note many of the actions being undertaken by the BSH, as the responsible professional society for the procedure, and outlined in their response to you which include improving existing consent processes, their exploration of the possibility of a registry of complications and establishing an audit process for Trusts.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Amelia, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

National Medical Director