H.M Area Coroner
Ms Sonia Hayes
Seax House
Victoria Road South Chelmsford
Essex
CM1 1QH

Nuffield Health
Epsom Gateway
Ashley Avenue
Epsom
Surrey
KT18 5AL

Ref: 2026-0164

6 May 2026

Dear Ms Hayes,

Regulation 28 Report - Response

I write in response to your Regulation 28 Report dated 18 March 2026 issued following the Inquest into the sad death of Mrs Julie Anne Pytches. Please consider this letter as Nuffield Health's formal response to the matters raised in the report.

At the outset, I would like to extend our deepest sympathies and condolences to Mrs Pytches' family for their loss. Our heartfelt sympathies go out to all those who have been affected by her death; we recognise that this has been an extremely challenging time for them. We have taken on board HM Coroner's comments, and I would like to reiterate our commitment to addressing, as far as possible, any area for improvement identified through internal and coronial review of this case.

Background

Mrs Pytches had a history of back pain. She was first seen as an NHS patient in an outpatient clinic at The Holly Hospital (operated by Nuffield Health) on 20 March 2023. Subject to obtaining updated imaging, it was agreed she would undergo L4/L5 spinal decompression and fusion. The consent form for surgery was signed at a follow up consultation on 13 July 2023, with possible risks and complications being discussed before signature.

Following a pre-operative assessment on 02 October 2023, Mrs Pytches was admitted for surgery on the morning of 14 October 2023. She was assessed by the Anaesthetist, and it was noted that she had pre-operative morbidities (high BMI, high blood pressure, diabetes) and deemed ASA grade 3. She was assessed as fit for surgery.

At approximately 08.30 Mrs Pytches was taken to theatre, anaesthetised and placed in the appropriate prone position. The first two hours of surgery went without complication. There was then a minor endplate bleed, when the disc material was removed, which was repaired. As the operating Consultant was preparing to insert the cage into the disc space, Mrs Pytches suffered a drop in blood pressure and a cardiac arrest. The Consultant removed the external metal work, packed the surgical site and she was turned onto her back (supine) in order that CPR could be commenced. A crash call was made.

Resuscitation commenced, as the Hospital Resus team responded to the crash call alongside two additional Consultant anaesthetists from adjoining theatres. Mrs Pytches received resuscitation fluids, blood and standard epinephrine. The Hospital made a 999 call, the first ambulance crew arrived at 11.00, the second arrived at 11.23 and fitted a LUCAS machine to deliver automatic chest compressions. Subsequently the HEMS team from the Air Ambulance arrived at 11.49. Mrs Pytches' abdomen started to distend, and the attending Consultant considered opening the abdomen to locate the source of the bleed, however, it was deemed that this would be futile. Sadly, after 90 minutes of resuscitation, a decision was made to stop resuscitation at 12.14 hours.

The initial Post-Mortem Report recorded the cause of death as:

1a) Intra-abdominal haemorrhage of uncertain aetiology
1b) Antecedent causes
1c) Morbid conditions (if any) giving rise to the above cause stating the underlying condition last
2) Spinal surgery (operated October 2023)

Following the provision of various witness statements, a supplemental Post-Mortem Report was prepared, which recorded the cause of death as:

1a) Massive intra-abdominal haemorrhage
1b) Spinal surgery (operated October 2023)
1c) Morbid conditions (if any) giving rise to the above cause stating the underlying condition
2) Other significant conditions contributing to death, but not related

The Inquest was partially heard on 14 and 15 April 2025 before being adjourned. The Inquest was re-convened on 27 – 30 October 2025.

At the Conclusion of the Inquest, HM Coroner recorded the medical cause of death as follows:

1a Intra-abdominal Haemorrhage of Uncertain Aetiology
1b Spinal surgery (operated October 2023)

HM Coroner recorded a short narrative conclusion as follows: Misadventure secondary to spinal surgery.

HM Coroner made findings under Regulation 28 and a Regulation 28 Report to Prevent Future Deaths was issued on 18 March 2026. HM Coroner raised four matters of concern under Regulation 28.

HM Coroner specifically noted that the Regulation 28 concerns did not contribute to this patient death.

Quality and safety are of paramount importance at Nuffield Health. We take any concerns about our systems and processes very seriously and will always work to learn from any incidents. The matters raised by HM Coroner have been considered and discussed by our Board Quality and Safety Committee and shared with the Trustees of the Charity as well as the Patient Safety Partner Team.

Our responses to the matters raised are set out below.

Matter of Concern 1

An Anaesthetist who responded to an emergency crash call had limitations on his ability to participate in resuscitation. These limitations had been declared to his team on the day but had not been shared with the Hospital Management where he was participating in surgery. The Hospital Management did not have an opportunity to consider the limitations on the Doctor's practice as a part of a risk assessment and to ensure that the limitations were acceptable in all the circumstances and that any potential risks mitigated. There is no requirement or process for doctors to notify their limitations to the private hospital management.

Nuffield Health's Response:

At the time of the Incident:

- When Mrs Pytches went into arrest she was attended by two Consultant Anaesthetists, the Consultant Surgeon, the Operating Department Practitioner, the theatre support staff and hospital resuscitation team.
- The concern related to a third Consultant anaesthetist who was requested to assist with the arrest and who was working in different operating theatre. He had informed his theatre team of limitations relating to musculo skeletal condition which meant that he was not physically able to assist with resuscitation. However, he had not followed due process by declaring this limitation to the hospital management team earlier.
- At the time of the incident (October 2023), it was an express requirement of the extant Practising Privileges Policy that the Consultant should notify the Hospital Director or Clinical Manager as soon as practicable of any health matters (including any mental health issues), which may affect their clinical practice and judgement or safety of patients and staff.
- This allows the hospital to assess patient risk, coordinate mitigation, and communicate promptly with relevant teams. On receipt of such a notification, hospital leadership is responsible for ensuring timely dissemination of information across affected teams and for establishing clear leadership of actions on the day, including consideration of case prioritisation, deferral, cancellation, or appropriate alternative cover (where clinically appropriate and with verified Practising Privileges).
- As a result of this incident the Hospital suspended the Consultant's Practising Privileges. Following a period of reflection and a full explanation from the Consultant his Practising Privileges were re-instated.

Actions / Measures already in place across all Nuffield Health hospitals:

- It is a requirement of the Nuffield's Practising Privileges policy that all medical practitioners must notify the Hospital Director or Medical Advisory Committee Chair of any health or personal issues that may affect performance, judgement, or patient safety. This includes temporary or permanent changes impacting practice.
- Nuffield's Practising Privileges renewal process (updated March 2026) now requires explicit confirmation that Consultants have discussed workload, wellbeing, and full scope of practice during their most recent appraisal, and that their workload remains safe and sustainable.

- In addition, Responsible Officer (RO)-to-RO information sharing processes support proactive communication of information of note where health matters may impact patient safety or lead to restrictions or changes in practice.
- General Medical Council (GMC) *Good Medical Practice* (2024) further reinforces the professional duty of doctors to seek advice and adjust practice when health conditions or treatment may affect performance.
- Where a concern is identified - either self-declared or raised by another team member - this is acted upon immediately. A proportionate risk assessment is undertaken, and the matter is escalated to the appropriate senior clinician or manager in accordance with local policy. Mitigating actions may include staff replacement, adjustment of roles, enhanced supervision, or delay or cancellation of the procedure where required to maintain safety.
- These arrangements, which are already in place, support a strong safety culture, encourage staff to speak up, and ensure that surgery only proceeds when it is safe to do so. The process is consistent with organisational policies on fitness to practice, escalation, and staff wellbeing, and reflects Nuffield Health's commitment to patient safety, effective teamwork, and regulatory compliance.

Further actions across Nuffield Health:

Although it is an express requirement of Nuffield Practising Privileges Policy for medical practitioners to share relevant health or personal issues, Nuffield are taking the following actions:

- In order to further communicate and reinforce the above requirement, the Consultant induction, and Practising Privileges renewal checklists will be updated to explicitly include the obligation to notify hospital management of any temporary or permanent limitations to practice, including same-day changes, by the end of June 2026.
- Any future learning arising from same-day inability to perform full duties will continue to be reviewed through established governance processes, including escalation where relevant via Patient Safety Incident Reporting Framework reporting.

Matter of Concern 2

Mrs Pytches suffered a major haemorrhage whilst undergoing spinal surgery and there was confusion about the protocol and procedures at the hospital. Consultants with practising privileges in this private healthcare organisation were not all aware of policies and emergency procedures required and these are subject to local variation within the Group organisation across the country. Doctors may have practising privileges in more than one hospital that may cause confusion as to what is required in individual hospitals within the Group. There is assurance that Consultants are required to acknowledge they have read policies, however this does not mean this local variation is clear particularly for a less frequently occurring emergency life-threatening event.

Nuffield Health's Response:

At the time of the Incident:

- At the time of the incident (October 2023), the Hospital was operating under the Aspen Practising Privileges Policy. It was an express requirement of the Policy that a Consultant **must** comply with all relevant policies and procedures applicable to their clinical practice and governance. The Aspen Practising Privileges Policy explicitly stated that it was the responsibility of medical practitioner to ensure they are aware of such policies and procedures and any amendments or replacements thereto.

Actions / Measures already in place across all Nuffield Health hospitals:

- It is also a requirement of NH's Practising Privileges Policy that all Consultants **must** at all times comply with all of NH's policies and procedures, at all of the hospitals where they hold Practising Privileges as made available and amended at any time by Nuffield.
- The Medical Director sent a letter to all Consultants with Practising Privileges in January 2024 specifically reminding them of this requirement, emphasising the need for Consultants to have read and understood the policies within the hospital where they work and to familiarise themselves with any Service Level Agreements in place between all of the hospitals at which they hold Practising Privileges and the local NHS Trusts.
- Nuffield has implemented *MyStaff*, a centralised policy management system providing real-time access to Group-level and local policies via desktop and secure mobile application. We are the first independent provider to have done this. This ensures policies are more accessible at the point of care and that users are alerted when documents are updated. Phase 1 (launched November 2025) migrated all Group policies and associated documents to the platform. Phase 2 (launched April 2026) introduced analytics to monitor readership of critical policies, strengthening assurance and enabling targeted follow-up. All staff and Consultants have 24/7 access to policies via the *MyStaff* app (on and off site).
- Emergency reference guides are consistently available across all departments and include guidance for cardiac arrest and major haemorrhage in line with Nuffield Health Policy CL71 Medical Emergencies and Resuscitation Council guidelines. The availability, accessibility and use of these guides are routinely reviewed and reinforced through regular emergency scenario training and simulations to ensure staff familiarity and effective application in practice. Laminated emergency algorithms, including adult major haemorrhage pathways, are located on resuscitation trolleys and in key clinical areas.
- Major haemorrhage scenarios are conducted three times per year at every hospital, including two internally led exercises (one of these must test the full end-to-end process for the timely escalation, request, and receipt of additional supplies from external providers) and one delivered by AtoE (our external training provider). In addition to this, other emergency scenarios are also undertaken quarterly via AtoE, supplemented by locally led sessions delivered by Resuscitation Leads. Every year, at least one of these scenarios is undertaken out of hours.
- Emergency scenarios are derived from NHS guidelines and adapted to account for local major haemorrhage protocols, including escalation, and for the requirements for higher volumes of blood products. Resident Doctors participate in the emergency scenarios.

Further actions across Nuffield Health:

- Ongoing review of policy access and readership analytics will be used to provide assurance that Consultants and staff are engaging with critical emergency documentation.
- Emergency scenarios are kept under review and amended as necessary in response to learnings from incidents.
- The induction and Practising Privileges renewal checklists will be updated ensure Consultants are aware of and have discussed *MyStaff* access and how to locate all relevant policies, including local emergency protocols with a target date of June 2026.

Matter of Concern 3

The site manager was new and although there had been some training for her role, there was a lack of understanding of the emergency protocols and this was also the case with nurses at the hospital for this event. A very senior member of ambulance crew was attempting to assist the site co-ordinator as to locate the most relevant documents. Training needs to be embedded and protocols readily available.

Nuffield Health's Response:

At the time of Incident:

- The site manager was new to the role but previously held a Senior clinical role as head of department in the Hospital for 9 years prior.
- The Transfusion Policies in place at the time were the Aspen Healthcare Limited Blood Transfusion policy and the Aspen Healthcare Limited Major Haemorrhage Policy. All staff including the site manager had received training on these.
- The Aspen Healthcare Limited–Standard Operating procedure Notification of Patient Death was also in place. Unfortunately, there was a short delay in the site manager identifying this policy after Mrs Pytches had died and the actions required. This is the document referred to by HM Coroner in the concern raised above. The site senior management team then supported the site manager in contacting the Coroner to obtain authorisation to release Mrs Pytches to the offsite mortuary.

Actions / Measures already in place across all Nuffield Health hospitals:

- As part of a comprehensive blood transfusion review in 2025, enhanced training requirements were introduced for all staff involved in any stage of the blood transfusion and major haemorrhage pathway. Scenario-based emergency testing has been strengthened, including rehearsal of escalation and onward transfer processes.
- Major haemorrhage scenarios are undertaken at least three times per year at every Nuffield hospital - two internally led exercises (one of which tests the full end-to-end process for escalation and receipt of additional blood products from external providers) and one by AtoE. Additional emergency scenarios are delivered quarterly by AtoE and locally by Resuscitation Leads. Scenario outcomes are captured via a structured dashboard and reviewed through pathology, transfusion, and governance forums, with action plans developed where learning is identified.

- As part of emergency scenario testing, assessment of staff understanding of staff protocols available and location is assessed and audited.
- In emergency situations, teams are expected to use laminated algorithms available on resuscitation trolleys, rather than relying on digital access. These tools are routinely reviewed for availability and clarity.
- At the Hospital, regular training sessions are carried out for site managers and site clinical leads, including access to protocols and how to access additional support if needed.
- Care of the dying policy – CL 62 issued in January 2025 and has been updated with recommendations from the Fuller Inquiry Part 2. Training for the policy has been undertaken at the hospital and rolled out across Nuffield Health.

Further actions across Nuffield Health:

- Nuffield's current major haemorrhage training module will be further developed to ensure clear end-to-end processes and highlighting differences from NHS pathways, with a target date of May 2026.
- Proposed new induction for site leaders, night coordinators, and senior nursing staff to be rolled-out to ensure strengthened, structured, mandatory coverage of emergency protocols and role responsibilities, with a target date of end of June 2026.
- Scenario testing will continue to test not only clinical response but also documentation standards and team role clarity, with learning reviewed quarterly through established governance routes.
- The major haemorrhage documentation template is currently being developed to enable enhanced clarity of documentation during emergency incidents, with target date of end of June 2026.

Matter of Concern 4

There was some confusion about the roles and responsibilities when there was a concern that an ambulance was required to attend to a major event to a private hospital where the patient was undergoing surgery in an operating theatre. Evidence was that Mrs Pytches was suffering from a major haemorrhage with an uncertain aetiology. There is a concern that Mrs Pytches did not regain stability such that she could have been safely moved and there was no plan as to whether Mrs Pytches required transfer to a tertiary centre. Calling an ambulance without an understanding of specifically what was required could impact on a future death taking this resource from a community emergency. Mrs Pytches already had the attendance of qualified surgeons and anaesthetists whilst suffering a major haemorrhage that could not be treated by community paramedics, however well qualified and experienced as in this case.

Nuffield Health's Response:

At the time of Incident:

- Emergency services were called to enable an urgent transfer of Mrs Pytches to an NHS facility that could provide Level 3 care. This was an appropriate emergency response for the critical clinical situation, where the Hospital did not have on site Intensive Treatment Unit facilities. A transfer would have been required if Mrs Pytches had survived and it was prudent and reasonable to make sure that this was available at the earliest possible opportunity.

Actions / Measures already in place across all Nuffield Health hospitals:

- A defined escalation pathway exists for emergency events, including the involvement of senior clinicians and site management when ambulance attendance or transfer is being considered.
- Major haemorrhage scenarios include escalation, communication, and decision-making elements, and at least one scenario annually tests ambulance activation and transfer decision-making as part of the wider emergency response.
- Scenario outcomes are reviewed through blood transfusion and resuscitation governance structures, pathology expert advisory groups, and national forums, with escalation to executive quality and safety committees where required.
- Introduction of SBARD - Situation Background Assessment Recommendation and Decision – which is a decision-based support tool to guide escalation and transfer discussions.

Further actions across Nuffield Health :

- Clarification and reinforcement of responsibilities for ambulance activation during theatre emergencies will be included in local Standard Operating Policies and emergency guides.
- Transfer decision-making, including criteria for tertiary referral and senior clinician-to-ambulance service communication, will be explicitly incorporated into scenario-based training.
- Ongoing monitoring will be undertaken through existing audit and assurance processes, including Interim Quality Assurance Report requirements, scenario dashboards, and governance reviews.
- Reinforce ambulance activation pathways through simulation training with AtoE input. The scenarios test the full patient journey from initial recognition of deterioration, structured assessment, escalation and intervention all the way through to the arrival of the ambulance and the clinical team providing handover using SBARD (Situation, Background, Assessment, Recommendation and Decision).

Monitoring and Governance

Assurance will be maintained through:

- Audit of emergency protocol training compliance.
- Regular checks on availability and accessibility of emergency documentation.
- Evidence of Consultant access of updated policies through *MyStaff*.
- Review of scenario-based training outcomes and action plans through established governance forums.

Learnings from the review of the Regulation 28 report and the Inquest generally have been shared at the quarter 1 2026 Mortality and Morbidity meeting and cascaded out to MAC Chairs for sharing across all hospitals.

We hope the measures we already have in place and the planned further actions collectively address the matters raised by HM Coroner and provide assurance that any risks have been mitigated and systems strengthened to reduce the risk of future harm.

Yours sincerely,

Date 06/05/2026

Chief Executive - Nuffield Health