REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. CEO Nuffield Health**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 24 October 2023 an investigation was commenced into the death of Julie Anne PYTCHES, aged 63 years. The investigation concluded at the inquest on 30 October 2025. The conclusion of the inquest was Misadventure secondary to spinal surgery. Medical cause of death of 1a Intra-abdominal Haemorrhage of Uncertain Aetiology 1b Spinal surgery (operated October 2023)
4	**CIRCUMSTANCES OF THE DEATH** Julie Anne Pytches died on 14 October 2023 in the operating theatre at The Holly Hospital during elective spinal surgery. Mrs Pytches was required to be prone for the procedure that appeared uneventful until there was a drop in blood pressure that did not respond to vasopressors. Mrs Pytches went into cardiac arrest. Surgery was immediately stopped; equipment removed from the surgical field and Mrs Pytches was turned supine. Advanced Life Support commenced with no return of spontaneous circulation over a period of approximately 90 minutes. Mrs Pytches had a small amount of bleeding noted in the surgical field just prior to her cardiac arrest that alone would not be sufficient to cause cardiac arrest. The cause of the cardiac arrest was a covert probable arterial bleed that caused major haemorrhage whilst she was prone during surgery. There was a sudden loss of cardiac output during an otherwise stable operation, and the finding of a substantial intra-abdominal haemorrhage is consistent with

	haemorrhage from an arterial source. In the prone position, this blood collected in the anterior component of the abdomen. Advanced life support with blood and fluid transfusion had no effect in reversing the cardiac arrest due to hypovolemia. Some distention of Mrs Pytches abdomen was noted on turning that increased during the resuscitation. The distention of the abdomen was examined but there was no surgeon available to open the abdomen. The transfusions did not have any effect. Mrs Pytches medical history and post-mortem findings identified no natural cause of the haemorrhage. The post-mortem did not locate the precise location of the defect due to the collapse of the blood vessels due to the cardiac arrest, haemodilution due to transfusion and limitation as the examination was 9 days after death. Equipment to take urgent blood gas readings were not functional.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Whilst these matters did not contribute to this death: (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. (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. (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. (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 Ptyches 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 May 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • Family • East of England Ambulance NHS Trust • Consultant Surgeon I may also send a copy of your response to any other person who I believe may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me,

	the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	[redacted] **18 March 2026** **HM Area Coroner for Essex Sonia Hayes**