8th September 2017

RCoA
Royal College of Anaesthetists

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Dear Dr Dinsmore,

The RCoA received a coroner's Regulation 28 ('Action to prevent future deaths') letter in June 2017 that described the death of a patient who had undergone lumbar discectomy. She sustained trauma to a common iliac artery during surgery that led to significant concealed haemorrhage. Hypotension was identified in the Recovery Room but the anaesthetists attending her did not appreciate that damage to the abdominal vessels is a recognised complication of spinal surgery. As a result, appropriate treatment was delayed and she died. As part of the RCoA's mandatory response to the coroner, we have undertaken to do the following:

- Communicate with those organisations actively involved in educating anaesthetists about the peri-operative management of patients undergoing spinal surgery, asking them to ensure that their teaching highlights damage to abdominal blood vessels as a possible complication. We are contacting the NACCSGBI, AAGBI and BSOA about this.
- Communicate with those responsible for the production of e-Learning for Anaesthesia (eLA), asking them to consider placing stress upon concealed haemorrhage as a potential cause of postoperative hypotension.
- Include a description of this case in the quarterly SALG Safety Bulletin.

I hope that you will feel able to support us in this Regulation 28 response. I would be happy to answer any questions that you might have.

With thanks and best wishes,

Dr William Harrop-Griffiths MA MB BS FRCA FCAI (Hon)
RCoA Council Member and Chair, RCoA Professional Standards Committee