	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Newcastle Upon Tyne Hospitals NHS Foundation Trust 2. Gateshead Health NHS Foundation Trust
1	**CORONER** I am Leila Benyounes, Assistant Coroner for the coronial area of Gateshead and South Tyneside
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 07/01/20 an investigation was commenced into the death of William Nichols age 66 years. The investigation concluded at the end of the inquest on 20/04/23. The conclusion of the inquest was: Mr Nichols suffered a catastrophic haemorrhage from the site of a right femoral endarterectomy due to deep patch infection. The significance of blood in the wound discharge at 5 weeks post-surgery having not been acted upon, the opportunity to prevent a fatal outcome was lost. The medical cause of death was: 1a) Hypovolaemic shock, 1b) Dehiscence of right femoral endarterectomy, 1c) Post-operative deep patch infection, 2) Type 2 diabetes mellitus, rheumatoid arthritis (on Toclizumab), hypertension, ischaemic heart disease and atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** Mr Nichols underwent surgery, a femoral endarterectomy, on 20/11/19, and developed a lymphatic leak and a post-operative infection, from which he was at an increased risk of developing. A week prior to his death, Mr Nicholas suffered a herald bleed due to deep patch infection, and on the evening of 02/01/21 Mr Nichols suffered a fatal catastrophic haemorrhage from the site of the right femoral artery.

	The blood in Mr Nichol's wound discharge observed on 26/12/19 is likely to have been a herald bleed, and from then Mr Nichols was at a significant risk of catastrophic haemorrhage. On 26/12/19 Mr Nichols should have been instructed to attend hospital immediately where the management would have included an urgent CT scan or CT angiogram before urgent surgery to eliminate the deep patch infection. On 27/12/19 Mr Nichols should have been admitted to hospital. At that point management would have been an urgent CT scan or CT angiogram before urgent surgery to eliminate the deep patch infection. If surgery had been undertaken on 26/12/19 or 27/12/19, or at any time prior to the catastrophic bleed on 02/01/20, the deep patch infection would have been eliminated and it is likely that Mr Nichols would have survived
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Despite the known catastrophic risks of deep patch infection following endarterectomy and the significance of a herald bleed: (1) Inconsistency in understanding between the hospital and the community teams as to the procedure to follow post discharge from vascular surgery and the points of access in the event of concern or complication (including suspected infection, or bleeding). (2) The absence of provision of documented advice to patients on discharge as to points of access in the event of concern or complication (including suspected infection or bleeding). (3) Poor communication from the vascular ward when concerns were raised post-operatively, particularly the concern about bleeding in the wound discharge. (4) Poor record keeping from the community team which meant that key clinical assessment information was not consistently recorded.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 13/10/23. 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, the Family of Mr Nichols, and Sunniside Medical Practice. 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	**LEILA BENYOUNES** **Assistant Coroner for Gateshead and South Tyneside** **18/08/23**