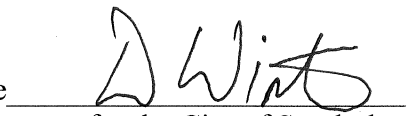
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: -** **Mr Ken W Bremner** **Chief Executive** **City Hospitals Sunderland NHS Foundation Trust** **Sunderland Royal Hospital** **Kayll Road** **Sunderland SR4 7TP**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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 23rd October 2016 Mr James Trevor Vinson aged 72 years died at Sunderland Royal Hospital. I concluded the Inquest as part of my investigation on 8th August 2017 recording a conclusion of an Accident. The Cause of Death following Post-Mortem Examination was: - Ia Intra-Peritoneal Haemorrhage; Ib Splenic tear following fall; Contributed to by II Bronchopneumonia; Cirrhosis of the Liver; Malignant Lymphoma
4	**CIRCUMSTANCES OF THE DEATH** Mr Vinson was a 72 year old man who, whilst in the USA, sustained an acute subdural haematoma, for which he was treated with a craniotomy on 16th September 2016. When in hospital in the USA he had one to one supervision, and on 2nd October 2016 a CT scan identified he had an enlarged spleen (16.5cm weighing 823g). Furthermore, he was identified as having a risk of falls and wore a wristband to that effect. On his escorted return home he was admitted to Sunderland Royal Hospital Stroke Unit on 10th October 2016 for rehabilitation. On 13th October 2016 he was found on the floor of his hospital room where he was in

	isolation for reasons of infection control. The fall was unwitnessed. On 16th October 2016 it was found that he had had a splenic laceration with an intra-peritoneal bleed. He remained unwell and was given palliative treatment until his death on 23rd October 2016 at 20:05 hours. The Post-Mortem Examination confirmed "the proximate cause of death to be a large intra- peritoneal bleed associated with capsular tears of the spleen. Very rarely such splenic ruptures are spontaneous but most are associated with trauma and the circumstances in which he was found indicate that this is most likely aetiology although no bruise could be identified on external examination of the body. Nevertheless, the spleen itself is intrinsically abnormal. It is markedly enlarged and soft and this has two underlying causes. Firstly, the post-mortem has revealed cirrhosis of the liver. Splenomegaly is a well-recognised association of this condition due to the complication of portal hypertension. Furthermore he has a haematological malignancy most in keeping with a high grade malignant lymphoma and the spleen is also enlarged due to infiltration by these atypical cells. These two natural disease processes have, therefore, caused the spleen to enlarge and make it more at risk to rupture from even mild trauma, although the latter has almost certainly been the precipitating event leading to his blood loss and subsequent demise".
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. Although the Splenomegaly (identified in Sunderland Royal Hospital on 16th October 2016) would not have led to any changes in the management of Mr Vinson, I was concerned to hear in evidence, that Mr Vinson was meant to be under close supervision in his hospital room, but this was not the case despite a review of the falls risk assessment. I heard evidence about a draft Enhanced Care/Observation Standard Operating Procedure (SOP), and copies were provided to me and the family. Although a SOP is to be piloted, I am further concerned that the plans for its implementation are not clear. Hence this Report to you. I emphasised in Court that this Report is not to be construed as any form of censure, but rather a means to clarify the actions to be taken and firm timescales.
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 6th October 2017. 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 • Sunderland Royal Hospital and their Solicitors • Care Quality Commission (CQC) 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	Dated this 9th day of August 2017 Signature  Senior Coroner for the City of Sunderland