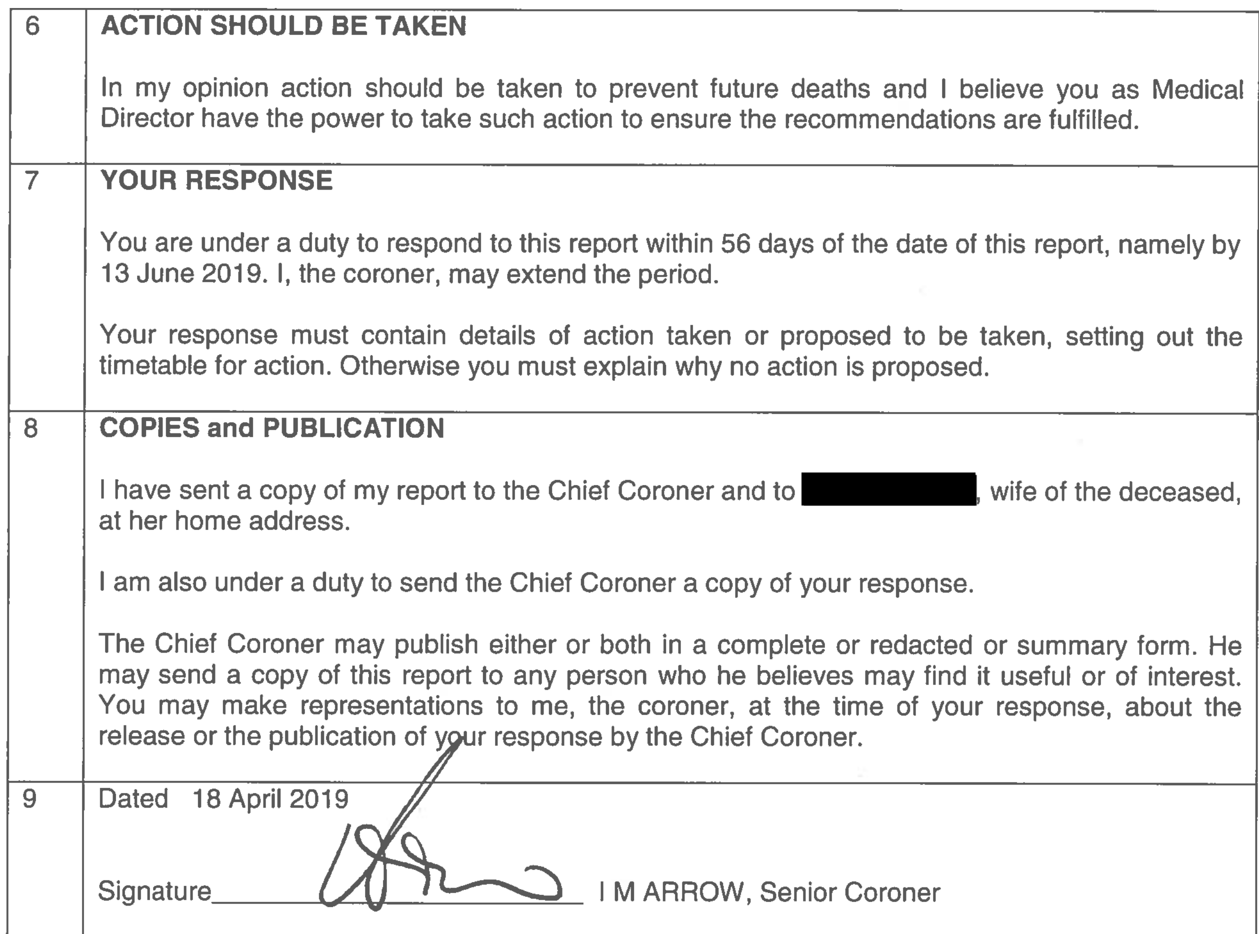
for Plymouth Torbay and South Devon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Medical Director, Derriford Hospital Trust
1	**CORONER** **Ian Arrow, Senior Coroner, Plymouth Torbay and South Devon**
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** **At an Inquest hearing at Coroner's Court, Derriford Park, Plymouth on the 17th day of April 2019 heard before Ian Michael ARROW, Senior Coroner, the following findings and determinations were made:** **Name of the deceased: Roger Albert NEAVES** **Medical Cause of Death:** **1a Sepsis** **1b Pneumonia** **1c Fractured Neck of Femur (left)** **II Parkinson Disease** **The Coroner recorded his conclusion as Accident**
4	**CIRCUMSTANCES OF THE DEATH** **The deceased fell in his bedroom on 16 October 2018. He fractured his left femur. He was conveyed to hospital. He deteriorated and died on 18 October 2018.**
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. – The Coroner received evidence from [redacted] the author of a Root Cause Analysis conducted by the Hospital Trust following Mr Neaves's death. That Root Cause Analysis made various recommendations which required action by the Hospital Trust. The Coroner is concerned to receive confirmation that the recommendations have been fulfilled.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Medical Director have the power to take such action to ensure the recommendations are fulfilled.
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 June 2019. 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 [REDACTED], wife of the deceased, at her home address. 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 18 April 2019 Signature__________________ I M ARROW, Senior Coroner