REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Stephen Covell, Assistant Coroner for the coroner area of Devon, Plymouth and Torbay.
2.	**DATE OF REPORT** **26 May 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. [redacted] Interim Cluster Chief Executive Officer NHS Devon and NHS Cornwall and Isles of Scilly Integrated Care Boards You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 July 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** There appears to be no 24 hour Consultant Radiologist cover across Devon's hospitals to review and report on complex x-rays or scans requiring consultant level expertise.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe that you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** **On 8 January 2024 an investigation was commenced into the death of John Thomas Cleave aged 70 years old.** **The medical cause of death was;**

	1a Aspiration Pneumonia b Fall and Cervical Spine Fracture 2 Ankolosing Spondylitis **In answer to the how, when and where questions I recorded;** **J**ohn Thomas Cleave died at 1800 on 29 December 2023 at Torbay Hospital as a result of complications from a cervical spine fracture sustained in an unwitnessed fall whilst the Deceased was at his allotment at around 1700 the previous day against a background of ankolosing spondylitis. The management of the Deceased's treatment at hospital was compromised by the radiological report of a CT-Scan failing to identify a high suspicion of a haemothorax and the Deceased's care not being led and directed by a clinician with appropriate experience for the complexity of the case. Care should have been transferred to the nearest major trauma centre at Derriford Hospital in Plymouth. **Conclusion** Accidental Death
8.	**CIRCUMSTANCES OF DEATH** At about 1700 on 28 December 2023 John Thomas Cleave sustained a fracture to his cervical spine and a probable haemothorax as a result of an unwitnessed fall on his allotment. The Deceased's injuries and subsequent treatment were complicated significantly by the fact that he suffered from the spinal condition ankolosing spondylitis and had previously undergone spinal fusions and suffered a cervical fracture. The Deceased was admitted to Torbay hospital Torquay at around 1930 and underwent a CT-Scan at around 2200. An initial view of the scan by the clinicians in the Emergency Department identified an unstable fracture of the cervical spine and a suspected haemothorax. A plan was made for the nearest major trauma centre in Plymouth to be contacted with a view to transferring the Deceased's care. Before the major trauma centre was contacted, at around 2300 the scan was reported by a registrar grade radiologist, who discounted any haemothorax. At the time of submitting the report there was no consultant radiologist on call to review the report. A consultant radiologist has recently reviewed the scan and indicated that it should have been reported as identifying a high suspicion of haemothorax. It is likely that the report wrongly discounting the haemothorax influenced the treatment plan for the Deceased and contributed to his not being transferred appropriately to the major trauma centre for treatment. The next day, the Deceased's care had been transferred to the Trauma and Orthopaedic Team, albeit his remaining in the emergency department . At approximately 1300 the Deceased was seen to vomit, aspirate and go into cardiac arrest. Whilst he was successfully resuscitated, his condition deteriorated and he died at 1800 on 29 December 2023 at Torbay Hospital. In the light of the injuries which the Deceased suffered on a background of a complex medical history involving his spine and chest, he should have been transferred to the major trauma centre at Plymouth as soon as the extent of his injuries and his previous medical history became known. .

9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: During the course of the inquest, evidence was given to me that a level of complexity due to the Deceased's medical history, his injuries and an apparent artifact in the CT-Scan caused by metalwork in the Deceased's spine from previous fusions required the expertise of a consultant radiologist. I was informed that there was (and is still) no out of hours consultant radiologist cover for hospitals in Exeter, Plymouth and Torbay. I am concerned that there will be from time to time a need for scans and x-rays to be considered and interpreted at consultant radiologist level to facilitate urgent treatment and there is at present a gap in such cover which puts patients at risk.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1.The Deceased's Family 2.Torbay and South Devon Healthcare NHS Foundation Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE [redacted] Stephen Covell - Assistant Coroner