ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mrs Katrina Percy** **Chief Executive, Southern Health NHS Trust** **Sterne 7** **Tatchbury Mount** **Calmore** **Southampton SO40 2RZ**
1	**CORONER** I am David Clark Horsley, senior coroner for the coroner area of Portsmouth and South East Hampshire.
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.
3	**INVESTIGATION and INQUEST** On 28th March 2013 I commenced an investigation into the death of George Robert Vickery, aged 89. The investigation concluded at the end of the inquest on 6th October 2014. The conclusion of the inquest was: Death due to an Accident.
4	**CIRCUMSTANCES OF THE DEATH** George Vickery fell after alighting from an ambulance outside the Oak Park Community Clinic, Havant. He was attending the clinic for leg treatment. He sustained a broken hip and was taken to Queen Alexandra Hospital in Portsmouth, where he died the next day.
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. – That the decision to treat Mr Vickery at the clinic rather than in his own home (as had been the case previously) was taken without regard to a request from his GP that he should be treated at home, not at a clinic. In my opinion, when assessing how and where a patient should be treated, or when assessing whether any changes should be made as to how and where a patient is treated, Southern Health's Integrated Community Services should formally consult with the Patient's GP and have proper regard to the GP's views on these matters.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 8th December 2014. 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: - Mr Vickery's son, [redacted] - Mr Vickery's GP, [redacted] 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	**13th October 2014** **[SIGNED BY CORONER]** **David Clark Horsley**