ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr M. Parish** **Chief Executive, Care UK** **Connaught House** **Colchester Business Park** **Colchester CO4 9QB** 2. [redacted] **Manager** **Harry Sotnick House** **Cranleigh Avenue** **Buckland** **Portsmouth PO1 5LU** 3. [redacted] **Head of Adult Social Care** **Portsmouth City Council** **Civic Offices** **Portsmouth PO1 2AL**
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 3rd June 2014 I commenced an investigation into the death of Alois Piska, aged 94. The investigation concluded at the end of the inquest on 17th October 2014. The conclusion of the inquest was that Mr Piska's medical cause of death was: - Ia: Subdural Haematoma - Ib: Head Injury - II: Bronchopneumonia, Ischaemic Heart Disease and that he had died due to an Accident.
4	**CIRCUMSTANCES OF THE DEATH** On 29th May 2014 Alois Piska was admitted to Queen Alexandra Hospital, Portsmouth, having fallen earlier that day in the lounge of the nursing home where he was a resident. No member of staff was present in the lounge when he fell. At the hospital he was diagnosed as having sustained a non-survivable head injury in the fall. He died peacefully at the hospital at 18.20 hours on 31st May 2014.

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. – There were inadequate numbers of staff at Harry Sotnick House to supervise residents in communal areas at all times when such areas are in use.
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 17th February 2015. 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 Mr Piska's son and daughter. 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	**23rd December 2014** **Mr David Clark Horsley**