David C. Horsley LLB, Solicitor
Her Majesty's Coroner
for Portsmouth and
South East Hampshire

The Coroner's Court
1 Guildhall Square
Portsmouth
PO1 2GJ

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

[redacted], Director Of Property and Housing Services, Portsmouth City Council, Civic Offices, Floor 5 Core 2-3, Portsmouth, Hampshire, PO1 2AY

1 CORONER

I am David Clark HORSLEY, Senior Coroner for the 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 12/05/2017 I commenced an investigation into the death of Ronald Frank JONES aged 88. The investigation concluded at the end of the inquest on 21/11/2017. The conclusion of the inquest was:

Mr JONES medical cause of death was 1a Bronchopneumonia, 1b Congestive Cardiac Failure, 1c Cardiac Hypertrophy and Amyloidosis, II Fractured Ribs, Chronic Kidney Disease, Diabetes Mellitus and Frailty of Old Age.

My Conclusion was Narrative Conclusion: Ronald Frank JONES died as a result of the processes of natural disease accelerated and significantly contributed to by a fall he sustained in his home on 25 January 2017.

4 CIRCUMSTANCES OF THE DEATH

On 25th January 2017 Mr JONES, a resident of sheltered housing at Arthur Dann Court, Portsmouth, fell in his bathroom. He was found by a Night Support Assistant and subsequently moved to his bed by a Night Responder. He was admitted to Hospital the next day where he died on 4th February 2017.

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 CONCERNS are as follows: I was told in evidence at Mr JONES inquest that following his fall, he was moved to his bed by personnel who had not undergone first aid training as this had been discontinued by Portsmouth City Council. If persons are moved following a fall, unless this is done correctly, there is a risk that they may be injured or their existing injuries exacerbated, potentially fatally. The Council should consider re-activating this training for all staff involved with residents in the City council's sheltered housing schemes.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe Portsmouth City Council have the power to take such action.

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7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by January 18, 2018. 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 JONES next of kin and [redacted], Deputy Chief Executive and City Solicitor, Portsmouth City Council who may find it useful or of interest.

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

David Clark HORSLEY
Senior Coroner for
Portsmouth and South East Hampshire
Dated: 23/11/2017