

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Commander N. Hare, Queen's Harbour Master, Portsmouth</p>
1	<p>CORONER</p> <p>I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 20th August 2012 I commenced an investigation into the death of Marco Antonio Lima De Araujo. The investigation concluded at the end of the inquest on 13th February 2014. The conclusion of the inquest was: The aforementioned person died due to an accident. The medical cause of his death was drowning.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 8th August 2012 the body of Marco Antonio Lima De Araujo was recovered from the water in Portsmouth Dockyard. On 26th July 2012 at about 15.45 hours he had gone into the sea by the Round Tower, Portsmouth, to assist in the rescue of two children who had got into difficulties in the sea. He was not seen alive again.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>I was told at the Inquest hearing that there is no formal protocol for reporting and co-ordinating rescue in relation to life threatening incidents in Portsmouth Harbour.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th April 2014. I, the coroner, may extend the period.</p>

	<p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>3rd March 2014 David Clark Horsley</p>