Ministry of JUSTICE

Summary of Reports and Responses under Rule 43 of the Coroners Rules

Sixth Report: For period 1 April 2011 - 30 September 2011

May 2012

Contents

1. Introduction

The Coroners (Amendment) Rules 2008 amended Rule 43 of the Coroners Rules 1984, with effect from 17 July 2008. The amended Rule 43 provides that:

- coroners have a wider remit to make reports to prevent future deaths. It does not have to be a similar death;
- a person who receives a report must send the coroner a written response within 56 days;
- coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response;
- coroners may send a copy of the report and the response to any other person or organisation with an interest;
- the Lord Chancellor may publish the report and response, or a summary of them; and
- the Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest (other than a person who has already been sent the report and response by the coroner).

The statutory instrument which amends Rule 43 can be viewed at the following link:

http://www.legislation.gov.uk/uksi/2008/1652/pdfs/uksi_20081652_en.pdf

This is the sixth Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 April and 30 September 2011.

We do not release all reports and responses in full. If you wish to obtain a copy of a particular report from the Lord Chancellor, please put the request in writing specifying;

- The report required, from those listed in Annex C of this publication; and
- The reasons why you will find the report of interest or useful.

Please send any requests to rule43reports@justice.gsi.gov.uk or to George Austin, Ministry of Justice, Administrative Justice, Coroners Division, 4.37 4th floor, 102 Petty France, London, SW1H 9AJ. We will acknowledge all applications.

We aim to send reports, redacted in accordance with Data Protection legislation, within 20 working days of receiving the request. We will provide a reason if we cannot release the report either within this timeframe or at all.

The Lord Chancellor wishes to thank coroners for continuing to provide copies of reports written and responses received in accordance with the provision of the amended Rule 43.

2. Statistical Summary

2.1. Rule 43 reports issued by coroners and trends

Between 1 April 2011 and 30 September 2011 coroners in England and Wales issued 210 Rule 43 reports. Some reports included the lessons learned from inquests into the death of more than one person and therefore these 210 reports include lessons learned from 262 inquests. 52 of those inquests arose as a result of the deaths from the London bombings on 7 July 2005.

As in previous summary bulletins, Rule 43 reports were most commonly issued in connection with hospital deaths, accounting for 36% of reports issued (75 reports), an increase of 5% on the last summary bulletin.

The second most frequently issued reports, accounting for 12% of reports, were in connection with road deaths (26 reports). This is in line with the percentage in the previous publication.

The third most frequently issued reports, accounting for 11% of reports, were in connection with community healthcare and emergency services related deaths (24 reports). This too is in line with the previous publication.

The fourth most frequently issued reports, accounting for 10% of reports, were in connection with mental health related deaths (21 reports).

The fifth most frequently issued reports, accounting for 7% of reports issued, relate to deaths in custody (16 reports).

A list of the number of rule 43 reports for each category of death is shown in **Table 1**.

Table 1: Rule 43 reports issued by coroners between 1 April and 30 September 2011, by broad category

Category	Number of inquests where Rule 43 reports issued
Hospital deaths	75
(Clinical procedures and medical management)	(72)
(Other)	(3)
Road deaths	26
(Highways safety)	(21)
(Vehicle safety)	(3)
(Driver and vehicle licensing)	(2)
Accidents at work and health and safety related deaths	12
Mental health related deaths	21
Community healthcare and emergency services related deaths	24
Deaths in custody	16
Drug and medication related deaths	5
Care home deaths	13
Service personnel deaths	2
Police procedures related deaths	3
Product related deaths	3
Railway related deaths	1
Other deaths	9
Total	**210**

2.2. Number of Rule 43 reports received from each coroner district

For the period covered by this report there were 114 coroner districts in England and Wales. Between 1 April 2011 and 30 September 2011, Rule 43 reports were issued by 61 (54%) of these coroner districts. This is broadly similar to the percentage of coroners issuing reports in previous bulletins.

In the six months covered by this bulletin, the Greater Manchester South coroner's district issued 13 reports, the highest number of reports, which equates to 6% of all those issued. However, coroners generally issue far fewer reports than this.

The number of reports a coroner issues is largely determined by the nature of the deaths he or she investigates and whether he or she believes that action could be taken to prevent future deaths. Often the coroner will be satisfied by evidence heard at an inquest that remedial action has already been taken, so may decide no useful purpose will be served by issuing a Rule 43 report after the inquest.

Annex A lists the 61 coroner districts which have issued Rule 43 reports during the period covered by this bulletin, with the number issued by each district.

2.3. Organisations to which Rule 43 reports have been sent

Rule 43 reports were sent by coroners to a wide range of organisations.

Table 2 shows a breakdown of these organisations. Sometimes coroners send reports arising from a single inquest to more than one organisation, so the number of organisations receiving a report is higher than the number of inquests held. In the period covered by this bulletin 291 reports were issued.

The majority of Rule 43 reports arose out of hospital deaths, and therefore NHS hospitals and Trusts were sent the most reports (37% of the reports issued).

A list of all organisations who have received a Rule 43 report in the period covered by this summary bulletin is included in the table at **Annex C**

Table 2: Rule 43 reports issued by coroners between 1 April 2011 and 30 September 2011, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	106
Individual Ministers/central Government departments	55
Local Authorities	27
Private companies	11
Regulatory bodies and trade associations	25
Police and emergency services	20
Prisons	8
Care and nursing homes	9
Other	30
Total	**291**

2.4. Responses to reports

The 2008 Rules introduced a new statutory duty for organisations to respond to a Rule 43 report sent to them by a coroner. The recipient of a report is required to provide a response within 56 days of the report being sent. The response should provide details of any actions which have been or will be taken, or provide an explanation when no action is deemed necessary or appropriate.

Coroners have the discretion to grant an extension to the time limit, on application by the recipient of the report.

Annex B lists organisations which the Ministry of Justice has been notified have not responded to the coroner within the 56 day timeframe and who have neither sent the coroner an interim reply nor been granted an extension.

2.5. Emerging Trends

The trends identified in the previous Rule 43 summary bulletins remain the main themes of the Rule 43 reports issued during the period under review.

In reports on hospital deaths issues around staffing were frequently identified. In particular, reports highlight concerns about staff numbers, training and the lack (or apparent lack) of awareness of procedures and protocols or knowing when to seek additional support and assistance as well as inaccuracies or omissions in staff keeping records and communication. Reports raised communication issues in several areas:

- between different departments or specialities within a hospital, including referrals for outpatient appointments following a stay in hospital or attendance at the hospital's Accident and Emergency department;
- between different members of staff involved in the patient's care, including when they change shifts;
- with patients and their families, and
- with community healthcare services about follow-up treatment after a patient's discharge from hospital.

Many of the reports on road deaths are very specific to the location where the incident which led to the death took place. Most frequently coroners ask for consideration to be given to speed limits, road markings, improved lighting and signage. Additionally, a number of reports have highlighted the need to erect roadside barriers to make it safer for pedestrians to cross busy roads

Reports on community healthcare and emergency services related deaths have identified

- the need for new parents to be made more aware of the dangers and risks of co-sleeping with their babies and of mothers falling asleep whilst feeding their babies.
- Communication policies and procedures both within organisations and between the various agencies involved in community care.

- Availability of access to services and agencies providing community care.

Reports relating to mental health related deaths have highlighted:

- the need to be vigilant about the security of patients especially where patients go missing for periods of time;
- the need to obtain psychiatric assessments at the earliest possible opportunity;
- the need to improve the level of observation particularly to minimise the risk of self harm;
- the need to improve communication generally and in particular with patients' families to ensure that any concerns they have are properly recorded and addressed.

As in previous bulletins, reports across all categories of deaths often identify communication and the lack of or the failure to follow procedures and protocols as major concerns. They also highlight health and safety issues including the need for first aid training and for appropriate risk assessments to be carried out. A common request across all categories of deaths is the need to share and implement lessons learned.

Responses continue to provide details of actions which have been taken and it is good to note that reported concerns are taken seriously. Most responses suggest that lessons have already been learned with appropriate action taken and that training and/or guidance is updated accordingly.

3. Rule 43 reports which have wider implications

A list of Rule 43 reports received by the Lord Chancellor between 1 April and 30 September is at **Annex C.**

The vast majority of reports are very specific to a local situation or organisation as in previous reports. However, a small number of the reports could have wider implications and these are summarised below. These summaries only include Rule 43 reports issued during the period covered by this bulletin for which a response has also been received. Any wider implications arising from a report to which a response is still awaited will be included in the next bulletin.

Hospital deaths

1. A two day old baby was found dead in his mother's bed in a single room at the Royal London Hospital. The baby was born by emergency caesarean section and although small was in good health. On the baby's second night it was agreed he should continue with three hourly observations in view of his low birth weight.

   On the night of the death a midwife observed the baby at about 23:15 when she advised the mother to change him and sit in the chair to feed him. As the mother did not speak English, the midwife mimed the actions but she did not specifically warn about the dangers of co-sleeping. The baby was observed again at 01:30 but no further checks were made until 05:45 when the baby was discovered lifeless in bed next to his mother. Attempts to resuscitate the baby sadly failed. It was concluded that the mother had taken the baby into bed with her and had fallen asleep whilst feeding him.

   The Trust's Maternity Management Guidelines stated that a leaflet entitled *"Sharing a bed with your baby"* is given and explained to new parents to ensure they understand the dangers of co-sleeping. In this case no staff member could recall advising the mother of this and it was confirmed that the leaflet is not usually given until discharge and then only in English.

   Following the inquest the coroner wrote to the Trust requesting they consider providing the information leaflet in languages other than English and shortly after birth rather than waiting till discharge and that their staff conduct regular checks on new mothers whilst in hospital to ensure they are not sleeping with their babies.

   The Trust responded by saying that:

   - a leaflet had now been translated into Bengali and is provided on admission to the post-natal ward (55% of births in that Trust are of Bangladeshi origin);
   - a poster to warn of the dangers co-sleeping had been successfully piloted for all non-English speaking mothers; and

- it had introduced a system whereby every midwifery staff perform “ward rounds” every 2 hours to check on all new mothers offering them advice, support and assistance as required.

2. In January 2011 a 28 year old man died at Sunderland Royal Hospital having been given intravenous antibiotic treatment and fluid on admission. A post-mortem examination indicated that there had been significant delays in administering some drugs. The coroner expressed concern about prescribing, dispensing and administering of medicine. He noted that the problem of loading doses i.e. a large dose of medicine administered over a short time to ensure a quick therapeutic response appeared to be well recognised but the deceased had died shortly after the National Patient Safety Agency (NPSA) issued a rapid response report in November 2010 (NPSA/2010/RRR/018).

   The coroner recognised, and the hospital acknowledged that errors can occur when a loading dose is administered, leading to over medication and that the problem was being addressed. However at the time of the inquest, the Trust’s plans and timescales for implementation were still not clear.

   The coroner wrote to the Hospital Trust and to the Secretary of State for Health requesting information on what action was being taken both locally and nationally to prevent fatalities from loading doses.

   The Trust replied advising that:

   - The National Patient Safety Agency (NPSA) alert related to specific medications, none of which were used in this case. However, the Trust recognised that many medicines are likely to cause harm if loading and subsequent maintenance doses are not prescribed and administered correctly. They had therefore produced a ‘critical’ list of medicines which included those administered in this case.
   - To complement the existing comprehensive prescribing guide they had provided additional information and guidance for staff which incorporated changes in national policy and legislation
   - The hospital’s electronic prescribing system has also been enhanced to ensure clinicians are alerted when prescribing a critical medicine.
   - Having reviewed their policy and procedure the Trust were confident that robust systems were now in place which would comply with NPSA/2010/RRR/018 by 25 November 2011 deadline.
   - Additionally they advised that an earlier NPSA alert, (NPSA/2010/RRR/009) addressed reducing harm from omitted and delayed medicines in hospital. Their existing omitted doses policy had been updated in line with the recent NPSA alerts. This requires all medicines to be administered or to be reported as ‘not administered’ with reasons within 90 minutes of the scheduled time for administration of each dose.

- Procedures are in place to ensure medicines are available 24 hours a day and an audit of omitted doses is carried out and the results reported to the appropriate clinical governance groups.
- As a result of all the actions taken by the Trust they were compliant with the implementation of this NPSA alert by the implementation date of 24 February 2011.
- The Department of Health (DH) replied confirming what the Trust had advised, that the Medical Director of the NHS North East Strategic Health Authority was satisfied with the Trust's work in this area.

DH also advised that

- National guidance to minimise the risks identified in this case had been issued in February 2010 in a Rapid Response Report (NPSA/2010/RRR/009) entitled *Reducing harm from omitted and delayed medicines in hospital.* This recommended a staged approach firstly focussing on specific critical medicines and longer-term work to ensure improvements were sustained over time
- In light of these NPSA reports there were no plans to issue any further guidance on this subject.

The Care Quality Commission considered compliance with alerts as part of their assessment of compliance with essential standards of quality and safety.

Police Procedures

1. A woman was murdered by her former boyfriend. The man had previous convictions for harassing women although the woman was probably unaware of the true extent and seriousness of the offences.

   There were several enquiries into the circumstances leading up to the death including scrutiny of the actions of the Greater Manchester Police (GMP), the Crown Prosecution Service (CPS), Salford City Council and Salford Women's Aid all of whom gave evidence at the inquest.

   The coroner acknowledged that recommendations of the various enquiries had all been actioned but she considered there were further actions which could be taken to prevent similar deaths and wrote to the Home Secretary to request that consideration should be given to the following matters.

   1. Disclosing such convictions to potential victims to enable them to make informed choices about their and their children's safety;
   2. Placing a maximum time limit for bail and the timely submission of files to the CPS;
   3. Introducing a national protocol to ensure early liaison between police forces and the CPS;
   4. Providing instructions to police forces nationally that potential suspects (or anyone else) should not be told over the telephone whether or not a complaint had been made;
   5. Introducing nationally agreed protocols for better exchange of information between agencies dealing with harassment/domestic violence;
   6. Giving police the same powers as courts to remand into custody when police bail is breached;
   7. Introducing a protocol that files passed to the CPS include information on bail history and full information about any subsequent incidents;
   8. Introducing national guidance that risk assessments in harassment/domestic violence cases be passed to the CPS as part of an investigation file, at the earliest opportunity.

   The Home Office, in conjunction with the Association of Chief Police Officers (ACPO) and the CPS, has responded to the coroner's points as follows:

   a. Disclosure of previous convictions is considered where an offender meets the Multi-Agency Public Protection management criteria and requires interagency management at Level 2 or 3 and where required to protect the public.

      In addition, following a consultation launched in October 2011, the Home Office announced on 5 March 2012 that there will be a one year pilot of a Domestic Violence Disclosure Scheme from the summer of 2012 to test a process for enabling the police to disclose to the public information

about previous violent offending by a new or existing partner where this may help protect them from further violent offending.

b. The length of bail should be time-limited and related to the appropriate time required to proceed with the conclusion of the investigation. Where this is beyond three weeks, it must be for specific reasons such as forensic testing. Additionally police bail legislation would be further considered as part of an ongoing review into pre-charge bail.

c. ACPO agreed that information on complaints about individuals should not be given by telephone and would be writing to all chief constables to highlight the risk this poses to victims of domestic violence.

   ACPO has shared best practice that highlights the good work that exists in improving the service provided to victims of abuse. This advice and guidance has catered for the sharing of information between parties ensuring that proportionality and necessity aspects are taken into account to safeguard victims and their families.

d. Multi Agency Risk Assessment Conferences (MARACs) have protocols in place for sharing information between agencies involved with cases of harassment and domestic violence. ACPO would also remind police forces to ensure that local information protocols are agreed between the various agencies involved and these are updated as required.

   ACPO has updated all Heads of Public Protection Units (PPUs) across England and Wales on the partnership approach including information sharing protocols.

e. Under Part IV the Police and Criminal Evidence Act 1984, the police have a power to arrest without warrant a person suspected of breaching any conditions of police bail. However, breach of police bail is not an offence. Unless the breach involves the commission of a new offence, police powers to detain the arrested person depend on whether, on arrival at the police station, there is sufficient evidence to charge the person in respect of the offence for which they were granted bail. If there is insufficient evidence, then the person may only be detained without charge if the custody officer has reasonable grounds to believe that their detention is necessary to obtain the evidence, otherwise the person must be released. For domestic violence cases where there is insufficient evidence to charge, the Home Office is piloting Domestic Violence Protection Orders (DVPOs) in three police force areas – Greater Manchester, West Mercia and Wiltshire. DVPOs are a new power that allow the police and magistrates to put in protection for the victim in the immediate aftermath of a domestic violence incident, where the alleged perpetrator could be prevented from returning to a residence for up to 28 days.

f. The Crown Prosecution Service is committed to improving their performance in prosecuting domestic violence cases. In the past four years, the volume of cases prosecuted has increased by 43% and, against this rise, the proportion of successful outcomes has remained steady at 72% over the past two years. Although good progress has

been made, it is acknowledged that there is still more to do in ensuring consistency.

g. At a national level, CPS and ACPO are developing a joint checklist for police and prosecutors on the key issues for enhanced evidence gathering and charging building on existing guidance. This includes information relating to bail history and the level of risk faced by the victim. Work is also ongoing looking at ways to improve the methods and timely electronic transfer of evidence from police to CPS.

Finally, it should be noted that, on 13 April 2011 the Home Office put domestic homicide reviews on a statutory basis under the Domestic Violence, Crime and Victims Act 2004 so that local areas and agencies must now undertake a multi-agency review following a domestic violence homicide. An expert group has been established to quality assure the reports and cascade lessons learned nationally with the overall aim of identifying lessons learned with a view to preventing future homicides and violence.

2 Following the inquests into the 52 deaths as a result of the bombings on the London Transport system on 7 July 2005 the coroner wrote to the Home Secretary; Director General of the Security Service; the London Resilience Team; Transport for London; the Secretary of State for Health; London Ambulance Service and Barts and the London NHS Trust.

The coroner asked these organisations to consider addressing the following:

- **Home Secretary and Director General of Security Service**:

1. Whether procedures can be improved to ensure that 'human sources' who are asked to view photographs are shown copies of photographs of the best possible quality, consistent with operational sensitivities;

2. Procedures to be examined by the Security Service to establish if there is room for further improvement in the recording of decisions relating to the assessment of targets.

- **London Resilience Team**

3. To review the provision of inter-agency major incident training for frontline staff, particularly with reference to the London Underground system.

- **Transport for London (TfL) and the London Resilience Team**

4. To review the protocols by which TfL (i) is alerted to major incidents declared by the emergency services which affect the underground network and (ii) informs the emergency services of an emergency on its own network (including the issuing of a 'Code Amber' or a 'Code Red' or the ordering of an evacuation);

5. To review the procedures by which (i) a common initial rendezvous point is established and its location communicated to all the arriving emergency

services and (ii) the initial rendezvous point is permanently manned by an appropriate member of London Underground;

6. To review the procedures by which confirmation is sought on behalf of any or all of the emergency services that the traction current is off and by which that confirmation is disseminated.

- **Transport for London (TfL)**

7. To (i) reconsider whether it is practicable to provide first aid equipment on underground trains, either in the driver's cab or at some other suitable location, and (ii) carry out a further review of station stretchers to confirm whether they are suitable for use on both stations and trains.

- **London Ambulance Service and Barts and London NHS Trust**

8. To review existing training in relation to multi casualty triage (i.e. the process of triage sieve) in particular with respect to the role of basic medical intervention.

- **Secretary of State for Health and London Resilience Team**

9. To review the emergency medical care of the type provided by London Air Ambulance and London Medical Emergency Response Incident Team and in particular its capability and funding.

The coroner received responses from each of the organisations to which she wrote.

- The Government response specifically addressed points 1, 2 and 9 all of which they accepted. This response additionally summarised the responses from the other organisations;
- The Greater London Authority response addressed points 3, 4, 5, 6 and 9;
- The Transport for London response addressed points 3, 4, 5, 6 and 7;
- The London Ambulance Service and Barts and London NHS Trust responses addressed point 8.

The coroner has published the rule 43 report and all the responses in full on the 7 July inquest website. These have therefore not been summarised in this publication. They can however be viewed via the links below:

http://7julyinquests.independent.gov.uk/docs/orders/rule43-report.pdfhttp://7julyinquests.independent.gov.uk/directions_decs/responses-rule43.html

Community health care and emergency services

An 82 year old man who suffered with Parkinson's Disease and was a wheelchair user was found dead at home. His wife, with whom he lived, was also disabled. Home care arrangements in place involved four visits each day by two agency carers. Plans were in place for the couple to have 2 weeks' respite care but on the date they were to go, they decided to stay at home. Carers had attended in the morning, Social Services were made aware of the changed situation and the social worker had advised their family that the home care arrangements would be reinstated.

However the social worker failed to act upon the information and carers failed to visit for 3 days when the man was found dead and his wife very distressed. Following the inquest, the coroner acknowledged that some changes to practice had already occurred between the time of the death and the inquest. However, he wrote to the Local Authority asking them to consider whether any additional policies, practices and procedures could be put in place to avoid this type of failure occurring in the future. He specifically asked the council to consider:

- how calls requiring action were recorded;
- how information was properly and promptly acted upon;
- how to ensure sufficient staff resources were available, and
- what supervision, checks and auditing were necessary to ensure that information was passed on and appropriate action taken.

In their response, the Local Authority advised that in addition to action already taken their Quality Assurance Team had carried out a further audit of duty arrangements which had identified service improvements to make the system more robust. Specifically in respect of the four areas the coroner had highlighted they noted:

- **Recording calls.** Staff are now required to prioritise cases to make it clear which need attention that day. Additionally a standard procedure for recording all calls at the first point of contact will be introduced using a duty record book which will be updated through the day and be the basis for checking processes and completion of actions and the responsible staff member. The new recording procedure was due to be operational from the beginning of October 2011.
- **Ensuring information is properly and promptly acted upon.** Comprehensive procedures for staff on duty will be introduced by October 2011 clarifying the role and purpose of the duty team, emphasising guidance on assessing risks and determining priorities and making clear that staff must check existing care/support plan to see if any services need to be reinstated or amended. A checklist completed at the end of the day to review and confirm actions taken will make it easier for staff to monitor work and compare this with the computer case management system.

- **Resourcing.** All duty teams will be staffed by people who work on duty permanently, rather than on a rota to ensure continuity of care and a stronger sense of ownership. Business continuity plans are being implemented to ensure contingencies in place to deal with unexpected absences, annual leave and exceptionally busy duty sessions and staff on duty rotas will not hold other caseloads.
- **Supervision checks and audit**. All duty teams have a manager on site available for advice and more robust management checks of work undertaken have been implemented.

The Council will commission a further audit six months after implementing all changes to ensure they are working efficiently and to see if any further improvements are required.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 April 2011 and 30 September 2011

Coroner district	Number of inquests in which Rule 43 reports issued
Avon	5
Berkshire	1
Birmingham and Solihull	3
Black Country	3
Blackburn, Hyndburn and Ribble Valley	1
Bridgend and Glamorgan Valleys	2
Brighton and Hove	5
Cardiff and the Vale of Glamorgan	8
Cheshire	5
Cornwall	3
Coventry	2
Cumbria: South and East	3
Derbyshire: Derby and South	1
Derbyshire: North	1
Devon: Exeter and Greater	2
Devon: Plymouth and South West	3
Dorset: West	2
Darlington and South Durham/North Durham	2
East Riding and Kingston-upon-Hull	1
Essex and Thurrock	3
Gloucestershire	3
Greater Manchester: City	12
Greater Manchester: North	1
Greater Manchester: South	13
Greater Manchester: West	8
Gwent	1
Hampshire: Central	1
Hampshire: Portsmouth and South East	2
Hertfordshire	4
Kent: Central and South East	4

Kent: Mid and Medway	1
Kent: North East	4
Leicestershire: City and South	3
Leicestershire: Rutland and North	1
Lincolnshire: West and Spilsby and Louth	5
London: City	1
London: Inner North	3
London: Inner South	4
London: Inner West	4
London: North	1
London: South	4
London: West	4
Milton Keynes	9
Newcastle-upon-Tyne	1
Norfolk	5
Northumberland: North	2
North Yorkshire: Eastern District	2
Nottinghamshire	5
Peterborough	1
Powys	1
Shropshire: Mid and North West	1
South Yorkshire: Eastern	5
South Yorkshire: Western	8
Staffordshire: South	7
Staffordshire: Stoke-on-Trent and North	2
Sunderland	2
Sussex: West	1
West Yorkshire: Eastern	9
West Yorkshire: Western	4
Wiltshire and Swindon	4
Worcestershire	1
Total	**210**

Annex B

Organisations which the Ministry of Justice has been notified have not responded to the coroner within the 56 day deadline and who have neither sent the coroner an interim reply nor been granted an extension.

- Care Quality Commission
- Clinical Children's Services, London
- Community Safety Partnership Group
- Department for Business Innovation and Skills
- Department of Health
- Department of Transport
- Health and Safety Executive
- Home Office
- Independent Police Complaints Commission
- Kent Highways Service
- Leicestershire Police
- National Institute for Clinical Excellence (NICE)
- Office of the Parliamentary Council
- Pennine Acute Hospitals NHS Trust
- Senior Transport Officer, Enong Province, Thailand
- South Warwickshire Foundation Trust
- Southern Railway
- University of Sussex
- Warwickshire County Council

Annex C

List of Rule 43 reports received between 1 April 2011 and 30 September 2011

Coroner District	Organisation	Summary	Response Received	Report
Hospital deaths: clinical procedures and medical management				
Gloucestershire	NHS Gloucestershire	To consider an urgent review of the criteria and procedures for assessing patients' discharge to community hospitals.	Yes	1
Essex and Thurrock	Princess Alexandra Hospital NHS Trust, Harlow	To consider a review of the systems in place for liaison between clinical teams when different teams treat the same patient and to check the effective use of the hospital computer system by clinicians.	Yes	3
Cardiff and the Vale of Glamorgan	Abertawe Bro Morgannwg University Health Board	To consider a review of guidance for midwives to better ascertain the nature of advice being sought and the systems for recording telephone calls in maternity units.	Yes	6
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider a review of the systems in place to allocate post operative beds to patients and communication between ward staff and lead consultants.	Yes	7
Staffordshire: South	Stafford Hospital	To consider whether any training or audit is required regarding the condition of medical records and whether there should be a dedicated bay for gastro-intestinal bleeds.	Yes	9
Hertfordshire	East & North Hertfordshire NHS Trust	To consider a review of procedures and sterilisation processes so that patients requiring surgery are operated on promptly and operations are not cancelled unnecessarily.	Yes	19
Northumberland: North	British Thoracic Society; Northumbria Healthcare NHS Foundation Trust	To consider changes to the Pulmonary Embolism Pathway Chart to highlight the possibility and risk of pulmonary embolism after surgery to clinicians, staff and patients even in apparently young, healthy patients.	Yes	24
Gloucestershire	Gloucestershire Hospitals NHS Foundation Trust	To consider an urgent review of the use of observation charts and to emphasise the importance of using them to all clinical staff.	Yes	25

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: South	Department of Health	To consider a review of the NICE guidelines for investigating head injuries through a CT scan.	Yes	27
Staffordshire: South	Queens Hospital, Burton Upon Trent	To consider a review of the systems in place for discharge planning.	Yes	36
Greater Manchester: South	University Hospital of South Manchester	To consider a review of the record retention policy in relation to mechanical implants.	Yes	44
London: South	National Institute for Clinical Excellence (NICE)	To consider issuing guidance regarding stopping patients taking clopidogrel before lung biopsies are undertaken.	No	46
Hertfordshire	Herts Urgent Care	To consider a review of the triage system available for patients on arrival; how patients are prioritised and the systems in place to alert duty doctors of the appropriate order in which to see patients.	Yes	52
Cardiff and the Vale of Glamorgan	Abertawe Bro Morgannwg University Health Board	To consider whether staff would benefit from further training on the use of CPR and CPR protocols.	Yes	54
South Yorkshire: Western	National Cancer Peer Review; Department of Health	To consider a review of the communication channels and their effectiveness between teams in the oncology department.	Yes	63
Nottinghamshire	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	To consider whether all patients on warfarin are reviewed by a specialist nurse or pharmacist before discharge; providing specific written instructions to GPs and patients when patients are discharged on a drug with significant interaction and the need for a robust method of highlighting such instructions.	Yes	66
Milton Keynes	Milton Keynes General Hospital	To consider a review of the composition of crash teams and whether an anaesthetist should be part of every crash team.	Yes	67
Kent: Central and South East	East Kent Hospitals University NHS Trust	To consider how best to prevent breaches of the Acute Coronary Syndrome Protocol and the process to ensure prompt transfer of patients to the Coronary Care Unit.	Yes	68
Greater Manchester: South	Tameside General Hospital	To consider whether there should be a protocol for obtaining a patient's consent for a surgical procedure when the patient lacks mental capacity.	Yes	69

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: South	Stockport NHS Foundation Trust	To consider a review of the staffing levels in the Emergency Department and how that needs to be changed to improve the throughput of patients whilst maintaining patient safety.	Yes	70
Brighton and Hove	Western Sussex Hospital NHS Trust	To consider a review of the protocols for post operative complication patients for bariatric surgery.	Yes	74
Cumbria: South and East	University Hospital of Morecambe Bay NHS Foundation Trust	To consider raising staff awareness about the need for full and accurate records; a review of how midwives and doctors can work more effectively together; keeping maternity unit staffing levels under review and exploring ways of ensuring continuity of care for mothers in the unit.	Yes	78
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider improvements to the communication between specialist teams and GPs about patient care.	Yes	79
London: Inner West	Fresenius Medical Care Renal Services Ltd.	To consider a review of renal units' records to ensure patients' past medical history and problem lists are kept up to date and used to inform risk assessments; staff training on the location and contents of lists before dialysis commences and the management of medical emergencies on the unit; that serious incidents are reported to the patient's renal consultant and their family by a senior nurse.	Yes	84
Greater Manchester: South	Tameside General Hospital	To consider a review of staffing levels within the emergency department and medical admissions unit; written procedures for handling incident reports; arrangements for nurses to summon help if required and the need to maintain accurate comprehensive and accessible notes.	Yes	85
Nottinghamshire	Sherwood Forest Hospitals	To consider a review of the hospital protocol on procedures to be followed when police are called to the hospital to deal with an incident and to ensure that staff and police are aware of this protocol and are trained in its application.	Yes	89
West Yorkshire: Western	Department of Health; National Patient Safety Agency	To consider introducing national protocols for the management of medical condition of Medium-Chain Acyl-CoA Dehydrogenase Deficiency.	Yes	94
Nottinghamshire	Sherwood Forest Hospitals	To consider introducing a policy which ensures any material changes of opinion between a radiolist's verbal and written report is communicated to the relevant clinician at the time the written report is made.	Yes	96

Coroner District	Organisation	Summary	Response Received	Report
Nottinghamshire	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	To consider a review of procedures regarding the administration and documentation of GP prescribed drugs.	Yes	97
Birmingham and Solihull	National Institute for Health and Clinical Excellence (NICE)	To consider ensuring that NICE guidelines are used for all patients on admission to hospital; reviewing the risk factors for thrombo-embolism in psychiatric patients, particularly with regard to psychiatric drugs and that thrombo-embolic problems in such patients are properly recorded before designing specific research into methods of prevention/treatment.	Yes	100
Lincolnshire: West and Spilsby and Louth	Louth Hospital, Lincolnshire	To consider a review of the falls risk assessment policy and whether the hospital's computer system could be programmed to set an alert on patient records to ensure that on handover and/or when a new user logs on that staff are aware a risk assessment has not been carried out and for this alert to remain on the record until the risk assessment has been completed.	Yes	101
East Riding and Kingston upon Hull District	NHS Hospital Hull; Prison Health Care Centre	To consider setting up a system to enhance the accurate transmission of clinicians' reports to the Prison Healthcare Centre following out-patient visits.	Yes	102
Milton Keynes	Care Quality Commission	To consider an urgent review of the organisation and management of paediatric services at Milton Keynes Hospital.	Yes	103
Greater Manchester: South	Pennine Care NHS Trust	To consider a review to ensure better note keeping and communication between medical staff; of the time taken for a scan to be conducted; of transfer of patients between wards and staffing levels at weekends.	Yes	104
Cumbria: South and East	University Hospitals of Morecombe Bay NHS Trust.	To consider a review of the practices and protocols regarding head injuries and the scanning of people who have such injuries.	Yes	106
Greater Manchester: City	Central Manchester NHS Foundation Trust; Manchester Primary Care Trust	To consider a review of providing 24 hour availability of consultant neuro surgical advice and surgery at the Royal Manchester Children's Hospital; the provision of BCG immunisation to children looked after under section 20 of the Children Act 1989; raising awareness of this case amongst all Greater Manchester PCTs and Social Services so they can review their procedures to ensure prompt treatment for tuberculosis and that BCG immunisation is not overlooked.	Yes	108

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: City	The Christie NHS Foundation Trust	To consider a review of processes, protocols and policies to ensure that patient tests are appropriately diarised to minimise the chance of oversight due to human error and the hospital to conduct its own investigation to ascertain what happened and what lessons can be learnt from this death.	Yes	110
Staffordshire: South	Stafford Hospital	To consider the arrangements for the transfer of orthopaedic patients from Stafford Hospital to Cannock Hospital and whether junior doctors should contact consultants out of hours more often.	Yes	111
London: Inner North	Barts and the London NHS Trust	To consider providing a leaflet about co-sleeping in foreign languages and as soon as possible after the birth and to review the policy for staff monitoring of new mothers.	Yes	113
West Yorkshire: Eastern	Mid Yorkshire Hospitals NHS Trust	To consider whether all Ward Managers should check all Patient Falls flowcharts immediately upon completion and staff training on completing such flowcharts.	Yes	117
West Yorkshire: Eastern	South West Yorkshire Partnership NHS Foundation Trust	To consider a review of the methods for opening internal and external doors at the non-secure units at Fieldhead Hospital Wakefield to better monitor who is leaving the units.	Yes	118
Milton Keynes	Milton Keynes Hospital	To consider a review of the use of the venous thromboembolism assessment tool and remind clinicians to use it.	Yes	121
Kent: Central and South East	East Kent Hospitals University NHS Foundation Trust	To consider a review of the practice of leaving detergents within reach of confused patients.	Yes	130
Milton Keynes	Department of Health	To consider a review of the shortage of Intensive Care Unit beds at Milton Keynes Hospital.	Yes	133
Lincolnshire: West and Spilsby and Louth	United Lincolnshire Hospitals	To consider whether scans should be reviewed by a radiologist and if no local expert is available obtaining an opinion from a teaching hospital.	Yes	145
Staffordshire: South	Stafford Hospital	To consider a review to improve communication between services; adopting a proper triage system in the Accident and Emergency Department; improving staffing levels to reduce delays and staff communication where a patient's condition changes after being booked in.	Yes	146
Milton Keynes	Milton Keynes Hospital	To consider following NICE protocols regarding the use of ultra sound.	Yes	147

Coroner District	Organisation	Summary	Response Received	Report
Cheshire	Macclesfield Hospital	To consider a review of the monitoring of patient nutrition and ensuring that notes are transferred automatically with patients between hospitals.	Yes	148
Darlington and South Durham/North Durham	University Hospital of North Durham; Department of Health	To consider an urgent review of the guidelines on care for mothers during vaginal delivery who have had a previous caesarean delivery and improving communication between medical staff and patients.	Yes	149
Cornwall	Royal Cornwall Hospital	To consider a review to improve the monitoring of patients; the accurate recording of observations; the completion of medical records and improving communication between medical and nursing staff.	Yes	152
Greater Manchester :West	Department of Health	To consider a review of the provision of services for adult metabolic patients and improving training in adult metabolicism.	Yes	153
Hertfordshire	Lister Hospital	To consider a review of its risk assessment form to ensure it conforms with the Department of Health form; specifically asking patients if they are taking oral contraception and handing patients warning leaflets on deep vein thrombosis when they have had lower limb surgery.	Yes	154
Cardiff and the Vale of Glamorgan	University Hospital of Wales	To consider how to improve communication between nurses and doctors and to reduce delays in obtaining laboratory tests.	Yes	155
Bridgend and Glamorgan Valleys	Cwm Taf Health Authority	To consider a review of training for surgeons and support for trainees.	Yes	157
London: North	Queen's Medical Centre, Nottingham	To consider a review to ensure all observations are properly recorded and patients see a doctor before leaving hospital.	Yes	158
Sunderland	Department of Health; City Hospitals Sunderland NHS Foundation Trust.	To consider a review of local and national practice to prevent fatalities from medication loading doses.	Yes	164
Milton Keynes	Milton Keynes Hospital	To consider a review of the system for taking blood tests to ensure that patients are not discharged before test results are known.	Yes	173

Coroner District	Organisation	Summary	Response Received	Report
West Yorkshire: Eastern	St. James's University Hospital, Leeds	To consider a review of the role of the Delivery Suite Co-ordinator in taking responsibility for arranging a doctor's review of transfers from the antenatal ward to the delivery suite if there are suspicious or pathological traces; undertaking an independent review if a patient with a pathological trace is reported by a midwife and whether doctors reviewing cardiotocographytraces should record categorisations.	Yes	177
London: Inner South	Great Ormond Street Hospital	To consider a review to determine whether there is any systematic weakness in the way medical advice is communicated to GPs and parents attending the Urology Department and, if so, to make changes to improve communication.	Yes	180
Devon: Exeter and Greater	NHS Devon	To consider a review to ensure the results of cytology tests are reviewed and appropriately communicated.	Yes	181
Cumbria: South and East	Furness General Hospital	To consider a review of the controls and directions in the administration of antibiotics; communication between medical staff; the availability of medical notes and how the length of time between pre-operative assessments and operations might be reduced.	Yes	187
Peterborough	Peterborough City Hospital	To consider a review of record keeping; communication between the medical staff and staffing levels.	Yes	188
Sunderland	City Hospitals Sunderland NHS Foundation Trust; Newcastle upon tyne NHS Foundation Trust	To consider a review of the management of operative intervention in deteriorating patients; establishing patients' choice about the hospital at which they can have a procedure and the standard of administrative support.	Yes	195
Greater Manchester: City	Manchester Mental Health and Social Care Trust; Pennine Acute Hospitals NHS Trust	To consider a review of the speed at which psychiatric reviews are conducted; the policies for carrying out such reviews; and improving families' access to staff involved in such reviews.	Yes	196
West Yorkshire: Western	Mid Yorkshire Hospitals NHS Trust	To consider a review of training on the benefits of inducing early births in appropriate cases.	Yes	197
Kent: North East	East Kent Hospitals University NHS Foundation Trust	To consider a review of training on head injuries; communicating to family members about falls and providing a head injury advice leaflet to family members.	Yes	198

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: City	North Manchester General Hospital	To consider implementing the recommendations and actions of the internal hospital enquiry and a general programme of training for all staff regarding care for patients with learning difficulties.	Yes	203
Greater Manchester: City	East Cheshire Hospitals NHS Trust	To consider a review of record keeping at Macclesfield Hospital; access to a CT scanner; escalation in the provision of treatment; the referral and advice procedure and the Trust's incident investigation process.	Yes	204
Birmingham and Solihull	Heart of Birmingham Teaching PCT	To consider whether hospitals should send a discharge letter to a known residential care establishment in addition to the patient's GP.	No	205
Cornwall	Derriford General Hospital	To consider a review of the co-ordination between the diabetes and vascular teams.	Yes	207
Cheshire	Cheshire and Wirral NHS Partnership Trust	To provide further details about the improvements in documentation and training of nursing staff at the Beeston View nursing home; the communication between tissue viability nurses and other agencies; and how patients with serious ulcers will be regularly reviewed even where not specifically requested.	Yes	210
Hertfordshire	West Hertfordshire Hospitals NHS Trust	To consider producing a leaflet for patients who have recently had surgery who have some immobilisation explaining symptoms which require immediate contact with medical services.	Yes	214

Hospital deaths: other

Gloucestershire	Care Quality Commission	To consider a review of the patient discharge system, in particular referrals to community care services, operating at Cheltenham Hospital.	Yes	2
Nottinghamshire	Castlebeck Care Ltd	To consider a review of the systems and procedures for caring for, escorting and restraining patients at Cedar Vale Hospital.	Yes	71
Greater Manchester: West	Royal Bolton Hospital NHS Foundation Trust; Care Quality Commission; Medicines and Healthcare Products Regulatory Agency	To consider a review of the use of tables with wheels to prevent them being used as walking aids.	Yes	115

Coroner District	Organisation	Summary	Response Received	Report
Road deaths: highway safety				
Cheshire	Highways Agency	To consider a review of the signage at the M56 - M6 Northbound slip road to warn of the dangers of overturning and setting a maximum speed.	Yes	15
Newcastle Upon Tyne	Northumberland County Council	To consider a review of the signage at the junction between the A68, Stagshaw Bank and the side road Sandhoe and similar junctions in the county.	Yes	29
Lincolnshire: West and Spilsby and Louth	Lincolnshire County Council	To consider a review of all county highways to see whether additional signage is required where undulations or other defects are indentified in the road.	Yes	32
Berkshire	West Berkshire District Council	To consider a review of the signage for drivers for the pedestrian crossing on the A4 at Lower Padworth.	Yes	37
London: Inner North	Mayor Of London; Transport for London; Tower Hamlets Council	To consider a review of the design of the junction of Whitechapel Road with Valance Road, London E1 to improve cyclists' safety.	Yes	51
Kent: Central and South East	Kent Highway Services	To consider adjustments to the crossing on Scanlons Bridge Road, Hythe to make it safe for pedestrians to cross.	Yes	60
Cheshire	Halton Borough Council	To consider erecting barriers (in areas where there are none at present) on Widnes Runcorn Bridge to prevent would be suicides.	Yes	86
Kent: North East	Kent Highway Services	To consider placing visible white hazard line markings on the area of the bend at the Waldershare Park Estate.	No	90
Kent: North East	Kent Highway Services	To consider providing warning signs to alert motorists of the presence of an informal pedestrian crossing point and that pedestrians may cross there.	No	92
Greater Manchester: South	Greater Manchester Police; Highways Agency	To consider amending protocols when police officers are dealing with vehicle recovery on narrow hard shoulder areas.	Yes	93

Coroner District	Organisation	Summary	Response Received	Report
Leicestershire: Rutland and North	Office of the Parliamentary Counsel; Department of Transport; Department of Health; Independent Police Complaints Commission; Health & Safety Executive; Leicestershire Police	To consider a review of the Police Reform Act 2002 so that Police Community Support Officers cannot manage traffic without Police Officer supervision.	No	114
Coventry	Warwickshire County Council	To consider placing road markings on the A45 near Packington Hall to warn road users of a pedestrian crossing.	No	120
Wiltshire and Swindon	Wiltshire Council	To consider reducing the speed limit on the A342 at Rowde, Wiltshire.	Yes	135
Staffordshire: South	Stafford County Council	To consider a review of safety signage on Old Landywood Lane, Essington.	Yes	168
Greater Manchester: South	Oldham Borough Council	To consider a review of road safety on Chew Valley Road, Greenfield, Oldham during brass band festivals.	Yes	172
Derbyshire: Derby and South	Derbyshire County Council	To consider a review of street lighting on the B6179, Alfreton Road, Little Eaton.	Yes	179
Blackburn Hyndburn and Ribble Valley	Blackburn and Darwen Borough Council	To consider installing road safety barriers on the A666 at Duckworth Street, Darwen.	Yes	185
Essex and Thurrock	Essex County Council	To consider a review of street lighting on an unnamed road in Essex with a 30 miles per hour speed limit.	Yes	186
Derbyshire: North	Derbyshire Constabulary	To consider installing clear warnings to motorcyclists about the presence of horses and a review of the speed limit to discourage motorcyclists from hard acceleration and revving near the Parkgate Equestrian Centre, Marsh Lane, West Handley, Derbyshire.	Yes	189
Greater Manchester: City	Department of Transport	To consider amending the law to make it a requirement for riders of quad bikes to wear crash helmets.	Yes	193

Coroner District	Organisation	Summary	Response Received	Report
Staffordshire: Stoke-on-Trent and North	Stoke-on-Trent City Council; Staffordshire Police	To consider erecting barriers to prevent road users emerging directly onto the road; felling a tree and removing overgrown vegetations posing obstructions; and upgrading the pedestrian crossing on Weston Coyney Road, between Farnworth Road and Bronson Avenue, Stoke-on-Trent.	Yes	211

Road deaths: vehicle safety

Lincolnshire: West and Spilsby and Louth	Department of Transport	To consider whether to change the current MOT test so that there is a requirement for the rear window of a vehicle to be completely transparent.	No	16
Black Country	Department of Transport	To consider introducing a requirement that lorries are fitted with forward facing mirrors so that drivers can see pedestrians better.	Yes	22
Brighton and Hove	Senior Transport Officer Renong Province, Thailand	To consider a review of how public buses in Thailand are inspected and whether such buses should be fitted with seat belts.	No	128

Road deaths: driver and vehicle licensing

West Yorkshire: Eastern	Livingstone GVTS (Vehicle & Operator Services Agency)	To consider a review of the current control mechanisms to ensure drivers comply with Working Time Directives including amendments to the Road Transport (Working Time) Regulations 2005, if appropriate.	Yes	34
Leicestershire: Leicester City and South	Driver and Vehicle Licensing Agency (DVLA)	To consider a review of the DVLA's decision not to withdraw a driving licence	Yes	140

Accidents at work and health and safety

South Yorkshire: Western	Health and Safety Executive, Yorkshire and North East Division	To consider a review of Bespoke Pre-Cast Limited's compliance with health and safety processes and whether their risk assessments and safe systems of work are task specific as opposed to being general in nature.	Yes	10
London: South	Health and Safety Executive	To consider whether it should be a requirement for those who supply hydraulic driven heavy plant to make a prominent warning readily visible on the vehicle for hydraulic technicians.	Yes	30

Coroner District	Organisation	Summary	Response Received	Report
West Yorkshire: Eastern	Shulmans LLP	To consider who owns and has responsibility for the area in Clarence dock so that the safety of the canal pathway might be improved.	Yes	33
South Yorkshire: Eastern	TCN Property Projects UK Ltd	To consider a review of maintenance of the life rings in place at Manvers Lake to ensure they are present at all times.	Yes	47
West Yorkshire: Eastern	Leeds Federated Housing Association	To consider fitting gates to the entrance to 131 Belle Vue Road, Leeds.	Yes	57
South Yorkshire: Western	IDS Logistics Ltd, Sheffield; Stirling Investments, Wetherby	To consider a review of the access arrangements to the loading bay roof and installing warning signage at IDS Logistics Ltd.	Yes	65
Greater Manchester: West	Department for Business Innovation and Skills; Department for Children Schools and Families; Liverpool John Moores University	Liverpool John Moores University to consider a review of its security systems in relation to ordering, storage, removal, distribution and use of chemicals or dangerous substances at the University. The Departments of Business Innovation and Skills and for Children Schools and Families to consider the existing security systems and procedures at educational institutions and the control and review of such systems.	Yes	99
Brighton and Hove	Brighton and Hove City Council	To consider a review of the signs to warn the public of dangerous parts of the seashore and install life vests/buoyancy aids.	Yes	112
South Yorkshire: Western	Co-operative Group Limited	To consider improving the safety of steps outside the Co-op store, Proctor Place, Hillsborough	Yes	132
Greater Manchester: City	Health and Safety Executive (Scotland); Health and Safety Executive (England) Manitou UK Ltd	Manitou UK Ltd to consider a review of the Manitou 932 extended boom lifting vehicle operating manual to give clearer warnings on not using it on a slope, the need for operatives to be properly trained and to use appropriate safety equipment; Health and Safety Executive to consider the issue of warnings or information leaflets regarding safety in using such vehicles.	Yes	190
Black Country	Home Office	To consider a review of engineers working to Safety Norm for Existing Lifts (SNEL) standards when carrying out statutory six monthly inspection of lifts.	No	209

Coroner District	Organisation	Summary	Response Received	Report
Kent: Central and South East	Royal Yachting Association (RYA)	To consider the recommendations from the Marine Accident Investigation Bureau that the RYA Safety and Technical Group considers a final definition and specification for side-impact protection for crew and implements a ruling for the 2010 season; 'side-impact protection' as a structural change be added to the boats' Measurement Certificate.	Yes	216

Mental heath related deaths

Greater Manchester: West	Greater Manchester West Mental Health NHS Foundation Trust	To consider a review of the systems in place for recording the absences of patients from wards.	Yes	4
Milton Keynes	University of Buckingham	To consider a review of the systems in place for responding to emergencies and the structure and operation of the University's Welfare Department.	Yes	5
Dorset: West	Dorset Primary Care Trust	To consider a review of risk assessments; the adequacy of treatment when there is a failure to improve; the need for an assessment by a psychiatrist; the failure to take account of concerns expressed by the GP; and the adequacy of "improving access to psychiatric therapy".	Yes	13
Greater Manchester: West	Greater Manchester West Mental Health NHS Foundation Trust	To consider a review of staff awareness about their responsibilities towards patients, including patients who have left a ward.	Yes	23
Greater Manchester: West	Care Quality Commission; Greater Manchester Police	To consider a review of the need for a national standard for fences surrounding mental health units and whether there should be a requirement for healthcare assistants to have access to a patient's complete records.	Yes	31
Norfolk	Norfolk & Waveney Mental Health NHS Foundation Trust	To consider a review of Trust polices on the Care Programme approach, risk assessment and management, the level of observations for patients at risk and effective staff training.	Yes	50
Devon: Plymouth and South West	Plymouth Teaching Primary Care Trust	To consider a review of patient review meetings and whether levels of support could be better handled and communicated to patients.	Yes	55

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: North	Royal Pharmaceutical Society of Great Britain; Department of Health	To consider adding warnings about the side effects of Selective Serotonin Reuptake Inhibitor (SSRI) anti depressants on the outside of their packaging.	Yes	56
Greater Manchester: South	Pennine Care NHS Trust	To consider a review of the circumstances in which patients are routinely referred to psychiatrists.	Yes	59
Leicestershire: Leicester City and South	Leicestershire Partnership NHS Trust	To consider options to ensure nurses' legal requirements are maintained: staff to patient ratios when incidents occur and how lessons learned from incident forms are acted upon at the Bradgate Unit, Glenfield Hospital.	Yes	116
Coventry	South Warwickshire NHS Foundation Trust	To consider a review to ensure that a full mental health assessment is carried out on appropriate patients before discharge; proper liaison between the Trust and Mental Health Teams and patient record keeping.	No	123
London: Inner North	Department of Health; East London NHS Foundation Trust	To consider that the diagnosis of diabetes in psychiatric patients forms part of clinical risk management procedures.	Yes	131
London: West	West London Mental Health NHS Trust	To consider a review of its policy of allowing items on wards which could be used as ligatures and improving search procedures and patient observation levels.	Yes	136
Norfolk	Norfolk Constabulary	To consider asking questions about the mental stability of family members when processing applications for shotgun licences.	Yes	143
Powys	National Institute for Clinical Excellence	To consider a review of the options for and communication with family members of mentally ill patients who are unwilling to cooperate.	Yes	160
Greater Manchester: South	Pennine Acute Hospitals NHS Trust	To consider a review of communication between the Community Mental Health Care and Crisis Teams; out of hours communication and Crisis Team availability and communication between the Mental Health Teams and Greater Manchester Police.	No	161
Norfolk	Hellesden Hospital, Norwich	To consider a review of support workers' access to GPs' computer records; whether GPs should make direct referrals to consultant psychiatrists and whether there should be a policy or guidance on recording family members' concerns.	Yes	162

Coroner District	Organisation	Summary	Response Received	Report
London: City	Wessex Local Medical Committees Ltd	To consider a review of whether local GPs can refer mental health patients directly to London based specialists and whether long, rather than short term, placements should be provided for patients with anorexia nervosa.	Yes	174
London: Inner South	South London and Maudsley NHS Foundation Trust	To consider a review of training in emergency situations on balancing client confidentiality against informing family members; of guidance to psychiatric nurses obtaining a second opinion and how to minimise the risks of patients self-harming.	Yes	178
Greater Manchester: City	Greater Manchester West Mental Health NHS Foundation Trust; Salford City Council	To consider the implementation and audit of the recommendations of the local authority and Mental Health Trust following this death and a review of psychiatric services for vulnerable patients.	Yes	192
Essex and Thurrock	South Essex Partnership Trust	To consider a review of record keeping and communication between those involved in patient care.	Yes	212

Community healthcare and emergency services related deaths

West Yorkshire: Western	Nursing and Midwifery Council;	To consider asking midwives to emphasise to nursing mothers the importance of staying awake whilst breastfeeding babies.	Yes	17
West Yorkshire: Western	Nursing and Midwifery Council; The Royal College of Midwives	To consider a review of the information given to parents by nurses and midwives about co-sleeping with their babies.	Partial response	18
Cardiff and the Vale of Glamorgan	Welsh Ambulance Service NHS Trust	To consider a review of training for paramedics on possible post-operative complications following a tonsillectomy.	Yes	21
Cardiff and the Vale of Glamorgan	Welsh Ambulance Service NHS Trust	To consider a review of whether paramedics should carry equipment enabling them to measure end tidal carbon dioxide.	Yes	38
London: Inner South	Clinical Children's Services Mabel Goodwyn House, London	To consider a review of health visitors' practice to ensure that they weigh babies and record their weights appropriately; of all child health surveillance clinics in its area to ensure they measure, record and plot children's growth at all important reviews and to consider how best to ensure that all those involved in child health clinical assessment are aware of the importance of failure to thrive as a diagnostic indicator.	No	42

Coroner District	Organisation	Summary	Response Received	Report
South Yorkshire: Eastern	Carcroft Health Centre, Doncaster China Cottage Nursing Home, Doncaster	To consider a review of the protocols and procedures in place to check a patient's medication when a nursing home resident has spent time in hospital to ensure that there are no obvious errors.	Yes	45
South Yorkshire: Western	Barnsley PCT	To consider offering remedial support to the relevant GP in respect of his/her record keeping.	Yes	48
South Yorkshire: Eastern	Whitehouse Farm Medical Centre, Doncaster	To consider a review of the effectiveness of communication between GPs and healthcare assistants in the Medical Centre.	Yes	76
Greater Manchester: City	Manchester PCT; Central Manchester NHS foundation Trust; Greater Manchester Police; Manchester Community Alcohol Team; Manchester City Council	To consider a review of referral policies when an individual with alcohol related problems contacts a hospital, district nurse or the Police to ensure they are referred to the appropriate agency and the Alcohol Treatment Team's to consider a review of their contact processes and policies.	Yes	109
Milton Keynes	Milton Keynes Council	To consider a review of the criteria for recognising vulnerable adults and the steps that can or should be taken to support them.	Yes	122
Norfolk	Norfolk County Council	To consider a review of Social Services policies, practices and procedures to ensure calls are recorded; information is properly and promptly acted upon; sufficient staff resources are available and supervision, checks and auditing on staff activities are conducted.	Yes	129
London: West	The Hillingdon Hospital; Marie Cure Cancer Care	To consider a review of communication between Health Authority staff and Marie Cure Cancer Care staff.	Yes	138
North Yorkshire: Eastern	Yorkshire Ambulance NHS Trust; Department of Health	To consider a review of the protocols for giving emergency treatment such as applying tourniquets.	Yes	139

Coroner District	Organisation	Summary	Response Received	Report
Cornwall	Sullivan Cuff Software Limited; Royal Cornwall Hospitals NHS Trust	Sullivan Cuff Software to provide an explanation of their procedures, reporting and audit processes for the use of INRstar for initiating the anti-coagulation process, including enquiries made when a patient dies; Royal Cornwall Hospitals to consider a review of staff awareness of the appropriateness of using INRstar for initiating the anti-coagulation process and the reporting and auditing procedures following an untoward incident.	Yes	150
South Yorkshire: Eastern	Yorkshire Ambulance Service	To consider a review of the need for a written protocol and communications with family members when someone refuses to attend hospital after an ambulance is called and the ambulance crew have concerns about the person's wellbeing.	Yes	151
Greater Manchester: City	Department of Health (DH); General Medical Council (GMC); Manchester Primary Care Trust (PCT); Greater Manchester Police (GMP); North West Ambulance Service (NWAS); Manchester Mental Health and Social Care Trust (MMSCT).	DH to consider a review of the criteria under which the GMC operates in overdose cases; GMC to consider a review of their policies and procedures for overdose cases; Manchester PCT to review their GMC complaints procedures; GMP and all police forces to consider a review of witness expertise; NWAS and Joint Royal Colleges Ambulance Liaison Committee to consider a review of the guidance provided to ambulance crews; MMSCT to consider a review of training in cases where GPs and psychiatrists give repeat prescriptions.	Yes	163
Sussex: West	NHS West Sussex	To consider a review of communication between the Community Mental Health Team and patients' GPs to ensure they are aware of medication prescribed	Yes	169
Avon	Avon Fire and Rescue Service	To consider a review of when the fire service should enter residential property; make detailed enquiries of other occupants; properly record reasons for unwanted fire signals (false alarm calls) and ensure that this example is used in future training.	Yes	170
Kent: North East	Kent and Medway NHS and Social Care Partnership Trust	To consider a review of communication with family members for potentially suicidal patients notwithstanding patient confidentiality.	Yes	171

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: City	Manchester Adult Social Services; Manchester Children's Social Services	To consider a review of information sharing between Adult and Children's services and of the database to ensure the information given is accurate.	Yes	175
Greater Manchester: City	Manchester Mental Health and Social Care Trust; Care Quality Commission.	To consider a review of the management and control of ward staff; the involvement of multi-disciplinary teams with alcoholic patients; contact with such patients' families and overall management and leadership.	Yes	176
London: Inner West	London Ambulance Service; NHS Direct	To consider a review of NHS Direct's clinical decision making software to upgrade the potential severity of dog bites; to allow such software to be overridden to ensure that ambulances can be sent and review nurse assessors training for such cases.	Yes	199
Greater Manchester: South	Department of Health	To consider updating a September 2007 NICE information leaflet on head injuries.	Yes	200
Cardiff and the Vale of Glamorgan	Abertawe Bro Morgannwg University Health Board	To consider asking midwives or health care professionals to enquire about new born babies' parents' sleeping arrangements and to provide advice about the potential dangers of co-sleeping; when a patient has a hearing impediment or whose language is not English, having independent interpreters attend at least one ante-natal consultation or where there is a particularly important health message to deliver.	Yes	208

Deaths in custody

London: West	Ministry of Justice; NHS Hammersmith & Fulham	To consider raising staff awareness of the potential risk to prisoners with mental health issues from access to plastic bin liners.	Yes	20
West Yorkshire: Eastern	Ministry of Justice; HM Chief Inspector of Prisons	To consider a review of the regime and culture at HMP Wakefield particularly with regard to its impact on prisoners with mental health issues.	Yes	28
Kent Mid and Medway	Department of Health; Ministry of Justice	To consider a review of how medical conditions such as epilepsy can be best managed in a prison environment.	Yes	35

Coroner District	Organisation	Summary	Response Received	Report
Cardiff and the Vale of Glamorgan	HM Prison Cardiff; Ministry of Justice	To consider a review of the way prison admission forms are completed to ensure prisoners are appropriately directed through the prison healthcare system; the effectiveness of training given to staff in Assessment and Care in Custody Teamwork related procedures and if improvements are needed and the accuracy of the prison's medical records.	Yes	43
South Yorkshire: Eastern	HMP Lindholme	To consider a review of the training available to staff on the use of defibrillators, how to convey information accurately and quickly, and whether a situation is Code Red or Code Blue.	Yes	53
Gwent	Gwent Police	To consider requiring custody sergeants to record on the police national computer whether a detainee has previously concealed drugs; a review of the training regime for custody sergeants and custody detention officers on all aspects of Custody Unit practice, emphasising the importance of individual risk assessments; procedures for shift handovers so that incoming officers are fully briefed about those in custody and their associated risks; and staffing levels for the Custody Unit.	Yes	73
Milton Keynes	Ministry of Justice	To consider a review of the "do not resuscitate policy" and to ensure decisions not to resuscitate are made only following consultation with the prisoner/patient themselves or with members of their family.	Yes	83
Staffordshire: South	HM Prison Feathersone, Wolverhampton	To consider a review of the prisoners' personal officer's role to include occasional reports on prisoner's overall condition; the availability of training courses and if demand exceeds supply to consider running more courses and of communications between prisons specifically to ensure that the reasons for a prisoner's move between establishments are noted.	Yes	105
West Yorkshire: Eastern	Ministry of Justice	To consider a review of cell sharing arrangements to prevent prisoners obtaining prescribed morphine sulphate capsules from cell mates where a prisoner is known to have previously traded these drugs to a cell mate who subsequently overdosed and to ensure prisoners occupying single cells are routinely observed during lockdown.	Yes	119

Coroner District	Organisation	Summary	Response Received	Report
Cheshire	HM Prison Styal	To consider adopting a written procedure for obtaining medical reports; a qualified health professional conducting a second screening for all new prisoners; a quarterly audit of these processes and ways of monitoring prisoners on methadone.	Yes	125
Shropshire: Mid and North West	West Mercia Constabulary	To consider a review of training on excited delirium.	Yes	137
Bridgend and Glamorgan Valleys	HMP - Young Offender Institution Parc	To consider a review of the assessment and management of prisoners with epilepsy and the sharing of medical information with non-medical staff.	Yes	156
Dorset: West	Ministry of Justice	To consider a review of eligibility for parole; policies on segregation, the transfer of prisoners, the Pathway to Parole and communication between medical and wing staff.	Yes	201
Birmingham and Solihull	Cannock Magistrates Court; St George's Hospital; Reliance Custodial Services; Birmingham and Solihull Mental Health NHS Foundation Trust; Heart of Birmingham Primary Care Trust; HM Prison Birmingham; GEOAmey Custodial Services	To consider a review of communications between professions when dealing with prisoners with mental health issues.	No	202
Worcestershire	HM Prison Helwell	To consider a change in policy to nominate a dedicated officer to conduct, and composite forms of recording, Assessment Care in Custody Teamwork observations.	Yes	206

Coroner District	Organisation	Summary	Response Received	Report
Leicestershire: Leicester City and South	HM YOI Glen Parva; Leicestershire Partnership NHS Trust; Ministry of Justice	To consider a review of the system of referring prisoners to mental health services so they are seen within a reasonable timeframe and that those making referrals can check if the necessary steps have been taken; increasing the number of smoke detectors in prisons to install one per cell; staff training including refresher sessions on opening and closing Assessment Care in Custody Team documents and for a cell sharing risk assessment to take place automatically whenever cell sharing is considered.	Yes	215

Drug and medication related deaths

West Yorkshire: Eastern	SHS International Ltd	To consider a review of the names of MSUD Maxamum and XP Maxamum and/or the size or shape of their containers to prevent them being confused by medical professionals	Yes	26
London: West	Medicines and Healthcare Products Regulatory Agency	To consider closing down websites which purport to supply controlled drugs without a prescription.	Yes	95
Black Country	Department of Health	To consider a review of whether there is, or could be, a mechanism to prevent patients obtaining medication prescribed by a GP for a period when they are subsequently admitted to hospital.	Yes	126
Greater Manchester :West	Bolton, Salford and Trafford Mental Health NHS Trust	To consider a review of the prescription of methadone and other similar drugs.	Yes	144
Avon	Community Mental Health Team (Somerset Partnership NHS Foundation Trust); Avon & Wiltshire Mental Health Trust	To consider a review of the measures in place to arrange face to face assessments within a reasonable time between discharge from A&E and referral to the Community Mental Health Team and of the audits in place to ensure compliance with these measures and time limits.	Yes	213

Coroner District	Organisation	Summary	Response Received	Report
Care home deaths				
Norfolk	Norfolk Community Health & Care NHS Trust; Norfolk County Council	To consider a review of the guidance, support and training that may be necessary in devising, drafting, implementing and monitoring eating, drinking and swallowing care plans for people with learning difficulties in residential care.	Yes	8
South Yorkshire: Western	Care Quality Commission	To consider if guidance should be issued to care homes about how to treat diabetic residents to prevent incorrect treatment with potentially fatal consequences.	Yes	11
Avon	Care Quality Commission	To consider whether guidelines similar to those issued by NICE should be circulated to all those caring for people with epilepsy.	No	12
Staffordshire: South	Elder Homes Group	To consider a review of whether staff training on and the reporting of falls is effective in the group's homes.	Yes	40
South Yorkshire: Western	Elder Homes Group; Independent Safeguarding Authority	To consider a review of communication between care home staff in relation to patient safety and including untoward events which might be relevant to patient care on the accident report form.	Yes	62
South Yorkshire: Western	Norwood Grange EMI Residential Home; Care Quality Commission; Adult Social Services, Sheffield City Council	To consider a review of the systems and protocols in place for monitoring and supervising residents during the night and the accurate recording of any visits.	Yes	72
Hampshire: Portsmouth and South East	St Vincent Care Homes Ltd	To consider whether a clinically qualified person should be present at all times to call out a doctor to examine a resident who has fallen.	Yes	77
Avon	Blanchworth Care Group	To consider a review of the measures in place to ensure bed rail assessments in its care homes are performed and recorded appropriately and that such assessments are filed and retained in residents' records.	Yes	88
Devon: Exeter and Greater	Care Quality Commission	To consider the implementation of risk assessments at Lucerne House, Exeter.	Yes	91

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: South	Daisy Nook Residential Care Home, Ashton-under-Lyne	To consider a review of procedures for record keeping on medication administered and security and entry into care homes.	Yes	98
Cardiff and the Vale of Glamorgan	Care and Social Services Inspectorate Wales	To consider a review of communication between staff in the Ty Hafod care home, Cardiff.	Yes	141
Darlington and South Durham/North Durham	Southern Cross Healthcare	To consider ensuring that carpets are properly laid in care homes.	Yes	183
Wiltshire and Swindon	The Orders of St John Care Trust, Lincoln	To report the outcome of their review into the falls risk assessment tool and to provide copies of any revised policies, procedures and new forms.	Yes	217

Service personnel deaths

Wiltshire and Swindon	Ministry of Defence	To consider a review of the guidance for the UK command structure in Afghanistan on embedment with members of Afghan national security forces to take account of incidents involving rogue Afghan national security forces and to consider whether it is appropriate for UK personnel should bear side arms when embedded in theatre.	Yes	64
Wiltshire and Swindon	Ministry of Defence	To consider issuing mandatory intelligence updates to all visitors to bases and a review of the suitability of fleet vehicles.	Yes	191

Police procedures related deaths

London: Inner West	Home Office; Security Service; London Resilience Team; Transport for London; London Ambulance Service; Barts and London NHS Trust; Department of Health	Please see page 12 for a summary of this rule 43 report, following the inquests into the 52 deaths as a result of the bombings on the London Transport system on 7 July 2005	Yes	41

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester :West	Home Office	To consider a review of processes in cases of domestic violence and harassment on the disclosure of previous convictions to potential victims; the timeliness of enquires and submission of files to the Crown Prosecution Service (CPS); nationally agreed protocols for the early contact between the police and CPS, the release of information about complaints by telephone, the exchange of information between the various agencies involved in dealing with these cases; improved sanctions for the breach of police bail; provision to CPS of the details of an individual's bail history and information about subsequent incidents and risk assessments.	Yes	75
Hampshire: Portsmouth and South East	Hampshire Police	To consider implementing a mandatory protocol that any information about a person's mental state revealed by searches on the Police National Computer and Record Management System searches is passed on to the enquiring police officer	Yes	80
Product related deaths				
London: South	Department for Business Innovation and Skills; Health and Safety Executive	To consider a review of the adequacy of existing safeguards and whether manufacturer's instructions to engineers who install and commission boilers should be amended; whether new regulations are required to deal with condensing boilers and if checking air/gas ratios at the time of installation and commissioning of new boilers should be mandatory notwithstanding manufacturers' statements that factory settings require no further checking or adjustment.	Yes	107
Avon	Rentokil	To consider a review of the warning notices on tins of rat poison.	Yes	142
London: Inner West	Department for Business Innovation and Skills	To consider a review of whether manufacturers should be responsible for foreign produced electrical equipment.	No	184
Railway related deaths				
Brighton and Hove	Southern Railway; Community Safety Partnership Group; University of Sussex	To consider erecting danger warning signs at Falmer Railway Station.	No	194

Coroner District	Organisation	Summary	Response Received	Report
Other deaths				
Lincolnshire: West and Spilsby and Louth	Department of Transport; Association of British Travel Agents; EC Air Safety Unit	To consider monitoring the compliance of One-Two-Go and Orient Airlines with the Air Accident Investigation Commission report recommendations and publicising the EU blacklist of banned airlines.	Yes	14
Staffordshire: Stoke-on-Trent and North	Staffordshire Police; The Premier League; The Football League; The Football Licensing Authority	To consider a review of the sale of alcohol inside football grounds.	Yes	39
Greater Manchester: South	Ministry of Defence	To consider a review of information provided to ex-service personnel's clinicians regarding medication prescribed whilst the individual was on or prior to active duty with HM Armed forces.	Yes	58
Devon: Plymouth and South West	Intertain UK; Sentinel Health Care South West; Ernesettle Primary Care Centre	Intertain UK to consider: establishing a protocol for dealing with serious medical emergencies on club premises; training for members of staff and security contractors; and obtaining a defibrillator; Sentinel Health Care South West and Emesettle Primary Care Centre to review procedures on how genetic heart conditions might be better identified.	Yes	61
London: South	Department of Transport	To consider installing flight data and cockpit voice recorders and implementing a regular inspection schedule of the throttle control mechanisms in light aircraft and provide clearer instructions on restarting engines in the manual for Cessna 500 aircraft.	Yes	81
North Yorkshire: Eastern	Hambleton District Council; Department for Culture Media and Sport	To consider monitoring those entering Hambleton Leisure Centre pool and preventing entry to anyone suspected of drinking alcohol; having an extra lifeguard in the main pool area when there are more than ten swimmers; making operational changes to the running of the pool at the *end* of the session not *during* the session; providing blinds on windows and/or the lights to prevent glare on the water and evaluating the use of additional methods of detecting who is in the pool	Yes	82

Coroner District	Organisation	Summary	Response Received	Report
Hampshire: Central	Ministry of Justice	To consider a review of systems to ensure that prisoners with a record of offences against children which pre date Police National Computer records who are serving indeterminate sentences can be identified; that records of their sexual offences identify victims under 18 and that this information is available to all prison staff throughout the sentence and not only when the prisoner is being considered for release on licence; that arrangements for passing relevant information between probation officers and independent hostels are equivalent to those for approved premises and that offender managers can monitor compliance with licence conditions.	Yes	87
Northumberland: North	Magdalene Fields Golf Club, Berwick on Tweed; Berwick Holiday park	To consider a review to prevent falls down a steep gulley and installing warning signs for visitors.	Yes	124
London: Inner South	British Cardiovascular Society; UK Athletics	To consider working together to raise awareness of myocarditis and related heart conditions and to disseminate appropriate information and guidance.	Yes	182

Produced by the Ministry of Justice

Alternative format versions of this report are available on request from Coroners Division – George Austin 020 3334 4593 or george.austin@justice.gsi.gov.uk