Ministry of JUSTICE

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

Seventh Report: For period 1 October 2011 – 31 March 2012

September 2012

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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 seventh Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 October 2011 and 31 March 2012.

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-Webster, Ministry of 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 October 2011 and 31 March 2012, coroners in England and Wales issued 233 Rule 43 reports. Some reports included the lessons learned from inquests into the death of more than one person and therefore these 233 reports include lessons learned from 242 inquests. This was the highest number of reports issued in any six month period since MoJ began reporting in July 2008.

Table 1: The number of Rule 43 reports issued by reporting period.

Reporting period	Number of Rule 43 reports issued
17 July 2008 – 31 March 2009	207
1 April – 30 September 2009	164
1 October 2009 – 31 March 2010	195
1 April – 30 September 2010	175
1 October 2010 – 31 March 2011	189
1 April 2011 30 September 2011	210
1 October 2011 – 31 March 2012	233
Total	**1373**

As in all previous summary bulletins, Rule 43 reports were most commonly issued in connection with hospital deaths, accounting for 38% of reports issued (88 reports). Second most common reports were in connection with road deaths (30 reports) and third were in relation to mental health related deaths (27 reports). This is the first report in which mental health related deaths has been one of the top three categories.

A list of the number of rule 43 reports for each category of death is shown in **Table 2**.

Table 2: Rule 43 reports issued by coroners between 1 October 2011 and 31 March 2012, by broad category

Category	Number of inquests where Rule 43 reports issued
Hospital deaths *(Clinical procedures and medical management)*	88
Road deaths	29
(Highways safety)	(21)
(Vehicle safety)	(5)
(Driver and vehicle licensing)	(3)
Mental health related deaths	27
Community health care and emergency services related deaths	22
Care home deaths	14
Deaths in custody	13
Drug and medication related deaths	12
Accidents at work and health and safety related deaths	8
Police procedures related deaths	4
Product related deaths	3
Railway related death	1
Other	12
Total	**233**

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

For the period covered by this report there were 113 coroner districts in England and Wales. Between 1 October 2011 and 31 March 2012. Rule 43 reports were issued by 63 (56%) 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 Cardiff and the Vale of Glamorgan coroner's district issued 11 reports, the highest number of reports, which equates to 5% 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 63 coroner's 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 3 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 314 reports were issued.

As the majority of Rule 43 reports arose out of hospital deaths, NHS hospitals and Trusts were sent the most reports (38% 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 3: Rule 43 reports issued by coroners between 1 October 2011 and 31 March 2012, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	120
Individual Ministers/central Government departments	46
Regulatory bodies and trade associations	40
Local Authorities	28
Care and nursing homes	25
Police and emergency services	21
Private companies	19
Prisons	13
Other	2
Total	**314**

2.4. Responses to reports

The 2008 Rules introduced a new statutory duty for organisations to respond to Rule 43 reports 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

Over a third of reports issued in this period relate to deaths in hospitals. This is now an established trend and has consistently been the case since MoJ began reporting. These reports frequently identify concerns over policies and practices in relation to note taking, staffing, training, communication and handover and the recording of medications. Coroners have reported directly to the Department of Health where they have identified concerns which may have national implications, or they feel information could usefully be disseminated to all NHS Health Trusts.

Mental health related deaths feature more prominently than in previous reports. A number of reports cite communications issues, particularly between different agencies and hospital departments. They also raise the importance of training staff in caring for patients at risk of self harm.

This bulletin includes reports made to the International Rugby Board, British Boxing Board of Control and UK Athletics as coroners look to mitigate the risks associated with participation in sport. This is also indicative of a move towards coroners approaching regulatory bodies, with those organisations receiving almost twice as many reports as they have in previous periods.

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 October 2011 and 31 March 2012 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.

Case 1

A man died from a pulmonary embolism in circumstances where he had been admitted to hospital 12 days earlier for investigation of possible seizures. Amongst other investigations he underwent a computerised tomography (CT) scan of his chest which had indicated bilateral pulmonary emboli. The results of the scan were, however, not reported to the treating clinicians and although the results were available on the hospital computer the system did not appear to have been reviewed. Although a copy of the report was sent to the patient's outpatient consultant the coroner considered that the radiologist had not taken satisfactory steps to ensure that it had been effectively communicated to the all the necessary parties.

Consequently, the man was not treated for the problems identified in the CT scan and was discharged home, where he subsequently died from a massive pulmonary embolism.

Following the inquest, the Coroner wrote to the Department of Health and the Doncaster and Bassetlaw Hospitals NHS Foundation Trust asking them to consider the following matters.

- A period of induction on appointment for new clinical staff with a focus on promoting departmental policies.

- A policy to enable effective communication between the reporting radiologist and treating clinicians.

In response, the Department of Health wrote to all Strategic Health Authority (SHA) medical directors to bring these issues to the attention of Trusts within their SHA areas and to ask medical directors, with their nursing director colleagues, to ensure that their organisation's processes and procedures comply fully with Safer Practice Notice (16) *'Early identification of failure to act on radiology imaging reports.'* issued in February 2007 by the National Patient Safety Agency.

In their response, Doncaster and Bassetlaw Hospitals NHS Foundation Trust confirmed there was already an induction period and that their Intranet was being upgraded to enable easier access to policies.

Case 2

A man died after being physical restrained by door and security staff following his ejection from a bar in Portsmouth. The inquest heard from expert witnesses, including a representative of the Security Industry Authority (SIA). It transpired that although new applicants for SIA licences since 2010 have to receive training in physical restraint techniques, this requirement has not been extended to those holding a licence originally granted before that date, who may still renew their licence without having to have such training. The inquest was told that over 100,000 people fell into this latter category.

The coroner asked The Home Office and SIA to give serious consideration to introducing a requirement for all applicants for SIA accreditation – whether new applicants or those seeking periodic renewal of licences granted prior to 2010 – to undergo training in safe physical restraint techniques.

The Home Office have since confirmed:

- Physical intervention training is to become mandatory for all door supervisors when they renew their SIA licence from February 2013.

- This training is already a compulsory part of the current nationally-recognised Award in Door Supervision introduced from June 2010. It is now to also become a requirement for those with the previous door supervision qualifications.

- From 4 February 2013, all door supervisors with one of the older qualifications will need to pass the new 'Up-Skilling Door Supervisors' award before they are able to renew their SIA licence.

- The award includes physical intervention skills training, awareness of terrorist threats, considerations in dealing with 14 to 18 year-olds and first aid awareness. Being trained in the appropriate techniques and how to use them will help door staff to manage difficult situations, minimising the risk of injury to members of the public and to themselves.

- Any individual who currently holds a door supervisor licence but does not carry out licensable activities in this sector can, after 4 February 2013, on renewal of their licence obtain instead a security guarding licence and will not have to take the additional training.

Case 3

A 3-month old baby was taken to the doctor with symptoms of viral infection and prescribed saline solution. By telephone later that day another doctor advised that the baby should be given paracetamol to reduce its temperature.

The baby's condition deteriorated and following admission to hospital died from septic endocarditis and myocarditis against a background of an abnormal aortic valve. The inquest heard evidence that suggested Vitamin D deficiency was relevant to the progression of the infection.

The Committee on Medical Aspects of Food Policy (COMA) sets dietary reference values (DRV's) for Vitamin D levels in order to prevent rickets in children and osteomalacia in adults. COMA examined the evidence between bone health and Vitamin D status in 1998 and recommended no change was needed to the DRV's.

Following the inquest the coroner reported to the Department of Health and recommended

- Consideration be given to increasing the awareness Vitamin D deficiency and its effects on health; and

- all pregnant and lactating mothers should receive 10µg Vitamin D (400 IU) daily.

In response, the Department of Health agreed that it was important to raise awareness of the issue and the Chief Medical Officer wrote to health professionals to strengthen their awareness of the need to prescribe Vitamin D supplements to at risk groups.

Case 4

A woman died from a stroke following a minor road traffic collision. Emergency services were called and the police and ambulance services were dispatched immediately. The police unit were first to arrive at the scene, the ambulance personnel having been delayed due to confusion about the location of the accident.

The woman was not breathalysed due to equipment failure, but was subsequently arrested on suspicion of driving under the influence of alcohol and drugs. She collapsed and was supported by police officers until the medical team arrived on the scene. At the hospital she was assessed by the neurological team but died later that day.

The toxicological report indicated no signs of the woman being under the influence of drugs or alcohol. The cause of death was recorded as haemorrhagic cerebral infarction.

At the inquest, a jury concluded that the loss of vehicle control stemmed from the woman's developing medical condition. The attending officers initially

interpreted her slurred speech and general demeanour as signs of intoxication rather than a neurological event. Although the coroner said that this was understandable several witnesses noticed that the woman's face drooped to one side and that they had informed the attending police of this.

The coroner wrote to South Wales Police to ask them to consider:

- That apparent intoxication may in reality be a medical condition or injury; and

- Asking witnesses what has happened upon arrival at scene, then listen to the information they give and act appropriately upon this.

South Wales Police replied that its training has been reviewed and lessons learned have been identified and implemented. Specifically, on the considerations proposed by the coroner.

- All its officers currently undergo mandatory first aid training. Irrespective of their role, they are all required to undertake a 10-hour course every three years and the training has always included a 10-minute DVD with teaching notes on the Face, Arm, Speech, and Time test. Unfortunately prior to this incident and the inquest, this content did not form part of the syllabus of the annual 4-hour refresher course. In response to the coroner's concerns, officers now receive a repeat of the stroke recognition input at the annual refresher course.

- During training officers are reminded that stroke victims will often display symptoms that can be confused with signs of intoxication. In a classroom discussion, all officers are asked to consider all available evidence and witness accounts before reaching conclusions. This case study is now used to reinforce the discussion.

Case 5

A man was electrocuted by an exposed live electric cable following cliff top erosion in Withersea. During the course of the inquest the coroner said that he was impressed with the positive way Northern Powergrid had addressed the issue. However he asked if actions could be taken to prevent a similar accident happening in the future, whether work could be undertaken with other electricity providers given that this was a potentially national issue.

In response, Northern Powergrid stated:

- Following the incident, they implemented "Coastal Erosion and Landslide Hazards Preparedness and Response Guidance" as a means of mitigating the risk. The Guidance aims to achieve an acceptable level of preparedness by focusing resources on areas where there is most risk of coastal erosion.

- They have established monitoring zones and a network of intelligence officers so they can take pre-emptive action when changes to the

coastline occur. They also feed in data from the council who fly over the coastline every six months and map the changing position of the land.

- They have presented to the industry's National Health and Safety Committee which was attended by district network operator safety managers to ensure lessons are learned at a national level.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 October 2011 and 31 March 2012

Coroner district	Reports issued
Avon	6
Birmingham and Solihull	5
Black Country	3
Blackburn, Hyndburn and Ribble Valley	2
Boston and Spalding	1
Bridgend and Glamorgan Valleys	6
Brighton and Hove	6
Buckinghamshire	5
Cardiff and the Vale of Glamorgan	11
Cheshire	4
Cornwall	1
Coventry and Warwickshire	1
Cumbria: North and West	1
Cumbria: South and East	3
North Durham and Darlington/South Durham	3
Derby and South Derbyshire	6
Devon: Exeter and Greater Devon	8
Devon: Plymouth and South West	3
East Riding and Kingston upon Hull	4
Essex and Thurrock	5
Gloucestershire	2
Greater Manchester: City	5
Greater Manchester: North	2
Greater Manchester: South	10
Greater Manchester: West	8
Gwent	1
Hertfordshire	2
Kent: Central and South East	2
Kent: North East	6
Kent: North West	3
Leicester City and South Leicestershire	2
Liverpool	3

Coroner district	Reports issued
London: East	5
London: Inner North	1
London: Inner South	6
London: Inner West	2
London: North	7
London: South	4
London: West	4
Milton Keynes	5
Newcastle upon Tyne	3
Norfolk	3
North Northumberland	3
North Yorkshire: East	3
North Yorkshire: West	2
Peterborough	1
Portsmouth and East Hampshire	3
Rutland and North Leicester	1
Shropshire: Mid and North West	3
Shropshire: Telford and Wrekin	1
Somerset: East	3
Somerset: West	1
South Yorkshire: East	5
South Yorkshire: West	6
Staffordshire: South	6
Stamford	1
Stoke-on-Trent and Staffordshire: North	3
Sunderland	2
Wales: North East	2
West Lincolnshire/Spilsby and Louth	2
West Sussex	1
West Yorkshire: East	10
West Yorkshire: West	4
Total	**233**

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.

- Aquasoothe Healthcare Ltd
- Cardiff County Council
- Department for Transport
- Devon County Council
- Essex County Council
- Ethelbert Children's Services
- Guys and St Thomas NHS Foundation Trust
- Leicester City Council
- Medacs Homecare
- Mental Health Providers Forum
- Monmouth Local Health Board
- National Council for Voluntary Organisations
- North Devon Healthcare NHS Trust
- North Tyneside Highways Department
- Royal College of Anaesthetists
- Tameside Metropolitan Borough Council
- The National Patient Safety Agency
- Transport for London

Annex C

List of Rule 43 reports received between 1 October 2011 and 31 March 2012

Coroner District	Organisation	Summary	Response Received	Report
Accidents at work and health and safety related deaths				
Black Country	National Inspection Council for Electrical Installation Contracting	To consider raising members' awareness of their liability for the authenticity of entries on domestic electrical installation certificates.	Yes	1
Bridgend and Glamorgan Valleys	Nolan Recycling Limited	To consider the supervision and safety arrangements at Nolan Recycling Limited.	Yes	2
Greater Manchester: South	(1) Salford Royal Hospital (2) Rugby Football Union (3) International Rugby Board	To consider a review of how medication is administered following sport accidents and to improve communication between clinicians, patients and their families.	Yes	3
Greater Manchester: West	Health and Safety Executive	To consider reviewing the content of the Fork Lift Truck Driver training package and whether guidance on the correct banksman procedure should be included.	Yes	4
London: Inner South	(1) Department for Communities and Local Government (2) Southwark Council	To consider whether a window latch can be altered to reduce the maximum opening or whether the risks are sufficiently great to merit the windows being fixed shut.	Yes	5
North Northumberland	Northumberland County Council	To consider a review of safety of the coastal path between North Sunderland and Seahouses.	Yes	6
Rutland and North Leicester	Ministry of Defence	To consider the suitability of the Vector vehicle in areas of conflict where it is likely to come into contact with improvised explosive devices.	Yes	7
South Yorkshire: East	South Yorkshire Police	To consider improving methods of managing police officers under internal investigation so as they might avoid additional stress.	Yes	8

Coroner District	Organisation	Summary	Response Received	Report
Care Home death				
Kent: North East	(1) Ethelbert Children's Services (2) Department of Health (3) Department for Education	To consider (1) training on when physical restraint of an absconding child might be appropriate; (2) implementing systems that prevent delays in the transfer of GP records; and (3) ensuring there are an appropriate number of qualified social workers.	No Yes Yes	9
London: East	Havering Court Nursing Home	To consider reviewing training of staff and processes for deciding appropriate care.	Yes	10
Black Country	Southern Cross Healthcare PLC	To consider a review of the standard of care in Ash Grange Nursing Home, Bloxwich.	Yes	11
Avon	Woodlea Nursing Home	To consider reviewing the policy and training of staff in cases when patients are found in an unresponsive state.	Yes	12
Cardiff and the Vale of Glamorgan	Adiemus Care Ltd	To consider reviewing procedures and training at Burges House, Cardiff in relation to 'do not resuscitate' orders and first aid.	Yes	13
Devon: Exeter and Greater Devon	(1) Devon Partnership NHS Trust (2) Devon County Council	To consider a review of its procedures for providing foster care	Yes	14
Greater Manchester: South	(1) Barton Brook Nursing Home (2) Urmston Cottage Nursing Home (3) Royal College of General Practitioners	To consider reviewing care standards and clarifying arrangements for responsibility of patients.	Yes	15
Greater Manchester: West	Camelot Health Care	To consider carrying out a review of the procedures when a resident is found to be in a collapsed and unresponsive condition and installing a panic buzzer system at the Fountains Care Home, Swinton.	Yes	16
London: Inner West	Nightingale House, London SW12	To consider reviewing how care staff identify information about potentially aggressive residents and ensuring they properly act on episodes of physical conflict.	Yes	17

Coroner District	Organisation	Summary	Response Received	Report
North Yorkshire: West	BUPA Care Homes	To consider introducing a system to monitor staff compliance with external recommendations.	Yes	18
Portsmouth and East Hampshire	Oak View Rest Home, Hayling Island, Hampshire	To consider training for staff so they know what to do when someone in their care chokes.	Yes	19
Stamford	Wellingore Hall, Lincoln	To consider reviewing care arrangements and emergency alarm systems.	Yes	20
West Yorkshire: East	Brandon House, Leeds	To consider reviewing staffing levels and the process for auditing patient notes.	Yes	21
West Yorkshire: East	Fairburn Chase Care Centre, Wheldon Road, Castlefield.	To consider reviewing its protocols for dealing with care resident in danger of choking on food.	Yes	22

Community Health Care and Emergency services related deaths

Bridgend and Glamorgan Valleys	(1) Minister for Health, Welsh Assembly (2) Welsh Ambulance Service NHS Trust (3) Monmouth Local Health Board (4) Aneurin Bevan Health Board	To consider improving the response times of the Welsh Ambulance Service.	Yes Yes No Yes	23
Greater Manchester: South	(1) Greater Manchester Police (2) Tameside Metropolitan Borough Council	To consider improving ~~the~~ policing arrangements and response times in Hattersley, Greater Manchester.	Yes No	24
London: Inner North	Medacs Homecare	To consider a review of the information given to carers following patients' discharge from hospital and that arrangements are made to replace carers who are late to an appointment.	No	25

Coroner District	Organisation	Summary	Response Received	Report
Bridgend and Glamorgan Valleys	(1) ABM University Health Board (2) Minister for Health, Welsh Assembly	To consider reviewing policies and practices on the transfer of patients from paramedics to Accident and Emergency staff	Yes	26
Brighton and Hove	(1) South East Coast Ambulance NHS Foundation Trust (2) Brighton General Hospital (3) Medicine and Healthcare Products Regulatory Authority	To consider ensuring that all clinical rooms at Brighton General Hospital have adequate resuscitation equipment and reviewing the protocol for managing anaphylaxis.	Yes	27
Cardiff and the Vale of Glamorgan	Hafod Care Association Ltd	To consider staff and family members the arrangements for holding spare keys to gain entry to residents' rooms at the Parc Hafod home in Whitchurch, Wales in cases of emergency.	Yes	28
Derby and South Derbyshire	Department of Health	To consider training advanced nurse practitioners to give treatment in serious medical emergencies such as cardiac arrests.	Yes	29
Devon: Plymouth and South West	Plymouth Community Health Care	To consider reducing delays and improving communication regarding the provision of psychiatric care and the treatment for adult patients.	Yes	30
East Riding and Kingston upon Hull	Humberside Fire and Rescue Service	To consider fitting a range of fire alarms when carrying out home safety visits to detect different types of fire.	Yes	31
Greater Manchester: South	Department of Health	To consider improving the training of district nurses in dealing with overdoses, particularly of insulin.	Yes	32
Greater Manchester: West	Greater Manchester Police (GMP)	To consider reviewing GMP's missing Persons Policy to improve clarity on who can determine and report that a person is missing.	Yes	33
Kent: North East	Association of Chief Police Officers	To consider implementing changes to police force control room responses in cases of suicide/suicide risk.	Yes	34
Kent: North West	(1) Department for Education (2) Ofsted	To consider raising awareness of 'the choking game' amongst young people.	Yes	35

Coroner District	Organisation	Summary	Response Received	Report
Leicester City and South Leicestershire	Leicester City Council	To consider what steps need to be taken to develop and promote a support network for foster parents and social workers.	Yes	36
Milton Keynes	Milton Keynes Community Health Service Trust	To consider carrying out a review of the risk assessment system for discharging patients at risk of self harm and communication channels between GP practices.	Yes	37
Milton Keynes	South Central Ambulance Service	To consider a review of the number of ambulances available to respond to critical calls and the procedure for calling in ambulances from other trusts.	Yes	38
North Northumberland	St Cuthberts Care, West Road, Newcastle-upon-Tyne	To consider reviewing the present arrangements for access to supported housing properties in case of emergency.	Yes	39
Portsmouth and East Hampshire	Hampshire Fire and Rescue Service	To consider a protocol giving guidance to the emergency services on whether an apparently lifeless water casualty can be rescusitated.	Yes	40
South Yorkshire: West	South Yorkshire Police.	To consider whether police officers should call for an ambulance at the earliest possible opportunity in an emergency situation.	Yes	41
Staffordshire: South	Department for Communities and Local Government	To consider installing a domestic sprinkler system in all new-build housing.	Yes	42
Stoke-on-Trent and Staffordshire: North	North Staffordshire Community Healthcare.	To consider improving training on tissue viability and improving the standard of record keeping.	Yes	43
Wales: North East	Betsi Cadwaladr University Health Board	To consider implementing annual refresher training on patients using insulin pumps.	Yes	44

Death in Custody

Bridgend and Glamorgan Valleys	Ministry of Justice	To consider providing prison accommodation in Wales for young offenders detained for sexual offences rather than keeping them on segregation wings.	Yes	45
Buckinghamshire	HM Prison Woodhill	To consider reviewing arrangements for transferring medical records when a prisoner is moved between prisons.	Yes	46
Cheshire	(1) HM Prison Risley (2) HM Prison Forest Bank	To consider amending procedures so that prison health records are transferred and acted on when prisoners are transferred between prisons.	Yes	47

Coroner District	Organisation	Summary	Response Received	Report
Darlington and North Durham/South Durham	HM Prison Durham	To consider a review to ensure that prisoners' medical records are available particularly on the first reception health screening.	Yes	48
Devon: Exeter and Greater Devon	HM Prison Dartmoor	To consider a review of procedures to minimise the risk of prisoners self harming or committing suicide.	Yes	49
Greater Manchester: City	(1) The Home Office (2) Department of Health (3) Ministry of Justice (4) Greater Manchester Police (5) Association of Chief Police Officers (6) National Policing Improvement Agency (7) National Offender Management Service (8) Manchester Primary Care Trust (9) Greater Manchester Probation Service (10) Chief Probation Officer (11) GEOAmey (12) Prison and Probation Ombudsman	To consider arrangements for the escort, care and management of detainees with mental health issues.	Yes	50
London: Inner South	National Offender Management Service	To consider reviewing the policy and practices to prevent suicide in young people sentenced to life imprisonment.	Yes	51
Peterborough	HM Prison Peterborough	To consider adopting a procedure to monitor self medication by prisoners.	Yes	52
Shropshire: Mid and North West	HM Prison and YOI Stoke Heath	To consider training officers in first aid and situations of possible self harm.	Yes	53

Coroner District	Organisation	Summary	Response Received	Report
West Sussex	(1) Home Office (2) Sussex Police	To consider improving the awareness of, and training in, the 2006 Home Office/Association of Chief Police Officers' "Guidance on the Safer Detention and Handling of Persons in Custody" and improving consistency in providing medical care.	Yes	54
West Yorkshire: East	National Offender Management Service	To consider improving the emergency medical equipment at HM Prison Whealstun and implementing a national 'code purple' response system similar to that of the Ambulance Service.	Yes	55
West Yorkshire: East	National Offender Management Service	To consider reviewing staffing arrangements and ensuring life support and first aid training is up to date.	Yes	56
West Yorkshire: West	Bradford District Care Trust	To consider arrangements for the timely access to prisoners' medical records.	Yes	57

Drug and medication related deaths

London: Inner South	Medicine and Health Care Products Regulation Authority	To consider reviewing the scientific evidence and safety reports on the use of Dabigatran as a peri-operative thromboprophylactic.	Yes	58
Avon	Avon and Somerset Constabulary	To consider taking licensing sanctions against a club in Bristol following its supply of illegal drugs.	Yes	59
Blackburn, Hyndburn and Ribble Valley	Department of Health	To consider whether steps can be taken to regulate drugs sold via the internet.	Yes	60
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider reviewing its administration of drugs and improving patient record keeping.	Yes	61
Cardiff and the Vale of Glamorgan	Chief Medical Officer for Wales	To consider raising awareness at a national level that constipation, developed as a side effect of taking the drugs clozapine and pirenzapine, may be fatal.	Yes	62
East Riding and Kingston upon Hull	Health House, Willerby	To consider highlighting the dangers to patients of using the drug Pregabalin.	Yes	63 and 64
Greater Manchester: North	Department of Health	To consider restrictions on the sale of alkyl nitrates.	Yes	65
Kent: North East	(1) Kent Community Health NHS Trust (2) Courts Chemist	To consider the policies and practices relating to the supply and prescription of dressings	Yes	66

Coroner District	Organisation	Summary	Response Received	Report
Shropshire: Mid and North West	Department of Health	To consider issuing guidance to NHS Trusts on dosages of intravenous paracetamol to underweight adults.	Yes	67
South Yorkshire: West	Medicine and Healthcare Products Regulatory Authority	To consider restrictions on the sale of phenylthlamine.	Yes	68
Staffordshire: South	Lloyds Pharmacy	To consider the policy for when a pharmacist wishes to hold back a prescription for further consideration.	Yes	69

Hospital deaths

London: Inner South	(1) Guys and St Thomas NHS Foundation Trust (2) National Institute for Health and Clinical Excellence (3) The National Patient Safety Agency	To consider~~,~~ in cases at St Thomas' Hospital, where the diagnosis is not clear whether a Registrar's opinion should be sought.	No Yes No	70
Derby and South Derbyshire	(1) Department of Health (2) Doncaster and Bassetlaw NHS Foundation Trust	To consider the training and induction period of new radiologists and the systems in place for escalating cases and if appropriate issuing national guidance.	Yes	71
London: North	Department of Health	To consider increasing public awareness of Vitamin D deficiency and its effects on health, especially for pregnant women and lactating mothers.	Yes	72
Birmingham and Solihull	University Hospitals Birmingham NHS Foundation Trust	To consider reinforcing practices relating to computerised tomography (CT) scans and prescription of medication.	Yes	73
Birmingham and Solihull	Care Quality Commission	To consider a review of the procedures for administering insulin at Good Hope Hospital, Sutton Coldfield.	Yes	74
Birmingham and Solihull	Birmingham Community Healthcare NHS Trust	To consider reviewing practices in relation the obtaining and recording of information on patient medication.	Yes	75

Coroner District	Organisation	Summary	Response Received	Report
Buckinghamshire	(1) National Institute for Health and Clinical Excellence (2) Royal College of Obstetrics and Gynaecology (3) Royal College of Midwives (4) Royal College of Paediatricians and Child Health (5) Association for Improvements in the Maternity Service (6) Independent Midwives UK	To consider reviewing policies and practices to mitigate the risk of polycythaemia during childbirth.	Yes	76
Devon: Exeter and Greater Devon	(1) Royal Devon and Exeter NHS Foundation Trust (2) North Devon Healthcare NHS Trust	To consider reviewing the guidance and procedure for treating patients with ear infections.	Yes No	77
Devon: Exeter and Greater Devon	University Bristol Hospitals NHS Trust	To consider improvements to the communication channels between hospital sites.	Yes	78
South Yorkshire: West	(1) The Association of Anaesthetists (2) Royal College of Anaesthetists (3) Royal College of Physicians	To consider developing guidelines for the management of patients with adrenal insufficiency undergoing surgical procedures.	Yes No Yes	79

Coroner District	Organisation	Summary	Response Received	Report
Avon	(1) Royal College of Obstetricians and Gynaecologists (2) Royal College of midwives (3) National Institute for Clinical Excellence (4) National UK Screening Committee	To consider issuing improving guidance to midwives on the parvovirus and raising knowledge of its effects and severity in pregnancy.	Yes	80
Bridgend and Glamorgan Valleys	Princess of Wales Hospital, Bridgend.	To consider reviewing the process by which decisions are made on patient monitoring levels.	Yes	81
Bridgend and Glamorgan Valleys	Cwm Taf Health Board	To consider further training of nursing staff to minimise the risk of falls and to ensure that they are accurately documented.	Yes	82
Brighton and Hove	Brighton and Sussex University Hospital NHS Trust	To consider the need for compliance with the Surgical Discharge Checklist and how medications are explained to patients.	Yes	83
Brighton and Hove	Brighton and Sussex University Hospital NHS Trust	To consider improving training and note recording in relation to administering opiate medication at the Royal Sussex County Hospital, Brighton.	Yes	84
Brighton and Hove	Brighton and Sussex University Hospital NHS Trust	To consider improving care in the evenings and at weekends and improving training, record keeping and investigative procedures at the Royal Sussex County Hospital, Brighton.	Yes	85
Brighton and Hove	Hove Polyclinic	To consider reviewing its arrangements for the withdrawal of pain medication.	Yes	86
Buckinghamshire	Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust	To consider (1) amending a form to improve recording observation levels; (2) improving out of hours medical cover; and (3) improving the observation of patients who have had a fall.	Yes	87
Buckinghamshire	Buckinghamshire Healthcare NHS Trust	To consider reviewing communication channels between medical disciplines and the arrangements for handover of patients.	Yes	88

Coroner District	Organisation	Summary	Response Received	Report
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider further training of nursing staff to minimise the risk of falls.	Yes	89
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider further training of nursing staff at the University Hospital of Wales to minimise the risk of falls.	Yes	90
Cardiff and the Vale of Glamorgan	(1) Cardiff and Vale University Health Board (2) Resuscitation Council	To consider improving communication between clinicians and staff at the University Hospital of Wales and reviewing the protocol for action following choking.	Yes	91
Cardiff and the Vale of Glamorgan	Chief Medical Officer for Wales	To consider issuing guidance to health boards on changes to the way x-rays display on a computer and the best practice for checking how a nasogastric tube is placed.	Yes	92
Cheshire	(1) Halton Borough Council (2) Warrington Hospital	To consider whether to adopt a requirement to obtain photographic evidence of injuries to a child and whether to review current capacity for child protection.	Yes	93
Cheshire	5 Boroughs NHS Trust	To consider reviewing its admission checklist to ensure all relevant documents and actions are properly logged.	Yes	94
Cumbria: South and East	(1) University Hospitals of Morecambe Bay (2) Lancashire Care NHS Foundation Trust (3) Cumbria Partnership NHS Foundation Trust	To consider reviewing procedure leading to discharging a patient.	Yes	95
Darlington and North Durham/South Durham	County Durham and Darlington NHS Trust	To consider a review of arrangements to ensure patients are diagnosed accurately.	Yes	96
Derby and South Derbyshire	(1) Department of Health (2) Royal Derbyshire Hospital	To consider implementing a policy of direct oral communication between radiologists and treating clinicians in all NHS Trusts.	Yes	97
Derby and South Derbyshire	Derby Hospital NHS Foundation Trust	To consider a review in Royal Derby Hospital's Children's Emergency Department to improve communications between clinical staff and note keeping.	Yes	98

Coroner District	Organisation	Summary	Response Received	Report
Derby and South Derbyshire	Tameside Hospital NHS Foundation Trust	To consider reviewing procedures to ensure concerns about a patient are accurately verified and recorded.	Yes	99
Derby and South Derbyshire	(1) Department of Health (2) Chesterfield Royal Hospital NHS Foundation Trust	To consider issuing guidance for presciption of drugs and to consider gastric protection measures when they are prescribed.	Yes	100
Devon: Exeter and Greater Devon	(1) Royal Devon and Exeter Hospital (2) Devon Doctors Limited	To consider improving the prioritisation of sick children in the Emergency Department.	Yes	101
Devon: Exeter and Greater Devon	Devon Doctors Limited	To consider reviewing policies on out-of-hours care.	Yes	102
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider reviewing the arrangements for discharging patients.	Yes	103
Essex and Thurrock	Colchester Hospital NHS Foundation Trust	To consider keeping a record of the location of scanners which can accommodate obese patients.	Yes	104
Essex and Thurrock	Broomfield Hospital, Chelmsford	To consider improving hospital note keeping at Broomfield Hospital, Chelmsford.	Yes	105
Essex and Thurrock	Mid Essex Hospital Services	To consider reviewing the arrangements for highlighting patient allergies.	Yes	106
Essex and Thurrock	Basildon and Thurrock University Hospitals	To consider implementating policies and practices to mitigate the risk of Legionella.	Yes	107
Gloucestershire	NHS Gloucestershire	To consider improving the maintenance and accessibility of patients' notes and to considergoing ahead with serious untoward incident investigations rather than delaying them pending coroners' investigations.	Yes	108
Gloucestershire	Frenchay Hospital, Bristol	To consider reviewing policies on out-of-hours care.	Yes	109

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: City	(1) North Manchester General Hospital (2) Food Standards Agency (3) DEFRA	To consider improving the detection and treatment of patients with symptoms of salmonella at North Manchester General Hospital.	Yes	110
Greater Manchester: South	University Hospital of South Manchester NHS Trust	To consider reviewing note taking and hygiene training and enhancing the education of those using cardiotocography.	Yes	111
Greater Manchester: South	Tameside General Hospital	To consider a review of procedures at Tameside General Hospital including procedures for observation, note-keeping and examination of young children.	Yes	112
Greater Manchester: South	Tameside General Hospital	To consider improving arrangements for staffing levels and record keeping.	Yes	113
Greater Manchester: South	Trafford Healthcare NHS Trust	To consider reviewing arrangements for recording of drugs given to patients.	Yes	114
Greater Manchester: West	The Nursing and Midwifery Council	To consider providing a nurse with additional training in administering drugs to patients.	Yes	115
Greater Manchester: West	Wrightington, Wigan and Leigh NHS Foundation Trust	To consider carrying out a review of the procedures at the Royal Albert Hospital, Wigan, to ensure prescribed medications are administered in a timely manner.	Yes	116
Greater Manchester: West	Department of Health	To consider reviewing practices in relation to placing nasogastric tubes.	Yes	117
Gwent	Cardiff and Vale University Health Board	To consider whether prospective patients with pyrexia of unknown origin following valve replacement surgery should have cultures taken for myobacterial infection.	Yes	118
Kent: Central and South East	East Kent Hospitals Trust	To consider improving the training and use of surgical observation charts at Kent and Canterbury Hospital and reviewing night time staffing arrangements.	Yes	119
Kent: North East	(1) Care Quality Commission (2) Department of Health	To consider reviewing arrangements for record handling and incident logging.	Yes	120

Coroner District	Organisation	Summary	Response Received	Report
Kent: North East	East Kent Hospitals University NHS Foundation Trust	To consider arrangements for notifying patients and their families of, and obtaining their consent to, surgical procedures.	Yes	121
Liverpool	Liverpool Primary Care Trust	To consider arrangements to enable locum doctors to access patient records and allergies.	Yes	122
London: East	Whipps Cross University Hospital, London	To consider the arrangements after patients are discharged from Accident and Emergency.	Yes	123
London: East	Barking Havering and Redbridge University Hospitals NHS Trust	To consider improving the monitoring and observation of mothers who are induced at the Kent and Canterbury Hospital.	Yes	124
London: East	Barking Havering and Redbridge University Hospitals NHS Trust	To consider a review of training, auditing and policies for controling and managing Novovirus outbreaks.	Yes	125
London: East	Barking Havering and Redbridge University Hospitals NHS Trust	To consider reviewing the process for blood transfusions and improving communications between medical staff.	Yes	126
London: Inner South	Guys and St Thomas NHS Foundation Trust	To consider improving the risk assessment and observation of emergency admitted patients who are in a confused state and ensuring that patients are triaged to ensure that those needing urgent attention see doctors without inappropriate delay	Yes	127
London: North	Barnet and Chase Farm Hospitals NHS Trust	To consider including transverse views of the right ventricular outflow tract, left ventricular outflow tract and the three vessels view and routine monitoring of oxygen saturation pre-discharge at Barnet General Hospital, Hertfordshire.	Yes	128
London: South	South London Healthcare NHS Trust	To consider ways of improving the accuracy of note taking and the associated guidance and training.	Yes	129
London: South	St Helier Hospital, Carshalton, Surrey	To consider reviewing arrangements for note taking and information sharing between the day and night staff.	Yes	130
London: West	Ealing Hospital NHS Trust	To consider addressing delays in surgical intervention.	Yes	131
Milton Keynes	Milton Keynes General Hospital	To consider whether a system should be introduced to ensure that patients with dementia have a near relative present when written consent is given.	Yes	132

Coroner District	Organisation	Summary	Response Received	Report
Milton Keynes	Milton Keynes General Hospital	To consider a review of the number of beds available for the use in the Accident and Emergency department.	Yes	133
North Northumberland	Northumbria Healthcare NHS Foundation Trust	To consider reviewing practices to ensure that patients are properly supervised whilst eating in order to prevent choking.	Yes	134
Shropshire: Telford and Wrekin	Shrewsbury and Telford Hospital Trust	To consider a review of procedures to ensure that information is effectively transferred and assessment plans continued between hospital sites.	Yes	135
Somerset: East	Yeovil District Hospital NHS Foundation Trust	To considering defining practices when cases are classified as urgent.	Yes	136
Somerset: East	Yeovil District Hospital	To consider improving record keeping and managing and co-ordinating patient care, particularly in relation to bowel care and avoiding pressure sores.	Yes	137
Somerset: East	Somerset Partnership NHS Foundation Trust	To consider reviewing arrangements for note taking and record keeping.	Yes	138
South Yorkshire: East	Doncaster and Bassetlaw NHS Foundation Trust	To consider reviewing arrangements for patient observations at Doncaster and Bassetlaw Hospitals.	Yes	139
South Yorkshire: East	Rotherham NHS Foundation Trust	To consider reviewing the protocol for lumbar punctures at Rotherham General Hospital.	Yes	140
South Yorkshire: East	Nottinghamshire Healthcare NHS Trust	To consider a review of the management of blood samples at HM Prison Moorlands.	Yes	141
South Yorkshire: East	Doncaster Royal Infirmary	To consider a review of the methods available for treating fractures in patients with peripheral vascular disease	Yes	142
South Yorkshire: West	(1) Department of Health (2) Barnsley District General Hospital	To consider improving the awareness of micro-nutrient deficiency for gastric bypass patients and improving note taking by nurses.	Yes	143
South Yorkshire: West	(1) Northern General Hospital (2) General Medical Council	To consider the need for completing all relevant forms and charts documenting a patient's medical history.	Yes	144
Staffordshire: South	Stafford Hospital	To consider the appropriate level of staffing on Christmas Day.	Yes	145

Coroner District	Organisation	Summary	Response Received	Report
Staffordshire: South	North Staffordshire Royal Infirmary	To consider a review of policy and practices relating to drip bags.	Yes	146
Stoke-on-Trent and Staffordshire: North	University Hospital of North Staffordshire.	To consider improving communication between clinicians about positive tests for MRSA and associated record keeping.	Yes	147
Stoke-on-Trent and Staffordshire: North	(1) University Hospital of North Staffordshire (2) Royal Shrewsbury Hospital	To consider reviewing its protocol for transfering patients and maintaining patient files.	Yes	148
Sunderland	Department of Health	To consider a review of the National Institute for Clinical Excellence (NICE) guidelines on treating children with epilepsy.	Yes	149
Sunderland	City Hospitals Sunderland NHS Foundation Trust	To consider whether to have a policy/guidance for relevant staff in the Emergency Department for assessing, treating and managing patients on long term anticoagulation therapy.	Yes	150
West Yorkshire: East	Leeds Teaching Hospitals NHS Trust	To consider ways of reducing a six-month waiting time for referring epileptic patients to consultant neurologists.	Yes	151
West Yorkshire: East	Leeds Teaching Hospitals NHS Trust	To consider employing a resident radiographer to carry out early diagnosis and crucial intervention.	Yes	152
West Yorkshire: East	Department of Health	To consider whether there should be 24-hour consultant cover in larger Hospital Trusts in urban areas.	Yes	153
West Yorkshire: East	Leeds Teaching Hospitals NHS Trust	To consider introducing permanent consultant cover in the Emergency Department	Yes	154
West Yorkshire: West	Calderdale and Huddersfield NHS Trust	To consider improving communication between clinicians and patient family members.	Yes	155
West Yorkshire: West	Calderdale and Huddersfield NHS Trust	To consider improving communication between clinicians and patient family members and the arrangements for 'do not attempt resuscitation' orders.	Yes	156
West Yorkshire: West	Mid Yorkshire Hospitals NHS Trust	To consider reviewing record handling and incident logging.	Yes	157

Coroner District	Organisation	Summary	Response Received	Report
Mental Health related death				
Birmingham and Solihull	Birmingham and Solihull Mental Health NHS Foundation Trust	To consider reviewing the assessment procedures for mental health patients and associated record keeping.	Yes	158
Newcastle upon Tyne	(1) Department of Health (2) National Council for Voluntary Organisations (3) Mental Health Providers Forum	To consider a review to improve communication between organisation when dealing with patients with severe mental heath conditions.	Yes No No	159
Avon	Avon and Wiltshire Mental Health NHS Trust	To consider guidance in relation to the administration of Lorazepam, particularly when reducing the dose given to a patient.	Yes	160
Avon	NHS Bath and North East Somerset	To consider improving the assessment, diagnosis and treatment of patients with autism and Asperger's syndrome.	Yes	161
Brighton and Hove	University of Sussex	To consider improving policies and processes in relation to communication between academic staff, students and welfare services to prevent suicides.	Yes	162
Cardiff and the Vale of Glamorgan	(1) Cardiff and Vale Mental Health Services (2) Llwynbedw Medical Centre	To consider the arrangements when a GP refers a patient to the community mental health team.	Yes	163
Cornwall	Cornwall Partnership NHS Foundation Trust	To consider reviewing the arrangements for GPs carrying out Mental Health Act assessments.	Yes	164
Devon: Exeter and Greater Devon	(1) Devon and Cornwall Constabulary (2) Devon Social Services	To consider the arrangements for the assessment and care of patients detained under Section 136 of the Mental Health Act 1983	Yes	165
Devon: Plymouth and South West	Devon Partnership NHS Trust	To consider improving the urgent admissions procedure for mental health patients at the Glenbourne Unit, Exeter.	Yes	166

Coroner District	Organisation	Summary	Response Received	Report
Greater Manchester: City	(1) Manchester Mental Health and Social Care Trust (2) Manchester Primary Care Trust	To consider improving the referral times for mental health assessments at Manchester Royal Infirmary and how GPs making referrals monitor their patients.	Yes	167
Greater Manchester: City	(1) Manchester Mental Health and Social Care Trust (2) Manchester Primary Care Trust (3) Rotherham, Doncaster and South Humber NHS Foundation	To consider improving the policies and practices relating to the care of patients with mental health problems.	Yes	168
Greater Manchester: City	(1) Staffordshire and Stoke-on-Trent Partnership NHS Trust (2) Stoke-on-Trent NHS Trust (3) North Staffordshire Combined Healthcare NHS Trust (4) Stoke-on-Trent City Council (5) Manchester Mental Health and Social Care Trust	To consider improving the policies and practices relating to the care of patients with mental health problems.	Yes	169
Greater Manchester: West	The Five Boroughs Partnership NHS Foundation Trust.	To consider whether it is necessary to implement a system to ensure that support workers escalate concerns expressed by service users to an appropriately qualified member of staff.	Yes	170
Greater Manchester: West	Wigan Council	To consider instituting a system to ensure social worker referrals to the Child and Adolescent Mental Health Services are appropriately followed up.	Yes	171

Coroner District	Organisation	Summary	Response Received	Report
Hertfordshire	Department of Health	To consider issuing an alert to raise awareness of self harm from ligature.	Yes	172
Hertfordshire	Barnet and Chase Farm Hospitals NHS Trust	To consider arrangements for psychiatric referrals and support for patients having undergone major surgery.	Yes	173
Kent: North West	Kent and Medway NHS and Social Care Partnership	To consider a review of staffing levels and policies and practices when handling Section 136 Mental Health Act assessments.	Yes	174
Liverpool	(1) Royal Liverpool University Hospital (2) Merseyside NHS Trust	To consider amending the form "Referral for Mental Health Assessment" to clarify whether a patient is a danger to themselves or others.	Yes	175
London: Inner South	South London and Maudsley NHS Foundation Trust	To consider training all nurses and social workers who work in mental health teams to conduct mental state examinations	Yes	176
London: Inner West	Kingston Hospital, Kingston upon Thames	To consider the process and practices in relation to the supervision and transfer of patients.	Yes	177
London: North	Arbours Association	To consider developing a policy and guidelines to prevent patients at high risk of self harm from leaving hospital and to notify next of kin in such situations throughout the Barnet, Enfield and Haringey Mental Health NHS Trusts	Yes	178
London: South	British Boxing Board of Control	To consider the support networks available when a boxer turns from amateur to professional to ensure they can cope with the extra mental pressures.	Yes	179
London: West	(1) West London Mental Health NHS Trust (2) London Borough of Ealing	To consider improving the completion of mental health assessments throughout the Trust and training when a warrant to enter premises is needed.	Yes	180
Norfolk	Norfolk and Suffolk NHS Foundation Trust	To consider whether changes are necessary to the policies, procedures and practices relating to risk assessments for patients at risk of suicide.	Yes	181
North Yorkshire: East	BT Group Plc	To consider improving policies at British Telecom to ensure that employees are given proper support and union representation during internal investigations and hearings.	Yes	182
North Yorkshire: West	NHS North Yorkshire and York	To consider implementing recommendations made in a Serious Incident report following the death concerning policies and practices in relation to mental health problems.	Yes	183

Coroner District	Organisation	Summary	Response Received	Report
West Lincolnshire and Spilsby and Louth	Lincolnshire NHS Foundation Trust	To consider i) improving note-taking particularly to ensure that telephone conversations are recorded and appropriately followed up, and ii) giving mental health patients a qualified key worker.	Yes	184

Other

East Riding and Kingston upon Hull	Northern Powergrid	To consider what could be done to reduce the risk posed by live wires in cases of costal erosion.	Yes	185
Portsmouth and East Hampshire	(1) Security Industry Authority (2) Home Office	To consider introducing requirements for all applicants for Security Industry Authority accreditation to undergo training in safe physical restraint techniques.	Yes	186
Leicester City and South Leicestershire	Leicester City Council	To consider installing warning signs on the Netherall Recreation Ground in Leicester.	No	187
West Lincolnshire and Spilsby and Louth	Security Industry Authority	To consider whether existing pre-2010 door supervisor licence holders should undergo training in physical restraint.	Yes	188
Greater Manchester: North	Rochdale Metropolitan Borough Council	To consider installing additional safety signs at a play area at Queen's Park, Heywood, Rochdale.	Yes	189
Liverpool	Andrew Louis Letting Agent	To consider improving safety warnings on fire escape windows.	Yes	190
London: North	UK Athletics	To consider the policies and practices of first aid provision at athletics events.	Yes	191
London: North	Mannings Amusements Ltd	To consider safety arrangements on funfair rides.	Yes	192
Milton Keynes	Department for Environment, Farming and Rural Affairs	To consider an urgent review of tree management by British Waterways and other organisations to improve the safety of waterways users.	Yes	193
Newcastle upon Tyne	Northumbrian Water	To consider reviewing safety measures on the River Tyne.	Yes	194
Wales: North East	Flintshire County Council	To consider a review of the safety of premises to be occupied by elderly persons.	Yes	195
West Yorkshire: East	Civil Aviation Authority	To consider a review of the arrangements for granting Display Pilot Authorisation.	Yes	196

Coroner District	Organisation	Summary	Response Received	Report
Police procedures related deaths				
Cardiff and the Vale of Glamorgan	South Wales Police	To consider raising police awareness of stroke symptoms and ensuring that appropriate questions are asked of the public upon arrival at a scene.	Yes	197
Boston and Spalding	(1) Lincolnshire Police (2) East Midlands Ambulance Services NHS Trust (3) G4S Forensic and Medical Service (UK) Ltd	To consider improving communications between the police and healthcare professionals to ensure that proper procedures are followed after road traffic accidents to determine the cause of illness/injury especially where breath test shows alcohol consumption.	Yes	198
Darlington and North Durham/South Durham	(1) Durham Police (2) Association of Chief Police Officers	To consider improving training and policies in relation to siege situations where officers are threatened with a crossbow.	Yes	199
Greater Manchester: South	Greater Manchester Police	To consider reviewing the criteria for escalating categorisation of missing persons.	Yes	200
Product related death				
Norfolk	Department for Business, Innovation and Skills	To consider issuing guidance on the danger of leaving barbeque equipment inside tents to reduce the danger of carbon monoxide poisoning.	Yes	201
Buckinghamshire	Cessna Headquarters USA	To consider installing a warning system in Cessna 185 aircraft to alert pilots if the fuel selector valve is in the 'off' position.	Yes	202
South Yorkshire: West	Health and Safety Executive	To consider a review of how customers are prioritised for heater servicing during periods of extreme cold.	Yes	203
Railway related death				
Cumbria: South and East	(1) Network Rail (2) Virgin Trains (3) Angel Trains	To consider improving track access, data capture and training on the West Coast Main Line.	Yes	204

Coroner District	Organisation	Summary	Response Received	Report
Road (Highways Safety)				
Cardiff and the Vale of Glamorgan	Cardiff County Council	To consider whether the crash barriers used across the county are of the safest design.	No	205
London: North	Transport for London	To consider installing an additional pedestrian bridge on the North Circular Road, London.	No	206
London: North	(1) Aquasoothe Healthcare Ltd (2) Director of Trading Standards, New Southgate, London (3) Department for Transport	To consider reviewing the safety labelling on mobility scooters.	No Yes No	207
Birmingham and Solihull	(1) Amey PLC (2) Birmingham City Council	To consider improving the skid resistance in lane 3 of the M6.	Yes	208
Essex and Thurrock	Essex County Council	To consider improving the safety and warning signs on the B194 Crooked Mile, Waltham Abbey close to Monkhams Hall and Eagle Lodge in Essex.	No	209
Kent: North East	Kent Highways Services	To consider if the A256 Sandwich bypass at the junction with Tilmanshone, Kent should be closed to improve safety.	Yes	210
Newcastle upon Tyne	North Tyneside Highways Department	To consider adding safety measures for pedestrians on the A189 dual carriageway from Peter Barratt's Garden Centre towards West Moor.	No	211
Somerset: West	Devon County Council	To consider cutting back overhanging hedges, bushes and trees bordering the A38 between the Devon and Somerset border and Exeter to improve safety for pedestrians	No	212
Black Country	Department for Transport	To consider improving the braking safety system on public service buses.	Yes	213
Avon	Highway and Traffic Services, Bristol City Council	To consider ways of encouraging riders of motorcycles and mopeds to secure and fasten their helmets safely.	Yes	214
Blackburn, Hyndburn and Ribble Valley	Lancashire County Council	To consider improving the signage at the junction of Fell Road and Mill Lane, Waddington.	Yes	215

Coroner District	Organisation	Summary	Response Received	Report
Cheshire	Chester/Ellesmere Port/Neston Highway Authority	To consider a review of the traffic light sequence on the A548 Sealand Road heading towards North Wales.	Yes	216
Coventry and Warwickshire	Warwickshire County Council	To consider improving the signage and warning signs on Harbury Lane outside the Mallory Court Hotel, Bishops Tachbrook.	Yes	217
Cumbria: North and West	Cumbria County Council	To consider improving the signage on the A689 road at the entrance to Silvertop Quarry near Hallbankgate.	Yes	218
Cumbria: South and East	Department for Transport	To consider installing sensors or other safety devices at the rear of vehicles which have blind spots to prevent accidents.	Yes	219
Devon: Exeter and Greater Devon	Highways Agency	To consider improving the road surface at Yard Cross, Monkton, near Honiton, Devon to reduce the level of rain water retention.	Yes	220
Greater Manchester: South	Auto Link Concessionaires (M6) PLC	To consider reviewing the road surface type used to reduce the risk of accidents on the A74(M) from junction 15 at Moffat North to the Strathclyde Police area.	Yes	221
Kent: Central and South East	Kent Highway Services	To consider whether there should be improvements to the warning signs on the A28 notifying drivers of bends in the road.	Yes	222
Kent: North West	DVLA	To consider whether lorry drivers should be required to undergo regular medical screening like train drivers and airline pilots and to consider amending Form D4 to require lorry drivers' GPs to state whether they may be affected by sleep apnoea syndrome.	Yes	223
London: South	Transport for London	To consider altering the phasing of traffic lights at the junction of Park Lane and George Street, London and putting louvers on the green signal.	Yes	224
London: West	London Borough of Hammersmith and Fulham	To consider improving the safety of a pedestrian crossing at Fulham Broadway.	Yes	225
London: West	Transport for London	To consider fitting side guards to refuse lorries to improve safety for cyclists.	Yes	226
Norfolk	Norfolk County Council	To consider safety measures for pedestrians on the A1074 Dereham Road at Costessey.	Yes	227
North Yorkshire: East	Highways Agency	To consider improving the road linkage on the A64 truck road leading from Barton Hill Crossroads towards Castle Howard.	Yes	228

Coroner District	Organisation	Summary	Response Received	Report
North Yorkshire: East	(1) Highways Agency (2) Department for Transport	To consider imposing speed restrictions and traffic calming measures on the A64 in the village of West Haslerton.	Yes	229
Shropshire: Mid and North West	Department for Transport	To consider raising driver awareness of vehicles with unfamiliar driving characteristics.	Yes	230
Staffordshire: South	Department for Transport	To consider the arrangements for the fitting of mirrors to left hand drive HGVs.	Yes	231
Staffordshire: South	Highways Agency	To consider the safety of a lay by on the A38 at Burton Upon Trent.	Yes	232
West Yorkshire: East	Leeds City Council	To consider whether measures could be introduced to assist cycle users and enhance their safety on the A6110.	Yes	233

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