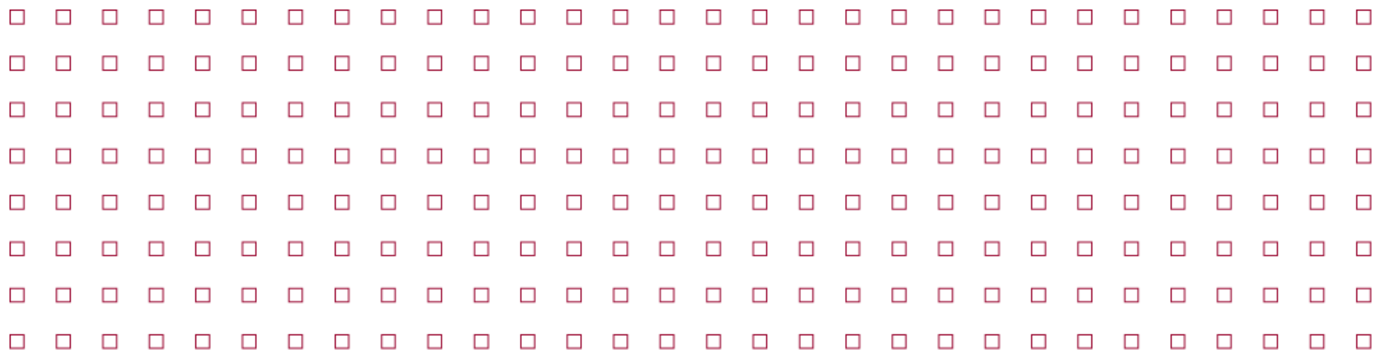
Summary of Reports and Responses under Rule 43 of the Coroners Rules

Eighth Report: For period 1 April 2012 – 30 September 2012

March 2013



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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:

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

This is the eighth Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 April 2012 and 30 September 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, Ministry of Justice, Coroners Division, 4.38 4th floor, 102 Petty France, London, SW1H 9AJ.

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 2012 and 30 September 2012 coroners in England and Wales issued 186 Rule 43 reports. Some reports included the lessons learned from inquests into the death of more than one person and therefore these 186 reports include lessons learned from 196 inquests.

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

Reporting period	Rule 43 reports issued
17 July 2008 – 31 March 2009	207
1 April 2009 – 30 September 2009	164
1 October 2009 – 31 March 2010	195
1 April 2010 – 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
1 April 2012 – 30 September 2012	186
Total	**1559**

As in all previous summary bulletins Rule 43 reports were most commonly issued in connection with hospital deaths (65 reports). Second most common were reports issued in connection with road deaths (22 reports) and third were those in relation to mental health related deaths (18 reports). Whilst the total number of reports has fallen the three most common categories remain the same as the previous report covering 1 October 2011 to 31 March 2012.

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 April 2012 and 30 September 2012, by broad category

Category	**Number of inquests where Rule 43 reports were issued**
Hospital deaths	65
Road deaths	22
Highways safety	*21*
Vehicle safety	*1*
Mental health related deaths	18
Community health care and emergency services related deaths	16
Accidents at work and health and safety related deaths	12
Deaths in custody	10
Care home deaths	9
Police procedures related deaths	8
Drug and medication related deaths	7
Product related deaths	6
Service personnel deaths	5
Railway related deaths	2
Other	6
Total	**186**

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

Between 1 April 2012 and 30 September 2012 Rule 43 reports were issued by 68 of the 112 coroner districts. This is the highest number of individual jurisdictions to report in a six month period.

In the six months covered by this bulletin, the Manchester South coroner's district issued 10 reports, the highest number by a single area. 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 70 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 234 reports were issued.

As the majority of Rule 43 reports arose out of hospital deaths, NHS hospitals and Trusts were sent the most reports (44% of the reports issued).

A list of all organisations which 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 April 2012 and 30 September 2012, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	102
Individual Ministers / central Government departments	31
Local Authorities	28
Regulatory bodies and trade associations	22
Police and emergency services	17
Prisons	12
Care and nursing homes	12
Private companies	9
Other	1
Total	**234**

2.4. Responses to reports

The 2008 Rules introduced a new statutory duty for organisations to respond to Rule 43 reports sent to them. 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 which 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 the Ministry of Justice began issuing summaries of reports. These reports frequently identify concerns over policies or in relation to note taking, staffing, training, communication and the recording of medication. 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 Trusts.

As with the previous MoJ Rule 43 report, mental health related deaths have featured prominently. A number of reports cite issues of communication particularly between different agencies and departments within hospitals.. They also raise the importance of training staff in caring for patients at risk of self harm.

In this period three reports were sent to the Department for Communities and Local Government calling for hard wired smoke alarms in rented properties to be made a legal requirement.

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

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 2012 and 30 September 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 woman who was 28 weeks pregnant attended a GP surgery unannounced to speak with a midwife. The midwife advised the woman to collect her maternity records from home and attend A&E. Approximately 30 minutes after the woman left the surgery she made a 999 call requesting an ambulance. During the phone call the woman gave birth at home. The baby, who was born two months premature, was in respiratory distress and died shortly after being taken to hospital by ambulance. The coroner gave the cause of death as peripartum hypoxia and severe prematurity and the verdict was natural causes.

During the course of the inquest it transpired that following a review by the North East Ambulance Service NHS Trust the decision had been made to include paediatric advanced life support training as a refresher to all their operational staff. The Trust had also been running a number of Emergency Life Support in Obstetrics courses. The coroner also heard that prior to the baby's death, the Ambulance Trust had a policy that a paediatric resuscitation bag containing an infant and child mask and paediatric oral pharyngeal airway devices were to be carried on their ambulances in line with recommendations set out by the UK Resuscitation Council. Following the baby's death in this case the Trust decided to further enhance their ability to respond to neonates in need of respiratory support by the introduction of size 0 neonatal facemasks and paediatric i-gels to further support airways management.

The coroner took the view that national implementation of the steps taken by the North East Ambulance Service could prevent future deaths and reported this to the Department of Health under Rule 43. Following the report:

- Professor Matthew Cooke, National Clinical Director for Urgent Emergency Care, raised the issues at a meeting of the National Ambulance Service Medical Directors.
- Professor Cooke wrote to all NHS ambulance trust medical directors to highlight the issues raised by this case and to ask them to consider the recommendations.
- Guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee included a much more extensive obstetric and neonatal section.

Case 2

An employee of Network Rail Limited was undertaking the duties of 'look-out' for a team of track engineers carrying out maintenance and repair work in the vicinity of the Whitehall West Junction, Leeds. He was struck by a train operated by Northern Rail and sustained fatal injuries. Following the inquest into his death the coroner reported a number of measures to be considered.

The Coroner asked Northern Rail to consider:

- additional training for train drivers on the circumstances in which they should sound the horn;
- the fitting of forward facing cameras in the cabs of its trains.

In their response Northern Rail confirmed they had:

- updated their training course materials and had undertaken to include these issues in classroom training which would be mandatory for all drivers;
- published guidance in their crew magazine which was issued to all drivers. The guidance covered when to sound the horn and advice on how a driver should interact with track side 'look-outs';
- already fitted all of their Class 158, 323 and 333 train fleets with front facing CCTV and had committed to considering the need for CCTV in any future fleet purchases.

Case 3

A young man died of a berry aneurism whilst he was being detained at HM Young Offenders Institution (HMYOI) Glen Parva. The approximate chronology of events is as follows:

Friday: The man arrived at Glen Parva on transfer from HMYOI Feltham. On his arrival neither the prison officers nor staff nurse who assessed him noted any cause for concern.

Saturday: The man reported to an officer that he had a headache and sore eye. He appeared in some pain and the officer made an appointment for him to be seen by the healthcare team on Sunday afternoon.

Sunday: On Sunday morning an officer asked if a nurse could attend the man and was told the nurse would see him 'during rounds'. On Sunday afternoon the man collapsed in the holding room having been taken there for his GP appointment. He was taken to hospital and died the following day.

Following the inquest the coroner sent a Rule 43 report to Leicestershire Partnership NHS Trust who have responsibility for the provision of healthcare at HMYOI Glen Parva. The coroner asked the Trust to consider clarifying how regularly triage clinics are held, what happens when there is an out-of-hours illness and what steps staff should take when prisoners report an illness.

In response Leicestershire Partnership NHS Trust issued new ‘rest in cell’ guidance. This guidance ensures prisoners who feel unwell are seen by a registered nurse on the same day they report their illness both on weekdays and at weekends. The new guidance also details the steps staff should take in these cases, and fully addresses the considerations which had been set out by the coroner.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 April 2012 and 30 September 2012

Coroner district	Reports issued
Avon	6
Berkshire	2
Birmingham and Solihull	4
Black Country	1
Blackburn, Hyndburn and Ribble Valley	1
Bridgend and Glamorgan Valleys	1
Brighton and Hove	6
Cardiff and Vale of Glamorgan	5
Cheshire	6
Cornwall	4
Coventry and Warwickshire	1
Cumbria: North and West	4
Cumbria: South and East	1
Darlington and North Durham/South Durham	3
Derbyshire: Derby and South	1
Derbyshire: North	1
Devon: Plymouth and South West	2
Dorset: West	1
East Riding and Hull	1
Exeter and Greater Devon	4
Gloucestershire	2
Gwent	1
Kent: North East	5
Kent: North West	1
Kent: South East	2
Leicester City and South Leicestershire	1
Lincolnshire: Central	3
Liverpool	4
London: East	2
London: Inner North	2
London: Inner South	6
London: Inner West	1
London: North	6
London: South	2
London: West	1
Manchester: City	5
Manchester: North	1
Manchester: South	10
Manchester: West	5

Coroner district	Reports issued
Mid Kent and Medway	1
Milton Keynes	3
Newcastle Upon Tyne	1
Norfolk	3
North Lincolnshire and Grimsby	1
North Yorkshire: West	1
Northumberland: North	2
Nottinghamshire	1
Peterborough	1
Portsmouth and East Hampshire	5
Preston and West Lancashire	1
South Yorkshire: East	2
South Yorkshire: West	3
Staffordshire: South	8
Stoke-on-Trent and North Staffordshire	1
Sunderland	3
Surrey	1
Sussex: East	1
Sussex: West	6
Teesside	1
Telford and Wrekin	1
Torbay and South Devon	1
Wales: Central North	2
Wales: North East	3
West Yorkshire: East	6
West Yorkshire: West	5
Wiltshire and Swindon	4
Wirral	1
Worcestershire	2
Total	**186**

Annex B

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

- Kent County Council
- Medicines and Healthcare products Regulatory Agency
- Merseyside NHS Trust
- North Middlesex University Hospitals NHS Trust

Annex C

List of Rule 43 reports received between 1 April 2012 – 30 September 2012

Coroner District	Organisation	Summary	Response Received	Report
Accidents at work and health and safety related deaths				
Devon: Plymouth and South West	Plymouth Community Homes	To consider issuing guidance formalising the relationship between gas inspectors and housing officers and clarifying their roles and responsibilities.	Yes	5
Brighton and Hove	UK Power Networks LTD	To consider the need for appropriate identification of sub-stations in accordance with Regulation 11 of The Electricity Safety, Quality and Continuity Regulations 2002.	Yes	137
Norfolk	(1) Department for Work and Pensions (2) North Norfolk District Council	(1) To consider amending the Health and Safety at Work Act 1974 to make provision for compulsory risk assessments at organisations which employ less than five people. (2) To consider an assessment of the process for granting and renewing riding establishment licences under the Riding Establishments Acts 1964 and 1970.	Yes	141
Darlington and North Durham/South Durham	Mattiolo Woods PLC	To consider a detailed survey of trees which may pose a threat to occupiers of the land or users of the highway.	Yes	25
Cumbria: North and West	Balkan Holidays	To consider introducing safety rails on balconies at the Sunny Beach Resort, Bulgaria.	Yes	65
North Yorkshire: West	Harrogate Borough Council	To consider an assessment of the safety precautions which are in place for wheelchair users at the Styan Centre, Harrogate.	Yes	66
Wiltshire and Swindon	Association of Chief Police Officers	To consider issuing guidance on welfare matters for Chief Officers under investigation.	Yes	71

Coroner District	Organisation	Summary	Response Received	Report
Liverpool	Network Rail	To consider improving the fencing and adding warning signs of the steep drop at the disused railway line at Weldon Street, Liverpool.	Yes	73
Manchester: City	(1) Department of Communities and Local Government (2) Manchester City Council	To consider reviewing legislation for bar owners to eliminate the risk of falling from a height and whether this risk can be considered when decisions on licencing a venue are made.	Yes	97
Staffordshire: South	Health and Safety Executive	To consider issuing guidance to raise awareness of asbestos in floor tiles and grout.	Yes	103
West Yorkshire: East	East North East Homes Leeds	To consider undertaking more frequent inspection of windows in high rise accommodation and a feasibility study of having fixed and permanent window restrictors fitted to restrict the opening width.	Yes	104
Teesside	Horner's Public House, Stockton-on-Tees	To consider additional lighting and improving the state of repair of the stairs leading to the toilet at Horner's Public House, Stockton-On-Tees.	Extension granted	165
Care home deaths				
Berkshire	Bupa Care Services	To consider the appropriateness of equipment used to administer oxygen and the training of staff in performing cardiopulmonary resuscitation.	Yes	14
Cheshire	Canterbury Care	To consider the need for a suction machine and oxygen mask to be readily available and the process for the reporting and recording of concerns.	Yes	67
South Yorkshire: West	Hill Care Ltd	To consider a review of policies for monitoring patients with low blood sugar levels.	Yes	114
Northumberland: North	Northlea Court Care Home, Cramlington	To consider: additional assessment of residents with difficulties in chewing or swallowing; training staff in the risk of feeding people and how to clear airway obstructions; and regularly reviewing care notes to ensure they are kept up to date.	Yes	133

Coroner District	Organisation	Summary	Response Received	Report
London: Inner South	Beechcroft Nursing Home, Catford	To consider ensuring there is always a member of staff who is trained in cardiopulmonary resuscitation.	Yes	140
Manchester: South	Tameside Metropolitan Borough Council	To consider the need for staff in care homes to be medically qualified.	Yes	142
Kent: North East	Kent County Council	To consider implementing a system to ensure all relevant medical records are made available to staff when a new resident arrives.	No	148
Cheshire	Care Quality Commission	To consider a review of emergency response practices at Tarvin Court Nursing Home, Littleton.	Yes	149
Wales: Central North	(1) Trewythen Hall Care Home (2) Wrexham Hospital	To consider alternative means by which the care home could be provided with a copy of the nursing specialist assessment review and the implementation of a policy which would ensure the home have this information before they undertake their own patient assessment.	Yes	181

Community health care and emergency services related deaths

Coroner District	Organisation	Summary	Response Received	Report
Mid Kent and Medway	NHS Protect	To consider how information is shared between ambulance crews and control centres and issuing guidance on best practice when responding to violent incidents.	Yes	31
Cardiff and Vale of Glamorgan	(1) Cardiff and Vale University Health Board (2) Royal College of General Practitioners (3) Welsh Ambulance Service NHS Trust	To consider reviewing policies on the provision of emergency ambulance services and training for GPs in conditions that may present as apparent gastroenteritis.	Yes	42
Sunderland	Department of Health	To consider national implementation of the North East Ambulance Service NHS Trust inclusion of paediatric advanced life support as a refresher to all operational staff.	Yes	61

Coroner District	Organisation	Summary	Response Received	Report
London: North	London Ambulance Service NHS Trust	To consider where an ambulance has been cancelled as the result of it being classified 'C4' (referred to a clinical telephone advisor) the cancellation should be made clear to the person requesting the ambulance.	Yes	72
Derbyshire: North	Derbyshire Health United	To consider issuing advice to GPs that patients with special mental or physical needs should have details of their information logged with local emergency call handlers.	Yes	77
Manchester: West	(1) Leigh Family Practice (2) NHS Greater Manchester	To consider a review of protocols for booking ambulances in emergency situations.	Yes	95
Lincolnshire: Central	East Midlands Ambulance Service NHS Trust	To consider policies relating to the allocation of resources to emergency incidents when this coincides with meal breaks.	Yes	102
Manchester: South	Pennine Care NHS Foundation Trust	To consider training in record keeping and providing written guidance on the prescription and administration of prescribed drugs.	Yes	110
Birmingham and Solihull	Issued for information to all health care providers in the Birmingham and Solihull jurisdiction – no response was required	To consider: advising all medical practitioners and the public of the risks of tuberculosis, including the risk of latent tuberculosis becoming active if it is triggered by another illness.	N/A	121

Coroner District	Organisation	Summary	Response Received	Report
Cheshire	(1) Care Quality Commission (2) Cheshire East Council (3) Cheshire West and Chester Council (4) East Cheshire NHS Trust (5) Halton Borough Council Care Quality Commission (6) St Helens and Knowsley Teaching Hospitals NHS Trust	To consider fire safety issues in relation to the organisation's service users; the referral routes to local Fire and Rescue services; and the escalation process if risks are identified.	Yes	122
Worcestershire	West Midlands Ambulance Service NHS Trust	To consider reviewing the number of staff trained in 'hot response' driving.	Yes	130
Birmingham and Solihull	National Health Service	To consider the merits of a national screening programme for Sudden Adult Death Syndrome.	Yes	139
Kent: North East	Thanet District Council	To consider the provision of a rescue boat covering Viking Bay, Broadstairs.	Yes	146
Cumbria: North and West	Carlisle City Council	To consider the introduction of a policy for handling serious physical illness at John Street Hostel, Carlisle.	Yes	156
Berkshire	Nursing and Midwifery Council	To consider introducing cardiopulmonary resuscitation as part of midwives' formal training.	Yes	168
Devon: Plymouth and South West	Mencap	To consider how to ensure that the inspection of care providers remains robust and when changes in current arrangements take place they serve to facilitate communication and co-ordination between different agencies.	Yes	179

Coroner District	Organisation	Summary	Response Received	Report
Deaths in custody				
London: West	(1) Department of Health (2) National Offender Management Service	To consider revising systems for recording medication, following up discharge from healthcare and obtaining patients' medical records	Yes	11
Leicester City and South Leicestershire	Leicestershire Partnership NHS Trust	To consider clarifying how regularly triage clinics are held, what happens when there is an out-of-hours illness and what steps staff should take when prisoners report an illness.	Yes	19
Darlington and North Durham/ South Durham	(1) National Offender Management Service (2) County Durham and Darlington NHS Foundation Trust	To consider the need for a multidisciplinary approach to the wellbeing of prisoners who pose a threat to their own health and safety.	Yes	27
Manchester: City	(1) Greater Manchester Probation Trust (2) Her Majesty's Prison Manchester (3) Manchester Mental Health and Social Care Trust (4) Manchester NHS Primary Care Trust (5) National Offender Management Service (6) Prison and Probation Ombudsman	To consider the arrangements for the escort, care and management of prisoners with mental health issues.	Yes	43
London: Inner South	Her Majesty's Prison Brixton	To consider reviewing the implementation and staff understanding of the cell sharing risk assessment policy and procedures.	Yes	45

Coroner District	Organisation	Summary	Response Received	Report
Dorset: West	Prison and Probation Ombudsman	To consider a national review of the effectiveness of drug testing equipment in prisons.	Yes	99
West Yorkshire: East	(1) Her Majesty's Prison Leeds (2) Leeds Community Healthcare NHS Trust (3) West Yorkshire Police	To consider: creation of a dedicated team of officers to investigate deaths in custody; closer monitoring of the Assessment of Care in Custody and Teamwork policy and procedure to ensure proper implementation; training in relation to handover procedure following discharge of an inmate from a healthcare centre; situations where inmates are discovered hanging; the use of the Big Word translation service; policies in relation to allegations of misconduct and the Support Officer Scheme.	Yes	112
Exeter and Greater Devon	(1) Her Majesty's Prison Exeter (2) Devon Partnership NHS Trust	To consider introducing mandatory training for prison officers in first aid and basic cardio-pulmonary resuscitation.	Yes	127
West Yorkshire: East	(1) National Offender Management Service (2) Leeds Community Healthcare NHS Trust	To consider: the need for monitoring of the Support Officer Scheme; appropriate training in the Assessment Care in Custody and Teamwork Policy and Procedure; training officers in cardiopulmonary resuscitation; and having an emergency bag located on each residential wing.	Yes	153
Milton Keynes	Her Majesty's Prison Woodhill	To consider amending the policy which states prison staff cannot call for an ambulance unless authorised by someone from healthcare.	Yes	169

Drug and medication related deaths

Coroner District	Organisation	Summary	Response Received	Report
Staffordshire: South	Mid Staffordshire NHS Foundation Trust	To consider reviewing the use of pre-filled syringes.	Yes	47
Black Country	Walsall Healthcare NHS Trust	To consider how to reduce the risk of patients being given the wrong dosage of prescribed medications.	Yes	56
Manchester: West	Medicines and Healthcare products Regulatory Agency	To consider a review of the use of Jevity and Osmalite feeds in relation to them solidifying.	Yes	107

Coroner District	Organisation	Summary	Response Received	Report
Lincolnshire: Central	Ministry of Justice	To consider what steps can be taken to close down websites which sell drugs intended for euthanasia and are purchased by those who intend to take their own life.	Yes	116
Portsmouth and East Hampshire	Portsmouth Hospitals NHS Trust	To consider reviewing the suitability and function of the syringe driver to administer Heparin.	Yes	124
Avon	Medicines and Healthcare products Regulatory Agency	To consider updating records to highlight that there is risk of cardiovascular death in patients taking Azithromycin.	No	136
Brighton and Hove	Foreign and Commonwealth Office	To consider revising travel advice for people visiting Thailand to make them aware of the dangers of 'China White', white heroin which can be confused with cocaine.	Yes	152

Hospital deaths

Coroner District	Organisation	Summary	Response Received	Report
Gloucestershire	NHS Gloucestershire	To consider a review of the criteria and procedures for assessing patients prior to discharge.	Yes	1
Birmingham and Solihull	Heart of England NHS Foundation Trust	To consider issuing guidance to specialist units that medical conditions of patients may not be within their expertise and that they should consider seeking expert advice from others to rule out unfamiliar conditions.	Yes	3
Newcastle Upon Tyne	North Cumbria University Hospitals NHS Trust	To consider the provision of dermatology services in Cumberland Infirmary.	Yes	7
London: South	Department of Health	To consider whether it is appropriate for bed managers to require the transfer of a patient undergoing treatment without consulting the clinicians involved in their treatment.	Yes	9
Manchester: West	Bridgewater Community Healthcare	To consider a review and audit of communications systems, the maintenance and compliance with care plans and training of district nurses in these areas.	Yes	10

Coroner District	Organisation	Summary	Response Received	Report
Manchester: South	Stepping Hill Hospital, Stockport	To consider having on-site consultant cover at all times.	Yes	12
London: East	Barking, Havering and Redbridge University Hospitals NHS Trust	To consider a clear policy setting out expectations of radiologists when they receive investigation requests.	Yes	13
Blackburn, Hyndburn and Ribble Valley	Department of Health	To consider whether steps need to be taken to ensure there are sufficient neurosurgical intensive care unit beds available in North West England.	Yes	15
London: Inner South	NHS Direct	To consider introducing measures to ensure GPs receive immediate information from NHS Direct when a telephone assessment of their patient takes place.	Yes	16
London: Inner South	South London Healthcare NHS Trust	To consider providing written information and emergency contacts to patients which supports the verbal advice they receive.	Yes	17
Coventry and Warwickshire	South Warwickshire NHS Foundation Trust	To consider reviewing systems in relation to discharge of patients, administration of antibiotics, availability of ultrasound and record keeping.	Yes	21
Manchester: City	(1) Pennine Acute Hospitals NHS Trust (2) Royal College of Surgeons (3) Department of Health	To consider the appropriateness of patients being in the lateral position during surgery.	Yes	23
Manchester: North	Resuscitation Council	To consider training attending clinicians in tracheotomy management in cases of cardiorespiratory distress.	Yes	26
Cardiff and Vale of Glamorgan	Riverside Health Centre, Cardiff	To consider practices relating to the prescription of antibiotics to patients taking anticoagulant medication.	Yes	29
Exeter and Greater Devon	Devon Partnership NHS Trust	To consider reviewing the shift plan documentation and the process for logging observations on patients at risk.	Yes	30

Coroner District	Organisation	Summary	Response Received	Report
South Yorkshire: East	NHS Rotherham Chantry Bridge Medical Practice	To consider a review of the questionnaire completed upon arrival at NHS walk-in centres.	Yes	34
Manchester: South	Tameside Hospital NHS Foundation Trust	To consider a review of note taking practices and the format of Emergency Department documentation.	Yes	35
Torbay and South Devon	Devon Partnership NHS Trust	To consider resourcing levels and the patient to doctor ratio.	Yes	40
Gwent	Aneurin Bevan Health Board	To consider: midwives routinely recording observations after discharge and that Health Board guidelines for physiological observations for post natal care are amended accordingly; establishing a defined pathway for mothers to report adverse symptoms; and annual refresher training for early recognition of post natal complications.	Yes	44
Cardiff and Vale of Glamorgan	Cardiff and Vale University Health Board	To consider the appropriate time for midwifery and obstetric interventions when women are giving birth.	Yes	48
Lincolnshire: Central	Lincolnshire Partnership NHS Foundation Trust	To consider the time allocated for a response when individuals are contacted following their referral to community services.	Yes	54
London: Inner South	Lewisham Healthcare NHS Trust	To consider raising awareness of the risks of chronic antibiotic therapy and the prevention and management of *clostridium difficile*; and informing GPs of sources of specialist advice to assist in preventing infections.	Yes	55
Staffordshire: South	NHS North Staffordshire	To consider issuing policy guidance on when GPs should attend elderly people in care homes and review their medication.	Yes	57
Sussex: West	Sussex Partnership NHS Foundation Trust	To consider reviewing arrangements for access to patient notes and consulting family members when further information is required.	Yes	59
Bridgend and Glamorgan Valleys	NHS Wales University Health Board	To consider additional training in appropriate techniques for staff to use during laparoscopic procedures.	Yes	62

Coroner District	Organisation	Summary	Response Received	Report
Portsmouth and East Hampshire	Portsmouth Hospitals NHS Trust	To consider reviewing the system for ensuring that patient's notes are monitored to ensure full coordination of care between different teams within the hospital.	Yes	70
Avon	Royal College of Nursing	To consider providing guidance to nursing staff who give medical assistance whilst off duty.	Yes	79
Staffordshire: South	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	To consider taking steps to improve communications between the Trust and families of patients, particularly in cases of self harm.	Yes	81
Staffordshire: South	Staffordshire and Stoke on Trent Partnership NHS Trust	To consider training and guidance for staff in assessing mental capacity and ways of improving communication between the various healthcare agencies involved in a patient's care.	Yes	82
West Yorkshire: West	Mid-Yorkshire Hospitals NHS Trust	To consider the importance of note-keeping as prescribed by the General Medical Council.	Yes	83
Kent: South East	(1) East Kent Hospitals University NHS Foundation Trust (2) Kent Community Health NHS Trust	To consider reviewing policies on the provision of information to community healthcare workers, note keeping and the treatment of pressure area damage.	Yes	85
London: East	Barking, Havering and Redbridge University Hospitals NHS Trust	To consider reviewing polices on staff contact with bed managers and when to approach King George's Hospital for additional resources.	Yes	86
Manchester: South	Stockport NHS Foundation Trust	To consider reviewing cases where patients are advised they can self-catheterise.	Yes	89
Wirral	Wirral University Teaching Hospital NHS Foundation Trust	To consider reviewing policies on the reporting of CT scans and other diagnostic tests.	Yes	90
Avon	Royal United Hospital Bath NHS Trust	To consider introducing a procedure that when discharging a vulnerable patient the families' views are taken into account and recorded.	Yes	91

Coroner District	Organisation	Summary	Response Received	Report
Liverpool	Aintree University Hospital NHS Foundation Trust	To consider processes for responding to abnormal haemoglobin levels.	Yes	92
Manchester: West	Bolton NHS Foundation Trust	To consider a review of systems for requesting radiology procedures to ensure procedures are performed within a reasonable period.	Yes	96
Nottinghamshire	Doncaster and Bassetlaw Hospital NHS Foundation Trust	To consider a review of post-operative management and the use of pre-operative plans.	Yes	101
Cheshire	Mid Cheshire Hospitals NHS Foundation Trust	To consider implementing policies to ensure full and complete notes are taken by staff and how to avoid delays in the administration of drugs.	Yes	106
Cumbria: North and West	North Cumbria University Hospitals NHS Trust	To consider training staff in the policies relating to discharging patients.	Yes	111
Staffordshire: South	Mid Staffordshire NHS Foundation Trust	To consider further training for staff on falls and mobility risk assessments.	Yes	115
South Yorkshire: West	Department of Health	To consider how greater emphasis can be placed by the medical community on learning lessons and dissemination of steps taken to prevent recurrence of untoward incidents.	Yes	117
Birmingham and Solihull	Birmingham Heartlands Hospital	To consider reviewing policies and practices in relation to the fitting and removal of catheters.	Extension granted	120
Portsmouth and East Hampshire	Portsmouth Hospitals NHS Trust	To consider a review into policies relating to CT scanning and how to improve the quality of note taking.	Yes	128
Portsmouth and East Hampshire	Portsmouth Hospitals NHS Trust	To consider a review of the format of patients' notes to see if consultants' ward round instructions could be more prominent.	Yes	129
London: Inner West	St George's Healthcare NHS Trust	To consider issuing a policy reminding staff of the minimum level of observation that is mandatory on a sedated patient.	Yes	134

Coroner District	Organisation	Summary	Response Received	Report
Manchester: South	Department of Health	To consider reviewing guidance issued by the National Institute for Health and Clinical Excellence on CT scans.	Yes	143
West Yorkshire: East	Leeds Teaching Hospital NHS Trust	To consider the transfer of patients from the Antenatal Ward to the Delivery Suite and if there is the need for a doctor's review at this point.	Yes	145
Kent: North East	(1) NHS Direct (2) South East Health Limited	To consider ways to improve communications between NHS Direct, GPs and out-of-hours services.	Yes	150
Brighton and Hove	5 Boroughs Partnership NHS Foundation Trust	To consider policies and practices relating to urgent referrals, and that all referrals are scrutinised by two persons.	Yes	155
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider the need for proper note taking and training in cannula insertions.	Yes	157
London: North	North Middlesex University Hospitals NHS Trust	To consider introducing a policy whereby patients admitted to the stroke unit have one to one supervision during their first night as they will be unfamiliar with their surroundings and at risk of falling.	No	162
London: North	Barnet and Chase Farm Hospitals NHS Trust	To consider ensuring any pregnant women with significant nephropathy, autonomic neuropathy, recurrent hypoglycaemia or hypoglycaemia unawareness are referred to a specialist centre for care during delivery.	Yes	163
London: North	Ealing Hospitals NHS Trust	To consider: training in caring for those with dementia and cognitive impairment; investigations when a patient shows signs of dementia and the appropriate accommodation for them; and a system to audit incident reports to ensure consistency.	Yes	164
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider further training in the use of the Modified Early Warning Score system.	Yes	166
Telford and Wrekin	Shrewsbury and Telford Hospital NHS Trust	To consider policies in relation to the treatment of patients with massive blood loss.	Yes	167

Coroner District	Organisation	Summary	Response Received	Report
Avon	Royal United Hospital Bath NHS Trust	To consider a review of falls risk assessment and care planning in the cardiology ward.	Yes	170
South Yorkshire: East	Doncaster and Bassetlaw Hospital NHS Foundation Trust	To consider: policies to improve note taking; guidance on what constitutes 'significantly reduced mobility'; and training on which assessments are to be undertaken at post operative review.	Yes	172
Cardiff and Vale of Glamorgan	NHS Wales Cardiff and Vale University Health Board	To consider reviewing policies for assessing and removing obstructions in advance of ventilation and the adequacy of communication channels between different teams.	Yes	174
Worcestershire	Worcestershire Acute Hospitals NHS Trust	To consider reviewing whether swipe cards can be upgraded to allow the Resuscitation Team access to Health and Care Trust premises at all times.	Yes	176
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider the referral process for patients requiring urgent procedures such as pericardiocentesis.	Yes	177
Sussex: West	Lime Tree Surgery, Worthing	To consider what can be done to improve record keeping and which checks need to be undertaken before repeat prescriptions are issued.	Yes	182
Wales: North East	NHS Wales University Health Board	To consider introducing a policy that all post operative patients pass a bowel movement before discharge from hospital or a warning notice to highlight the potential post operative risk of not doing so.	Yes	183
Wiltshire and Swindon	Salisbury NHS Foundation Trust	To consider introducing a flagging system on observation charts which notes where prescribed drugs could potentially conceal true vital signs.	Yes	184
Gloucestershire	Gloucestershire Hospitals NHS Foundation Trust	To consider the processes in place when elderly patients are discharged to a nursing home and any referrals they may need.	Yes	186

Coroner District	Organisation	Summary	Response Received	Report
Mental health related death				
Liverpool	Merseyside NHS Trust	To consider whether nearest relatives and carers of discharged patients could be provided with details of who to contact in the event of a mental health crisis.	No	28
Cornwall	(1) Cornwall Drug and Alcohol Action Team (2) Cornwall Partnership NHS Foundation Trust	To consider how to improve coordinating treatment of those with alcohol dependency and mental health and physical issues.	Yes	37
Cornwall	(1) Cornwall Drug and Alcohol Action Team (2) Cornwall Partnership NHS Foundation Trust	To consider how to improve coordinating treatment of those with alcohol dependency and mental health and physical issues.	Yes	38
Liverpool	(1) Lord Mayor of Liverpool (2) Merseyside Police	To consider not using the term 'crisis line' when referring to the Mental Health Advice Line and reviewing training in relation to mental health issues.	Yes	39
London: Inner North	(1) Metropolitan Police (2) East London NHS Foundation Trust	To consider agreeing and regularly reviewing a set of quality standards for the involvement of the Police in Mental Health Assessments.	Yes	50
Cardiff and Vale of Glamorgan	(1) Cardiff and Vale University Health Board (2) Birchgrove Surgery, Heath	To consider what improvements can be made in communication between the surgery and the Cardiff Community Mental Health team.	Yes	53
Cumbria: North and West	Cumbria Partnership NHS Foundation Trust	To consider reviewing the actions to be taken when a mental health patient is not contactable on planned or expected home visits.	Yes	63

Coroner District	Organisation	Summary	Response Received	Report
Wiltshire and Swindon	(1) Alabare Christian Care and Support (2) Avon and Wiltshire Mental Health Partnership NHS Trust (3) St Ann's Street Surgery, Salisbury (4) Unity House, Chipenham	To consider a review of processes involved in moving patients from supported accommodation in one area to another which entails a change of GP, particularly where there is a regime of daily prescriptions.	Yes	74
West Yorkshire: West	Department of Health	To consider reviewing the psychiatric care needs of those aged 16-18 who may be too old for children's services but are too young for adult services.	Yes	75
Sunderland	Department of Health	To consider: raising public awareness of mental health signs and symptoms; reviewing whether mental health referrals should be taken from family and friends in addition to the medical profession; and introducing a lead agency coordinating the various agencies concerned in mental health cases.	Yes	78
Manchester: South	(1) Greater Manchester Police (2) Pennine Care NHS Foundation Trust	To consider the training given to officers in dealing with members of the public who may have mental health issues and how they may be restrained if they have not committed an offence.	Yes	88
South Yorkshire: West	British Association for Counselling and Psychotherapy	To consider introducing policies to ensure counsellors take adequate notes, particularly where clients have inflicted serious self harm.	Yes	100
Manchester: West	Manchester Mental Health and Social Care Trust	To consider a review of procedures to ensure that patient management plans are implemented.	Yes	108
Sussex: East	Department of Health	To consider issuing national guidance on suicide prevention in mental health institutions.	Yes	118

Coroner District	Organisation	Summary	Response Received	Report
London: North	(1) Department of Health (2) Central and North West London NHS Foundation Trust	To consider: ensuring ligature cutters are available on all psychiatric units; developing a national system to capture patients' level of suicide risk; and guidance on when higher level observations should be authorised.	Yes	119
Kent: North East	(1) Kent and Medway NHS Social Care Partnership Trust (2) East Kent Hospitals University NHS Foundation Trust	To consider reviewing arrangements for admitting patients who need mental health services and the training requirements of those who attend to them.	Yes	151
Sussex: West	Care Quality Commission	To consider a review of note taking and observations and also training in how decisions should be made under the Mental Health Act 2005.	Yes	180
Wales: Central North	(1) NHS Wales University Health Board (2) North Wales Police	(1) To consider policies for prioritising cases where there is a suicide risk. (2) To consider how improvements could be made to family liaison and open communications regarding patient care.	Yes	185

Other

Coroner District	Organisation	Summary	Response Received	Report
Derbyshire: Derby and South	Department for Communities and Local Government	To consider making the provision of hard wired smoke alarms a requirement in all rented properties.	Yes	22
Avon	The British Balloon and Airship Club	To consider amending guidelines in relation to the use of supplementary oxygen tanks in hot air balloons.	Yes	41
Sussex: West	Department for Communities and Local Government	To consider making the provision of hard wired smoke alarms a requirement in all rented properties.	Yes	49
Manchester: City	(1) Security Industry Authority (2) Home Office	To consider whether there should be a mandatory national syllabus in physical intervention techniques for door supervisors.	Yes	52

Coroner District	Organisation	Summary	Response Received	Report
Milton Keynes	Department for Communities and Local Government	To consider introducing legislation to require private landlords to register their properties with the local authority and for houses in multiple occupancy to be required to have a sprinkler system fitted.	Yes	87
Sussex: West	Department for Communities and Local Government	To consider making the provision of hard wired smoke alarms a requirement in all rented properties.	Yes	125
Police procedures related deaths				
Preston and West Lancashire	Lancashire Constabulary	To consider policies on the provision of prescription medication to detained persons, particularly when they are under the influence of alcohol.	Yes	32
Manchester: South	Greater Manchester Police	To consider the policies on police vehicle pursuits and the staffing of the Control Room.	Yes	46
Cheshire	Cheshire Constabulary	To consider reviewing procedures for the safe transportation of those arrested and detained.	Yes	58
Cheshire	Cheshire Constabulary	To consider raising knowledge and awareness of the provisions of police powers under the Mental Capacity Act 2005.	Yes	64
Darlington and North Durham/South Durham	Durham Constabulary	To consider training for police call handlers in cases where the caller indicates they are suicidal.	Yes	80
London: North	Metropolitan Police	To consider introducing a system to correctly identify priority for police response and to ensure police dispatched to make a welfare check are aware of all the circumstances.	Yes	98
Peterborough	(1) Cambridge Constabulary (2) Peterborough and Stamford Hospitals NHS Foundation Trust	To consider policies in relation to the healthcare and restraint of detained persons, particularly those under the influence of drugs or alcohol.	Yes	105

Coroner District	Organisation	Summary	Response Received	Report
Staffordshire: South	Multi Agency Safeguarding Hub, Staffordshire Police	To consider clarifying the purpose of the Multi Agency Safeguarding Hub and the process for referrals.	Yes	171

Product related death

Coroner District	Organisation	Summary	Response Received	Report
East Riding and Hull	Medicines and Healthcare products Regulatory Agency	To consider whether more could be done to advise consumers of the risks associated with mobility scooters, particularly when the user does not have full use of their arms.	Yes	4
Cornwall	Electrical Safety Council	To consider issuing guidance on the importance of fitting residual current devices to electrical core systems to mitigate the risk of fault and fire.	Yes	68
West Yorkshire: West	Trading Standards	To consider work to publicise the risk of accidental inhalation of disposable cigarette filters.	Yes	76
Kent: South East	Department for Business, Innovation and Skills	To consider the addition of a valve to helium gas canisters which stops the flow of gas after a couple of seconds.	Yes	113
London: South	Department for Business, Innovation and Skills	To consider whether any better restrictions should be placed on the importing and marketing in the UK of wheat bags and whether improvements can be made to labels and warnings on the use of wheat bags and the fire dangers which may arise.	Yes	138
Cornwall	Cornwall and Isles of Scilly Primary Care Trust	To consider raising awareness of the potential hazards of stair safety gates.	Yes	158

Railway related death

Coroner District	Organisation	Summary	Response Received	Report
West Yorkshire: East	(1) British Transport Police (2) Network Rail (3) Northern Rail	To consider: training in when to sound the horn of a train; the provision of forward facing cameras on the front of trains; policies on track maintenance; and training in the preservation of evidence for officers investigating deaths on railways.	Yes	109

Coroner District	Organisation	Summary	Response Received	Report
Manchester: City	(1) Manchester City Council (2) Office of Rail Regulation (3) Rail Accident Investigation Board (4) RAPT Dev UK Ltd (5) Stagecoach Metrolink (6) Transport for Greater Manchester	To consider what can be done to increase safety of the tram line where pedestrians cross from Piccadilly Gardens to Parker Street, Manchester.	Yes	154

Road (Highways Safety)

Coroner District	Organisation	Summary	Response Received	Report
Avon	Gloucestershire Highways	To consider additional signage warning of the bend in the road between Cobbs Cross and the A417, Gloucestershire.	Yes	2
Milton Keynes	Milton Keynes Council	To consider improving street lighting on Saxon Street, Fishmead.	Yes	6
Exeter and Greater Devon	Devon County Council	To consider placing a convex mirror on the northern side of the railway bridge on the B3215 at Ironbridge Cross, North Tawston.	Yes	8
Norfolk	Norfolk County Council	To consider whether any further road safety measures should be put in place on Brettenham Road, Kilverstone.	Yes	18
Cumbria: South and East	Highways Agency	To consider if the weather station sensors on the A590 are sufficient to assess road conditions over the full length of the road.	Yes	20
Kent: North West	(1) Department for Transport (2) Kent County Council	To consider undertaking work to improve the condition of the Main Road at Knockholt Pound, Kent and whether there should be a compulsory requirement for cyclists to wear helmets.	Yes	24
Wales: North East	Flintshire County Council	To consider placing a 'hidden dip' warning sign outside Kinnerton Lodge on Kinnerton Lane, Kinnerton.	Yes	33

Coroner District	Organisation	Summary	Response Received	Report
Norfolk	Norfolk County Council	To consider placing signs warning about the footpath crossing on the A17, Terrington St Clement.	Yes	51
Wales: North East	Wrexham County Borough Council	To consider signage or road markings to provide advance notice of a bend in the road on the A539 at Penley at the junction with Pigeon Lane.	Yes	60
Northumberland: North	Highways Agency	To consider additional warning signs and road markings, a revised road layout and clearing vegetation to improve safety on the A1 at Swarland, Northumberland.	Yes	69
West Yorkshire: West	City of Bradford Metropolitan District Council	To consider undertaking work to improve the quality of the surface of the A65.	Yes	84
North Lincolnshire and Grimsby	North Lincolnshire Council	To consider placing additional signage to reduce risks on the A18 west of the junction with the A161, Crowle.	Yes	93
Sussex: West	Department for Transport	To consider placing additional signage on the A27 west of the Whyke roundabout warning of the pedestrian crossing and whether a bridge at this location would be appropriate.	Yes	94
Manchester: South	The Bridgewater Canal Company Ltd	To consider signage and barriers to discourage cycling on the Bridgewater Canal Path, Trafford Park.	Yes	123
Staffordshire: South	Staffordshire County Council	To consider undertaking a survey to assess whether it is necessary to improve safety on the A518 between Stafford and Haughton.	Yes	135
West Yorkshire: West	Leeds City Council	To consider reviewing safety measures at the pedestrian crossing at the junction of Blenheim Walk, Woodhouse Lane and St Mark's Road, Leeds.	Yes	144
West Yorkshire: East	Leeds City Council	To consider placing warnings of the pedestrian crossing on Swinnow Road near the junction with Sunnyside Road, Bramley, and also consider the feasibility of installing a pelican crossing there.	Yes	147
London: Inner South	Foreign and Commonwealth Office	To consider whether public concerns about road safety in Thailand require further discussions with Thai authorities or more detailed notification of the risk to travellers.	Yes	159

Coroner District	Organisation	Summary	Response Received	Report
Kent: North East	Kent County Council	To consider the addition of a designated right turn area for vehicles turning from Flamingo Drive on to the A2990, Herne Bay.	Yes	160
Stoke-on-Trent and North Staffordshire	The Highways Agency	To consider additional safety measures on the approach to joining the M6 at Junction 15, including additional lighting and closure of the lay-by.	Yes	161
London: Inner North	Transport for London	To consider the need for extended use of road side safety mirrors and advanced stop lines for cyclists.	Yes	178
Road (Vehicle Safety)				
Manchester: South	Parcelforce	To consider installing additional reversing aids on their fleet of vehicles.	Yes	132
Service personnel deaths				
Exeter and Greater Devon	(1) Office of the Gas and Electricity Markets (2) Ministry of Defence	To consider whether the Ministry of Defence should be consulted on planning applications for pylons which may cause a hazard to pilots training at very low altitudes.	Yes	36
Wiltshire and Swindon	Ministry of Defence	To consider reviewing how operational intelligence can be best used and disseminated.	Yes	126
Surrey	Ministry of Defence	To consider: the need for threat and risk to be properly balanced against benefit and available resource; policies relating to the conduct and operation of Operation Barma drills; and, how concerns can be escalated through the chain of command.	Yes	131
Sunderland	Ministry of Defence	To consider: implementation of the recommendations of the Non-Statutory Inquiry into the incident; and, the 9-line procedure bearing in mind the incident at Kajaki in 2007.	Yes	173
Portsmouth and East Hampshire	Ministry of Defence	(1) To consider modifications to the Joint Personnel Administration system to allow a captain sight of previous assessments for potential crew members. (2) To consider retrofitting Royal Navy vessels with modified secure rifle racks.	Yes	175

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