Ministry of JUSTICE

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

September 2011

Contents

1. Introduction

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

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

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

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

This is the fifth Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 October 2010 and 31 March 2011.

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

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

Please send any requests to rule43reports@justice.gsi.gov.uk or to Lynette Hill, Ministry of Justice, Administrative Justice, Coroners and Burials and Court Fees Portfolio, 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

1. Rule 43 reports issued by coroners and trends

Between 1 October 2010 and 31 March 2011 coroners in England and Wales issued 189 Rule 43 reports. Some reports included the lessons learned from inquests into the death of more than one person and therefore these 189 reports include lessons learned from 203 inquests.

As in the four previous summary bulletins, Rule 43 reports were most commonly issued in connection with hospital deaths, accounting for 31% of reports issued (58 reports), broadly in line with the percentage in previous publications.

A further 13% of reports were issued in connection with community healthcare and emergency services related deaths (25 reports). This is the first time that community healthcare and emergency services related deaths have been the second most commonly issued reports; they were the third most common type of reports in the fourth summary.

The third most frequently issued reports, accounting for 12% of reports, were in connection with road deaths (22 reports).

Reports in connection with deaths in custody and accidents at work and health and safety related deaths, both of which have featured in the top three most commonly issued reports in previous reports, were the fourth and fifth most commonly issued reports in this summary (21 reports (11%) and 17 reports (9%) respectively).

Table 1 gives a breakdown of the reports issued, under the broad categories of subject upon which each report was based.

Table 1: Rule 43 reports issued by coroners between 1 October 2010 and 31 March 2011, by broad category

Category	Number of inquests where Rule 43 reports issued
Hospital deaths	58
(Clinical procedures and medical management)	(56)
(Other)	(2)
Road deaths	22
(Highways safety)	(20)
(Vehicle safety)	(2)
(Driver and vehicle licensing)	(0)
Accidents at work and health and safety related deaths	17
Mental health related deaths	11
Community healthcare and emergency services related deaths	25
Deaths in custody	21
Drug and medication related deaths	9
Care home deaths	4
Service personnel deaths	1
Police procedures related deaths	10
Product related deaths	7
Railway related deaths	0
Other deaths	4
Total	**189**

2. Name and number of Rule 43 reports received from each coroner district

There are currently 114 coroner districts in England and Wales. Between 1 October 2010 and 31 March 2011, Rule 43 reports were issued by 65 (57%) of these coroner districts. This is approximately the same percentage as in previous bulletins.

In the six months covered by this bulletin, the Greater Manchester City coroner's district issued 15 reports, the highest number of reports, which equates to 8% 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 65 coroner districts which have issued Rule 43 reports during the period covered by this bulletin, with the number issued by each district.

3. Organisations to which Rule 43 reports have been sent

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

Table 2 shows a breakdown of these organisations. Sometimes coroners send reports arising from a single inquest to more than one organisation, so the number of organisations is higher than the number of inquests. In the period covered by this bulletin 258 reports were issued.

The majority of Rule 43 reports arose out of hospital deaths, and therefore NHS hospitals and Trusts were sent the most reports (33% of the reports issued).

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

Table 2: Rule 43 reports issued by coroners between 1 October 2010 and 31 March 2011, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	86
Individual Ministers/central Government departments	63
Local Authorities	24
Private companies	15
Regulatory bodies and trade associations	19
Police and emergency services	27
Prisons	7
Care and nursing homes	7
Other	10
Total	**258**

4. Responses to reports

The Coroners (Amendment) Rules 2008 introduced a new statutory duty for organisations to respond to a Rule 43 report sent to them by a coroner. The recipient of a report must 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.

5. Emerging Trends

The trends identified in the four previous Rule 43 summary bulletins remain the main themes of the Rule 43 reports issued during the period covered in this bulletin.

Approximately a third of reports relate to hospital deaths, with the major issues being staff training, absence, or an apparent lack of staff awareness, of procedures and protocols, staff failing to follow such procedures and protocols, inaccuracies or omissions in record keeping, and concerns about communication. Communication concerns are raised in a number of areas:

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

Several reports also highlight the absence of both appropriately trained or sufficient numbers of staff and a lack of knowledge of when to seek additional support or assistance.

The second most frequently issued reports relate to community healthcare and emergency service deaths. Again communication concerns between the various agencies involved with the deceased are a key feature of these reports. Additionally, difficulties in accessing, or knowing how to access, and the effectiveness of services provided outside normal working hours, together with the following up of procedures and protocols also feature in many of this category of report.

Additionally, two common themes across the healthcare and care home reports are requests for consideration of:

- the policy on dealing with falls; the care of patients who have fallen and accurate reporting of falls; and
- reviews of serious incident investigation procedures.

The third most commonly issued reports relate to road deaths. Many of these are very specific to the area in which the incident which lead to the death took place. Most frequently coroners ask for consideration to be given to speed limits, road markings and signs. Additionally, in this period several reports have requested a review of road surfaces and the effectiveness of drainage systems in preventing flooding.

As identified in previous bulletins, reports across all categories of deaths frequently highlight communication issues and the absence of procedures and protocols or procedures and protocols not being followed or communicated properly. Health and safety issues are also a common feature in many reports across all kinds of deaths with the need for first aid training and for appropriate risk assessments to be carried out featuring in several reports. The need for sharing and implementing lessons learned after a death is a common request across all categories of deaths.

Many responses continue to set out in detail the action which has been taken and it is pleasing that many organisations take seriously the concerns that are brought to their attention. The majority of responses indicate that lessons have been learned and appropriate action already taken and that these lessons will be shared in future training and/or guidance.

3. Rule 43 reports which have wider implications

A list of Rule 43 reports received by the Lord Chancellor between 1 October 2010 and 31 March is at **Annex C.**

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

Hospital deaths

1. A man died from asphyxiation after placing a plastic bag over his head during a period of voluntary admission to an acute psychiatric ward. The man had been suffering from severe and chronic depression, and had attended the hospital following a drug overdose and an attempt to cut his wrists. After admission he had been placed on 15-minute observations but was found to have asphyxiated himself with a plastic bin liner during the night. Following the inquest the coroner wrote to the National Patient Safety Agency (NPSA) suggesting action that could be considered to reduce or eliminate the risk of self harm due to plastic bag suffocation.

   The NPSA responded that they had recently undertaken a review of incidents within the National Reporting and Learning System following similar deaths in mental health units. As a result, it had been decided to address and update the risks associated with self-harm using objects (including plastic bags) available on mental health units through the Suicide Prevention Toolkit. The NPSA also recommended that Primary Care Trusts undertook the audit prescribed by the Toolkit on a monthly basis, with more detailed annual assessment.

2. A young woman died from complications following an overdose of paracetamol tablets. After taking the overdose, the woman had promptly attended her local accident and emergency department where blood tests indicated that she could be placed on the “high risk treatment line” of the graph, as set out in Toxbase and the British National Formulary. However, as she did not meet the other criteria required to place her in that treatment line she was discharged without being offered the antidote (N-acetylcysteine).

   The following day the woman sought medical attention from the GP out of hours service, but was again discharged without being offered the antidote as she did not meet all the criteria.

   The next day, the woman returned to the accident and emergency department but her condition had deteriorated to the extent that she was immediately transferred to another hospital and placed on the urgent liver transplant list. Two days after her admission to that hospital it was decided that an intracranial pressure monitor should be inserted to observe possible swelling of her brain. Tragically, the monitor caused a bleed at the site of

insertion and the woman died as a result. Changes were made to the treatment programmes in light of the woman's death and following the inquest the coroner wrote to the Medicine and Healthcare products Regulatory Agency (MHRA) asking that consideration be given to:

- whether the changes made in the British National Formulary and Toxbase following this woman's death could be communicated to all clinical staff who may come in to contact with similar cases;
- whether Hospital Trusts could advise patients to return to hospital immediately if their symptoms continued or worsened following a paracetamol overdose;
- whether there could be a more accurate way of defining "short term fasting";
- whether there should be a presumption in all cases of paracetamol overdose that N-acetylcysteine should be given unless there are reasons not to do so;
- whether research should be conducted into:
  - the use of currently available biomarkers to increase accuracy in the identification of patients at risk from hepatotoxicity; and
  - new biomarkers of risk; and
- whether research should be conducted into the pharmacogenetics of paracetamol-induced hepatotoxicity to help identify which patients are at particular risk.

The MHRA responded that they had conducted a review of the use of N-acetylcysteine for the treatment of paracetamol overdose following the woman's death. Questions were raised about the evidence used to establish the normal and high risk treatment lines on the current British National Formulary and Toxbase graphs, and their interpretation as regards individual patients.

As a result of this, the Commission on Human Medicines has recommended that an expert working group be established to examine concerns in relation to the treatment of paracetamol overdose. This group includes both clinical and lay members and is reviewing the available preclinical and clinical evidence on the use of N-acetylcysteine for treating paracetamol overdose, including a review of worldwide experience. It is also considering how the treatment of paracetamol overdose can be optimised including consideration of the use of the risk graph and of how the use of N-acetylcysteine can be improved by examining dosage and administration regimens. The group will also advise on options for regulatory action and a communications strategy. The MHRA expected to be able to report back on the preliminary findings from the group in 2011.

Police Procedures

1. A man shot himself with a sawn off shotgun during a police siege after he had barricaded himself in his home with his children. During the siege, the man's family members had gathered at the outer cordon and made themselves known to police officers. However, their presence was not made known to the Silver Commander or the Negotiations Co-ordinator and a Family Liaison Officer (FLO) was only dispatched on the second morning of the siege, which could have delayed the collection of intelligence on the deceased.

   Following the inquest, the coroner wrote to the South Yorkshire Police suggesting that they considered:

   - improving systems of communication between the outer cordon and the Gold or Silver Commander;
   - early deployment of FLOs in all suitable cases to improve intelligence gathering;
   - relaxing national guidance on using family members as intermediaries in some sieges and, if not, that the decision *not* to involve family members was communicated clearly to all those present.

   South Yorkshire Police responded as follows:

   - Improvements to systems of communication between outer cordons and Gold and Silver Commanders would be notified to all Gold and Silver Commanders at the next available Strategic Training Day, and incorporated into future training programmes for those officers.
   - The Association of Chief Police Officers (ACPO) have raised awareness amongst all negotiators and negotiator co-ordinators about the importance of briefing officers on outer cordons on the possibility of deploying family members as intermediaries during similar incidents.
   - ACPO was also considering issuing guidance on briefing officers about family members, within the relevant chapters of their 2011 Manual of Guidance on the Management, Command and Deployment of Armed Officers.
   - ACPO had additionally considered issuing guidance on the deployment of FLOs in their 2011 Manual and South Yorkshire Gold and Silver Commanders would receive specific guidance on this issue at the next training event.
   - Lastly, whilst the decision to deploy a third party (i.e. a family member) intermediary is for the incident commander on a case-by-case basis, South Yorkshire Police were reviewing their risk assessment form for third party intermediaries to help improve informed decision-making.

2. Twelve people died as a result of gun shot wounds after a man opened fire on them over a wide area of Cumbria. Following the inquests the coroner wrote to the Home Office and Department of Health asking for consideration to be given to:

   - The functioning of the Police Airwave System. During this incident the system was working at 97% capacity given the number of calls being received, and police had difficulty in communicating. The coroner was concerned that if the airwave radio network overloaded or did not operate efficiently in a similar situation, there was a risk that injured people might die.
   - Communication between the ambulance service and the police to ensure:
     - an appropriate level of strategic communication between the two services;
     - compatibility between the ambulance and police airwave communication systems to enable the two services to communicate; and
     - that police are aware of ambulance service protocols on ambulance staff attending the scene of an incident.
   - Whether ambulance service protocols which preclude ambulance personnel from attending a scene involving knives or firearms until the area has been declared safe by the police could lead to lives being lost.

The Home Office responded as follows:

- The report commissioned after this incident identified that problems with the Airwave network were because only one local channel was being used rather than with the system itself. If multiple channels had been used, it would have lessened the strain on the system and enabled more effective command and control of the incident.
- A National Circular issued by the Association of Chief Police Officers (ACPO) Armed Policing Secretariat has communicated the lessons learned across the police service. The Circular refers police forces to the Standard Operating Practice which provides guidance; an ACPO group is working towards ensuring these practices are included in learning across all police forces.
- Promoting better communication with other emergency providers through proper technical and procedural application of Airwave is being addressed by the police at national level and through Local Resilience Forums. Work is underway to embed local Airwave Interoperability Standard Operating Procedures throughout the UK which will ensure that different emergency service commanders can establish tactical and operational multi-agency communications to aid coordination of the response.

- It has been facilitating work to ensure that emergency responders are equipped and trained to take a flexible approach to risk management at the scene of an incident to improve the quality and speed of joint decision-making among responders. Although protocols need to be developed and shared at local level, the wider work is aimed at ensuring that they minimise casualties whilst properly evaluating and managing risk to emergency service providers.

The Department of Health (DH) responded as follows:

- During the roll out of the Airwave system, DH and Ambulance Trusts ensured the system was configured and implemented in a way that met their operational requirements for both major incidents and business as usual usage. DH review Airwave's performance monthly including a check that the capacity requirements are being met, with action taken if they are not.

- All police and ambulance services are required to have and test major incident procedures to comply with the Civil Contingencies Act 2004. Since this incident, work has been undertaken at national level on the interoperability of using the Airwave radio system. A set of dedicated "talk-groups" has been established so that emergency service commanders will be able to communicate on separate channels in a future major incident. A national Memorandum of Understanding was signed by all three emergency services in 2010 and all ambulance services have signed local memoranda with their fire and police service and tested the "talk-groups".

- A protocol for ambulance service personnel attending incidents involving knives or firearms has been in place for many years. Since this incident substantial training and equipment has been provided to dedicated ambulance personnel to enable them to respond more rapidly to casualties involved in mass shootings. Additionally, should an incident such as this occur again, rather than determining the safety of the incident as a whole, each individual scene will be risk assessed by the staff attending and they will decide on the most appropriate action.

- The lessons learned from this incident would be shared with all senior ambulance leaders at a conference in June 2011 and the National Ambulance Director will be meeting ACPO to discuss the ambulance service's approach to any future incidents.

Community health care and emergency services

A man died in hospital after suffering ventricular fibrillation and subsequent cardiac arrest in an ambulance, having been attended to at home following a myocardial infarction. The ambulance crew had administered cardiopulmonary resuscitation (CPR) but the defibrillator in the ambulance did not function correctly and the chances of the man surviving the cardiac arrest were substantially reduced.

After the inquest, the coroner wrote to Yorkshire Ambulance Service (YAS) and the Medicine and Healthcare Products Regulation Agency (MHPRA) to suggest that:

- the defibrillator in question should be taken out of use immediately (as reportedly, following thorough testing, it was back in circulation);
- schedules for defibrillators and other ambulance equipment should be strictly adhered to so that all are serviced regularly;
- the battery of the defibrillator in question should be checked, and if that is no longer possible, all batteries used by YAS are decommissioned and replaced;
- the training programme for ambulance personnel is revisited to ensure that they are fully aware of error messages displayed by the defibrillator; and
- the MHPRA should consider a full examination of the ambulance service's equipment.

YAS responded that since the death a Serious Untoward Incident investigation had commenced, in line with the YAS NHS Trust's Incident and Serious Untoward Incident reporting policy, and that the Trust had acted on the recommendations of that report.

However, the Trust had since reviewed the Serious Untoward Incident investigation and concluded that it did not adequately identify the root causes of the incident, which may have had an effect on lessons learnt.

YAS reported the following:

- The defibrillator in question has been taken out of service and all defibrillators used by the Trust will have been replaced with newer models by December 2010.

- The Fleet and Equipment Department has put in place a full maintenance schedule for all defibrillators. Compliance with this schedule has been added as a key performance indicator within the Trust's integrated performance report, which, in turn, is monitored by the Trust's Executive Team and public board meetings and a newly formed Policy Assurance Group. In addition, all new equipment has been fitted with an automatic prompt to notify operators that they require servicing.

- Engineers working within the Fleet and Equipment Department have received training in battery management for all models of defibrillator, and batteries are now assessed and replaced at specific intervals in accordance with the programme of battery management (based on the manufacturer's recommendations). Batteries are also serviced as recommended and charged/tested at ambulance stations (as well as being on charge whilst in the vehicles).

- All equipment used on patients now has an asset tag with a unique number so that it can be tracked. A red tag system has also been introduced to enable staff to flag up defective equipment and a defibrillator with a tag on it is taken out of service immediately for inspection.

- All clinical staff have been reminded of the need to familiarise themselves with information about defibrillator error reports and training on this will be cascaded down to operators.

MHRA responded as follows:

- They do not routinely test hospital or pre-hospital equipment. In any case, they do not consider it would be meaningful to test the defibrillator in question given that the incident occurred in 2008.
- They have nevertheless published advice to healthcare professionals entitled *Management of Medical Devices*, which contains a specific section on defibrillators.
- They review advice given to healthcare professionals on an annual basis in the Device Bulletin. This advice includes details about reporting and quarantining devices involved in adverse incidents.
- They had been working with the London Ambulance Service on improving the level of reporting for adverse incidents and that they would cascade any lessons learnt to other ambulance trusts following completion of that work.

Deaths in Custody

A man died in a police station custody suite after drinking an excessive amount of water, possibly up to 34 pints. None of the officers in charge of the man were aware that drinking excessive amounts of water can be dangerous. Following the inquest the coroner wrote to South Wales Police and the Ministry of Justice suggesting that police officers and prison governors should be made aware of the dangers of drinking excessive amounts of water.

South Wales Police (SWP) responded as follows:

- Since the death they had listed excessive consumption of water as self harm.
- This information is being shared between SWP and the prison service and will be included in risk assessments and care plans for persons detained in police custody.
- Any persons detained in the custody suite in question in future who are identified as at possible risk of drinking excessive amounts of water will be placed in a cell without its own water supply.
- All police custody officers and medical staff employed by the police in custody suites have been trained in the recognition and care of excessive consumption of water.

- They have raised awareness of this death within ACPO so the lessons learned can be shared at regional and national level.

The Ministry of Justice National Offender Management Service confirmed that the lessons learned from this death would be disseminated to prison governors when the next safer custody newsletter was published, which was proposed for April 2011.

Product related deaths

A man died from burns injuries sustained when scalding water from a central heating pipe poured onto him. The heating system in the house where the incident happened was a continuously operated recirculation system and the pipe was manufactured to British Standard BS7291. However, it appeared that over a period of time the plastic pipe had deteriorated where it joined with the copper pipe. One cause of this may have been the heating system operating with very hot water. Following the inquest the coroner wrote to the British Plastics Federation (Plastic Pipes Group) and The Chartered Institute of Plumbing and Heating Engineering. He asked them to consider whether the potential dangers and ramifications of using British Standard BS 7291 plastic pipes in this type of heating system was well known in the industry and to raise awareness of these as a result of this death.

The British Plastics Federation responded to the coroner that they had:

- Communicated with all their member companies who manufacture plastic pipe systems reminding them of the limitations of the products included in National Standards BS 7291-1:2010 and to specifically exclude the use of such pipes in continuously operated recirculation hot water supply systems.
- Updated their own guidance note to reflect concerns about using plastic pipe in such heating systems
- Sent their guidance note to the Chartered Institute of Plumbing and Heating Engineering and the Health and Safety Executive to enable them to communicate this to their stakeholders and offered further technical support to these organisations to ensure correct dissemination of this information.

The Chartered Institute of Plumbing and Heating Engineering confirmed they had communicated the details of this incident in their own as well as trade publications to ensure widespread awareness of the revised guidance.

Accidents at work and health and safety

A boy died whilst on a school trip to an activity centre. He appeared to suffer a fit after he entered the water when the canoe he was in capsized. Despite being rescued and airlifted to hospital, he never regained consciousness. The boy had previously fainted whilst in a swimming pool and the medical form completed prior to the visit had mentioned that he had previously fainted whilst in water. However, it appeared that the school failed to recognise the potential significance of this: there had been no formal review of information on the

medical forms and staff at the activity centre had not been made aware of the boy's history of fainting in water. There was therefore no assessment of the risk of the boy participating in activities which could lead to him entering water or of whether there were appropriate systems in place to assist if he did get into difficulties.

Following the inquest, the coroner wrote to Adventure Activities Licensing Service (AALS) asking if the lessons learned from this death could be disseminated more widely. The coroner acknowledged that it would be impossible to eliminate risk altogether but nevertheless asked whether AALS would consider issuing guidance to all organisations who organise or provide activities to children to emphasise the importance of:

- assessing all available information;
- carrying out full and proper risk assessments of specific activities for specific individuals; and
- ensuring that parental consent to participation in such activities is as fully informed as possible.

In its response AALS advised it carries out inspections of certain providers of adventure activities on behalf of the Health and Safety Executive (HSE) who are designated as the Adventure Activity Licensing Authority on behalf of the Secretary of State for Work and Pensions. Where AALS is satisfied that good safety management practice is being followed by the provider of activities, a licence is issued in accordance with the Activity Centres (Young persons) Safety Act 1995. AALS also has a policy of disseminating lessons learned widely amongst the outdoor activity community, whether or not they are licence holders. Following this tragic incident AALS, in agreement with HSE, will raise the general matter of parental consent and medical information at future inspections of adventure centres. Additionally, the lessons learned from this tragic incident will be included on the HSE Information Log on the Adventure Licensing section of its website as well as on the website run by the Lessons Learned Group, an informal group of outdoor professionals who consider lessons to be learned by the wider global outdoor community.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 October 2010 and 31 March 2011

Coroner district	Number of inquests in which Rule 43 reports issued
Bedfordshire and Luton	1
Berkshire	3
Birmingham and Solihull	3
Black Country	1
Blackburn, Hyndburn and Ribble Valley	1
Bridgend and The Valleys	2
Brighton and Hove	2
Cardiff and The Vale of Glamorgan	12
Carmarthenshire	1
Cheshire	4
Cornwall	4
Coventry	1
Cumbria: North and West	4
Cumbria: South and East	2
Darlington and South Durham/North Durham	4
Derbyshire: Derby and South	4
Derbyshire: North	1
Devon: Exeter and Greater	7
Devon: Plymouth and South West	2
Essex and Thurrock	7
Greater Manchester: City	15
Greater Manchester: North	2
Greater Manchester: South	12
Greater Manchester: West	2
Gwent	1
Hertfordshire	6
Isle of Wight	1
Kent: North East	1
Kent: North West	1
Kingston upon Hull and East Riding of Yorkshire	1
Leicestershire: City and South	2

Lincolnshire: North and Grimsby	1
Liverpool	3
London: City	1
London: Inner North	2
London: Inner South	8
London: Inner West	1
London: North	1
London: South	2
London: West	3
Milton Keynes	1
Norfolk	1
North East Wales	1
North Yorkshire: Western	1
Northampton	2
Northumberland: North	1
Oxfordshire	2
Peterborough	2
Powys	2
Preston and West Lancashire	1
Shropshire: Mid and North West	7
Shropshire: South	1
Somerset: East	1
South Yorkshire: Eastern	4
South Yorkshire: Western	4
Staffordshire: South	4
Staffordshire: Stoke-on-Trent and North	2
Sunderland	1
Sussex: West	3
Warwickshire	2
West Yorkshire: Eastern	3
West Yorkshire: Western	3
Wiltshire and Swindon	4
Worcestershire	3
York	1
Total	**189**

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.

Association of Chief Police Officers

Brighton and Sussex University Hospitals NHS Trust

Connectplus, New Denham

Home Office

North East Lincolnshire Council

North Lincolnshire Council

North West London Hospitals NHS Trust

South London and Maudsley NHS Foundation Trust

Southwark Health and Social Care

The Royal Society of Medicine

West Hertfordshire Hospitals NHS Trust

Annex C

List of Rule 43 reports received between 1 October 2010 and 31 March 2011

Coroner District	Report sent to	Details	Response received	Report number
Hospital deaths: clinical procedures and medical management				
Milton Keynes	Milton Keynes Hospital NHS Trust	To consider employing a 'diabetic psychologist' on a part-time basis.	Yes	1
Birmingham and Solihull	Heart of England NHS Foundation Trust; Birmingham and Solihull Mental Health NHS Foundation Trust	To consider implementing an agreed care plan between physicians and the psychiatric team when a patient has mental health problems, to deal with potential aggressive/non-compliant behaviour or where the patient wishes to discharge themselves against medical advice; and to arrange for a security officer, or other appropriate person, to follow vulnerable patients who discharge themselves against medical advice.	Yes	3
London: Inner South	Lewisham Healthcare NHS Trust	To consider investigating why there were no references to the diagnosis of MRSA and related discussions on how to manage it in the medical records; why the bacteriological diagnosis was not disclosed at the first inquest hearing and why a serious untoward incident investigation was not automatically activated by a death due to MRSA.	Yes	6
London: Inner South	South London and Maudsley NHS Foundation Trust	To consider widening its action plan to publish a definitive statement outlining where responsibility lies for securing housing for patients with personality disorders and challenging behaviours and routes of access to such housing; to explore the need for new staffed housing provision for patients with personality disorders and challenging behaviour.	Extension granted	7
London: Inner South	Brighton and Sussex University Hospitals NHS Trust; Royal College of Physicians	Brighton and Sussex University Hospitals NHS Trust to consider reviewing how acutely ill diabetics admitted under surgeons receive medical care during their hospital stay; consulting the Royal College of Physicians about good practice in delivering medical care to diabetics admitted under the care of surgeons; implementing a plan based on this review and consultation. The Royal College of Physicians to advise Brighton and Sussex University Hospital NHS Trust during the consultation.	Yes	8

Coroner District	Report sent to	Details	Response received	Report number
Hertfordshire	Department of Health; Hertfordshire Partnership NHS Foundation Trust	The Department of Health to consider issuing an alert regarding unsecured loft hatches in their premises. Hertfordshire Partnership NHS Foundation Trust to consider using written care plans for their patients.	Yes	11
London: Inner North	National Patient Safety Agency	To consider issuing a Patient Safety Alert to reduce or eliminate the risk of patient self harm by plastic bag suffocation.	Yes	15
Hertfordshire	West Hertfordshire Hospitals NHS Trust	To consider the arrangements for the availability of blood in the event of massive haemorrhages occurring during surgery.	Yes	17
London: North	North West London Hospitals	To consider including NICE guidelines in literature supplied to users of midwife-led maternity units.	No	19
Cheshire	Warrington Hospital	To consider changing how a patient's International Normalised Ratio is measured.	Yes	20
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of the delay in commencing antibiotic therapy and to ensure in-patients receive proper nutrition and assistance with eating if required.	Yes	31
Coventry	University Hospital, Coventry	To consider ensuring that all clinicians are aware of the Trust's guidelines on sepsis and that doctors in different treatment areas of the hospital communicate regarding patient care.	Yes	42
Staffordshire: South	New Cross Hospital, Wolverhampton	To consider the arrangements for the type of transport used for transferring patients to other hospitals.	Yes	43
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of the procedures for assisting with the personal hygiene of patients suffering from clostridium difficile diarrhoea and for nurses advising family members about the likelihood of a patient dying contrary to the prognosis of a doctor.	Yes	44
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of the procedures for performing exploratory surgery when a patient's condition deteriorates after ileostomy; ensuring that night care teams consider the patient's whole medical history and that overnight observations are conducted as requested.	Yes	45

Coroner District	Report sent to	Details	Response received	Report number
Powys	Powys Local Health Board	To consider clarifying the procedure at Bronllys Hospital for referrals to other hospitals, including more frequent meetings of the Individual Patient Commissioning Panel, and improving the process for following up referral decisions; improving processes at the hospital for psychological assessment and the provision of treatment to patients and clarifying the hospital's observation policy.	Yes	47
Leicestershire: City and South	Leicester City Community Health Service	To consider a review of the process and staff training to ensure that nursing documentation is complete, accurate and up to date, and shared within multi-disciplinary teams.	Yes	48
Greater Manchester: City	Department of Health; National Patient Safety Agency	To consider reviewing guidelines on checking the position of nasogastric tubes.	Yes	55
Greater Manchester: South	General Healthcare Group, Brentford	To consider ensuring that patient neck collars are available in a range of sizes and reviewing staffing levels on wards.	Yes	56
Greater Manchester: North	North West Ambulance Service NHS Trust	To consider allowing patients to use walking aids with which they are familiar, including when travelling by ambulance.	Not required	57
West Yorkshire: Eastern	Mid-Yorkshire Hospitals NHS Trust	To consider amending guidance to require a CT scan to be carried out when a patient prescribed warfarin or similar medication has suffered a head injury.	Yes	58
Shropshire: Mid and North-West	Shrewsbury and Telford Hospital Trust	To consider implementing a process by which the referring doctor in the community can discuss the case with the receiving doctor at the hospital and the senior doctor reviewing the case at the hospital has direct access to all relevant information.	Yes	59
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider implementing a process to ensure that doctors who qualified and have worked in other countries understand the professional norms of hospitals in the UK and communicate openly with colleagues about different medical experience and practice.	Yes	63
London: Inner South	South London Healthcare NHS Trust; Medway NHS Foundation Trust	To consider investigating the adequacy of communications between the Trusts about clinical information and making recommendations for best practice.	Yes	65

Coroner District	Report sent to	Details	Response received	Report number
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider the policy on consultant supervision of trainee surgeons undertaking surgical procedures; providing training and support for surgical teams when routine procedures lead to a patient's unexpected death.	Yes	71
Bedfordshire and Luton	Luton & Dunstable Hospital NHS Foundation Trust	To consider a review of staffing arrangements for operating theatres at weekends and bank holidays to deal with emergency operations.	Yes	77
West Sussex	Brighton & Hove City Primary Care Trust	To consider implementation of monitoring communications between patients and staff and amongst staff and a review of out of hours cover arrangements to ensure these are operating as intended.	Yes	79
West Yorkshire: Western	Mid-Yorkshire Hospitals NHS Trust	To consider incorporating other sources of information at initial diagnosis, particularly the Ambulance Service's patient report form; reviewing procedures for assessment of fitness for discharge and reviewing policy on initiating serious untoward incident procedures.	Yes	85
Sunderland	Department of Health; City Hospitals Sunderland NHS Foundation Trust	Department of Health to advise whether there is any guidance regarding Early Warning Score (EWS) systems and whether NICE guidelines are due to be updated; City Hospitals Sunderland NHS Foundation Trust to consider further modifications to the EWS system and provision of training for all nursing and medical staff.	Yes	92
Staffordshire: Stoke-on-Trent and North	University Hospital of North Staffordshire; Mid Staffordshire NHS Foundation Trust	To consider a review of the procedures for transferring patients between Stoke and Stafford hospitals.	Yes	95
Greater Manchester: South	Stockport NHS Foundation Trust	To consider a review to ensure medical notes taken in Accident and Emergency are complete and accurate and of the triage system in Accident and Emergency.	Yes	97
Derbyshire: Derby and South	Derbyshire County Council; Derbyshire Hospital NHS Trust	Derbyshire County Council to consider developing a policy for care home staff on when to seek medical advice about residents; Derbyshire Hospital NHS Trust to consider providing training for advanced nurse practitioners and junior medical staff in the assessment of head injuries in accordance with NICE guidelines; adopting a structured proforma for such assessments and implementing a policy of discharge in such cases being agreed and recorded by the senior Accident and Emergency doctor.	Yes	99

Coroner District	Report sent to	Details	Response received	Report number
Greater Manchester: South	Tameside NHS Foundation Trust	To consider implementing a process whereby locum doctors can have immediate access to the computerised x-ray request programme; a review of senior house officer and house officer staffing levels and installing lavatory locks that can be opened from the outside by staff.	Yes	100
North East Wales	Betsi Cadwaladr University Health Board	To consider printing the recommended frequency of neurobservations on the neurobservation report form and implementing a system to issue reminders to nursing staff carrying out such observations.	Yes	107
Greater Manchester: City	North Manchester General Hospital; Macclesfield General Hospital	To consider ensuring that patients with learning difficulties and/or conditions on the autistic spectrum are accompanied at assessment by a family member or carer wherever possible.	Yes	110
Cornwall	Derriford Hospital, Plymouth	To consider reviewing the protocols for using anti-coagulant measures post-surgery.	Yes	113
Cornwall	Royal Cornwall Hospital	To consider a review of staffing levels on wards and assessments of patients at risk of falls.	Yes	114
Oxfordshire	Nuffield Orthopaedic NHS Trust	To consider its policy on preservation of specimens, including consultation with the pathologist and coroner.	Yes	119
Leicestershire: City and South	University Hospitals of Leicester NHS Trust	To consider a review of guidance on completion of medical records to ensure these are complete and accurate; improving the monitoring of patient observations and ensuring nursing staff know when to call for assistance if a patient's health deteriorates.	Yes	125
West Sussex	Maidstone and Tunbridge Wells NHS Trust; Queen Victoria NHS Foundation Trust	Maidstone and Tunbridge Wells NHS Trust to consider a review of the completion of nursing and medical notes to ensure these are complete and accurate; Queen Victoria NHS Foundation Trust to consider its policy on communication with patients and their families to ensure this is fully recorded and understood by them; a review of patient consent for biopsies and all letters issued by the hospital to ensure they are dated.	Yes	127
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of communication between medical and physiotherapy staff involved in the treatment of patients with spinal injuries.	Yes	136

Coroner District	Report sent to	Details	Response received	Report number
London: South	Department of Health	To consider guidance to clinical staff on the types of cases to be referred to a coroner and the need to retain important evidence in these cases in the event of death.	Yes	137
Greater Manchester: South	Stockport NHS Foundation Trust; Department of Health	Stockport NHS Foundation Trust to consider clarifying what is meant by a paediatrician being present at a caesarean and/or instrumental delivery and to review the manner and format of its Sudden Untoward Incident investigations; Department of Health to consider a nationally agreed algorithm for the basic questions a consultant should ask of a junior doctor requesting advice on a birth.	Yes	138
Cumbria: South and East	Cumbria Partnership NHS Foundation Trust	To consider a review of its policies on locking ward doors at the Kentmere Ward, Westmorland General Hospital; preparing patients for review meetings; shift hand-over communications; patient risk assessment procedures; whether patients are housed in the most appropriate care setting to meet their needs; the involvement of patients' families in their care; the management structure; communication with family members following a death of a patient; and to consider providing a copy of the report into this death to the family.	Yes	140
Greater Manchester: City	Pennine Acute Hospitals NHS Trust	To consider a review of its procedures to ensure patients receive continuity of care; histology results are received and acted on in a timely manner; improved communication between pathologists and the clinical team; and to consider making further enquiries as to why subsequent appointments were not made in this case.	Yes	149
Greater Manchester: City	Manchester Royal Infirmary	To consider a review of procedures to ensure a full review is taken of existing medication when a patient is admitted to hospital; to consider the need to maintain overall care of a patient and to involve the orthopaedic department when an orthopaedic patient's health deteriorates.	Yes	150
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider a review of its protocols for staffing, patient care and communications.	Yes	153
South Yorkshire: East	Rotherham NHS Foundation Trust	To consider a review of protocols and staff training on the importance of accurate and effective communication.	Yes	163

Coroner District	Report sent to	Details	Response received	Report number
Greater Manchester: City	University Hospital South Manchester	To consider a review of its internal investigation procedures; disseminating the learning from the internal review into this case and implementing the consultant's recommendation on how care for patients could be improved.	Yes	166
Oxfordshire	Oxford Radcliffe Hospital NHS Trust	To consider whether all patients under the care of the renal transplant unit should have a named senior specialist in overall charge of their care.	Yes	170
Greater Manchester: City	Pennine Acute Hospitals NHS Trust	To consider its serious incident investigation procedures and its falls risk assessment documents.	Yes	171
South Yorkshire: West	The College of Emergency Medicine	To consider a review of the hospital notes system to ensure notes from Accident and Emergency attendances are automatically available at subsequent appointments.	Yes	172
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust; Martlets Hospice, Hove	Brighton and Sussex University Hospitals NHS Trust to consider a review to ensure adherence to its discharge procedures and documentation requirements; Martlets Hospice to consider a review to ensure adherence to and staff awareness of its procedures on admission and on reporting of deaths to the coroner.	Yes	175
Greater Manchester: City	Lancashire Teaching Hospitals NHS Trust; Nursing and Midwifery Council	To consider a review of training provided to midwives at the Chorley Unit; regular auditing to ensure all Trust midwives have current knowledge of guidance on monitoring foetal heart rates and a review of its Serious Untoward Incident investigation policy.	Yes	177
Shropshire: Mid and North-West	Shrewsbury and Telford Hospital Trust	To consider a review of its policies on falls and record keeping of such policies; its communication with patients' families and information contained in discharge letters.	Yes	182
West Sussex	West Sussex Hospitals NHS Trust	To consider a review of communication with patients' families; the content of medical records and the lack of interaction between medical and nursing records.	Yes	183

Hospital deaths: other

Devon: Exeter and Greater	Royal Devon and Exeter NHS Foundation Trust	To consider a review of the provision of fire-fighting equipment on wards and the guidance on fire prevention.	Yes	83
Shropshire: Mid and North-West	Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry	To consider a definition of what modifications to surgical equipment constitute notifiable alterations of use; and to review its Serious Untoward Incident report to confirm if any further lessons can be learnt and that outstanding issues have been addressed.	Yes	123

Coroner District	Report sent to	Details	Response received	Report number
Road deaths: Highway safety				
Black Country	Walsall Metropolitan Borough Council	To consider changing the pedestrian crossing at the junction between Church Road and the Black Country New Road, Moxley.	Yes	12
Cornwall	The Highways Agency	To consider removing the hazard of water collecting on the road approaching the Trerulefoot roundabout on the Plymouth bound carriageway of the A38.	Yes	13
Shropshire: Mid and North-West	Telford and Wrekin Council	To consider putting solid white lines on the B5062 Cruddington to Newport road on the Newport side of the Cruddington crossroads.	Yes	18
Staffordshire: South	Staffordshire County Council	To consider putting warning signs on the A52 at Stanton Dale.	Yes	22
Cheshire	Warrington Borough Council	To consider the safety of the A57 at Rixton.	Yes	24
Carmarthenshire	Dyfed Powys Police	To consider assessing safety where vehicles can cross a dual carriageway from a central reservation.	Yes	28
Essex and Thurrock	Highways Agency	To consider putting crash barriers around all lampposts on the M25.	Yes	32
Berkshire	Royal Borough of Windsor and Maidenhead	To consider improving the temporary lighting on the B470, King Edward VII Avenue, Windsor for pedestrians leaving the Royal Windsor Tattoo and placing warning signs for pedestrians to cross the road only at designated places.	Yes	35
Essex and Thurrock	Essex County Council	To consider more frequent inspection and clearance of drainage gulleys on the A13 and the use of warning notices that the road is prone to flooding.	No	49
Greater Manchester: North	Oldham Metropolitan Borough Council	To consider an urgent review of the road surface on the A640 Huddersfield Road, Oldham.	Yes	50
Wiltshire and Swindon	Highways Agency	To consider closing the gaps on the A419/417 Swindon to Gloucester road or prohibiting u-turns at the gaps.	Yes	51
Bridgend and Glamorgan Valleys	South Wales Trunk Road Agency	To consider monitoring of surface water on the A465 eastbound, between Hirwaun and Baverstocks, in heavy rain and implementing a system for formal reporting of problems with road conditions by route stewards.	Yes	61
Kent: North East	Kent County Council	To consider improving the safety of the Holly Road entrance to St Lawrence College, Ramsgate.	Yes	80

Coroner District	Report sent to	Details	Response received	Report number
Greater Manchester: West	Bolton Council	To consider implementing measures to prevent pedestrians crossing Washacre, West Houghton at the junction with Leigh Road, other than by the pelican crossing.	Yes	89
Wiltshire and Swindon	Wiltshire County Council	To consider additional road markings, warning signs and a reduction in the speed limit on the northbound approach to the hump back bridge on Station Road, Seend.	Yes	130
Norfolk	Norfolk County Council	To consider a review of safety measures at the pedestrian crossing on the Norfolk Street junction on Railway Road, Kings Lynn.	Yes	132
Cumbria: South and East	Cumbria County Council	To consider an inspection, assessment and survey of the A592 at Balkeholme and review what improvements may be made to the road's drainage system.	Yes	133
Staffordshire: Stoke-on-Trent and North	The Highways Agency	To consider completing works to the central reservation and increasing and recording the checks made to drains and gullies to address water accumulation on the A500 southbound carriageway between the Etruria slip road and Shelton New Road Bridge, Stoke-on-Trent.	Yes	135
Derbyshire: North	Derbyshire County Council	To consider road safety improvements on the A61 Chesterfield Road, Alfreton at its junction with the B6025.	Yes	155
Hertfordshire	Connectplus, New Denham	To consider a review of the central reservation barriers on the M1 near junction 5.	No	168

Road deaths: vehicle safety

Blackburn, Hyndburn and Ribble Valley	Department for Transport	To consider making it compulsory for quad bike drivers and passengers to wear protective head gear.	Yes	70
London: Inner South	Department for Transport	To consider a review of the risks to cyclists from heavy goods vehicles which are not fitted with proximity sensors and what action can be taken to encourage fitting of such sensors.	Extension granted	165

Coroner District	Report sent to	Details	Response received	Report number
Accidents at work and health and safety				
Devon: Exeter and Greater	Ministry of Defence; Devon County Council; Health and Safety Executive	Ministry of Defence to consider an agreed minimum number of team training excursions for the Ten Tors Challenge and making certification of Team Managers' competence a requirement. Devon County Council and the Health and Safety Executive to consider applying state school trips standards to independent schools.	Yes	30
Shropshire: Mid and North-West	Shropshire Council	To consider installing a gate on the slipway to the River Severn at Coton Hill, Shrewsbury.	Yes	37
Peterborough	St Ives (Peterborough) Ltd, Peterborough	To consider putting in place a system for reporting and investigating any incident where printing presses malfunction.	Yes	40
Essex and Thurrock	HM Railway Inspectorate	To consider checking that stress and fatigue calculations have been carried out on all mobile elevated working platforms in use.	Yes	41
West Yorkshire: Eastern	Bezier Limited, Wakefield; Crossland UK Limited, Manchester	To consider fitting braking and automatic cut-out systems to Platen printing machines; changing the design so that operators are not placed in jeopardy when clearing mis-feeds; and reviewing training for operators.	Yes	66
Greater Manchester: South	Stretford Mall, Manchester	To consider improving safety on the top floor of the Arndale Centre car park, Stretford to prevent climbing over the existing fencing.	Yes	68
Staffordshire: South	Browne Jacobson, Solicitors	To consider whether there has been a review of safety around the lake at the Patshull Park Hotel and Country Club.	Yes	74
Greater Manchester: South	St George's Church, Heaviley, Stockport	To consider the design of the font and immediate surround.	Yes	81
Greater Manchester: South	William Fairey Engineering Ltd, Stockport; Unisign, Panningen, The Netherlands	William Fairey Engineering Ltd to consider reviewing and remedying a number of operator safety issues with the Unisign 2 machine; Unisign to confirm that the design of the machine has been altered to improve operator safety.	Yes	101
Shropshire: South	Health and Safety Executive; McCartneys LLP, Ludlow	To consider making it compulsory to wear hard-hats with chin-straps at all times when working in animal pens at livestock markets.	Yes	115

Coroner District	Report sent to	Details	Response received	Report number
Cardiff and the Vale of Glamorgan	Health and Safety Executive; Sinclair Garages Limited, Port Talbot; Welsh Government	Health and Safety Executive and Welsh Government to consider guidance on alternatives to placing wiring across floors, particularly in areas accessed by people who are elderly or have a disability; Sinclair Garages to consider a review of their risk assessment procedures and action required to reduce the risk of trips caused by floor wires.	Yes	139
Devon: Plymouth and South West	Health and Safety Executive	To consider additional guidance on hay baling.	Yes	147
South Yorkshire: East	Health and Safety Executive	To consider making it mandatory for inter-locking gates to be installed in mine shaft landings.	Yes	148
Berkshire	British Gas; Health and Safety Executive	To consider a review of the circumstances in which it is appropriate to label a gas boiler 'at risk' rather than 'immediately dangerous'.	Extension granted	151
Powys	Adventure Activities Licensing Service, Cardiff	To consider issuing risk assessment guidance to organisations arranging activities for children which includes advice that all available evidence must be properly assessed for each participant.	Yes	157
Greater Manchester: City	Astra Signs, Manchester; Crown Prosecution Service; Greater Manchester Police; Health and Safety Executive	Astra Signs to consider a review of the training and experience of staff using movable work platforms and its risk assessment procedures and to introduce spot checks to ensure safety measures are being used; Health and Safety Executive to consider publicising this case to raise awareness of the issues; Police and Crown Prosecution Service to consider their protocols on carrying out reviews, their communication on time limits and with family members and the choice of expert witnesses.	Yes	167
Greater Manchester: South	Coral Cay Conservation Limited, London, Department for Business, Innovation and Skills	Coral Cay Conservation Limited to consider a review of information provided in their documentation and on their website to ensure it accurately reflects the health and safety provisions on Tokoriki Island; training provided to expedition leaders and its risk assessment procedures; Department for Business, Innovation and Skills to consider regulation of companies offering expedition trips abroad.	Yes	189

Mental health related deaths

Hertfordshire	West Hertfordshire Hospitals NHS Trust	To consider issuing guidance to reception staff about notifying the psychiatric team when a recently assessed patient returns shortly afterwards still behaving in a bizarre manner.	Yes	86

Coroner District	Report sent to	Details	Response received	Report number
London: West	West London Mental Health NHS Trust	To consider a system for creating a new patient care plan rather than using another patient's plan as a template, and ensuring that patient safety policies are cascaded to all staff.	Yes	94
Worcestershire	Worcestershire Mental Health Partnership NHS Trust	To consider implementing a policy to require that independent verification of the accommodation to which in-patients will be discharged is obtained and reviewing its policy and guidance on the 7-day follow-up.	Yes	104
Worcestershire	Worcestershire Mental Health Partnership NHS Trust	To consider making it policy for mental health assessors to consider the details of any clinical referral and for two mental health clinicians to sign off the agreed treatment plan.	Yes	105
Greater Manchester: City	Central Manchester NHS Foundation Trust; Manchester Mental Health and Social Care NHS Trust; Manchester Primary Care Trust	To consider making access to the mental health liaison team available 24 hours a day and ensuring triage assessments are complied with except for any exceptional reasons.	Yes	109
Derbyshire: Derby and South	University of Derby; Derbyshire Mental Health Services NHS Trust	University of Derby to consider waiving confidentiality and disclosing information to the appropriate authorities when a student or the public could be at risk; Derbyshire Mental Health Services NHS Trust to consider a review of the urgency with which they carry out an assessment of new patient referrals with a possible psychotic illness.	Yes	120
Cumbria: North and West	Cumbria Partnership NHS Foundation Trust	To consider a review of recording of observations; staff availability; involvement of patients' families and carers and risk assessment procedures at the Carleton Clinic.	Yes	134
Essex and Thurrock	Norfolk and Waveney Mental Health Trust	To consider a review of how information received by the crisis/primary care teams is disseminated to link workers and whether changes are need to the procedures for doctors who need to refer patients to the service.	Yes	141
Greater Manchester: City	University of Manchester	To consider implementing the recommendations in its report following this death and a review of its occupational health procedures on sharing students' health issues.	Yes	143

Coroner District	Report sent to	Details	Response received	Report number
London: West	West London Mental Health NHS Trust; Ealing Hospital NHS Trust	To consider a review of communication and provision of documentation between the two Trusts; the lines of responsibility for patients' safety when they are transferred to hospital from a secure wing and the provision of staff to provide special observations.	Yes	161
Devon: Plymouth and South West	Department of Health	To consider providing support for those accused of serious sexual offences as part of its suicide prevention strategy.	Yes	176

Community healthcare and emergency services related deaths

York	Yorkshire Ambulance Service; Medicines and Healthcare Products Regulatory Agency	Yorkshire Ambulance Service to consider rigorous servicing of all their defibrillator equipment in accordance with service schedules; decommissioning and replacing all defibrillator batteries and improving the training of ambulance staff in the use of defibrillator machines. Medicines and Healthcare Products Regulatory Agency to examine rigorously all the Ambulance Trust's equipment to prevent it malfunctioning.	Yes	4
London: Inner South	South London and Maudsley NHS Foundation Trust; Southwark Health and Social Care	South London and Maudsley NHS Trust (SLAM) to consider consulting Southwark Health and Social Care and conducting a needs assessment to determine the clinical effectiveness of long-term residential treatment and rehabilitation for patients with severe alcohol dependency and mental illness; the extent of unmet need in the local population; and sending the report to national and local commissioners. Southwark Health & Social Care to consider advising SLAM on existing information held by commissioners about the local population and any missing details required; supporting SLAM by making available suitable public health or other resources to help the assessment; and ensuring that the final report is prioritised for action by the commissioning body.	No	10
London: Inner South	South London and Maudsley NHS Foundation Trust; The Royal College of Psychiatrists; The Royal Society of Medicine	South London and Maudsley NHS Trust to consider reviewing the information provided to patients being cared for in the community and their families on how to obtain assistance in a crisis; consulting the Royal College of Psychiatrists and Royal Society of Medicine about good practice when investigating alternative medication; and drawing up and implementing a plan, based on these consultations, to optimise psychiatric care in the community. The Royal College of Psychiatry and Royal School of Medicine to advise the Trust.	Partial response	21

Coroner District	Report sent to	Details	Response received	Report number
Cheshire	Cheshire East Homecare, Macclesfield	To consider implementing a 24-hour reporting mechanism for acute situations in community care cases.	Yes	23
Cheshire	Pathways to Recovery, Warrington	To consider improving communication between Pathways clinicians and GPs, so that patient safety is not compromised.	Yes	25
Greater Manchester: South	Department of Health	To consider issuing guidance to all Ambulance Service Trusts that operators in despatch rooms ask callers what drugs the patient has taken, if any.	Yes	29
London: West	London Borough of Ealing	To consider implementing more thorough vetting procedures for contracted-out carers.	Yes	60
Cardiff and the Vale of Glamorgan	Burges House Care Home, Cardiff	To consider amending its falls protocol to require residents who are taking blood-thinning medication to be taken to Accident and Emergency, even when there is no obvious external injury.	Yes	72
Northampton	St Mary's Hospital, Kettering	To consider a review of whether the Community Resolution Home Treatment Team's view of fitness for discharge of patients with psychiatric conditions should be recorded in hospital discharge plans.	Yes	78
Hertfordshire	Department of Health; Sport England; West Hertfordshire Hospital NHS Trust	Department of Health to consider disseminating information to all Ambulance Trusts about best practice for communications between call centre and despatch staff and ambulance crews; Sport England to consider advising operators of sports grounds to display clearly the full address and postcode; West Hertfordshire Hospital NHS Trust to consider drawing up acute/anaphylactic treatment plans for all those at risk of developing severe allergic reactions.	Partial response	87
Derbyshire: Derby and South	East Midlands Ambulance Service NHS Trust; Joint Royal Colleges Ambulance Liaison Committee	To consider equipping ambulance crews with equipment to effect forcible entry, and providing training in its use.	Yes	96
Northampton	St Mary's Hospital, Kettering	To consider an urgent review of mental health teams' response to patients in crisis.	Yes	111

Coroner District	Report sent to	Details	Response received	Report number
Birmingham and Solihull	Health and Safety Executive; Birmingham City Council	To consider whether the Health and Safety Executive's guidance regarding water temperatures in care homes should also apply to care hostels.	Yes	116
London: Inner North	Barnet, Enfield and Haringey Mental Health NHS Trust; Department of Health	NHS Trust to consider a review of its root cause analysis training; Department of Health to consider reminding all Mental Healthcare Trusts and general practitioners of the risk of patients on antipsychotic medication developing diabetes.	Yes	122
Kent: North West	East of England Ambulance Service NHS Trust; South East Cost Ambulance Service	To consider a review of policy to enable the communication of important patient medical information to the ambulance area responding to the request.	Yes	124
Cardiff and the Vale of Glamorgan	Royal College of General Practitioners	To consider reminding GPs of their child protection responsibilities; to consider a review of systems in place to alert GPs if a pregnant patient has not engaged with local midwifery services.	Yes	126
South Yorkshire: East	Meadow View Nursing Home, Mexborough	To consider a review of training on wound and pressure sores management, when to seek advice of tissue viability nurses and accurate record keeping.	Yes	129
Cumbria: North and West	Department of Health	To consider a review of investigations into potential allergies; drawing doctors' attention to the differences between rubber and latex allergy and noting patients' records of penicillin allergies.	Yes	131
Hertfordshire	Department of Health	To consider disseminating the London Ambulance Service's action plan arising from their Serious Untoward Incident investigation to all ambulance services throughout England.	Yes	154
Greater Manchester: South	North West Ambulance Service; NHS Direct	To consider a review of how information provided to the Ambulance Service and NHS Direct is assessed and to ensure that a diagnosis of metabolic ketoacidosis is considered when symptoms being described could indicate this condition.	Yes	160
Derbyshire: Derby and South	East Midlands Ambulance Service NHS Trust; Department of Health; British Thoracic Society	East Midlands Ambulance Service to consider a review of its policy on solo responders attending emergencies and crew meal break arrangements; Department of Health to consider if national guidelines on these policies are required; British Thoracic Society to consider issuing guidance on managing outpatients with pulmonary embolism.	Yes	162

Coroner District	Report sent to	Details	Response received	Report number
Devon: Exeter and Greater	Devon Partnership NHS Trust	To consider a review of its arrangements for reallocating caseloads when a member of staff is absent on sick leave.	Yes	173
Devon: Exeter and Greater	NHS Devon	To consider guidance provided to doctors' surgeries on action to be taken when no contact can be made with patients who have a telephone appointment.	Yes	174
Cumbria: North and West	Department of Health; Home Office	To consider a review of the Police Airwave System; communication between the Police and Ambulance Service at strategic level and Ambulance Service protocols when ambulance personnel attend the scene of a violent incident.	Yes	178
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider issuing patient discharge letters to district nursing teams when they are involved in post-discharge patient care.	Yes	181

Deaths in custody

Greater Manchester: City	HM Prison Manchester	To consider fitting fixed, sealed window units in all cells in the Healthcare Centre and reviewing cell design; completing an Assessment, Care in Custody, and Teamwork form for any prisoner who expresses self-harm or suicidal intent and ensuring that information about any expressed self-harm or suicidal intent is passed to the prison doctor.	Yes	33
Shropshire: Mid and North-West	HM Prison Shrewsbury	To consider ensuring there are clear care plans for conditions which are difficult to diagnose, that information about health care is passed between shifts, all medical records are fully accurate and up to date and extending the use of debriefs to all deaths in custody.	Yes	36
Greater Manchester: West	Ministry of Justice	To consider introducing annual first-aid skills training for prison officers in all public and private prisons; ensuring the back record is considered as part of the Cell Sharing Risk Assessment when a prisoner is recalled to prison from licence and strengthening the process for obtaining a prisoner's previous convictions, including a process for prioritisation of requests.	Yes	46
Staffordshire: South	HM Courts Service	To consider implementing a policy for making available to prison staff all relevant court documents, particularly those expressing a risk of self-harm.	Yes	64
Darlington and South Durham/North Durham	NHS; HM Prison Durham; Ministry of Justice	To consider whether GPs who provide healthcare to the prison should attend all meetings about prisoners and prison systems and ensure healthcare forms are completed fully and accurately.	Yes	76

Coroner District	Report sent to	Details	Response received	Report number
Liverpool	Ministry of Justice	To consider whether correspondence between prisoners and their lawyers marked "legal correspondence" should be given the status of that marked "Rule 39 correspondence", and whether the Law Society and Criminal Bar Association should be reminded of the requirements of Rule 39 prisoner correspondence; issuing guidance that prisoners' relatives should be notified when Assessment, Care in Custody, and Teamwork plans are closed; and analysing fatal and near-fatal incidents to ascertain whether analgesia had been sought by the prisoner prior to the event.	Yes	93
Preston and West Lancashire	Department of Health; Judicial Studies Board; Equality and Human Rights Commission; Mencap; Ministry of Justice	To consider a review of the care and support provided to learning disabled prisoners; how the various staff groups involved in a prisoner's care are co-ordinated to ensure full continuity of care in the event of a prison transfer; the facilities and reasonable adaptations required when dealing with learning disabled prisoners, including raising awareness of the requirements of the Disability Discrimination Act 2005 and communication between facilitators of sex offender treatment programmes and wing staff.	Yes	98
Essex and Thurrock	HM Prison - Young Offender's Institute (HMP-YOI) Chelmsford; Essex Police	HMP-YOI Chelmsford to consider reviewing its computer system to ensure previous mental health referrals are available to maximise accuracy of risk assessments; Essex Police to consider reviewing mental health training provided to police officers, to ensure the forensic medical examiner is called in prescribed circumstances.	Yes	106
Greater Manchester: City	Prisons and Probation Ombudsman; Ministry of Justice; Chorlton Approved Premises	In similar deaths Prison and Probation Ombudsman to consider interviewing all relevant staff and residents of approved premises, obtaining all prison records and arranging for a clinical review; Ministry of Justice and Chorlton Approved Premises to consider reviewing suicide/self-harm risk assessment and IT procedures for obtaining GP records as a matter of course; simplifying the recording of information about residents; reviewing induction processes and documentation; and reviewing night-time staffing levels and training staff in CPR techniques.	Yes	108
Darlington and South Durham/North Durham	Ministry of Justice	To review policy on and training for opening Assessment, Care in Custody and Teamwork documents.	Yes	117

Coroner District	Report sent to	Details	Response received	Report number
Warwickshire	Warwickshire Police	To consider the procedures for checking the accuracy of information provided by forensic medical examiners and amending the guidance for police officers in custody suites on the symptoms of alcohol withdrawal.	Yes	121
Isle of Wight	Ministry of Justice	To consider a review of prison officer first aid and resuscitation training.	Yes	128
Darlington and South Durham/North Durham	Ministry of Justice	To consider a review of refresher training on the need to seek specific advice when dealing with prisoners' behavioural problems and on involving prisoners' families in their care.	Yes	145
Greater Manchester: City	HM Prison Manchester	To consider a review of information provided to family members on visiting rights when a prisoner is in hospital and of communication between the prison and the hospital on the prisoner's state of health.	Yes	146
Greater Manchester: City	Guild Lodge Hospital, Preston	To consider a review of its referral form to avoid confusion with referral criteria and so that its referral chart includes timescales for assessments.	Yes	152
Worcestershire	Ministry of Justice	To consider ensuring that documentation which confirms a prisoner's categorisation is sent to the prison with them.	Yes	164
Cardiff and the Vale of Glamorgan	Ministry of Justice; South Wales Police	To consider raising the awareness of prison and police officers of the dangers of excessive water consumption.	Yes	180
Devon: Exeter and Greater	Ministry of Justice; HM Inspector of Prisons	To consider a review of prison policy on the abuse of drugs by inmates and clarification of what checks may be made on prisoners considered at risk.	Yes	184
Liverpool	Ministry of Justice	To consider a review of its policy on allocation of cells to prisoners known to suffer from epilepsy.	Yes	185
Berkshire	Department of Health	To consider whether social workers should be required to make contact with, and communicate key information to, a prison when someone in their care is detained.	Yes	186
Darlington and South Durham/North Durham	Ministry of Justice; NHS County Durham and Darlington	To consider a review of the Assessment, Care in Custody and Teamwork review procedures.	Yes	187

Drug and medication related deaths

Somerset: East	Somerset Primary Care Trust	To consider what safeguards are in place to prevent multiple prescriptions being issued to the same patient by separate surgeries.	Yes	38

Coroner District	Report sent to	Details	Response received	Report number
Cornwall	Royal Cornwall Hospital	To consider notifying the relevant authorities of deaths from known complications of rituximab.	Yes	75
Birmingham and Solihull	Medicines and Healthcare Products Regulatory Agency	To consider highlighting the changes made to the British National Formulary and Toxbase in respect of paracetamol overdose and arranging for all hospital trusts to provide information leaflets about such cases for patients; to consider research into biochemical markers and the pharmacogenetics of paracetamol induced hepatoxicity.	Yes	82
Devon: Exeter and Greater	Royal Devon and Exeter NHS Foundation Trust	To consider a review of adherence to protocols for the administration of anticoagulant medication.	Yes	84
North Yorkshire: Western	Citihealth NHS Nottingham; Department of Health	To consider issuing guidance to walk-in centre staff which emphasises the need to consider deep vein thrombosis as a possible diagnosis for leg pain in women who are taking a contraceptive pill.	Yes	88
West Yorkshire: Western	Mid-Yorkshire Hospitals NHS Trust	To consider reviewing the procedures for handling and investigating allergic and other adverse drug reactions; implementing a review of medical records in such cases or discussing with the treating doctors before completion of the Medical Certificate of Cause of Death; ensuring risk management teams process critical incident reports appropriately.	Yes	102
Wiltshire and Swindon	Department of Health	To consider implementing a standard cancer network protocol throughout England.	Yes	103
Northumberland: North	Toxbase, Newcastle-upon-Tyne	To consider reviewing the guidelines relating to monitoring use of citalopram.	Yes	112
Lincolnshire: North and Grimsby	North Lincolnshire Council; North East Lincolnshire Council	To consider a multi-agency review of the availability of methadone in the community; the effectiveness of supervised administration and decisions to allow self-medication.	No	179

Care home deaths

South Yorkshire: West	Darwin House, Sheffield	To consider ensuring that any person acting as a care home manager carries out a proper assessment of individual patients' care; implementing a policy for use of the grab-handle and using a more effective system for staff to communicate incidents to management.	Yes	16

Coroner District	Report sent to	Details	Response received	Report number
Greater Manchester: City	Ashley House Nursing Home, Didsbury	To consider putting in place, and making staff aware of, procedures to deal with medical emergencies and providing staff with first-aid training.	Yes	53
West Yorkshire: Eastern	Westward Care Limited, Leeds	To consider implementing a policy of reviewing medication prescribed to its residents and for two members of staff to be present when medication is administered.	Yes	156
Cumbria: North and West	Cumbria County Council	To consider a review of its risk assessment procedures for care home residents to ensure they are carried out and acted upon in a timely manner.	Yes	169

Service personnel deaths

South Yorkshire: East	Ministry of Defence	To ensure that the filler in soldiers' body armour is assembled correctly.	Yes	62

Police procedures related deaths

London: Inner West	Metropolitan Police	To consider clarifying the distinction between the Firearms Tactical Advisor and the Firearms Bronze Commander during operations; and reviewing the police presence when dealing with vulnerable individuals and reviewing guidance documentation for Firearms Officers.	Yes	2
Shropshire: Mid and North-West	West Mercia Constabulary	To consider a review of the chain of command for the police negotiator and armed officers to avoid confusion when dealing with a firearms incident.	Yes	14
Greater Manchester: South	Greater Manchester Police; Association of Chief Police Officers	To consider clarifying the force's policy on what action officers should take when a motorcycle fails to stop when requested; issuing guidance on the use of clear terminology and monitoring policy on pursuits, to identify any bad practice or breach of policy.	Yes	26
Wiltshire and Swindon	Wiltshire Police	To complete the revision of the force's welfare call procedures.	Yes	27
London: City	Metropolitan Police; Association of Chief Police Officers; Home Office	To consider making the Pre-Release Risk Assessment a requirement before releasing someone from police custody; delivering training in person on Pre-Release Risk Assessment to all officers who might perform a custody role, including those who carry out this duty on a part-time basis; and developing a system for the immediate delivery of clinical medical services to those detained or about to be released.	Partial response	34

Coroner District	Report sent to	Details	Response received	Report number
Peterborough	Cambridgeshire Constabulary; HM Prison Peterborough	Cambridgeshire Constabulary to consider ensuring that any recommendations made by the Forensic Medical Examiner (FME) are acted upon; all relevant actions or occurrences relating to a detained person are entered in the detention log and medical and medication forms are sent to the prison with the Personal Escort Report (PER). HM Prison Peterborough to confirm that procedures are in place to ensure full health and behaviour records for prisoners are maintained; the treatment of heroin users with methadone complies with current protocols and in the absence of the medical form and PER, enquiries are made with the police about whether the prisoner has been examined and any recommendations made by the FME.	Yes	39
Bridgend and Glamorgan Valleys	South Wales Police	To consider training officers to control and restrain, monitor and mouth-search suspects during the execution of a search warrant, particularly where it relates to controlled drugs and training officers regarding the appropriate use of first-aid techniques when a suspect has swallowed an item.	Yes	52
South Yorkshire: West	South Yorkshire Police	To consider implementing a system in sieges for information to be passed from public cordons to the Commanders and a family liaison officer to be deployed as early as possible after a siege develops.	Yes	54
London: South	Metropolitan Police	To consider a review to ensure adherence to the requirements under PACE to rouse intoxicated prisoners and under Standard Operating Procedures to engage with prisoners through conversation; the arrangements for passing information about prisoners to custody staff and for the handovers of shifts; the management of custody assistants; the use of CCTV monitoring and the access for ambulances at Bromley police station.	Yes	67
Cardiff and the Vale of Glamorgan	Gwent Police	To consider reminding officers to carry resuscitation facemasks and for them to call for immediate medical attendance if a member of the public's medical condition deteriorates; to include in risk assessments the possibility of drugs being swallowed, particularly in situations where officers are conducting a drugs search.	Yes	118

Coroner District	Report sent to	Details	Response received	Report number
Product related deaths				
Kingston upon Hull and East Riding of Yorkshire	British Plastics Federation; The Chartered Institute of Plumbing and Heating Engineering	To consider issuing and disseminating guidance to members, pipe manufacturers and plumbers regarding the dangers and risks of using British Standard BS 7291 plastic pipes in continuously operated recirculation systems.	Yes	5
Liverpool	Department for Business, Innovation and Skills	To consider whether written regulations are needed to warn DIY enthusiasts about the safe and secure fitting of fireplaces/mantelpieces.	Yes	9
Gwent	Welsh Assembly Government	To consider an urgent review of the enforcement of food hygiene regulations.	Yes	73
Essex and Thurrock	Department for Business, Innovation and Skills	To consider a review of measures to be taken regarding the safety of blind cords.	Yes	90
London: Inner South	Medicines and Healthcare Products Regulatory Agency; Greenwich Council	Medicines and Healthcare Products Regulatory Agency to consider introducing fire safety regulations for furniture used as medical equipment; Greenwich Council to ensure that contracted-out suppliers of medical furniture and equipment comply with manufacturers' instructions when delivering and installing furniture.	Yes	91
South Yorkshire: West	Clark and Partners, Sheffield	To consider modifications to the breaking system on its Supatravala Plus scooter to enable it to stop when the "push along" mode is engaged.	Extension granted	142
Essex and Thurrock	British Standards Institute; Health and Safety Executive; Essex County Council; Casterbridge Nurseries Limited, London	British Standards Institute to consider if the British Standards guidance for toys needs amendment to include risks of neck entrapment; Health and Safety Executive and Essex County Council to consider if this or other playhouses which present an entrapment risk despite complying with current British Standards are still being sold; Casterbridge Nurseries to consider its purchasing policy for toys and playground equipment and its policy on staff using mobile phones whilst on duty.	Yes	158

Coroner District	Report sent to	Details	Response received	Report number
Other deaths				
Greater Manchester: South	G4S plc	To consider reviewing procedures when it is persistently impossible to contact someone who is wearing an electronic tag.	Yes	69
Devon: Exeter and Greater	Medicines and Healthcare Regulatory Authority; Health and Safety Executive	To consider regulating the availability of helium gas.	Yes	144
Warwickshire	Warwickshire District Council	To consider providing floatation aids on the River Avon, Myton Fields, Warwick.	Yes	159
West Yorkshire: Western	Office for Standards in Education, Children's Services and Skills	To consider a review of first aid training provided to nursery nurses and information provided to nurseries on food preparation.	Yes	188

Produced by the Ministry of Justice

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