Ministry of JUSTICE

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

March 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 fourth Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 April and 30 September 2010.

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, Coroners and Burials Division, 4.38 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 April and 30 September 2010 coroners in England and Wales issued a rule 43 report in 175 inquests.

As in the three previous summary bulletins, rule 43 reports were most commonly issued in connection with hospital deaths, accounting for 26% of reports issued (46 reports), broadly in line with the percentage in previous publications. A further 13% of reports were issued in connection with deaths in custody (23 reports), again broadly in line with the percentage with the third publication. The third most frequently issued reports, accounting for 12% of reports, were in connection with community healthcare or emergency services related deaths (21 reports).

This is a change from the previous summary bulletins, in which the second most common category of reports issued was in connection with road deaths. In this summary this category accounted for 10% (18 reports). The percentage of this category of deaths is reducing when compared to that in previous publications.

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 April and 30 September 2010, by broad category

Category	Number of inquests where Rule 43 reports issued
Hospital deaths	46
(Clinical procedures and medical management)	(43)
(Other)	(3)
Road deaths	18
(Highways safety)	(16)
(Vehicle safety)	(1)
(Driver and vehicle licensing)	(1)
Accidents at work and health and safety related deaths	6
Mental health related deaths	14
Community healthcare and emergency services related deaths	21
Deaths in custody	23
Drug and medication related deaths	6
Care home deaths	11
Service personnel deaths	2
Police procedures related deaths	6
Product related deaths	6
Railway related deaths	7
Other deaths	9
Total	**175**

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 April and 30 September 2010, rule 43 reports were issued by 59 (51%) of these coroner districts.

In the six months covered by this bulletin, the Staffordshire South coroner district issued the highest number of reports (12 reports) equating to 7% of reports 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 59 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 217 reports were issued arising out of 175 inquests.

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 April and 30 September 2010, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	72
Individual Minsters/central Government departments	44
Local Authorities	22
Private companies	17
Regulatory bodies and trade associations	21
Police and emergency services	22
Prisons	10
Care and nursing homes	6
Other	3
Total	**217**

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 three previous rule 43 summary reports remain the main themes of the rule 43 reports issued during the period covered in this report.

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

- between different hospital departments or specialities;
- 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 discharge from hospital

Several reports also highlight the absence of both appropriately trained and sufficient numbers of staff, and the need for lessons learned after a death to be shared and implemented.

The second most frequently issued reports relate to deaths in custody. The main issue in these reports is medical care of prisoners, particularly those with mental health concerns. Problems with communication and prison procedures and protocols also feature in many of the reports in this category of deaths.

As identified in previous bulletins, reports across all categories of deaths frequently highlight communication issues between the different agencies involved with the deceased. The absence of procedures and protocols or procedures and protocols not being followed or communicated properly are also commonly mentioned. This is particularly the case in community healthcare deaths, the third most commonly issued reports in this period, where concerns about the prescribing, dispensing and the availability of drugs, or other substances which might be open to abuse, are raised. Health and safety issues are also a common feature in many reports across all kinds of deaths.

Many responses continue to set out in detail the action which has been taken and it is pleasing that many organisations take the concerns brought to their attention seriously. The majority of responses indicate that lessons have been learned and appropriate action taken.

3. Rule 43 reports which have wider implications

A list of Rule 43 reports received by the Lord Chancellor between 1 April and 30 September 2010 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.

i) Accident at work and health and safety related deaths

A man drowned in a swimming pool at a hotel in Turkey whilst on a Thomas Cook holiday. Following his inquest the coroner wrote to Thomas Cook, and the Association of British Travel Agents (ABTA) Limited, expressing concern that the insufficient safeguards at the swimming pool, which had been indentified by a Thomas Cook audit earlier that year, had not been rectified or drawn to the attention of potential holidaymakers. The coroner asked if consideration could be given to bringing such defects to the attention of holidaymakers going to those locations.

ABTA Limited responded stating:

- They have been lobbying for the introduction of European hotel safety standards for some years. Their campaign was re-launched in 2008, when they formed an Expert Group Project. The aim of the Project was to produce reports on three aspects of holiday safety to demonstrate the need for and benefit to consumer safety of a European Directive setting minimum standards on tourist accommodation safety.
- Safety standards vary across the world and courts in England and Wales accept that it is the legal standards in the holiday destination that apply to the actual provision of holiday services. Therefore, in the vast majority of cases there are no breaches of local standards as hotels generally comply with these. There remains a difference between local safety standards and those that the UK travel industry wishes to see as normal or minimum standards.
- Some of its members have voluntary risk assessment programmes and promote safety awareness, education and improvement which ABTA support. However, whilst ABTA believe all travellers should be able to rely on proper local regulation, there is no legal obligation on travel organisers to carry out safety assessments and the vast majority do not have the resources or expertise to do so. ABTA do not think it is appropriate for travel organisers to be required to carry out such risk assessments.
- The 1990 European Package Travel Directive creates a regime where travel organisers must accept civil responsibility for a supplier's failure but that is judged against the local standard. This regime provides a mechanism for consumers to seek redress in their own country if something goes wrong. ABTA believe that responsibility for safety

should lie with owners or operators of hotels rather than on travel organisers.

- In exceptional circumstances, where substantial deficiencies against local regulatory standards are brought to the travel organiser's attention, it would be appropriate for them to take action to persuade the supplier to address the issue. If this proves unsuccessful, the travel organiser may consider it appropriate to notify customers.

Thomas Cook responded as follows:

- They agreed with the response from ABTA Limited.
- They prioritise customer health and safety and carry out a resort audit before they contract with a property. However, this does not replicate the obligations of those who own, manage or control the property, and who have responsibility for the health and safety of all guests, but rather it emphasises the importance Thomas Cook place on health and safety and sharing their experience.
- If they become aware of significant health and safety risks they would only enter into a contract once these have been satisfactorily addressed. If a contract has already been signed, they would remove the property from sale and withdraw customers from the resort. However, they cannot expect the same standards as exist in the UK and case law makes it clear that tour operators only have to ensure that hotels comply with their local regulations and standards, in this case Turkish ones.
- They do not consider the hotel fell below Turkish standards or that their audit indicated that defects had been identified that could amount to any breach of Turkish law or regulation. However, there was evidence that the hotelier had taken some action in response to their audit, which is what they seek to achieve by drawing areas for potential improvement to their attention. Resort owners' willingness to implement recommendations is an important factor in the company's decision to continuing working with them.
- Where an overseas hotelier complies with their local laws and regulations, it is not feasible for them to insist that they take actions to comply with UK regulations.
- On the issue of drawing attention of unremedied defects to potential customers, they do not consider they need to communicate detailed resort audit information to customers. However, their brochures draw attention to a number of health and safety issues, including on swimming pools.

ii) Drug and medication related deaths

a) A prisoner receiving treatment for Hodgkin's disease died in 2007, when his prescription for oral chemotherapy was incorrectly dispensed at the hospital. At the inquest it was found that the following actions had contributed to the death:

- the prescribing doctor had been confused by the consultant's handwriting;

- the pharmacist carrying out the professional check of the prescription had failed to carry this out in line with the standard operating procedures;
- the dispenser had misread the prescription and over-dispensed the medication;
- the pharmacist carrying out the final check had failed to check correctly both the dispenser's work and the labels to ensure the drugs commenced on the correct date in line with the consultant's instructions;
- the hospital, prison and Primary Care Trust (PCT) had failed to liaise to ensure the prescription was correctly taken;
- the hospital's systems had been defective as there was failure:
    - in the pharmacy checking procedure, with the result that the same individual carried out the professional and the accuracy check;
    - adequately to implement, circulate, manage and maintain pre-printed prescriptions.

At the time of the incident there was only one pharmacist in the dispensary and this individual was responsible for carrying out the professional and final check of the dispensed medicines. However, this individual had no specialist cancer chemotherapy experience or training, could only contact such a pharmacist by telephone, and was not familiar with the Prednisolone, Etoposide, Chlorambucil and CCNU (lomustine) (PECC) regimen or the drugs concerned.

There was also no evidence that the prisoner knew how to take his medication correctly either before he left the hospital or when he was given it at the prison.

Following the inquest, the coroner wrote to the Department of Health, acknowledging that the prison healthcare service and the PCT had made a number of changes and that the hospital now had an implementation plan in place. Nevertheless, he asked them to consider a review of policy and practice in respect of oral chemotherapy to eliminate the risk of future deaths.

The Department of Health responded as follows:

- In August 2009 the National Chemotherapy Advisory Group (NCAG) had published a report 'Chemotherapy Services in England: Ensuring quality and safety'. The report aims to improve services for cancer patients and makes recommendations on chemotherapy, such as the decision to treat, patient consent, prescribing and dispensing and information for patients and carers. The report's recommendations apply to all forms of systemic anti-cancer treatment, including oral chemotherapy.
- The report recommends that:

  - Chemotherapy prescriptions should be checked by an oncology pharmacist, who has undergone specialist training, demonstrated their competence and is locally authorised/accredited. A list of designated pharmacists should be kept in each hospital where chemotherapy is prescribed or delivered.
  - Each chemotherapy service should ensure the same process of care is used for oral and parenteral chemotherapy
  - All chemotherapy service providers should urgently ensure that the safety measures highlighted by the National Patient Safety Agency (NPSA) regarding oral chemotherapy are in place.
- A National Chemotherapy Implementation Group has been set up to provide oversight and commission national work to support local teams to determine how the recommendations can be taken forward. National work is now underway on oncology models, chemotherapy capacity planning and data collection and development of a skilled workforce.
- The Manual for Cancer Services is also being updated to include measures based on the NCAG report. The manual provides a set of measures against which local NHS teams can assess the quality of cancer services they provide.
- In January 2008 the NPSA issued an alert about the risks of incorrect dosing of oral anti-cancer medicines. Among the points this makes are:
  - Staff dispensing oral anti-cancer medicines should be able to confirm that the prescribed dose is appropriate, and the patient is aware of the required monitoring arrangements by having access to the written protocol and treatment plan from the treating hospital, and advice from a pharmacist with experience in cancer treatment at that hospital;
  - Patients should be fully informed, receive verbal and up-to-date written information about their oral anti-cancer therapy from the treating hospital. This information should include contact details for specialist advice, written information on the details of the oral anti-cancer regimen, treatment plan and monitoring arrangements.
- The Chief Pharmaceutical Officer is:
  - checking what proportion of cancer chemotherapy prescriptions within the NHS are handwritten; and
  - considering the issue of a professional letter to chief pharmacists in the NHS reminding them of the risks related to cancer chemotherapy and of the guidance available to reduce such risks.
- The General Pharmaceutical Council are aware of and are reviewing the events which occurred in this incident.

b) A woman who suffered from idiopathic primary pulmonary hypertension was prescribed the drug Sitaxsentan but suffered a reaction to it. This led to liver and multiple organ failure from which she died. Evidence at the inquest indicated that it was known that liver problems can occasionally result from this drug and its use is accompanied by recognised and recommended procedures and tests, including monthly liver function tests.

Following the inquest, the coroner wrote to Pfizer, who manufacture Sitaxsentan, asking them to consider the recommendations they provide for its

use, including the appropriate manner and frequency of testing to monitor possible liver damage.

Pfizer confirmed that Sitaxsentan (approved in 2006 and commercialised as Thelin®) is one of three approved drugs in the UK belonging to a class of treatments called endothelin receptor antagonists (ERAs) and liver function abnormalities are recognised adverse affects of ERAs. As a result, the labelling for ERAs advises monthly monitoring of liver function. All ERAs have Risk Minimisation Plans (RMPs); the European RMP for Sitaxentan of 31 March 2008 lists all the pharmacovigilance actions which are a condition of marketing authorisation.

Since being made aware of this incident Pfizer:

- Promptly notified regulatory agencies of this case in countries/regions where this drug is licensed or where clinical trials were ongoing and initiated its medical review procedure.
- Conducted a thorough internal review of all cases of hepatotoxicity which had been reported and a comprehensive literature review of all ERAs. This concluded there was no evidence to suggest any change in the benefit/risk profile of Sitaxentan nor any difference in the safety profile between Sitaxentan and other ERAs.
- Held a global expert panel meeting which concluded that:
    - all ERAs can be associated with hepatotoxicity and reiterated the importance of appropriate monitoring and education;
    - the exact mechanisms underlying ERA hepatotoxicity are not fully understood and it is unknown if they are the same across all ERAs;
    - additional labelling may be required with respect to monitoring, contra-indications etc.;
    - there does not appear to be any difference in the safety profile between Sitaxentan and other ERAs;
    - the risk of significant hepatotoxicity can be adequately mitigated and the benefit/risk of Sitaxentan remains favourable.
    - Pfizer will continue to explore the causes of raised liver enzymes through research and internal safety reviews.
- Offered the national Pulmonary Hypertension physicians' group monthly blood testing free of charge via a private provider for all patients prescribed Sitaxentan. This has not yet been implemented but remains on offer for consideration.
- Have updated its Core Data Sheet for Sitaxentan and a safety change to the European Union Summary of Product Characteristics (SmPC) for Sitaxentan was submitted to the European Medicines Agency in December 2009. A revised SmPC was approved in July 2010.

[Since submitting its response in August 2010, Pfizer has received new information related to this case and two other cases of hepatotoxicity. Based on the information available and given the availability of alternative treatments, Pfizer has concluded that the overall risk/benefit profile of Thelin® (sitaxentan) is no longer favourable. In December 2010, the company

announced its decision to withdraw the drug from all countries worldwide where it had been marketed].

iii) Product related deaths

a) Two children died when they caught their heads in the looped cords attached to window blinds. Following their inquests the coroner wrote to the Department for Business Innovation and Skills referring to safety standard BS13120 but noted that the blinds involved in these deaths did not appear to comply with this. He asked if further steps could be considered to ensure compliance with the safety standard or to ban looped cords completely.

In their response the Department for Business Innovation and Skills (BIS) confirmed:

- They were working with the British Blind and Shutter Association (BBSA) and European colleagues to strengthen EN13120 further to improve its scope to include virtually every blind type. This Standard is also being developed to include testing of safety devices both on new blinds and on those available for retrofitting.
- In 2009 BBSA mandated all its members to comply with the child safety aspects of EN13120 and BIS is working with the British Retail Consortium and BBSA to encourage wider adoption of the Standard by major high street retailers.
- There are millions of blinds already in homes and many people may be unaware of the potential hazards posed by blind cords to young children. BIS is working with the BBSA, and their "Make it Safe Campaign", the Royal Society for the Prevention of Accidents, the Child Accident Prevention Trust and Trading Standards Offices to increase education by providing appropriate safety messages to consumers, particularly those with young children.
- Banning looped cords altogether would not be appropriate for all blind types. However, there are blinds available on the UK market which have no cords and BBSA members and others in the UK industry have also developed a number of concealed cord systems for blinds.
- BBSA confirm that no new blind products are being developed by their members without child safety being developed into the product.

b) A man died when he was hit by a car being manoeuvred in a domestic garage onto heavy duty car ramps which skidded forward a number of feet. The owner of the ramps had bought them over 30 years previously and did not know their make. It was, however, established that ramps of the same design were still available and carried no warnings. Following the inquest the coroner wrote to Kent County Council Trading Standards. She drew attention to the death and raised concern that there was nothing in the ramps' design specifically to prevent or reduce the possibility of sliding or skidding on a hard surface, suggesting that the ramps are kept in place by weight and friction.

Kent County Council Trading Standards responded by confirming that these ramps would be deemed consumer products and that therefore they should be safe:

- They had considered the companies which traded in these products, liaising with Trading Standards in the areas where these companies were based. The design of these ramps is such that there is likely to be a degree of slippage if they are used in certain circumstances. However, this would not make the product unsafe provided the hazard was brought to the consumer's attention.
- Producers are required to provide consumers with information to enable them to assess the risks in a product throughout its normal or foreseeable period of use, where these risks are not immediately obvious without adequate warnings, and to take precautions against those risks. Failure to do so is an offence. They must also consider industry standards setting out the construction and labeling requirements for products.
- 'British Standard AU 224b:1997 Standard on specification for portable wheel ramps for cars and light vans' sets out the specifications for construction and design, structural integrity and factor of safety, marking and the warning notice. Some but not all aspects of the warning notice have to be permanently marked on each ramp.
- All the ramps Trading Standards had reviewed had included the required warnings and instructions. Therefore they could confirm that the manufacturers had all complied with the Regulations and the Standard in respect of labeling requirements and are not manufacturing a dangerous product.
- However, if the labeling and notice are not present the product would present a hazard and Trading Standards would use their enforcement powers to deal with the ramps, their importer and manufacturer, including prosecuting if appropriate.

iv) Other deaths

A man died following an injury he received whilst playing a game of rugby. After his initial injury he had sat out of the game complaining of a headache and fuzzy eyesight. He improved somewhat and returned to the field at half-time. There was no trained first aider in attendance who could assess the man's fitness to return to the game and when the referee saw him staggering, the man said he was fit to continue. The referee had no power to declare him unfit. The man subsequently left the field again and collapsed but was still technically within the playing area. The referee did not stop the game which potentially put the player at further risk.

Following the inquest the coroner wrote to the Rugby Football League asking them to consider action to prevent a similar situation happening in the future.

The Rugby Football League (RFL) responded that it is committed to ensuring there is proper protection for all players of rugby league. However, since this tragic death RFL has:

- Issued a guidance document, 'Guidance on Managing Head Injuries in Rugby League'. This sets out advice for those providing first aid at

matches as well as coaches and referees. This Guidance has been developed with RFL's Head of Human Performance and Chief Medical Officer. RFL expects the Guidance will be followed at all levels of the game.

- In consultation with the British Amateur Rugby League Association, begun drafting a single set of Operational Rules for all teams and clubs within amateur Rugby League. These Rules will introduce the requirement for a first aider, who is familiar with the RFL guidance on head injuries, to be present at every amateur match and for the referee to confirm this prior to the start of the match. Additionally, if the referee has any concerns about a player who has sustained a head injury they will be able to order the player off the field to be assessed by the first aider.
- Begun reviewing the provision of first aid training and investigating ways in which to underwrite or contribute to first aid training of volunteers. They plan to implement a system of a 'lead' first aider who will be the primary contact with the RFL and who will be continually provided with information and training which they will be expected to cascade to other first aiders in the team.
- Reminded clubs that where a player collapses in the field of play the match must be stopped whilst help is provided. This is in accordance with a long-standing directive at all levels of rugby league.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 April and 30 September 2010

Coroner district	Number of inquests in which Rule 43 reports issued
Birmingham and Solihull	1
Black Country	1
Bridgend and The Valleys	1
Cardiff and The Vale of Glamorgan	6
Cheshire	10
Cornwall	4
Coventry	1
Darlington and South Durham/North Durham	2
Derbyshire: Derby and South	3
Derbyshire: North	1
Devon: Exeter and Greater	6
Devon: Plymouth and South West	1
Devon: Torbay and South	1
Dorset: Bournemouth, Poole and Eastern	2
Dorset: West	1
Essex and Thurrock	2
Gloucestershire	4
Greater Manchester: City	8
Greater Manchester: North	3
Greater Manchester: South	11
Greater Manchester: West	3
Hampshire: Portsmouth and South East	2
Hertfordshire	5
Kent: Central and South East	1
Kent: Mid and Medway	2
Kent: North East	3
Leicestershire: City and South	1
Lincolnshire: West and Spilsby and Louth	4
Liverpool	1

London: City	1
London: Inner North	6
London: Inner South	2
London: Inner West	1
London: North	1
London: West	3
Newcastle upon Tyne	4
Norfolk	6
North Yorkshire: Eastern	1
Northampton	2
Northumberland: North	2
Oxfordshire	1
Peterborough	1
Preston and West Lancashire	1
Somerset: East	3
Somerset: West	1
South Yorkshire: Eastern	2
South Yorkshire: Western	4
Staffordshire: South	12
Sunderland	2
Surrey	2
Sussex: West	3
Teesside	2
Telford and The Wrekin	1
Warwickshire	1
West Yorkshire: Eastern	5
West Yorkshire: Western	7
Wiltshire and Swindon	5
Wolverhampton	1
Worcestershire	1
Total	**175**

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.

City of Bradford Metropolitan District Council

NHS Devon

E.on UK PLC

Health and Safety Executive

Home Office

HM Prison, Exeter

Mount Gould Hospital, Plymouth

NHS Gloucestershire

Royal Pharmaceutical Society

Sudden Infant Death Syndrome Research

Annex C

List of all Rule 43 reports received between 1 April and 30 September 2010

Coroner District	Report Sent to	Details	Response received	Report number
Hospital Deaths: clinical procedures and medical management				
Norfolk	Norfolk and Norwich University Hospitals	To consider if further measures and/or additional training are needed to ensure monitoring of patients' conditions is recorded regularly and in sufficient detail in nursing notes.	Yes	4
Derbyshire: Derby and South Derbyshire	Department of Health; Nursing and Midwifery Council	To consider whether psychiatric nurses should be made aware of other medical conditions by being attached to an acute medical ward as part of their training.	Yes	5
Greater Manchester: South	Medical and Healthcare Regulatory Agency	To consider a review of the packaging of pre-loaded syringes of Atropine Adrenaline and Amiodarone so that the two drugs are clearly identified, to avoid confusing them.	Yes	11
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To investigate whether there are clear post-operative instructions on prescribing prophylactic anticoagulants to prevent blood clotting following orthopaedic surgery.	Yes	14
Newcastle Upon Tyne	Newcastle upon Tyne Hospitals NHS Foundation Trust	To consider a review of the provision of support staff to assist nursing staff at night; procedures for recording actions taken by staff; staff following medical procedures and handover arrangements between medical and nursing staff at the end of shifts.	Yes	15
Greater Manchester: South	Department of Health	To consider introducing a nationally agreed protocol or algorithm to ensure that all appropriate questions are answered and considered when junior doctors seek advice from on call consultants.	Yes	23
London: Inner South	Maidstone and Tunbridge Wells NHS Trust	To consider a review of ambulance procedures and hospital treatment for children presenting with possible neuro-surgical emergencies.	Yes	28

Coroner District	Report Sent to	Details	Response received	Report number
Kent: Central and South East	East Kent Hospitals University NHS Foundation Trust	To consider investigating delays in reviewing and carrying out treatment which may have contributed to the patient's death.	Yes	36
Bridgend and Glamorgan Valleys	Cwm Taf Local Health Board	To consider a review of patient medical records for their adequacy and accuracy; procedures for performing tracheotomies; radiologists' expertise to read the results of CT scans on tracheotomy patients.	Yes	39
Oxfordshire	Oxford Radcliffe Hospital NHS Trust	To consider a review of procedures to ensure that doctors' recommended treatment and equipment checks are carried out in a timely manner; staff training in track and trigger procedures and write contemporaneous notes.	Yes	40
Newcastle Upon Tyne	Newcastle upon Tyne Hospitals NHS Foundation Trust	To consider a review of its provision of specialist tissue viability nursing and of raising staff awareness of existing procedures for providing appropriate equipment for patients with pressure sores.	Yes	43
West Yorkshire: Eastern	Leeds Teaching Hospitals NHS Trust	To consider a review of advice and information provided to patients who sustain fractures and are immobile on the dangers and symptoms of Pulmonary Embolism from Deep Vein Thrombosis, especially to female patients taking oral contraceptives.	Yes	57
Greater Manchester: South	Stockport NHS Foundation Trust	To consider a review of hospital policy on how nurses' requests for doctors to see patients are communicated and acted upon; arrangements for ensuring in-patients attend follow-up appointments; transferring patient notes, or a copy of such notes, between hospitals.	Yes	58
Leicestershire: City and South Leicestershire	University Hospitals of Leicester NHS Trust	To consider a review of staffing levels to enable procedures in the operating department to be properly followed.	Yes	74
Greater Manchester: City	Manchester Mental Health and Social Care Trust	To consider establishing a joint procedure with the Acute Hospital Trust to deal with patients with perceived mental health problems and at risk of self harm.	Yes	76
Teesside	County Durham & Darlington NHS Foundation Trust	To consider the availability of MRI scanning out of hours.	Yes	77

Coroner District	Report Sent to	Details	Response received	Report number
Hertfordshire	East and North Hertfordshire NHS Trust	To consider a review of the discharge system to ensure that patients' discharge letters are consistent and give full and accurate information and that primary and secondary care clinicians understand the time interval required for ongoing medical investigations.	Yes	80
Greater Manchester: City	Central Manchester University Hospital NHS Foundation Trust	To review its general policy of checking on patients every 30 minutes and to adjust this accordingly for cases needing special attention.	Yes	83
Staffordshire: South	Stafford Hospital	To consider the independent report received following this death on emergency department staff having access to nursing and ambulance records; on greater clarity for when and by whom patients should be seen, when junior doctors should contact consultants and clearer procedures for referral to tertiary centres.	Yes	85
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board; Chief Medical Officer for Wales	Cardiff and Vale University Health Board to consider a review of the speed with which its medical staff respond to patients suffering from a stroke; Chief Medical Officer for Wales to consider a review of procedures and number of staff involved in running a drugs trial.	Yes	89
Cornwall	Royal Cornwall Hospitals NHS Trust	To consider a review of the completeness of medical record entries when patients' medications are altered; protocols for dealing with suspected MRSA patients and record keeping for MRSA; to confirm that a revised protocol on treating of pressure sores is in place across the Trust.	Yes	96
Cornwall	Royal Cornwall Hospitals NHS Trust	To consider a review to ensure that the protocols on observation and monitoring of fluid intakes are consistently followed.	Yes	97
Greater Manchester: South	Stockport NHS Foundation Trust	To consider a review of the arrangements for post-operative follow-up appointments and the records kept by call centre staff.	Yes	98

Coroner District	Report Sent to	Details	Response received	Report number
Cheshire	Leighton Hospital (Mid Cheshire Hospitals NHS Foundation Trust)	To consider a review of procedures for staff and record keeping to monitor the safety of vulnerable patients and for returning patients who remove themselves from hospital.	Yes	100
Greater Manchester: South	Cheadle Royal Hospital	To consider a review of procedures to ensure staff fully understand the required levels for monitoring patients, know how to complete medical records properly and are aware of CPR protocol in emergencies.	Yes	118
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider introducing a policy and guidelines to support risk assessments of patients with epilepsy.	Yes	119
North Yorkshire: Eastern	Department of Health	To consider a review of the NICE guidance on when to give chemical prophylaxis.	Yes	120
Greater Manchester: City	Pennine Acute Hospitals NHS Trust	To consider a review of the inquest evidence which indicated that an unidentified member of the nursing staff's view that the deceased was feigning his symptoms was not recorded on his medical records.	Yes	123
Gloucestershire	Gloucestershire Hospitals NHS Foundation Trust	To consider a review of record keeping and dissemination of all necessary information to ensure there is appropriate nursing care and sufficient staff on Knightsbridge Ward at Cheltenham General Hospital.	Yes	128
Greater Manchester: South	Trafford NHS Foundation Trust	To consider a review of training for senior nurses to ensure they can carry out all the functions required on their particular ward; staff training in recognising and managing patients with incontinence/mobility difficulties; protocols for informing next of kin of falls and a patient's death and medical staff levels at Trafford Hospital.	Yes	129
Kent: North East	East Kent Hospitals University NHS Foundation Trust	To consider a review of the use of acronyms and the times used to record observations in patients' medical notes; discharge procedures including providing clear instructions to parents of what to expect and when they might need to seek further medical advice.	Yes	130

Coroner District	Report Sent to	Details	Response received	Report number
Newcastle Upon Tyne	Newcastle upon Tyne Hospitals NHS Foundation Trust	To consider re-emphasising to staff procedures for using chest drain bottles, potential problems with their use and the need to monitor constantly their use and condition; to review its communication procedures to ensure relatives are kept informed.	Yes	135
Cheshire	The Intensive Care Society; National Patient Safety Agency	The Intensive Care Society to consider how it communicates guidance to its members; National Patient Safety Agency to consider a review of training, systems for monitoring, recording, standards and guidelines for tracheotomy care and management.	Yes	138
South Yorkshire: Eastern	Doncaster and Bassetlaw NHS Foundation Trust	To consider a review of its procedures for obtaining appropriate medical care for patients whose health deteriorates and keeping accurate patient records to document fully all actions taken.	Yes	140
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To review its procedures on sharing information about a patient's risk of falling and communicating with a patient's family when there is a poor survival prognosis.	Yes	147
Staffordshire: South	Heartlands Hospital, Birmingham	To consider a review of its patient discharge protocol and in particular whether the location to which the patient is discharged meets their needs.	Yes	149
Staffordshire: South	Stafford Hospital	To consider implementing the remaining recommendations and action plan of the review which followed this death.	Yes	150
Northumberland: North	Northumberland Tyne and Wear NHS Trust	To consider a review of shift handover and observation arrangements.	Yes	155
London: Inner North	National Patient Safety Agency	To consider taking further action on the work in progress to develop and implement recommendations for structured models of training, practice and continuous assessment for safer prescribing.	Yes	157
Staffordshire: South	Stafford Hospital	To consider a centralised or consolidated system for monitoring staffing and practical improvements implemented since this death and developing an impact assessment procedure to deal with potential reductions in staff.	Yes	158

Coroner District	Report Sent to	Details	Response received	Report number
Wiltshire & Swindon	Wiltshire Primary Care Trust; Salisbury District Hospital NHS Trust	To consider a review of the training and support given to non-emergency department staff to raise awareness of mental health issues including how to deal with such patients.	Yes	162
London: Inner North	Department of Health; Barts and the London NHS Trust	To consider a review of its procedures on removing cannulae before discharge and mentioning in medical notes all tubes inserted; to consider action to reduce theft of alcoholic hand cleaners.	Yes	165
Greater Manchester: City	Pennine Acute Hospitals NHS Trust	To consider a review of protocols to ensure specialist paediatric advice is sought, and the treating consultant attends, to review the mother when there is concern about the health of an unborn baby.	Yes	175
Hospital Deaths: other hospital deaths				
Shropshire: North and The Wrekin	Shrewsbury and Telford Hospital NHS Trust	To consider a review of the level of staffing on Ward 8 at the Princess Royal Hospital, Telford.	Yes	56
London: Inner North	Department of Health; Barts and the London NHS Trust	To consider action to reduce the theft of alcoholic hand cleaners, the risks associated with abuse of such cleaners and trespass on hospital premises to obtain them.	Yes	160
London: Inner North	Department of Health; Barts and the London NHS Trust	To consider action to reduce the theft of alcoholic hand cleaners, the risks associated with abuse of such cleaners and trespass on hospital premises to obtain them.	Yes	166
Road Deaths: highways safety				
Somerset: East	Somerset Highways	To consider whether it is more appropriate for the minor roads at the Marshalls Elm crossroads to be "Stop" rather than "Give Way" junctions.	Yes	16
Somerset: East	Somerset Highways	To consider a review of the inspection regime for missing road signs.	Yes	17

Coroner District	Report Sent to	Details	Response received	Report number
Somerset: East	Somerset Highways	To consider appropriate action to improve the drainage system on the A361 at Torr Works, East Cranmore, Somerset; to inspect more frequently for blocked drains; to install lighting to alert drivers of flooding and signs to warn drivers the road is liable to flooding.	Yes	18
Kent: Mid and Medway	Highways Agency	To consider installing a metal safety barrier across the existing 126-metre gap on the M26 on the approach to the M20 junction.	Yes	19
Gloucestershire	Gloucestershire County Council	To consider a review of the road signs at the bend at Milestone Copse on the A435, Cheltenham Road, North Cerney.	Yes	27
Surrey	Surrey County Council	To consider a review of all crossings and traffic lights in Dorking town centre to ensure their suitability for safe use by both pedestrians and motorists.	Yes	45
Norfolk	Norfolk County Council	To consider a review of the street lighting on the A148 Wootton Road/Queen Elizabeth Avenue junction, Kings Lynn so that the road surface is easier to see; to consider bringing forward the planned date of refurbishment of street lighting at this location.	Yes	62
Devon: Torbay and South	Devon County Council	To consider installing signs on the C794 Avonwick to Totnes road to warn drivers of oncoming traffic when they leave the lay-by to drive towards Totnes.	Yes	64
Wiltshire and Swindon	Wiltshire Council	To consider erecting barriers to protect motor vehicles from coming into contact with the bridge parapet and to prevent them from travelling down the embankment on the A350 Western Way, Melksham at the River Avon bridge.	Yes	72
West Yorkshire: Western	City of Bradford Metropolitan District Council	To consider extending the barrier to prevent pedestrian access to the road before the crossing between Parkinson Road and Buck Street, Denholme.	No	82
Sussex: West	Department for Transport	To consider a review of the visibility of the junction at the Havenwood Caravan Park site on the A27, Binstead on the eastbound carriageway.	Yes	102

Coroner District	Report Sent to	Details	Response received	Report number
Northampton	Highways Agency	To consider erecting a pedestrians crossing warning sign on the A45 dual carriageway at Wootton, Northamptonshire.	Yes	124
Surrey	Highways Agency	To consider installing signage on the southern section of the M25 (marker point 434-8B) to alert drivers to the possibility of flooding.	Yes	139
Somerset: West	Somerset County Council	To consider erecting a speed camera at the Williton end of the Withycombe Straight on the A39 between Taunton and Minehead.	Yes	153
Greater Manchester: West	Bolton Council	To consider action to reduce the risk of flooding and drainage problems on the A6 Blackrod bypass, Bolton.	Yes	156
Sussex: West	Highways Agency	To consider improving and increasing the number of signposts on the Longbridge Way/Airport Way roundabout at North Terminal, Gatwick Airport.	Yes	161
Road Deaths: vehicle safety				
Gloucestershire	Department for Transport	To consider a review of the MOT test to include the requirement that the vehicle will fail if its tyres are more than 10 years old.	Yes	105
Road Deaths: driver and vehicle licensing				
West Yorkshire: Western	Department of Transport	To consider making it mandatory for doctors who diagnose patients as suffering from fits to notify the DVLA automatically to withdraw the person's driving licence.	Extension granted	66
Accidents at work and health and safety related deaths				
West Yorkshire: Eastern	Wakefield Council	To consider whether to increase the height of the parapet wall or erect some other form of barrier to prevent public access at Kemps Bridge, Wakefield.	Yes	10
Northampton	Health and Safety Executive; The National Federation of Roofing Contractors Ltd.	To consider producing guidance or a protocol to require roofing contractors to cover roof lights to prevent roofers falling through fragile lights.	Partial response	44

Coroner District	Report Sent to	Details	Response received	Report number
West Yorkshire: Western	Thomas Cook; Association of British Travel Agents	To consider how defects highlighted in a travel agent's audit of a holiday destination which have not been rectified can be brought to the attention of holidaymakers going to those resorts, so they can make an informed choice.	Yes	69
London: Northern	Eon	To consider identifying properties where gas supply readings have not changed and contacting the occupier/owner about dealing with the gas supply; informing householders by way of a notice on gas meters and gas bills that disconnecting gas appliances or changes to gas pipe work must be undertaken by a Gas Safe engineer.	No	115
Greater Manchester: West	J Mills Contractors Ltd, Manchester	To confirm what Health and Safety training has now been put in place for its employees on working at height and particularly on fragile roofs.	Yes	167
Black Country	Health and Safety Executive	To consider alerting all owners/occupiers/users of cold store buildings with roof insulation panels of the risk of fixings deteriorating over a period of time which might weaken such panels.	Yes	168
Mental health related deaths				
Staffordshire: South	St George's Hospital, Stafford	To consider a review of communication between staff and families of mentally ill patients.	Yes	12
Wiltshire and Swindon	Wiltshire Police; Avon and Wiltshire Mental Health Partnership	To consider a review of the absence of police policy or procedure on notifying vulnerable people or those with special needs that police investigations into an alleged offence have ceased; to consider sharing relevant information between the Mental Health Partnership and the police.	Yes	13
West Yorkshire: Eastern	South West Yorkshire Partnership NHS Foundation; West Yorkshire Police	To review the protocols used by the Crisis Resolution Service, in particular communication with the police when their patients hold a gun licence.	Yes	20

Coroner District	Report Sent to	Details	Response received	Report number
Warwickshire	Warwickshire Police; Coventry and Warwickshire NHS Partnership Trust; Warwickshire County Council	Warwickshire Police to review training, risk assessment checklists, arrestable offences and recording of domestic violence cases; NHS Trust to review its risk assessment procedure; recording system and nomination of care co-ordinators for domestic violence cases; Warwickshire County Council to review its serious case review criteria, critical incident response, risk assessment guidance and procedures, recording system for domestic violence cases and the role and training of mental health professionals.	Yes	21
Wolverhampton	Beatties Store, Wolverhampton	To consider restricting public access to the higher levels of the car park to prevent suicide attempts.	Yes	22
Greater Manchester: City	Manchester Mental Health and Social Care Trust; North West Ambulance Service	North West Ambulance Service to consider a review of its protocol on firearms and stabbing incidents; Manchester Mental Health Trust to consider a review of its policies and protocols on the possession and use of cannabis by patients detained under the Mental Health Act 1993, arrangements for patients who leave the mental health unit and on record keeping.	Yes	25
Staffordshire: South	St George's Hospital, Stafford	To consider a review of how senior management deal with work concerns raised by staff.	Yes	29
Peterborough	The Home Office	To consider setting up a central database for firearms and shotgun certificates to which all dealers would have access and which they would be obliged to check before selling a shotgun or firearm.	Yes	49
Greater Manchester: North	Pennine Acute NHS Trust	To consider a review of discharge procedures for patients deemed vulnerable and at risk so they do not leave the hospital without having had a psychiatric assessment.	Yes	54
Devon: Exeter and Greater Devon	Devon Partnership NHS Trust	To consider a review of the provision of services to those who fall outside the remit of organisations providing the mental health service but have difficulties coping on their own; to investigate the circumstances surrounding this death and what can be done to prevent a similar situation in the future.	Yes	60

Coroner District	Report Sent to	Details	Response received	Report number
Teesside	Cleveland Police; Tees Esk and Wear Valley NHS Trust	To consider a review of its communication procedures and establishing a joint protocol for dealing with concerns about vulnerable patients, particularly those detained under the Mental Health Act 1983.	Yes	75
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of the procedures used by the mental health team to decide which care setting is most suitable for a patient's care requirements.	Yes	88
Greater Manchester: North	Department of Health	To consider a protocol that mental health information is shared with the UK Border Agency when moving asylum seekers away from existing support might have an adverse affect.	Yes	145
Devon: Exeter and Greater Devon	Devon Partnership Trust, Department of Health	Devon Partnership Trust to consider introducing Service Level Agreement with Trusts and stakeholders; Department of Health to consider a review of the community support provided to people with drug addictions.	Yes	173
Community healthcare and emergency services related deaths				
South Yorkshire: Western	Emis (software supplier); Department of Health	Emis to consider restricting user access to its system of generating prescriptions without medical supervision, and implementing a more robust audit trail of their work; Department of Health Chief Medical Officer to consider issuing guidance to doctors on appropriate tasks for receptionists and increasing awareness amongst doctors and practice managers that they can restrict rights on who can generate repeat prescriptions.	Yes	3
Greater Manchester: City	Manchester City Council	To consider a review of staff training in first aid including health and safety issues for themselves and a protocol for considering families' specific accommodation needs.	Yes	26
Hertfordshire	Hertfordshire County Council	Community Mental Health Team to consider not starting to assess potential residential patients until funding for placements is secured.	Yes	30

Coroner District	Report Sent to	Details	Response received	Report number
West Yorkshire: Western	Department of Health	To consider a review of formulaic guidance to ensure alternative diagnoses are considered when symptoms could indicate a number of illnesses.	Yes	38
Greater Manchester: South	Mastercall Healthcare Limited, Stockport; North West Ambulance Service NHS Trust; Trafford Primary Care Trust	Mastercall to consider a review of how information is disseminated to GPs working for its out of hours service; North West Ambulance Service to consider staff training in telephone triage; Trafford Primary Care Trust to consider how its service providers implement findings from Root Cause Analysis investigations.	Yes	42
Staffordshire: South	West Midlands Ambulance Service NHS Trust	To clarify its policy on how ambulance crews decide to which hospital to take patients.	Yes	46
Liverpool	Ministry of Justice	To consider whether national guidance should be established for when a community sentence is passed but a first appointment with probation cannot be given at court; whether a circular similar to 25 of 2007 could be issued to deal with transferring of new cases from one probation area to another.	Yes	50
Staffordshire: South	Bideford Way Surgery, Cannock	To confirm its policy of restricting the number of tablets prescribed where the patient is liable to abuse them; to give a further explanation of the drugs prescribed to this patient.	Yes	71
West Yorkshire: Western	Yorkshire Ambulance Service NHS Trust	To consider a review of staff knowledge and understanding of emergency driving procedures, particularly when proceeding through red traffic lights.	Yes	81
Greater Manchester: South	Trafford Primary Care Trust	To consider a review of whether drug prescription forms should all be the same colour and format; why district nurses cannot carry or administer the drug Naloxone; protocols for when discussions on changing staff working arrangements should be conducted.	Yes	91

Coroner District	Report Sent to	Details	Response received	Report number
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider clarifying the definition of "urgent referrals" for all healthcare professionals so they understand exactly what this means; GPs to ensure that wherever possible they have full records available when seeing patients.	Yes	94
South Yorkshire: Western	South Yorkshire Fire and Rescue Service	To consider a review of the Brigade Standard Operating Procedures for vehicles responding to an emergency which cross a red light; use of audible warning equipment; monitoring of in-vehicle video records to ensure blue light safety and wearing seatbelts when responding to an emergency.	Yes	101
Gloucestershire	NHS Gloucestershire; Phoenix Surgery, Cirencester	NHS Gloucestershire to consider providing a peripatetic phlebotomist to make home visits to vulnerable patients who find it difficult to attend for blood tests but are not completely housebound; Phoenix Surgery to consider following up warfarin blood test results reported by telephone with a letter.	Partial response	104
Hertfordshire	Hertfordshire Partnership NHS Trust	To consider implementing procedures to ensure effective liaison between the Community Mental Health and Crisis Assessment and Treatment Teams treating patients.	Yes	121
Lincolnshire: West and Spilsby and Louth	East Midlands Ambulance NHS Trust Service	To review its procedure to include providing written information to patients who have overdosed on Methadone about the length of time the effects of an overdose may be present and that further Naloxone treatment may be needed.	Yes	125
Cheshire	Millcroft Medical Centre, Crewe	To consider implementing a protocol on prescribing potentially addictive medication to patients.	Yes	134
Coventry	Coventry Community Health Services	To consider implementing a protocol under which drugs are only referred to by their generic name on patient records.	Yes	137
Cheshire	Cheshire East Council	To consider a review of communication and referral protocols when it receives notification of concern for a person's welfare.	Yes	143

Coroner District	Report Sent to	Details	Response received	Report number
Derbyshire: North	Derbyshire Constabulary; East Midlands Ambulance Service; National Policing Improvement Agency (NPIA)	Derbyshire Constabulary and NPIA to consider a review of their first aid training for operational police officers; East Midlands Ambulance Service to consider a review of its training on assessing and managing patients with a reduced level of consciousness and diversity awareness; communication of its policies and procedures and how these should be applied by staff; a policy for dealing with inquest matters generally and the provision of all relevant documentation to coroners.	Yes	144
Greater Manchester: South	Lockside Medical Centre, Stalybridge	To consider a review of how it issues prescriptions, to bring it into line with Paragraphs 40(a) to (f) of the General Medical Council's *Good Practice in Prescribing Medicines* , of September 2008	Yes	152
Staffordshire: South	West Midlands Ambulance Service	To consider taking appropriate action to reconcile timings recorded by ambulance control, ambulances, first response vehicles and the staff involved.	Yes	159
Deaths in custody				
West Yorkshire: Eastern	Ministry of Justice; Samaritans	Ministry of Justice to consider implementing and properly administering a robust system for cell-sharing risk assessment. Samaritans to consider expanding the exceptions to the limited circumstances where they can disclose information they have received.	Yes	1
Devon: Exeter and Greater Devon	Exeter Prison	To consider a review of communication between different teams of staff caring for vulnerable prisoners and a review of training in CPR for discipline staff.	No	24
Derbyshire: Derby and South Derbyshire	G4S Care & Justice Services (UK)	To consider and review the effectiveness of the level A rub-down search in finding drugs; the procedures for assessing prisoners' mental health; the effectiveness of communication between custody officers.	Yes	37

Coroner District	Report Sent to	Details	Response received	Report number
Cheshire	HM Prison Styal	To consider a review of procedures to ensure experienced staff are used at the First Night Centre and a review of charts monitoring drug withdrawal to remove ambiguities and ensure correct labelling.	Yes	41
London: Inner West	Metropolitan Police Service	To consider a review of guidance provided to police officers.	Yes	47
South Yorkshire: Eastern	South Yorkshire Police	To consider further training for custody sergeants on available medical support services, specifically mental health services.	Yes	52
Norfolk	Ministry of Justice	To consider establishing a mandatory national training programme for all prison officers on mental health awareness to assist them in identifying possible signs of mental illness.	Yes	55
West Yorkshire: Eastern	Ministry of Justice	To consider implementing a protocol that whenever a prisoner is informed that they have a long-term progressive or terminal illness, a multi-discipline assessment is made on whether an Assessment, Care in Custody and Team working (ACCT) plan should be opened within 7 days and whether there should be an ongoing duty to consider an ACCT plan if one is not opened at the time.	Yes	70
Kent: Mid and Medway	Ministry of Justice; Nursing and Midwifery Council; HMP Elmley	The appropriate agencies to consider the training and quality of staff on duty and the protocols and guidance in place for nursing staff caring for prisoners.	Yes	78
London: Western	Metropolitan Police Service; NHS Hammersmith and Fulham; Serco Group PLC; Ministry of Justice	To consider a review of how information on prisoners is passed from one agency to another and within the agencies themselves; all agencies to have a common understanding of the Prisoner Escort Record and how it should be used.	Yes	79

Coroner District	Report Sent to	Details	Response received	Report number
Essex and Thurrock	HMP Chelmsford; United Kingdom Border Agency	HMP Chelmsford to review its practice on making mental health assessments of prisoners and to provide written guidance on everything the mental health assessment must cover; United Kingdom Border Agency to consider implementing a protocol to ensure deportation papers are served promptly on both prisoners and their legal representatives.	Yes	84
Staffordshire: South	HM Youth Offenders Institute Swinfen Hall	To consider checking cells and arranging for possible ligature points to be removed.	Yes	87
London: City	Department of Health	To consider a review of the Electronic Medical Records System (EMIS) to ensure that false or backdated entries cannot be entered.	Yes	92
Cheshire	NHS Warrington	To consider a review of the protocol to ensure that all relevant clinical information accompanies prisoners at HMP Risley when they are transferred to hospital.	Yes	93
Essex and Thurrock	HMP Chelmsford	To consider a review of increasing staff awareness of mental health issues and how a prisoner's behaviour can display such health issues.	Extension granted	103
Preston and West Lancashire	Lancashire Constabulary	To consider a review of the force's strategic approach to training and what improvements could be made to its training on excited delirium.	Yes	106
Devon: Exeter and Greater Devon	HMP Exeter; Devon Partnership NHS Trust	HMP Exeter to provide an update on its review of prisoners' take-up of hospital appointments with reasons for their non-attendance and the results of its Infection Control audits and steps taken to remedy deficiencies; Devon Partnership Trust to provide updates on the availability of medical records to Exeter prison healthcare staff; training in palliative care; identification of staff completing healthcare records and its review of the equipment store and to give consideration to inspecting cells for insanitary conditions.	Partial response	113

Coroner District	Report Sent to	Details	Response received	Report number
Norfolk	Ministry of Justice	To consider a review of procedures for reception health care screening and continuing care of prisoners requiring specialist medical treatment; the use of disciplinary measures which might impact on prisoners healthcare needs; including medical information on Prisoner Escort Record forms and providing information on prisoner health and self-harm risk to all those involved in their care; additional training on the Assessment, Care in Custody and Team working plans process.	Yes	116
Greater Manchester: West	Ministry of Justice	To consider a review of all medical procedures and communication protocols relating to prisoners at risk of self-harm, including Assessment Care in Custody Teamwork plans.	Yes	136
London: Western	Ministry of Justice; NHS Hammersmith & Fulham	To consider training all staff on PSO 2700 Assessment Care in Custody and Teamwork plans and procedure on obtaining medical information from prisoners' GPs.	Yes	141
Lincolnshire: West and Silsbee and Louth	HMP Lincoln	To consider implementing a periodic audit of cells for ligature points by independent prison officers.	Yes	154
Norfolk	Ministry of Justice; HMP Norwich	Ministry of Justice to consider reviewing the cell-sharing risk assessment form to ensure it clearly takes account of PSO 2700 Annex 6B, paragraph 4 guidance on prisoners withdrawing from drugs; HMP Norwich to consider a review of staff awareness of the increased risk of suicide for those withdrawing from drugs.	Yes	163
Staffordshire: South	HM Youth Offender Institute Brinsford	To consider a review of the Incentives and Earned Privileges scheme; to clarify the emergency response to a hanging incident; to review staff awareness of the availability of in-cell education.	Yes	171
Drug and medication related deaths				
Cornwall	Cornwall and Isles of Scilly Drug and Alcohol Team	To consider a dedicated facility for vulnerable female adults with drink and alcohol related issues.	Yes	2

Coroner District	Report Sent to	Details	Response received	Report number
Newcastle Upon Tyne	Pfizer	To consider the warnings in place for the drug Sitaxentan, and, in particular the risk of fatal liver damage.	Yes	9
Devon: Exeter and Greater Devon	Primary Care Trust Devon; Royal Pharmaceutical Society	To consider reinforcing the checks made by pharmacists when issuing prescriptions to patients.	No	32
Sunderland	Department of Health	To consider wider dissemination of Sunderland Royal Hospital's "Amiodarone Treatment Pathway" checklist.	Yes	59
Cheshire	Boots UK Ltd	To consider a review of its procedures when a prescription is presented unsigned; making contact with the prescribing doctor when a large daily dose of furosemide is prescribed; and protocols to identify pharmacists who issue each prescription.	Yes	99
Sunderland	Department of Health	To consider changes to policy and practice in how oral chemotherapy treatment is prescribed to reduce the scope for errors.	Yes	169
Care home deaths				
Cardiff and the Vale of Glamorgan	Willowbrook House Nursing Home, Cardiff	To consider documenting and communicating to unqualified carers instructions for patient care during meal times.	Yes	6
Darlington and South Durham/North Durham	North Park Care Home, Darlington	To consider disseminating the conclusions of risk assessments and ensuring these conclusions are adhered to and implemented.	Yes	7
Worcestershire	Dimensions (UK) Ltd, Reading	To consider a review of its procedures on who should conduct and regularly review risk assessments on care home residents and training for staff who carry out risk assessments.	Yes	53
Hertfordshire	Care Quality Commission	To consider ensuring that care home staff are given proper training on dealing with medical emergencies or the sudden and unexpected death of residents in their care.	Yes	86
Greater Manchester: South	Belmont Court Care Home, Stockport	To consider a review of staffing to ensure a resident's care plan, which requires two members of staff to assist when they are mobile is met.	Yes	108

Coroner District	Report Sent to	Details	Response received	Report number
Greater Manchester: South	Stamford Court Care Centre, Stalybridge	To consider a review of procedures to ensure fluid/feeding charts are completed and for contacting a GP when a patient is clearly is unwell.	Yes	109
Cheshire	The Old Rectory Nursing Home, Chester	To confirm full implementation of its health and safety plan on the nutrition and care needs of residents at risk of choking and that staff are aware of the plan's requirements; to consider providing a suction pump to assist with resuscitation.	Yes	111
Cheshire	Arbury Court, Warrington	To consider introducing an emergency code system to convey details of an emergency to staff without alarming patients and to review the arrangements for stock control and audit of medication.	Yes	112
South Yorkshire: Eastern	Doncaster Metropolitan Borough Council	To consider a review of the protocol for carers that they should seek timely medical advice when the health of vulnerable elderly adults deteriorates.	Yes	127
Derbyshire: Derby & South Derbyshire	Derby City Council	To consider a review of its policy on preparing care plans for those admitted to Council-run residential care homes.	Yes	133
Kent: North East	Care Quality Commission	To consider a review of the risk assessment process when new residents move into shared bedrooms at the Hockeredge and Jasmine Centre, Thanet.	Yes	151
Service personnel deaths				
Wiltshire and Swindon	Ministry of Defence	To consider producing a written document of Tactics, Techniques and Procedures for using Viking and Warthog vehicles in theatre.	Yes	35

Coroner District	Report Sent to	Details	Response received	Report number
Wiltshire and Swindon	Ministry of Defence	To consider a review of existing procedures for Forward Air Controllers monitoring and checking potential misidentification of targets and friendly forces; checks on numbers of personnel after fatalities; mental health assessment of soldiers in theatre; procedures relating to the Human Factors Team and reviews carried out by this team; the provision of GPS locators and head sets and actions taken in response to the reports prepared during the investigations into these deaths.	Yes	65
Police procedures related deaths				
Greater Manchester: City	Greater Manchester Police; National Policing Improvement Agency; Association of Chief Police Officers	To consider requiring formal risk assessments and additional training material to be prepared and communicated to those supervising training exercises which involve the use of live ammunition.	Yes	8
London: Inner South	Metropolitan Police	To consider a review of training provided on positional asphyxia.	Yes	31
Darlington and South Durham/North Durham	Durham Police	To consider a review of training for officers responding to emergencies, to include making reasonable enquiries and searches for all normal means of access to a property.	Yes	90
Cheshire	Cheshire Constabulary	To consider a review of training for officers to include information about the dangers and symptoms of hypothermia.	Yes	110
Hampshire: Portsmouth and South East Hampshire	Hampshire Constabulary; Home Office	To consider introducing guidelines at national and regional level to assist police officers dealing with lone intoxicated females.	Partial response	122
Lincolnshire: West and Spilsby and Louth	Home Office; National Policing Improvement Agency ; Nottinghamshire Constabulary	To consider a review of arrangements for gathering, storing, sharing and assessing intelligence information and of the 'Witness Protection' and 'Threats to Life' policies.	Partial response	170
Product related deaths				

Coroner District	Report Sent to	Details	Response received	Report number
Dorset: Bournemouth, Poole and Eastern Dorset	Clarke International Limited, Epping; Department for Communities and Local Government	To consider a review of guidance for installing multi-fuel stoves and appliances, to include reference to appropriate building regulations and the risk of carbon-monoxide poisoning from poor installation.	Yes	33
Staffordshire: South	Department for Business, Innovation and Skills	To consider whether any steps can be taken to ensure compliance with window blind safety standards and whether looped cords for blinds should be completely banned.	Yes	63
Cornwall	Local Safeguarding Children's Board, Royal Cornwall Hospitals NHS Trust; Department of Health; Department for Business, Innovation and Skills	To consider publicising and educating the public about the danger of babies being of asphyxiated by nappy sacks.	Yes	95
Greater Manchester: North	Health and Safety Executive	To consider issuing a safety alert about the risk of scalding from older shower units in residential care homes which do not have a health care setting to regulate water temperature.	Yes	117
Kent: North East	Kent County Council	To consider action to place warning notices on heavy-duty car ramps to inform users that they may skid or slide on a hard surface.	Yes	131
London: Western	BT Group PLC	To review the safety of the power adaptor of British Telecom Home Hubs.	Yes	132
Railway related deaths				
Dorset: Bournemouth, Poole and Eastern Dorset	Bournemouth Railway Station	To consider a review of the closed-circuit camera coverage at Pokesdown Station.	Yes	34
Hampshire: Portsmouth and South East Hampshire	Network Rail	To consider a review of how frequently items discarded onto the track at Emsworth Railway Station should be cleared.	Yes	48
Sussex: West	Department of Transport	To consider action to prevent access onto the railway line near Crawley Station and the nearby Horsham Road and Brighton Road level crossings.	Yes	73

Coroner District	Report Sent to	Details	Response received	Report number
Northumberland: North	Network Rail	To consider a review of its fencing and erecting warning notices to prevent access onto the railway line near Widdrington Station, Northumberland.	Yes	107
Hertfordshire	Network Rail Infrastructure Ltd; Association of Train Operating Companies (ATOC)	Network Rail to consider a review of how it obtains specific information about clamping forces and the current state of adjustable points; risk assessment of adjustable points; replacing main and lock nuts with hard-lock nuts; design of insulating brushes; procurement and auditing of components; instructions provided to staff; reporting of defects and highlighting systemic problems; safety management systems. Network Rail and ATOC to consider a review systems for dealing with rough ride reports.	Interim response	142
London: Inner North	Transport for London	To consider introducing an operating policy on how to deal with concerns raised about the welfare of a customer or passenger, including involving the British Transport Police.	Yes	148
London: Inner North	Transport for London	To consider a review of its policy of staff using CCTV footage to identify passengers behaving suspiciously or appearing distressed and providing clear guidance for staff in dealing with such passengers.	Yes	172
Other deaths				
West Yorkshire: Western	Rugby Football League, Leeds	To consider a review of the number of officials attending rugby league matches to include a trained first aider who can assess whether a player injured during a match should be allowed to return to the field.	Yes	51
West Yorkshire: Western	Kirklees Council	To consider a review of why the advice of the drug liaison midwife was overruled, so allowing the baby to return home with her parents.	Yes	61
Lincolnshire: West and Spilsby and Louth	Civil Aviation Authority	To consider imposing a restriction on the maximum permissible time between overhauls of all aircraft engines.	Yes	67

Coroner District	Report Sent to	Details	Response received	Report number
Dorset: West	Light Aircraft Association	To consider a review of the circumstances of how the aircraft involved in this accident was examined and a review of the Permit to Fly Inspection procedures with a view to making them more rigorous.	Yes	68
South Yorkshire: Western	UK Border Agency	To consider its instructions to managers to clarify that staff will not see a distinction between fact-finding and disciplinary investigations and that support may be required by staff facing either type of investigation.	Yes	114
Devon: Exeter and Greater Devon	Sudden Infant Death Syndrome Research; Mount Gould Hospital, Plymouth	To consider including in their research investigating the origin and the presence of harmful materials/chemical agents in cuddly toys found with the baby to see if they could have adversely affected its health.	No	126
Norfolk	Federation Equestre Internationale	To consider a mandatory requirement that riders participating in Endurance events wear medical armbands containing basic medical history and status.	Yes	146
Greater Manchester: City	Manchester City Council	To consider a review of its homelessness strategy, including liaison with other local authorities to compare best practice.	Yes	164
Birmingham and Solihull	UK National Screening Committee	To consider introducing a national policy of screening all expectant mothers for velamentous insertion of the umbilical cord.	Yes	174

Alternative format versions of this report are available on request from Coroners and Burials Division – Lynette Hill 020 3334 6408 or lynette.hill@justice.gsi.gov.uk

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