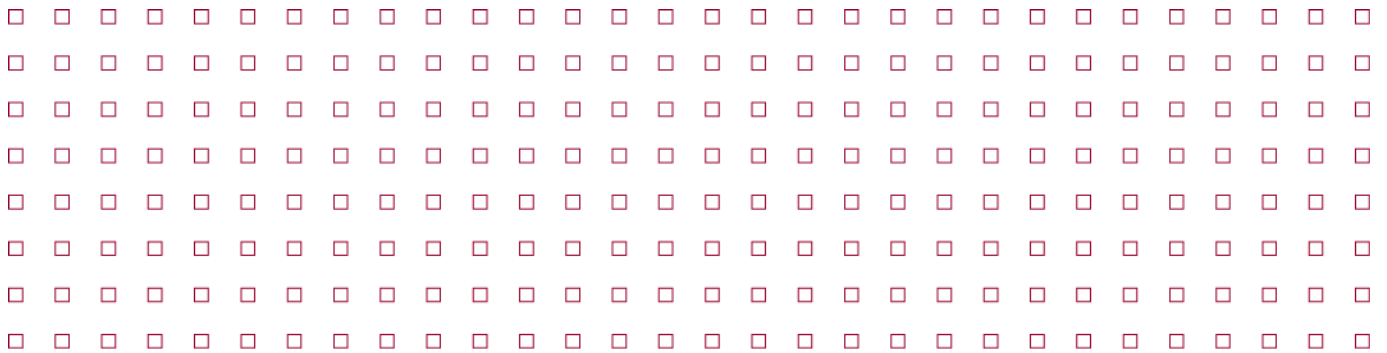
Ministry of Justice

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

Ninth Report: For period 1 October 2012 – 31 March 2013

June 2013



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1. Introduction

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

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

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

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

This is the ninth and final report which will be published by the Ministry of Justice. The Chief Coroner will assume responsibility for Prevention of Future Death (Rule 43) Reports following implementation of powers under the Coroners and Justice Act 2009[1]. All future reports will therefore be issued from the Office of the Chief Coroner.

We do not release all reports and responses in full. If you wish to obtain a copy of a particular report, 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 requests to: rule43reports@justice.gsi.gov.uk.

The Lord Chancellor wishes to thank coroners for continuing to provide copies of reports written and responses received.

[1] http://www.legislation.gov.uk/ukpga/2009/25/schedule/5
http://www.legislation.gov.uk/ukpga/2009/25/section/36

2. Statistical Summary

2.1. Rule 43 reports issued by coroners and trends

Between 1 October 2012 and 31 March 2013 coroners in England and Wales issued 235 Rule 43 reports. Some reports included the lessons learned from inquests into the death of more than one person and therefore these 235 reports include lessons learned from 254 inquests.

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

Reporting period	Rule 43 reports issued
17 July 2008 – 31 March 2009	207
1 April 2009 – 30 September 2009	164
1 October 2009 – 31 March 2010	195
1 April 2010 – 30 September 2010	175
1 October 2010 – 31 March 2011	189
1 April 2011 – 30 September 2011	210
1 October 2011 – 31 March 2012	233
1 April 2012 – 30 September 2012	186
1 October 2012 – 31 March 2013	235
Total	**1,794**

As in all previous summary bulletins Rule 43 reports were most commonly issued in connection with hospital deaths (79 reports). Second most common were reports issued in connection with road deaths (32 reports) and third were those in relation to deaths in custody (20 reports). This is the highest number of reports received in one six month period and continues the trend where the October to March period has a higher volume of reports than the preceding April to September period.

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

Table 2: Rule 43 reports issued by coroners between 1 October 2012 and 31 March 2013, by broad category

Category	**Number of inquests where Rule 43 reports were issued**
Hospital deaths	79
(Clinical Procedures and medical management)	(77)
(Other)	(2)
Road deaths	32
(Highways safety)	(24)
(Driver and vehicle licensing)	(5)
(Vehicle safety)	(3)
Deaths in custody	20
Care home deaths	19
Mental health related deaths	17
Community health care and emergency services related deaths	14
Accidents at work and health and safety related deaths	13
Drug and medication related deaths	11
Police procedures related deaths	9
Product related deaths	5
Railway related deaths	3
Service personnel deaths	1
Other	12
Total	**235**

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

Between 1 October 2012 and 31 March 2013 Rule 43 reports were issued by 70 of the 111 coroner districts. This is the highest percentage of individual jurisdictions to report in a six month period.

In the six months covered by this bulletin, the Manchester West coroner's district issued 11 reports, the highest number by a single area. However, coroners generally issue far fewer reports than this.

The number of reports a coroner issues is largely determined by the nature of the deaths he or she investigates and whether he or she believes that action could be taken to prevent future deaths. Often the coroner will be satisfied by

evidence heard at an inquest that remedial action has already been taken, so may decide that no useful purpose will be served by issuing a Rule 43 report after the inquest.

Annex A lists the 70 coroner's districts which have issued Rule 43 reports during the period covered by this bulletin, with the number issued by each district.

2.3. Organisations to which Rule 43 reports have been sent

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

Table 3 shows a breakdown of these organisations. Sometimes coroners send reports arising from a single inquest to more than one organisation so the number of organisations receiving a report is higher than the number of inquests held. In the period covered by this bulletin 324 reports were issued.

As the majority of Rule 43 reports arose out of hospital deaths, NHS hospitals and Trusts were sent the most reports (31% of the reports issued).

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

Table 3: Rule 43 reports issued by coroners between 1 October 2012 and 31 March 2013, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	103
Central Government departments	58
Regulatory bodies and trade associations	35
Police and emergency services	35
Local Authorities	31
Private companies	25
Prisons	16
Care and nursing homes	15
Other	6
Total	**324**

2.4. Responses to reports

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

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

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

2.5. Emerging Trends

Since MoJ began collating reports in 2008 there has been a year on year increase in their volume, with the October to March period routinely having a higher number of reports than the preceding April to September. We would expect this trend to continue as the Coroners and Justice Act 2009 elevates Rule 43 provision to primary legislation and strengthens it by requiring coroners to report actions to prevent future deaths to relevant persons.

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

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

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

Responses continue to provide details of actions which have been taken and it is good to note that reported concerns continue to be taken seriously. Most responses suggest that lessons have already been learned with appropriate action taken and that training and/or guidance is updated accordingly. In many cases the recipient attended the inquest and has already had the opportunity to address the concerns.

3. Rule 43 reports which have wider implications

A list of Rule 43 reports received by the Lord Chancellor between 1 October 2012 and 31 March 2013 is at **Annex C**.

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

Case 1

A man, believed to be under the influence of the drug methylenedioxypyrovalerone (MDPV) came into contact with the police. He was displaying agitation, sweating and muscle twitching, his pupils were dilated and his eyes were rolling back into his head. He had caused damage to a bathroom which could have been as a result of paranoia. The police immediately called for an ambulance but when paramedics arrived an officer considered him as 'not safe to be seen' although the evidence was unclear whether the man refused to be seen by the paramedics or whether it was unsafe. The paramedics left without seeing the man or agreeing with the police how he should be dealt with. At this point the man started to throw items out of a window and when he threw a glass the officers moved to arrest him. Perceiving a threat of violence, one of the officers discharged his Taser and the man fell to the ground, resisting and struggling against restraint. Once handcuffs and leg restraints had been secured, the man was carried into a police van, transported to hospital and handed over to doctors in the accident and emergency unit where he suffered a cardiac arrest and was pronounced dead. Whilst the inquest found the death was most likely caused by the MDPV, following the inquest the coroner reported issues for consideration to a number of organisations.

The Coroner asked The College of Policing to consider:

- Whether to revise guidance in the Personal Safety Training manual.
- Whether training on medical implications is going to be made compulsory and how to ensure suitable standard training is implemented.
- What needs to be done to ensure that all police services comply with appropriate guidance and training.

In their response, the College of Policing stated:

- National guidance for custody and detention will be reviewed and updated during 2013. Risk assessments at pre-custody stage, booking in and throughout the period of detention are expected to form part of this review.
- There will also be a link to the Personal Safety Manual on restraint. They will be working with the Association of Chief Police Officers and other

policing partners to ensure the most effective review and response. The section of guidance on acute behavioural disorder will also be reviewed in line with the issues the coroner had raised.

- Training on medical implications is covered in the following mandatory training courses: Initial Police Learning and Development Programme (IPLDP); Personal Safety Training (PST); and First Aid training. IPLDP is undertaken by all new recruits and includes PST and First Aid. All operational officers are required to refresh their PST and First Aid annually.
- They have compliance monitoring processes in place for IPLDP and PST and this is being expanded to include First Aid training. This means that delivery in forces is monitored annually for compliance with the current curriculum.

In a separate report, the coroner asked The North West Ambulance Service NHS Trust (NWAS) to consider:

- Reviewing training to ensure that all their staff are trained (a) on the symptoms of acute behavioural disturbance and excited delirium and (b) in assessing a person's mental capacity with consideration given to training on liaison with the police, so that they can give effect to protocols between the police and NWAS.
- In conjunction with the police forces party to the protocol, the possibility of joint training between police officers and paramedics in how to implement the protocol in circumstances similar to those in this case.

In their response, NWAS stated:

- They had significantly improved the staff training and information on how to jointly manage with the Police drug overdose patients who lack capacity and may be violent.
- They had organised a series of inter-agency training sessions and the Joint Operational Protocols for Inter-agency assistance would specifically focus on how different agencies jointly manage individuals exhibiting mental health and mental capacity concerns.
- They had organised joint Police and Ambulance training on ensuring that Advanced Paramedics and the Police have the same level of understanding of how to manage these types of patients in line with the Mental Capacity Act 2005 and Mental Health Act 1983.
- Joint Regional Protocols have been reissued to all NWAS staff and will be distributed to operational staff during mandatory training sessions.
- A Regional Drugs Awareness bulletin was issued to all NWAS staff in February 2013 raising awareness of illicit street names drugs and the commonly associated symptoms of drugs like MDPV.

Case 2

An in-patient at Southend University Hospital NHS Foundation Trust died when he fell from a second floor window, having removed the single hook restrictor to open the window. At the time he was in an acutely confused, delusional and paranoid state following major surgery.

The hospital believed that the single hook restrictor would prevent the window from being forcibly opened although during the inquest the coroner heard evidence that this type of restrictor would not stop a determined effort to force open a window.

Following the inquest, the coroner wrote to the Department of Health (DH) asking them to reconsider using single hook restrictors on hospital windows. The coroner was concerned that other hospitals were placing undue faith in this type of restrictor and thought they should be reminded of the importance of reviewing the safety and efficiency of their window restrictors.

In response DH acknowledged the coroner's concerns and issued alerts to the NHS in England and the devolved administrations for Wales, Scotland and Northern Ireland. The alerts advised NHS providers that window restrictors may be inadequate in preventing determined effort to force a window open beyond the 100mm restriction, and asked them to:

- Review guidance on the installation, use and maintenance of window restrictors and advice from The Health and Safety Executive (HSE);
- Inspect all installed windows; and
- Consider replacing single restrictors with more substantial or robust devices, and/or add a second restrictor to better resist determined efforts to open the window beyond 100mm.

In addition, DH has proposed updating its technical guidance relating to windows in their draft programme of work for 2013-14. The HSE are currently undertaking research into window restrictors, the outcome of which will be incorporated into the guidance.

Case 3

A private tenant of a ground floor flat died from carbon monoxide poisoning following a leak from a portable gas heater which operated on bottled gas. The deceased was only found when a carbon monoxide alarm was triggered in the neighbouring terraced property and the fire brigade were called to investigate.

Following the inquest the coroner wrote to the National Landlords Association (NLA) asking them to consider recommending to their members that carbon monoxide alarms be installed in their rental properties to avoid further deaths of this nature.

In response, the NLA updated their guidance to members which now states unequivocally that they should install audible carbon monoxide alarms in all

properties. They also issued a press release during Gas Safety Week which was covered in 21 publications, including regional and trade press, setting out landlords' legal requirements to have gas appliances checked every 12 months and of the importance of installing carbon monoxide detectors.

Also in response to the coroner's report, North East Lincolnshire Council passed the coroner's considerations to private and social landlords through their e-communication group, encouraging them to install carbon monoxide alarms and inviting them to work collaboratively with the Council on this issue.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 October 2012 and 31 March 2013

Coroner district	Reports issued
Avon	5
Berkshire	2
Birmingham and Solihull	6
Black Country	4
Blackburn, Hyndburn and Ribble Valley	1
Bournemouth, Poole and Eastern Dorset	1
Bridgend and Glamorgan Valleys	4
Brighton and Hove	4
Cambridgeshire: South and West	3
Cardiff and Vale of Glamorgan	5
Cheshire	2
Sunderland	1
Cornwall	4
Coventry	1
Cumbria: North and West	1
Cumbria: South and East	2
Darlington and South Durham	2
Derby and South Derbyshire	2
Devon: Plymouth and South West	4
Dorset: West	1
Durham: North	5
East Riding and Kingston upon Hull	3
Essex and Thurrock	2
Exeter and Greater Devon	2
Gloucestershire	2
Gwent	1
Hertfordshire	2
Kent: Central and South East	2
Kent: North East	3
Leicester City and South Leicestershire	3
Lincolnshire: Central	1
Lincolnshire: South	1
Liverpool	2
London: City	1
London: East	7
London: Inner North	2
London: Inner South	10
London: Inner West	8
London: North	8
London: South	2
London: West	5

Coroner district	Reports issued
Manchester: City	10
Manchester: South	9
Manchester: West	11
Merseyside	1
Mid Kent and Medway	2
Milton Keynes	4
Norfolk	7
North Lincolnshire and Grimsby	1
North Wales: East and Central	1
North Yorkshire: East	2
Northumberland: North	4
Nottinghamshire	3
Oxfordshire	4
Portsmouth and South East Hampshire	2
Preston and West Lancashire	3
Shropshire: Mid and North-West	2
Shropshire: South	1
South Yorkshire: East	2
South Yorkshire: West	2
Southend and South East Essex	3
Staffordshire: South	10
Stoke-on-Trent and North Staffordshire	4
Sunderland	3
Sussex: West	1
Teesside	1
West Yorkshire: East	5
West Yorkshire: West	6
Wiltshire and Swindon	3
Worcestershire	1
Total	**235**

Annex B

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

- Home Office
- NHS Airedale, Bradford and Leeds

Annex C

List of Rule 43 reports received between 1 October 2012 and 31 March 2013

Coroner District	Organisation	Summary	Response Received	Report
Accidents at work and health and safety related deaths				
London: East	IETG - An IDEX Water and Wastewater Business	To consider the need to apply to the relevant Local Authority when undertaking works which use traffic management and review ways of improving regulatory knowledge.	Yes	3
Manchester: West	Armstrong Environmental Services Limited	To consider improving the signposting of pedestrian walkways on the company's premises and introducing a system to review pedestrian safety on a regular basis.	Yes	13
Manchester: West	Liverpool Archdiocesan Centre for Evangelisation	To consider: training priests in risk assessments and health and safety responsibilities; devising a system so that experience is readily available when carrying out site specific risk assessments; and providing each church with an accident book.	Yes	16
North Lincolnshire and Grimsby	National Landlords' Association	To consider requiring members to install carbon monoxide alarms in their properties.	Yes	17
Preston and West Lancashire	British Horse Society	To consider introducing training materials on the safe construction and deconstruction of haystacks, referencing Health and Safety Executive guidance, and giving guidance that haystack areas should only be accessible to yard staff.	Yes	18
London: South	Department for Communities and Local Government	To consider regulations on the safe construction of communal stairwells including providing handrails on both walls, periodic inspection and maintenance.	Yes	21
Oxfordshire	Jewson Ltd	To consider issuing guidance on situations where two forklift trucks are loading or unloading the same lorry, so as to decrease the risk of collision.	Yes	26

Coroner District	Organisation	Summary	Response Received	Report
West Yorkshire: West	Health and Safety Executive	To consider raising awareness of the danger of using multiple thin pieces of timber to support scaffolding on uneven ground and the more appropriate use of a single solid block of timber.	Yes	52
Dorset: West	Freshwater Beach Holiday Park, Dorset	To consider providing signs at the approaches to the beach and cliff warning of the danger of spontaneous cliff falls, at the Freshwater Beach Holiday Park, Dorset	Yes	101
London: Inner West	Health and Safety Executive	To consider whether the licensing process for a venue applying to have external seating on a pavement could require the applicant to carry out a suitable survey of the surrounding structural integrity.	Extension	116
Cornwall	(1) Cornwall Association of Local Councils (2) The National Trust (3) Ministry of Defence (4) Bourne Holidays Ltd.	To consider how to raise public awareness of adits and mines and the associated dangers.	(1) Extension (2) Yes (3) Yes (4) Yes	128
London: Inner West	T E Scudder Demolition Ltd.	To consider introducing a policy on the training needed before a person can work in a situation where fall arrest equipment should be worn.	Extension	167
South Yorkshire: West	HI Quality Steel Castings Ltd.	To consider: reviewing the process for reporting, recording and investigating 'near miss' incidents: establishing a health and safety plan and reviewing the associated training; and periodic unannounced inspections of tools and toolboxes.	Yes	224

Care home deaths

Coroner District	Organisation	Summary	Response Received	Report
Cardiff and Vale of Glamorgan	Hallmark Care Homes	To consider how residents' dietary requirements can be best met to avoid the risk of choking and a review of practices when responding to a resident's emergency buzzer.	Yes	11
Nottinghamshire	Aslockton Hall Nursing Home	To consider revising the accident policy to make it clear that blood pressure, pulse and level of consciousness as well as the required frequency of observations should be recorded.	Yes	14

Coroner District	Organisation	Summary	Response Received	Report
Devon: Plymouth and South West	(1) Plymouth Community Healthcare (2) Wonford House Hospital, Plymouth	To consider: reviewing patient observations and record keeping; clarification of roles and the allocation of tasks; and the location of the handover room.	Yes	24
Stoke-on-Trent and North Staffordshire	Ravenswood Care Home, Stoke-on-Trent	To consider what action can be taken to reduce the risk of residents falling on stair cases.	Yes	40
Cornwall	Care Quality Commission	To consider assisting the King Charles Court Nursing Home, Carrick, to ensure they are implementing the best practices in distribution of medication and end of life care.	Yes	74
London: West	Ealing Council	To consider the safeguards which ensure nursing homes employ staff who are fully trained and are able to recognise when to implement first aid and resuscitation.	Yes	87
West Yorkshire: East	Wakefield Council	To consider a thorough review of practices at Monument House nursing home, Pontefract.	Yes	107
London: Inner South	(1) Care Quality Commission (2) Excel Care Holdings (3) NHS South East London	To consider the need for Windmill Care Health Ltd and NHS South East London to review their policies, service level agreements and guidance to staff in nursing homes and primary health care when making Do Not Resuscitate orders for patients transferring from hospitals to nursing homes.	Yes	110
London: Inner West	James Hill House, Kensal Road, London	To consider: the importance of completing incident forms; the need for monitoring of fall patients to be well documented and handed over between shifts of staff; ensuring staff call ambulances immediately when patients are unresponsive; and training in the dangers of falls when residents take anti-coagulant medication and how to monitor their neurological status post fall.	Yes	111

Coroner District	Organisation	Summary	Response Received	Report
Leicester City and South Leicestershire	(1) Leicestershire Partnership NHS Trust (2) Norton House, Leicester	To consider reviewing the process for housing those with severe mental illness who have been evicted from a care placement.	Yes	115
Hertfordshire	Care Quality Commission	To consider raising awareness of the dangers of incorrect use of hoists and all day slings and the importance of carers having a sufficient command of English to be able to understand and communicate instructions.	Yes	125
Stoke-on-Trent and North Staffordshire	Four Seasons Healthcare	To consider training staff in the risk of residents choking and how to respond when this occurs at Westfield Lodge Nursing Home, Stoke-on-Trent.	Yes	144
London: East	Goodcare Ltd.	To consider a review of the system for auditing staff checks and monitoring residents at Almadene Care Home, Highams London.	Yes	146
London: Inner South	Castlebar Nursing Home, Sydenham	To consider a review of staffing, staff training, emergency care policies and emergency service reception out of hours.	Yes	150
Brighton and Hove	Brighton and Hove Council	To consider a review of policies, practices and systems at Ireland Lodge care home, Brighton.	Yes	165
London: Inner South	South London and Maudsley NHS Foundation Trust	To consider a review of the efficacy of training given to care home staff, particularly in first aid and cardiopulmonary resuscitation.	Yes	191
Oxfordshire	Four Seasons Healthcare	To consider a review of the training of care assistants at the Triangle Nursing Home, Wheatley.	Yes	204
Black Country	Charter Care West Midlands Ltd.	To consider a review of how the care plan is used to communicate patient information to carers and ensuring that plans are completed prior to care being implemented.	Yes	210
Leicester City and South Leicestershire	HC-One Ltd	To consider: the need for complete and accurate record keeping; providing greater clarity on the resuscitation policy; and updating staff training in cardiopulmonary resuscitation.	Yes	227

Coroner District	Organisation	Summary	Response Received	Report
Community health care and emergency services related deaths				
Gloucestershire	Gloucestershire County Council	To consider a review of the urgent case conference procedure in relation to vulnerable children and the length of time it takes to arrange a conference.	Yes	1
Manchester: City	(1) Central Manchester Hospitals NHS Foundation Trust (2) Medacs Healthcare	(1) To consider: what steps can be taken to ensure serious incident investigations are sufficiently robust; an audit to establish the history and availability of paper records; and when reports should be shared with patients families. (2) To consider: issuing guidance for Medacs' nurses attending police stations; improving note taking and recording of symptoms; and carrying out checks on medical history in advance of prescribing medication.	Yes	7
Manchester: City	Greater Manchester Police	To consider: a review of the protocol for grading 999 calls; an audit of the accuracy and compliance with grading criteria in response to calls; a review to ensure the current wording for the grading criteria is appropriate; and providing guidance to staff training call takers on when they should intervene during an emergency call.	Yes	8
Essex and Thurrock	Essex County Fire and Rescue	To consider taking action to reduce the potential danger to road users when two emergency response vehicles are using the same siren.	Yes	38
Cornwall	Cornwall Partnership Foundation Trust	To consider the need to implement recommendations contained in the Homicide Review Report commissioned by the NHS South of England following this case.	Yes	68
Cardiff and Vale of Glamorgan	Welsh Ambulance Service NHS Trust	To consider revising the medical priority dispatch system, used to handle 999 calls, to include an assessment of the efficacy of breathing.	Yes	92
Oxfordshire	Oxfordshire County Council	To consider the procedure for receiving referrals, acting upon such referrals and the criteria for an initial assessment for vulnerable people requiring social services.	Yes	123
London: North	Department of Health	To consider issuing guidance on the care of patients with spinal injuries and training for those involved in their care.	Yes	134
London: Inner South	Metropolitan Police Service	To consider the recommendations of the Operation Econfina report and take appropriate action to reduce the risk of delays in shutting down railway lines in an emergency.	Yes	152

Coroner District	Organisation	Summary	Response Received	Report
London: South	London Ambulance Service NHS Trust	To consider the response to patients who have taken an overdose, and whether there are currently sufficient vehicles and crews to respond within a reasonable time frame.	Yes	161
London: East	The Grove Medical Centre, Walthamstow	To consider the systems which are in place to ensure unregistered patients, who are unwell, can still be attended by a GP.	Yes	181
Staffordshire: South	Trent and Dove Housing Ltd.	To consider a review of a device they have issued which should provide a notification to the company if the user has fallen.	Yes	183
Sunderland	Department of Health	To consider local and national initiatives to reduce delays in ambulances responding to 999 calls.	Extension	216
Kent: North East	(1) Prince's Golf Club (2) South East Coast Ambulance Service NHS Trust	(1) To consider making a defibrillator available in the club house at Prince's Golf Club, Sandwich. (2) To consider the process for categorising emergency calls.	Yes	226

Deaths in custody

Coroner District	Organisation	Summary	Response Received	Report
Birmingham and Solihull	(1) Her Majesty's Inspectorate of Prisons (2) Ministry of Justice	To consider the need for someone trained in resuscitation and first aid to be available in prisons at all times.	(1) Yes (2) Extension	15
East Riding and Kingston upon Hull	(1) City Health Care Partnership CIC (2) Her Majesty's Prison Hull (3) Ministry of Justice	To consider ways of ensuring patient's medical records are transferred at the earliest opportunity, particularly when they are in the process of withdrawing from drugs.	Yes	29
Shropshire: Mid and North-West	Ministry of Justice	To consider: reviewing arrangements for the transfer of records between prisons; how visitors' names are logged and relayed to prisoners; stopping the use of torn sheets as washing lines in cells; and altering the standard light fitting in cells so it cannot be used as a ligature point at Her Majesty's Prison Woodhill.	Yes	31

Coroner District	Organisation	Summary	Response Received	Report
Derby and South Derbyshire	Her Majesty's Prison Foston Hall	To consider: formalising a process for wing transfers and creating a document which enables a structured assessment of the transfer; introducing a policy for effective communication of any significant disclosure by a prisoner; introducing a policy for sharing information with the probation service; putting in place a system for communicating requests for medical assistance; and carrying out an audit of the decency policy to ensure it is being enforced and adhered to by staff.	Yes	50
East Riding and Kingston upon Hull	(1) Her Majesty's Prison Wolds (2) Hull and East Yorkshire Hospitals NHS Trust	To consider what steps can be taken to ensure patients receive the correct prescriptions and a review of the processes in place when a prisoner's appointment with an outside hospital needs to be rearranged.	Yes	80
Worcestershire	(1) Her Majesty's Prison Hewell (2) Worcestershire Health and Care NHS Trust	(1) To consider a review of practices to ensure night staff check prisoners before morning 'unlock'. (2) To consider amending the computer system so it has the facility to record why medication was given and ensuring external medical records for prisoners are routinely requested.	Yes	84
Cambridgeshire: South and West	Her Majesty's Prison Littlehey	To consider: prison healthcare (PHC) informing the Mental Health In Reach Team (MHIRT) of any issues with prescription or collection of medicine; PHC and MHIRT taking joint decisions on 'in possession' medication; and improving communication between prison security, PHC and MHIRT.	Yes	85
London: West	Her Majesty's Prison Wormwood Scrubs	To consider increasing the effectiveness of the supervision and monitoring of staff performance and ensuring routine patrols and inspections are carried out.	Yes	102
London: Inner South	Her Majesty's Prison Belmarsh	To consider measures to speed up the period between referring and committing prisoners into acute psychiatric environments.	Yes	109
Cardiff and Vale of Glamorgan	Her Majesty's Prison Cardiff	To consider further training for staff in the use of the 'cell sharing risk assessment and the 'assessment, care in custody and teamwork' forms.	Yes	119
Cheshire	Her Majesty's Prison Risley	To consider whether the night patrol system is functional and introducing a system for auditing patrols.	Yes	126

Coroner District	Organisation	Summary	Response Received	Report
Durham: North	Her Majesty's Prison Service	To consider a review of the 'Assessment, Care in Custody and Teamwork' form.	Yes	139
Manchester: West	(1) Ministry of Justice (2) Her Majesty's Prison Altcourse	(1) To consider issuing national guidance to simplify the emergency codes used across the prison estate, changing them from numbers to colours. (2) To consider a review of the provision of psychiatric services within Her Majesty's Prison Altcourse.	(1) Extension (2) Yes	153
Manchester: City	(1) Department of Health (2) Her Majesty's Prison Manchester (3) Ministry of Justice	To consider amending the 'System 1' record keeping system so that a prisoner's thoughts of self harm or suicide are captured at the earliest opportunity and improving the computer system so that entries are easier to understand.	Yes	168
Norfolk	Ministry of Justice	To consider guidance on when personal officers in prisons should be appointed; a description of the role; whether the identity of the officer should be made known to the family of the prisoner; training for these officers; and auditing of their work, supervision and support. To consider whether mental health awareness for prison staff should be made available to all prison staff; the need for it to be of a sufficiently high quality; and the need to training materials to be regularly reviewed and updated.	Yes	171
Liverpool	(1) Her Majesty's Prison Liverpool (2) National Offender Management Service	To consider: first aid refresher training for staff; guidance on staff using the correct call codes when requesting medical assistance; clarifying the procedures for recording information following a near death incident; and providing details of the alleged offence to the prison receiving the prisoner.	Yes	180
Teesside	Care UK	To consider what systems and training are in place at Her Majesty's Prison Holme House, to: prepare a care plan quickly after a prisoner's admission; keep adequate health records; and instructing a GP to be responsible for the prisoner's care.	Extension	184
Mid Kent and Medway	Her Majesty's Prison Maidstone	To consider training staff to ensure all relevant information is logged on the 'Assessment, Care in Custody and Teamwork form'.	Yes	218

Coroner District	Organisation	Summary	Response Received	Report
Manchester: City	(1) Her Majesty's Prison Manchester (2) National Offender Management Service (3) Greater Manchester Probation Trust	To consider: amending Prison Service Order 2205 so that it states a time limit in which records should be checked; protocols about when and how to access OASys, the electronic records system; and the need for OASys records to be full and accurate.	(1) Yes (2) Extension (3) Yes	222
Bournemouth, Poole and Eastern Dorset	Ministry of Justice	To consider creating a centralised facility to arrange prisoner transfers.	Yes	232

Drug and medication related deaths

Coroner District	Organisation	Summary	Response Received	Report
London: West	(1) Hounslow Council (2) Rowlands Pharmacy	To consider how to reduce the risk of giving the wrong medicine to patients and checks that support workers can undertake to ensure they are administering the correct medicine.	Yes	25
West Yorkshire: West	Novartis Pharmaceuticals Ltd	To consider if there is a need to adjust the dose of Clozapine when someone tries to give up smoking.	Extension	34
Sunderland	(1) Chief Medical Officer (2) Department of Health	To consider a review of policies relating to the use of Pneumovax	Yes	71
Northumberland: North	(1) Ethicon, a Johnson & Johnson company (2) Medicine and Healthcare products Regulatory Agency	To consider what action can be taken, by way of warnings, modifications and alerts, to minimise the risk of life-threatening and fatal air embolism posed by sprayable sealants.	Yes	105
Hertfordshire	Home Office	To consider classifying synthetic cannabinoid receptor agonist AM-2201 under the Misuse of Drugs Act 1971.	No	108

Coroner District	Organisation	Summary	Response Received	Report
Devon: Plymouth and South West	Marlborough Street Surgery, Plymouth	To consider reviewing the amount of sedative medicine prescribed to patients with a psychotic illness.	Yes	118
Brighton and Hove	East Sussex Healthcare NHS Trust	To consider a review of hospital protocols for the use of Gentamicin.	Yes	148
Portsmouth and South East Hampshire	Medicine and Healthcare Products Regulatory Agency	To consider reviewing guidelines on the assessment and monitoring of children and young adults in light of the possible link between the use of Isotretinoin and self-harm and suicide.	Yes	166
Berkshire	Department of Health	To consider issuing national guidance on the prescription of non-steroidal anti-inflammatory drugs.	Extension	186
Manchester: City	(1) Chief Pharmaceutical Officer (2) Home Office	To consider a review of the systems, regulations, controls and processes and steps that could be taken to stop or reduce the risk of people acquiring controlled drugs via the internet.	Yes	221
Darlington and South Durham	General Pharmaceutical Council	To consider sharing information regarding high risk patients with community pharmacists.	Yes	12

Hospital deaths (Clinical Procedures and medical management)

Coroner District	Organisation	Summary	Response Received	Report
Mid Kent and Medway	Kent and Medway NHS and Social Care Trust	To consider implementing a system to ensure reports are provided to GPs informing them of the results of referrals and notifying them of any treatment or assistance provided.	Yes	9
South Yorkshire: East	Doncaster and Bassetlaw NHS Foundation Trust	To consider the need for D-dimer testing to be carried out before a patient has been given a dose of Herapin.	Yes	19
Milton Keynes	Milton Keynes Hospital	To consider a review of the provision of care for seriously ill children and the availability of the rapid response team, particularly for those on the High Dependency Pathway.	Yes	22

Coroner District	Organisation	Summary	Response Received	Report
Manchester: South	The Alexandra Hospital, Cheadle	To consider reviewing: the level of out of hours staffing: the appropriate ratio of locum to non-locum staff; the staff to patient ratio; note taking and record keeping; and the system for recording the administration of drugs.	Yes	33
Cardiff and Vale of Glamorgan	(1) Cardiff and Vale University Health Board (2) Chief Medical Officer for Wales (3) Waterfront Medical Centre, Barry	To consider practices when dealing with a patient who may have suffered a stroke and the index of suspicion in relation to a bleed when the patient is undergoing Warfarin therapy.	Yes	35
Essex and Thurrock	(1) Basildon and Thurrock University Hospitals NHS Foundation Trust (2) Department of Health	(1) To consider reviewing the Trust's resuscitation policy so the 'Do Not Attempt Resuscitation' (DNAR) form clearly states the plan of care. (2) To consider whether there is merit to having a national policy on DNAR orders.	(1) Yes (2) Extension	37
Nottinghamshire	Doncaster and Bassetlaw Hospitals NHS Foundation Trust	To consider: increasing the number of interventional radiologists trained in embolisation procedures; introducing a protocol to facilitate the transfer of patients requiring endovascular procedures; and improving communication between clinicians.	Yes	39
Avon	(1) Department of Health (2) Royal United Hospital, Bath	(1) To consider a national policy on the labelling of fluid bags and the adequacy of arterial line sampling. (2) To consider whether it would be more appropriate to have a single human resources file for each member of staff, to enable more effective performance management.	Yes	41
Northumberland: North	Northumbria Healthcare NHS Foundation Trust	To consider improving the clarity of roles and communication between the hospital, the district nursing and GP service when treating patients with diabetes.	Yes	46

Coroner District	Organisation	Summary	Response Received	Report
Nottinghamshire	Nottingham City Council	To consider practices relating to the use and disposal of fontanel patches in care homes and hospitals and guidance on what action staff should take if a fontanel patch is missing from a patient.	Yes	53
South Yorkshire: East	Doncaster Royal Infirmary	To consider how decisions relating to medication are recorded and the need for those records to be accurate.	Yes	54
Manchester: West	Central Manchester University NHS Foundation Trust	To consider a review of the system of requesting and booking ultra-sound scans to ensure they are performed and reported within a reasonable time frame.	Yes	55
Darlington and South Durham	Durham and Darlington NHS Trust	To consider: implementing a robust enquiry and review process following untoward incidents; and reviewing documents used to record the handover from accident and emergency to the receiving ward and a system to record any delays.	Yes	56
Milton Keynes	Milton Keynes General Hospital	To consider establishing a system whereby decisions by nurses for patients to be given additional care are promptly actioned.	Yes	57
Northumberland: North	(1) Northumbria Healthcare NHS Foundation Trust (2) Royal College of Obstetricians and Gynaecologists	To consider reviewing communication practices and awareness training regarding 'alert and talking' patients with deranged observations.	Yes	58
Devon: Plymouth and South West	(1) Cornwall Primary Care Trust (2) Serco Group Plc.	To consider: reminding clinicians of the possibility of a congenital hernia as a diagnosis; giving the appropriate weight to the history provided by a baby's mother; and lowering the threshold for escalating treatment so that if an infant has been seen by three doctors in 24 hours a referral is made to a consultant paediatrician.	(1) Extension (2) Yes	59
Gloucestershire	Gloucester Primary Care Trust	To consider a review of the discharge process and patient care plans.	Yes	62
Exeter and Greater Devon	Northern Devon Healthcare NHS Trust	To consider a review of the care arrangements in place for patients with pressure sores.	Yes	63

Coroner District	Organisation	Summary	Response Received	Report
Kent: Central and South East	Kent and Medway NHS and Social Care Trust	To consider ways of improving: training staff in hospital policies; risk assessments for self harm; the Trust's policy on misuse of alcohol; and record keeping and information sharing.	Yes	64
Berkshire	Millbarn Medical Centre, Beaconsfield	To consider a review of the arrangements when patients with long term degenerative diseases undergo surgery.	Yes	66
West Yorkshire: West	National Institute for Health and Clinical Excellence	To consider issuing advice on the use of thromboembolic prophylaxis in post-operative patients.	Yes	67
Norfolk	James Paget University Hospitals NHS Foundation Trust	To consider whether the procedures for the use of syringe drivers are operating satisfactorily and whether staff need further training.	Yes	69
Birmingham and Solihull	Birmingham Children's Hospital NHS Foundation Trust	To consider implementing a rapid response team which could be contacted by the family if they felt the treating physicians were either not listening to concerns or not responding in an appropriate way, and whether implementing the model used in Cincinnati Children's Hospital, which allows the family to monitor pulmonary, extravascular and water scores, would be practicable.	Extension	72
Birmingham and Solihull	Department of Health	To consider the need to raise awareness of rare complications with total parenteral nutrition feeding in neonates and if there is any research which can be undertaken into the matter.	Extension	76
Manchester: West	The Royal Bolton Hospital	To consider: a detailed training needs assessment of nursing staff in relation to neurological observations; issuing guidance on the Glasgow Coma Scale chart to assist nurses; and issuing a reminder to wards of the importance of reading patients notes at admission so that observations can be interpreted in light of patient history.	Yes	78

Coroner District	Organisation	Summary	Response Received	Report
Shropshire: South	(1) Shrewsbury and Telford Hospitals NHS Trust (2) West Midlands Ambulance Service NHS Trust	To consider the need for accurate and contemporaneous record keeping.	Yes	79
Avon	2gether NHS Foundation Trust	To consider instructing staff that any patient complaining of chest pain must be assess by a doctor rather than a nurse.	Yes	81
Manchester: City	Blackpool Teaching Hospitals NHS Foundation Trust	To consider a broad range of recommendations to improve the care of critically ill children.	Yes	83
Sussex: West	Nursing and Midwifery Council	To consider making it compulsory for nurses to record the calculations used to work out the quantities of intravenous drugs they administer.	Yes	86
Manchester: South	Tameside General Hospital	To consider how to improve communication between staff and family members and that the hospital has the appropriate staffing levels.	Yes	88
Avon	Stoke Gifford Medical Centre, Bristol	To consider ways of gaining accurate information from callers about a patient's true condition to ensure that there are no 'red flags' or missed emergencies and that all information is accurately recorded.	Yes	89
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider training staff in treating patients with Baclofen implants and whether the resources available to the Disability Liaison Team are sufficient in Derriford Hospital.	Yes	91
London: West	Kingston Hospital, Surrey	To consider a review of the provision of acute gastric bleed endoscopy and that the timing of the request, delivery and administration of blood or blood products to those patients who require such treatment should be properly audited.	Yes	94
Staffordshire: South	South Staffordshire and Shropshire NHS Trust	To consider how communication can be improved between the Trust, GPs and patients' families.	Yes	95

Coroner District	Organisation	Summary	Response Received	Report
Preston and West Lancashire	(1) General Medical Council (2) NHS Blackburn and Darwen Primary Care Trust	To consider a review of the treatment of patients with chest pains.	Yes	96
West Yorkshire: West	Bradford Teaching Hospitals NHS Trust	To consider a review of the maintenance of crash trolleys used during resuscitation attempts and the recording of basic observations.	Yes	98
Bridgend and Glamorgan Valleys	Abertawe Bro Morgannwg University Health Board	To consider a review of: systems in place for junior doctors to escalate cases; the use of the sepsis screening tool; and training in compliance with the National Early Warning Score.	Yes	100
Manchester: South	Tameside General Hospital	To consider a review of staffing levels in the accident and emergency department, the use of the Manchester Triage System and the training of staff in operating the Glasgow Coma Scale	Yes	106
London: North	Department of Health	To consider issuing guidance on whether a hospital treating voluntary patients can have locked exit doors.	Extension	117
Durham: North	County Durham and Darlington NHS Foundation Trust	To consider reviewing the Multi Disciplinary Falls Care Prevention Plan and the need for the Plan to be completed accurately.	Yes	120
London: Inner West	Department of Health	To consider a review of the forms which have to be completed by nurses to ensure that their time is being well spent.	Yes	121
Norfolk	NHS Norfolk and Waveney	To consider whether patients with restricted mobility should be regularly monitored by a nurse so that pressure sores can be dealt with at the earliest opportunity.	Yes	122
North Yorkshire: East	York District Hospital	To consider a review of the circumstances in which a full body CT scan is carried out.	Yes	127
London: North	Department of Health	To consider alerting doctors to the possibility of extravasation into the pleura of total parenteral nutrition from a long line to the point where it causes plural effusion.	Extension	130

Coroner District	Organisation	Summary	Response Received	Report
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider, regarding the Enhanced Recovery Programme: if patients are to be discharged early there should be a note of abdominal examination to ensure there is no distension of abdomen, no absence of bowel sounds and to note the patient has passed flatus; what information is provided to the family and the provision of a carer leaflet; and the need for contact to be made with patients following their discharge.	Yes	131
London: North	Department of Health	To consider developing a health screen for patients who may have been exposed to Asbestos.	Yes	135
Preston and West Lancashire	West Lancashire GP Service	To consider reviewing arrangements for out-of-hours doctors access to patient's medical records.	Yes	136
Bridgend and Glamorgan Valleys	Primecare, Birmingham	To consider ensuring doctors are fully acquainted with the necessary guidelines for the treatment of serious head injuries and when it is necessary for a patient to be referred to hospital.	Yes	137
Norfolk	Norfolk and Norwich University Hospital NHS Foundation Trust	To consider making it an absolute requirement to communicate with relatives when decisions are made not to resuscitate.	Yes	140
London: East	Withybush General Hospital, Haverfordwest	To consider increasing staffing levels in the radiology department and a review of the current systems for recording clinical decisions, observations and reviews.	Yes	143
Manchester: West	Wrightington, Wigan and Leigh NHS Foundation Trust	To consider a review of: how the quality of patients' notes is assessed and the procedures to ensure the correct documentation is fully completed: and the requirement for completion of early warning score sheets and an escalation procedure.	Yes	147
Manchester: West	Wrightington, Wigan and Leigh NHS Foundation Trust	To consider a review of the Trust's serious and untoward incident investigation system.	Yes	154

Coroner District	Organisation	Summary	Response Received	Report
London: East	Barking Havering and Redbridge University Hospitals	To consider training to ensure all staff are aware of the Trust's protocol for reporting faulty equipment and take steps to reduce the risk of patients falling from trolleys.	Yes	160
Southend and South East Essex	South Essex Partnership University NHS Foundation Trust	To consider measures to ensure patients referred from a GP or accident and emergency are provided with the most appropriate support.	Yes	163
Manchester: South	Department of Health	To consider whether there should be a limitation on the ability of bank nurses to work within a specified area of expertise.	Extension	169
Manchester: West	Royal Bolton Hospital NHS Foundation Trust	To consider a review of the systems for reporting an x-ray result to the requesting department and audit systems to check actions have been carried out.	Yes	170
Exeter and Greater Devon	(1) Medicine and Healthcare Products Regulatory Agency (2) The Royal College of Physicians (3) The Royal College of Surgeons (4) The Vascular Society	To consider a review of the safety and reliability of reusable Doppler probes.	Yes	172
Birmingham and Solihull	Birmingham and Solihull Mental Health NHS Foundation Trust	To consider ways of ensuring that medical records are easily accessible by medical practitioners.	Yes	177
Bridgend and Glamorgan Valleys	Abertawe Bro Morgannwg University Health Board	To consider a review of neurological observations and additional training for staff in assessing head injuries.	Yes	179
West Yorkshire: West	Mid Yorkshire Hospital NHS Trust	To consider reviewing policies and training of staff in the use of Do Not Attempt Cardiopulmonary Resuscitation orders.	Yes	185

Coroner District	Organisation	Summary	Response Received	Report
Durham: North	Durham County Council	To consider a review of the systems for making patient information available to staff and recording observations.	Yes	187
Derby and South Derbyshire	(1) Hywel Dda Health Board (2) Welsh Ambulance Service NHS Trust	To consider: training staff in the diagnosis and treatment of patients with spinal injuries and their pre-discharge assessment; the need for the Patient Report Form to document why spinal immobilisation may not have taken place and when a patient declines analgesia.	Yes	188
Brighton and Hove	Brighton and Sussex University Hospitals NHS Trust	To consider a review of how patient follow up checks can be better organised.	Yes	193
Norfolk	Norfolk and Norwich University Hospitals NHS Foundation Trust	To consider a review of the process for ensuring ambulance records are seen by the appropriate medical staff and assessing staff for CT scans.	Yes	194
Sunderland	City Hospitals Sunderland NHS Foundation Trust	To consider a review of communication, staffing levels, early warning score systems and the upkeep of medical records.	Yes	195
Black Country	Sandwell and Birmingham Hospitals NHS Trust	To consider ways of ensuring adherence to the Trust's policies on 'Do Not Attempt Resuscitation' orders.	Yes	197
Milton Keynes	Department of Health	To consider national guidance on the procedure to follow if a patient has suffered a suspected anaphylactic reaction following the administration of a drug.	Extension	198
Avon	(1) Avon and Wiltshire Mental Health NHS Trust (2) South Gloucestershire Clinical Commissioning Group	To consider introducing a procedure whereby a summary is sent from psychiatric services to the hospital on admission of an anorexic patient highlighting any mental health issues that might influence or assist clinical judgements and treatments.	Yes	199
Milton Keynes	Care Quality Commission	To consider a review of the prescribing procedures at Willen Village Surgery, Milton Keynes.	Yes	201

Coroner District	Organisation	Summary	Response Received	Report
Lincolnshire: Central	Department of Health	To consider a review of the IT system used by GPs to make patients' medical history more prominent.	Extension	202
London: Inner South	Lewisham Healthcare Trust	To consider a review of the way prior clinical information is processed and issuing guidance to assist doctors making immediate treatment decisions.	Yes	203
Bridgend and Glamorgan Valleys	(1) Cardiff and Vale University Health Board (2) Fresenius Medical Care Renal Services Ltd	To consider a review of record keeping and training for staff in the importance of identifying problems with wounds and when to refer to a consultant.	Yes	205
Manchester: South	(1) Hollister Ltd. (2) Central Manchester University Hospitals NHS Foundation Trust	(1) To consider a review of training given to hospital staff. (2) To consider ways of improving feeding patients, communication between staff and note taking and record keeping.	(1) Extension (2) Yes	211
Manchester: West	(1) Department of Health (2) Royal Bolton Hospital (3) Salford Royal Hospital	To consider a review of the treatment of patients with spinal injuries, particularly in relation to the fitting and use of braces and the provision of orthotist services.	(1) Extension (2) Yes (3) Yes	215
Kent: Central and South East	East Kent Hospitals Trust	To consider the need for communication between nurses and consultants when changing a patient's medication during anticoagulation therapy.	Yes	220
London: East	Newham University Hospitals NHS Trust	To consider what steps can be taken to store patient records more securely.	Extension	228
London: Inner North	The Whittington Hospital NHS Trust	To consider improving the quality of medical records and the out-of-hours service.	Extension	233

Coroner District	Organisation	Summary	Response Received	Report
Hospital deaths (Other)				
Southend and South East Essex	Department of Health	To consider issuing guidance to hospitals that a single 'hook restrictor' on a window is not adequate to stop it being opened by force.	Yes	49
North Wales: East and Central	Betsi Cadwaladr University Health Board	To consider a recall of patients who had moles or lesions removed by Rysseldene Surgery between 2008-2012 who did not have samples histologically tested in order to ascertain whether the diagnosis provided by Rysseldene Surgery was accurate.	Yes	212
Mental health related death				
Birmingham and Solihull	Department of Health	To consider a review of policies relating to the prescription of Citalopram and referrals by GPs to mental health trusts.	Extension	2
Northumberland: North	(1) Northumbria Healthcare NHS Foundation Trust (2) Northumberland Tyne and Wear NHS Foundation Trust	To consider how communication channels can be improved between addiction services and the hospitals and a review of policies on assessments under the Mental Health Act 1983.	Yes	5
London: Inner South	(1) Croydon Primary Care Trust (2) Lambeth Primary Care Trust (3) Lewisham Primary Care Trust (4) Southwark Primary Care Trust	To consider a review of how patients with enduring mental health problems are assessed, discharged and monitored.	Yes	6

Coroner District	Organisation	Summary	Response Received	Report
London: Inner South	(1) Independent Commission, Scotland Yard (2) Lambeth Council (3) Metropolitan Police Service (4) Penrose Housing Authority (5) South London and Maudsley NHS Foundation Trust	To consider: reviewing training of health professionals and staff involved in facilitating an Order under the Mental Health Act 1983; joint protocols to clarify the roles and responsibilities of each organisation in meeting the needs of those with urgent psychiatric problems; and the approach of the Metropolitan Police Service to those detained in custody with a mental illness.	Yes	20
London: City	Department of Health	To consider a review of the treatment of patients suffering from paranoid schizophrenia.	Yes	45
London: Inner South	(1) Lambeth Adult Safeguarding Board (2) London Borough of Lambeth (3) South London and Maudsley NHS Foundation Trust	To consider what actions can be taken to ensure staff perform their duties with respect to care coordination and adult safeguarding and that the way they communicate and report is improved to reduce risk of harm to their clients.	Yes	51
London: North	(1) Department of Health (2) New Scotland Yard	(1) To consider issuing guidance to medical practitioners to clarify the circumstances in which they would be permitted to use their holding powers under s5(2) or s5(4) of the Mental Health Act 1983. (2) To consider: the need for a detained person who may be suffering from a mental health illness to have a prompt and full assessment; the need for accurate record keeping; and training for officers on their powers under S136 of the Mental Health Act 1983.	Yes	65

Coroner District	Organisation	Summary	Response Received	Report
Cambridgeshire: South and West	(1) NHS Cambridgeshire (2) Priory Fields Surgery, Huntingdon	To consider the need for routine clinical reviews of patients with mental health issues who have repeat prescriptions and clear, well documented, lines of responsibility for the patient.	Yes	132
Coventry	Coventry and Warwickshire Partnership Trust	To consider additional staff training in the treatment and monitoring of patients sectioned under the Mental Health Act 1983.	Yes	151
Sunderland	Northumbria Police	To consider reviewing the arrangements for forensic medical examiners communicating a patients risk of suicide to mental health professionals.	Yes	159
Manchester: West	Department of Health	To consider national guidance, as part of training for mental health nurses, on patients who display excessive water drinking.	Yes	162
Manchester: West	Greater Manchester West Mental Health NHS Foundation Trust	To consider including a reminder in the prompt list for mental health practitioners to ask patients if they have any objections to friends and family being included in their assessment and for the practitioner to contact the person or organisation that made the referral.	Yes	175
West Yorkshire: East	(1) Bradford Council (2) Bradford District Care Trust	To consider issuing guidelines on situations when patients should remain under the care of the Adult Mental Health Team and the need for a needs assessment prior to patients' discharge.	Yes	213
Manchester: South	(1) Greater Manchester Police (2) North West Ambulance Service (3) Pennine Care NHS Foundation Trust (4) Stepping Hill Hospital	To consider raising awareness in all agencies involved in mental health work of the roles, legal powers, working and limitations of each organisation.	(1) Yes (2) Extension (3) Yes (4) Yes	214

Coroner District	Organisation	Summary	Response Received	Report
West Yorkshire: East	(1) Mid Yorkshire Hospitals NHS Trust (2) South West Yorkshire Partnership NHS Foundation Trust	To consider: implementing the recommendations of the Mid Yorkshire Hospitals NHS Trust's Root Cause Analysis Investigation report; providing greater clarity in communicating contact details for mental health services within the Trust and that these are published in all relevant clinical areas; and training all clinical staff in the provision of the National Institute for Clinical Excellence Guideline 16 - Self Harm.	Yes	217
Cumbria: South and East	Cumbria Partnership NHS Foundation Trust	To consider training staff in the importance of engaging patients, even if they are reluctant to do so, when carrying out assessments under the Mental Health Act 1983.	Yes	225
London: Inner West	Central and North West London NHS Trust	To consider: the use of quetiapine as a first line mood stabiliser in bipolar disorder; the configuration of psychiatric services; and including contact details for psychiatric care on the discharge letters sent to GPs.	Yes	235

Other

Coroner District	Organisation	Summary	Response Received	Report
Oxfordshire	European Aviation Safety Agency	To consider what changes can be made to allow a visual inspection of the 'lower bolt' on the SZD-24-4A Foka 4 Glider.	Yes	61

Coroner District	Organisation	Summary	Response Received	Report
Manchester: City	(1) Crown Prosecution Service (2) Department of Health (3) General Medical Council (4) Greater Manchester Police (5) Health and Care Professions Council (6) Manchester City Council (7) Manchester NHS Primary Care Trust (8) National Institute for Health and Clinical Excellence (9) Nursing and Midwifery Council (10) The College of Social Work	To consider improving the policies and practices relating to the protection of victims of domestic abuse and their children.	Yes	82
Staffordshire: South	Spanish Consulate General, London	To consider raising awareness that tourists in Spain may be asked to pay a fee by emergency paramedics, before treatment is given.	Yes	97
Stoke-on-Trent and North Staffordshire	Steelite International Plc.	To consider training for managers, supervisors, human resources staff and directors to assist in identifying and dealing with bullying and issuing a reminder to staff of the 'Dignity at Work' policy.	Yes	145
Black Country	Creative Supports Ltd.	To consider a review of the policies for gaining access to supported housing properties when there is concern about the welfare of the resident.	Yes	156

Coroner District	Organisation	Summary	Response Received	Report
London: West	A2Dominion Housing Group Ltd	To consider a review of the window limiters used, and whether they can be adjusted to improve child safety.	Yes	192
Durham: North	(1) British Medical Association (2) Department of Health (3) Durham Constabulary (4) General Medical Council (5) Home Office	To consider a root and branch review of policy, guidance and procedures relating to firearm licencing.	(1) Yes (2) Extension (3) Yes (4) Yes (5) Extension	208
Cambridgeshire: South and West	(1) Peterborough Flying Club PAC (2) Peterborough Flying Club PFC (3) Pooler's Flight Guide Ltd (4) Safety Regulation Group, Aviation House	To consider: publishers of guides to airfields providing consistent information on recording the presence of hazards; all airfield websites to contain full information on the presence of hazards: and Sibson Airfield alerting callers intending to fly to the airfield of the website before embarking.	Yes	219
London: Inner North	Department of Health	To consider making it mandatory for gymnasiums to install defibrillators and to have a staff member in attendance who is trained in using it.	Extension	229
London: Inner West	Department for Culture Media and Sport	To consider hair testing be used at regular intervals to screen for drug misuse in all professional sports men and women.	Yes	230
Staffordshire: South	Health and Care Professions Council	To consider issuing guidance that staff suspensions be carried out face to face.	Yes	231

Coroner District	Organisation	Summary	Response Received	Report
London: Inner South	(1) Department for Communities and Local Government (2) London Fire Brigade (3) The Mayor and Burgesses of The London Borough of Southwark	The full Rule 43 reports and responses made following the Lakanal house fire can be viewed here: http://www.lambeth.gov.uk/Services/CouncilDemocracy/LakanalHouseVerdicts.htm	Yes	234
Police procedures related deaths				
Cheshire	Cheshire Constabulary	To consider: providing written materials to support all classroom training; a procedure to ensure delegates understand and retain information; how best to attend to detainees' medical needs; and how to ensure practice follows written policies.	Yes	30
Gwent	Gwent Police	To consider: issuing a reminder on the importance of carrying out and recording full and detailed risk assessments on a regular basis; a review of the information and intelligence captured and the importance of sharing knowledge with the custody officer.	Yes	32
Durham: North	Durham Constabulary	To consider, in relation to detained persons: training in risk perception, first-aid, the appropriate words to use when performing an arrest and the use of pepper spray; how to select the appropriate vehicle for transporting a detainee and fitting those vehicles with CCTV; and a system to ensure officers are properly equipped to undertake their duties.	Yes	43
Merseyside	Home Office	To consider ensuring all police forces are aware of the Safer Detention and Handling of Persons in Police Custody manual, and that a copy of this document is kept in the custody office of all police stations.	Yes	47

Coroner District	Organisation	Summary	Response Received	Report
Birmingham and Solihull	West Midlands Police	To consider the need, during a 999 call, for the call handler to obtain as much information as possible, and to make a clear note of their decision if police attendance is not considered appropriate.	Extension	73
West Yorkshire: East	(1) British Transport Police (2) Leeds City Council (3) NHS Airedale, Bradford and Leeds	(1) To consider a new policy and training staff in dealing with vulnerable persons. (2 and 3) To consider providing treatment facilities in Leeds where people who are drunk can be supervised whilst they become sober, rather than them being detained in police custody.	(1) Yes (2) Yes (3) No	164
Manchester: South	Greater Manchester Police	To consider reviewing the processes for grading and escalating emergency calls.	Yes	173
Manchester: City	(1) Association of Chief Police Officers (2) Devon and Cornwall Police (3) Greater Manchester Police	(1) To consider a regular review and audit of all changes made since the event. (2) To consider training for officers in the documents which need to be served when summonsing a person of 17 years of age so that the parental notice is not delivered at the same time. (3) To consider a review of whether or not 17 year olds should, on a non-statutory basis, have their parents or guardians notified of their arrest.	Yes	174
Cumbria: South and East	(1) Association of Chief Police Officers (2) College of Policing Ltd. (3) Cumbria Constabulary (4) Her Majesty's Inspectorate of Constabulary (5) North West Ambulance Service NHS Trust	To consider making training on restraint and its medical implications compulsory, reviewing existing training arrangements and seeking to improve cooperation between agencies.	Yes	206

Coroner District	Organisation	Summary	Response Received	Report
Product related death				
London: North	British Standards Institution	To consider enclosing all fridge and freezer compressor compartments in a pressed steel compartment and that all capacitors are the P2 type, or a capacitor with similar protection to avoid failure resulting in fire.	Yes	93
Staffordshire: South	Department for Business, Innovation and Skills	To consider regulating or banning the use of open pot bio-fuel fires.	Yes	103
London: Inner West	Health and Safety Executive	To consider placing a warning on window blinds highlighting the dangers of strangulation from the cords and advising that the cords be placed out of reach of children.	Extension	141
Manchester: City	(1) Central and North West London NHS Trust (2) Home Office	(1) To consider: reviewing current service arrangements to ensure timely patient treatment is maintained; distributing to all clinical leads and managers lessons learnt in this case; and making the national commissioning body aware of the case. (2) To consider introducing regulations to require helium gas cylinders to have control valves that dispense only small amounts of gas at any one time and regulations to reduce the volume of cylinders for hire and sale.	(1) Yes (2) Extension	189
Manchester: City	Home Office	To consider introducing regulations (i) to require helium gas cylinders to have control valves that dispense only small amounts of gas at any one time and (ii) to reduce the volume of cylinders for hire and sale.	Extension	223
Railway related death				
London: East	Office of Rail Regulation	To consider the need for warning signs and barriers on the sloping platforms at Rainham Railway Station.	Yes	4
Cornwall	(1) Cornwall Council (2) Network Rail	To consider closing Mexico Foot Crossing which crosses the train track at Long Rock, Penzance.	Yes	90
Manchester: South	Northern Rail Ltd.	To consider improving the railings and lighting of the stairway at Hyde Railway Station.	Yes	114

Coroner District	Organisation	Summary	Response Received	Report
Road (Highways Safety)				
West Yorkshire: East	Leeds City Council	To consider improving pedestrian safety at the traffic light controlled junction of the A6120 Seacroft Ring Road and Coal Road, Leeds.	Yes	23
East Riding and Kingston upon Hull	Premier Foods Plc.	To consider introducing a fence and resurfacing the footpath next to the river at Drypool Bridge on the River Hull.	Yes	27
Blackburn, Hyndburn and Ribble Valley	Lancashire County Council	To consider adding advanced warning signs or chevron boards at the junction of the B6243 and the access road for Spade Mill Reservoir, Longridge.	Yes	28
West Yorkshire: West	Bradford District Council	To consider introducing measures to prevent pedestrians crossing at Thong Street west of Knowles Lane, Bradford, or placing lights which indicate when it is safe to cross.	Extension	36
Kent: North East	Kent County Council	To consider making changes to the junction of the A254 Ramsgate Road and Old Ramsgate Road, Margate, to improve safety for drivers.	Yes	44
London: North	Myddelton House, Bulls Cross	To consider an additional sign showing the route pedestrians should take from the side of the canal to reach Ponders End Railway Station.	Yes	60
Norfolk	King's Lynn and West Norfolk Borough Council	To consider the review carried out by the Mart Task Group, and whether there is a need to implement its recommendations to improve safety on King Street, King's Lynn.	Yes	70
Manchester: South	Trafford Borough Council	To consider the addition of a pedestrian phase being built into the traffic lights at the junction of Manchester Road and Park Road, West Timperley.	Yes	77
Wiltshire and Swindon	Highways Agency	To consider widening the parameters of road inspections so that parts of the road which may become slippery when wet, and a danger to motorcyclists, are considered to constitute a defect.	Yes	99
London: Inner West	London Borough of Merton Council	To consider a review of the traffic calming measures in place and adapting speed bumps which may be of danger to motorcyclists on Stamford Road, Barking and Dagenham.	Extension	112

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Kent: North East	Kent County Council	To consider a review into the safety of parking arrangements on College Road, Canterbury.	Yes	113
Wiltshire and Swindon	Highways Agency	To consider improving the safety of the A36 at Upton Lovell, at the junction with Manor Road.	Yes	124
London: North	Department for Transport	To consider an addition to the Highway Code that states 'when a pedestrian is in the road all vehicles should slow down or stop until the pedestrian has moved out of danger'.	Yes	129
Norfolk	(1) East of England Ambulance Trust (2) Norfolk Constabulary	(1) To consider: a review of the policy for responding to road traffic collisions; how appropriate 'backup' can be made available to those attending the scene; and further training in when to seek additional support. (2) To consider what steps can be taken to enhance inter-agency cooperation between emergency services in Norfolk to ensure that responses are planner, coordinate and well managed under a well established and acknowledged line of command.	Yes	138
Liverpool	Liverpool City Council	To consider a review of pedestrian safety at the junction of Rathbone Road and Picton Road, Liverpool and the possibility of a pedestrian phase being built into the traffic lights.	Yes	149
South Yorkshire: West	North East Waterways	To consider the addition of warning signage and low perimeter fencing at Tinsley Canal which has an unusual depth of 2.5 metres with no escape ladders, grab chains or life-saving apparatus.	Yes	155
Leicester City and South Leicestershire	Leicestershire County Council	To consider carrying out work to make the warning signs more visible on Bath Lane, Bruntingthorpe.	Yes	157
Staffordshire: South	Staffordshire County Council	To consider reviewing the safety of the A458 Brignorth Road, Dudley, including the positioning of the chevron boards and the proximity of foliage.	Yes	158
Black Country	Wolverhampton City Council	To consider what steps can be taken to improve pedestrian safety on Blaydon Road, linking Droveway and Oxley Moor Road, Pendeford.	Yes	178
Shropshire: Mid and North-West	Canal and River Trust	To consider whether the steps on the aqueduct bridge are fit for purpose at Berrisford Road, Market Drayton.	Yes	190

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Wiltshire and Swindon	Anchor Trust	To consider how to improve the safety of pedestrians crossing outside Clift House on Langley Road, Chippenham.	Yes	196
Cumbria: North and West	Cumbria County Council	To consider removing the boulder which supports the 'keep left' sign and re-painting the white lines at the start of the dual carriageway of the A591 towards Thirlmere at Dunmail Raise.	Yes	200
Staffordshire: South	(1) Staffordshire County Council (2) West Midlands Ambulance Service	(1) To consider how driver safety can be improved where the A51 Tamworth Road in Lichfield meets Cricket Lane. (2) To consider implementing the draft driving policy and training staff in the various emergency vehicles.	Yes	207
Avon	Canal and River Trust	To consider further fencing next to the weir at the Jolly Sailor Public House, Saltford.	Yes	209
Road (Vehicle Safety)				
Staffordshire: South	Jungheinrich Ltd	To consider altering the forklift truck lighting system so that a red handbrake sign does not display when the footbrake is deployed.	Yes	104
Staffordshire: South	Department for Transport	To consider regulating that people who use mobility scooters should have a health check to include hearing and eyesight, that their vehicle should be suitable to their needs, that they undergo appropriate training and that they wear a high visibility jacket.	Yes	142
Staffordshire: South	Department for Transport	To consider legislating so that wheelchairs have compulsory crash test certificates that allow them to be used in the back of vehicles.	Yes	182
Road Deaths (Driver and vehicle licensing)				
Stoke-on-Trent and North Staffordshire	Department for Transport	To consider introducing legislation to improve the safety of users of mobility vehicles, including the need for helmets or seat belts and what may or may not be carried on such a vehicle.	Yes	10
Cardiff and Vale of Glamorgan	British Driving Society	To consider making the wearing of safety hats compulsory in horse and trap events.	Yes	42
Southend and South East Essex	Department for Transport	To consider statutory regulations on the training and testing of those who provide horse and carriage rides to the public.	Yes	48

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Lincolnshire: South	Driver and Vehicle Licensing Agency	To consider what actions could be taken to ensure that people with visual impairments which may affect their driving report the information to the DVLA.	Yes	133
North Yorkshire: East	Department for Transport	To consider regulating on the minimum level of eyesight required to operate a mobility scooter and the appropriate level of training.	Yes	176
Service personnel deaths				
Portsmouth and South East Hampshire	Ministry of Defence	To consider producing and distributing generic risk assessment material throughout the Royal Navy's fleet and ways to raise the appreciation of health and safety matters.	Yes	75

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