Ministry of JUSTICE

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

September 2010

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1. Introduction

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

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

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

http://www.opsi.gov.uk/si/si2008/uksi_20081652_en_1

This is the third Ministry of Justice summary bulletin. It covers reports and responses received by the Lord Chancellor between 1 October 2009 and 31 March 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 provisions of the amended Rule 43.

2. Statistical Summary

1. Rule 43 reports issued by coroners and trends

Between 1 October 2009 and 31 March 2010 coroners in England and Wales issued a rule 43 report in a total of 195 inquests.

As in the two previous summaries, reports were most commonly issued in connection with hospital deaths, accounting for 30% of reports issued (58 reports). A further 12% of reports were issued in connection with road deaths (24 reports). The third most frequently issued reports, accounting for 11% each, were in connection with accidents at work or health and safety issues (23 reports) and deaths in custody (22 reports). This is a much higher number for deaths in custody than in the previous summaries. Mental health deaths, which have previously received the third highest number of reports, accounted for 10% (20 reports) during this period.

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

Table 1: Rule 43 reports issued by coroners between 1 October 2009 and 31 March 2010, by broad category

Category	Number of inquests where Rule 43 reports issued
Hospital deaths	58
(Clinical procedures and medical management)	(54)
(*Other)*	(4)
Road deaths	24
(highways safety)	(21)
(*vehicle safety)*	(2)
(driver and vehicle licensing)	(1)
Accidents at work and health and safety related deaths	23
Mental health related deaths	20
Community healthcare and emergency services related deaths	14
Deaths in custody	22
Drug and medication related deaths	5
Care home deaths	10
Service personnel deaths	3
Police procedure related deaths	3
Product related deaths	5
Railway related deaths	1
Other deaths	7
Total	**195**

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

There are currently 114 coroner districts in England and Wales. Between 1 October 2009 and 31 March 2010, rule 43 reports were issued by 67 (59%) of these coroner districts.

In the six months covered by this report, the Greater Manchester South coroner district issued the most reports, 17 reports, equating to 9% of reports issued. However, coroners commonly issue many fewer reports than this. The number of reports a coroner issues is governed by the circumstances of the deaths he or she investigates and whether the coroner believes that action could be taken to prevent future deaths. Often the evidence heard at an inquest will satisfy the coroner that remedial action has already been taken, so he or she may decide no useful purpose will be served by issuing a rule 43 report after the inquest.

Annex A lists the 67 coroner districts which have issued rule 43 reports during the period covered by this bulletin, together 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 the organisations which were recipients of reports. Sometimes coroners send reports arising from a single inquest to more than one organisation, so the number of organisations receiving reports is higher than the total number of inquests after which a report has been sent.

The majority of Rule 43 reports arose out of hospital deaths, and therefore NHS hospitals and Trusts were the most frequent recipients. They received 32% of the reports issued by coroners between 1 October 2009 and 31 March 2010.

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 September 2009 and 31 March 2010, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	74
Ministers/central Government departments	39
Local Authorities	34
Private companies	19
Regulatory bodies and trade associations	26
Police and other emergency services	22
Prisons	14
Care and nursing homes	8
Other	7
Total	**243**

4. Responses to Rule 43 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 to the coroner within 56 days of the date when the report is sent. The response should provide details of any actions which have 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 if an application is made by the recipient of the report.

The Lord Chancellor has received 200 responses to Rule 43 reports in respect of the 243 reports issued between 1 October 2009 and 31 March 2010. Of the

remaining responses, some organisations had been granted an extension and the remainder were not yet due. **Annex B** sets out those organisations which the Ministry of Justice have been advised have not responded to the coroner within the 56-day deadline and who had neither sent the coroner an interim reply nor been granted an extension at 28 February 2010.

5. Emerging Trends

In this third summary report the trends identified in the previous reports continue to be the main themes of the Rule 43 reports issued following inquests.

Almost a third of the reports issued relate to hospital deaths, with the major issues being those of communication, procedures and protocols, and staff training as in the earlier bulletins. Procedures on discharge from hospital and ensuring appropriate medical support and/or instructions for patients discharged again emerge as an area of concern raised in several reports.

The second most frequently issued reports again relate to road deaths and as in the earlier bulletins the majority of reports in this category ask for a review of road layout, signage or speed limits, with the aim of improving road safety.

As also identified previously, irrespective of the category, many reports address concerns about lack of communication between the different agencies involved with the deceased and procedures or practices which might have contributed to the death. Additionally, several reports again suggest a review of roles and responsibilities to promote greater clarity, additional training and the need for accurate and full record keeping. This is especially so for hospital deaths, deaths in custody and mental health related deaths.

Many responses received set out the action which has been taken in detail and it is pleasing that organisations receiving rule 43 reports have frequently indicated that lessons have been learned which have led to changes which might prevent future deaths.

3. Rule 43 reports which have wider implications

The list of Rule 43 reports received between 1 October 2009 and 31 March 2010 is at **Annex C**

As in the two 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 received 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) Road Deaths

A woman died as a result of injuries sustained following a collision with a car coming in the opposite direction. Before her death the woman had been advised by her ophthalmologist that her vision would not meet the driving standard. Following the inquest the coroner expressed concerns that the woman had disregarded expert advice about her vision, and had also failed to report it to the Driving Vehicle Licensing Authority (DVLA). He therefore wrote to the DVLA querying the obligation on individuals treating or who know a driver, to report such a matter if it is noted that the driver's health is failing and may affect their ability to drive.

The DVLA responded as follows:

- Licence holders are required by law to inform DVLA about the onset or worsening of a health condition which may affect their ability to drive. Failure to inform DVLA is a criminal offence.
- DVLA's medical licensing procedures allow investigation of fitness to drive following notification from third parties.
- DVLA publishes advice on the medical standards of fitness to drive, *'At a Glance guide to current Medical Standards of Fitness to Drive*', which is available to all health care professionals and is on their website.
- DVLA provides a dedicated, confidential helpline to provide advice to healthcare professionals which can provide specific or general guidance.
- Whilst there is no legal obligation on medical professionals who are treating deteriorating health in drivers to notify DVLA, there is a duty of care, not only to patients, but also to the general public. On that basis there is an obligation on all medical professionals (as well as third parties) to report instances to the DVLA where they consider the driver unfit to drive.
- This is supported by the guidelines issued by the General Medical Council and the College of Optometrists, which advise that a report to DVLA when a patient refuses to stop driving when advised to do so is a justifiable breach of patient confidentiality.

ii) Accidents at work and Health and safety related deaths

a) A man died at his rented home as a result of carbon monoxide poisoning. This was caused by a blockage of by-products in the rear flue pipe of the Rayburn solid fuel cooker which provided hot water, cooking facilities and some heating to the property. It was ascertained that there are no direct regulatory requirement on landlords to ensure that appliances using solid fuel are maintained to a safe standard as there are for gas appliances. In the case of oil-fired appliances there is a voluntary code and certification process under regulation by the Oil Firing Technical Association (Oftec), and for solid fuel and wood fuel appliances a similar scheme exists operated by the Heating Equipment Testing and Approval Scheme (HETAS).

The coroner wrote to the Secretary of State for Business, Innovation and Skills suggesting the introduction of regulations covering and enforcing the maintenance to a safe standard of non-gas appliances, pipe work and flues/chimneys. It was also suggested that the Health and Safety Executive (HSE) take a more pro-active role in checking compliance with any regulations.

HSE responded as follows:

- A cross-Government group has been re-established to act as a single body to champion issues relating to gas safety and carbon monoxide awareness.
- There are non-regulatory provisions in place for managing non-gas carbon monoxide risks. These rely upon a tiered approach of proper installation, the education of appliance owners, and initiatives to raise awareness among the general public and medical professionals of the dangers and symptoms of Carbon Monoxide poisoning.
- Although there is no specific legislation for the maintenance of solid fuel appliances in the way there is for gas appliances, Section 3(1) of the Health and Safety at Work etc Act 1974 may be applicable depending on the circumstances.
- Part J of the Building Regulations, enforced by local authority building control officers, sets out the requirements for the installation of non-gas appliances as well as requiring that they are installed in accordance with the manufacturer's instructions.
- The Department of Communities and Local Government issued a consultation in September 2009 proposing an amendment to Building Regulations Part J, which would stipulate that any installation of solid fuel burning appliances would require the accompaniment of a carbon monoxide alarm.
- Since the response was written Ministerial approval to these changes was received in April 2010, and the changes to the Building Regulations Part J were made and are expected to come into force in October 2010.

b) An 8 month old child died from sustaining a head injury after the vehicle in which he was travelling spun through 180º at a very high speed. He was strapped into a car seat at the time but the lack of restraint for that kind of lateral movement provided no protection for him. The coroner wrote to the United Nations Economic Commission for Europe (UNECE) to suggest that they amend UNECE Regulation R44.03 to include a requirement for child restraints to be tested for lateral impact. At present this regulation provides that all child restraints sold in the United Kingdom must conform to various design and construction requirements, as well as pass a series of performance tests, but the current performance tests only examine impact on the car seat from the front, back and on overturning, and not for impact with the side of the seat.

The secretariat of the World Forum for Harmonization of Vehicle Regulations (WP.29) of UNECE replied as follows:

- Discussion on a proposal for a new Regulation parallel to the current Regulation No. 44 is under way among the UNECE Contracting Parties of the Working Party on Passive Safety (GRSP), a subsidiary body of WP.29, responsible for updating Regulation No. 44 and the most relevant Regulations on passive safety at global level. The new draft Regulation will include lateral impact tests. During the May 2010 session of GRSP, the issue raised by the coroner was presented to the Working Party's experts.

- GRSP confirmed during its May 2010 session that the new draft Regulation will include a lateral impact test that takes into account door intrusion so as to deal with the issue raised by the coroner.

- The requirements of these tests have not been finalised but it is expected that the final proposal will be concluded by GRSP at its December 2010 session.

- The secretariat of WP.29 also informed the coroner that there are an increasing number of child restraint systems fitted with falsified UNECE approval marks currently in circulation within the European market. These do not conform to the quality or performance requirements guaranteed by the current Regulation No. 44 and the safety of children may be at risk. However, it was not implied that this was the case with the seat that was being used when this death occurred.

c) A Polish HGV driver died from carbon monoxide poisoning in the cab of his truck. The poisoning occurred because the driver used a gas-fuelled camping stove to heat the cab overnight. The cab was poorly ventilated as the fresh air ventilators were partially restricted by a fire extinguisher case and the engine air intake pipe. After the deceased was discovered, tests found that owing to the poor ventilation, the gas-fuelled camping stove would have used up all available oxygen very quickly, causing the flame to deteriorate, and the stove to produce carbon monoxide at an accelerated rate. This is a process known in the gas industry as 'vitiation'. A further examination of the cab revealed that it did not appear to have been fitted with an overnight heater, which appeared to explain why the driver had chosen to use a gas-fuelled camping stove as a source of heat. The coroner wrote to the company who employed the driver, the Head of Traffic at the Greater Manchester Police (GMP), the Health and Safety Executive (HSE), and the Association of Chief Police Officers asking that consideration be given to ensure all vehicles driven on UK roads did not have their ventilation system blocked and to highlight this death amongst HGV drivers to warn of the dangers of using gas-fuelled appliances in enclosed cabs.

HSE, incorporating information from the company who employed the driver and Polish National Labour Inspectorate (PNLI), responded as follows:

- HSE are in the process of deciding whether they can usefully translate the findings from this death into an information leaflet. At present they are looking at the possibility of issuing an industry-specific safety alert to the haulage industry at large, and are considering industry-specific press to spread lessons learnt from this case.
- HSE were also looking to engage with the Road Distribution Action Group (RDAG) over the use of gas-fuelled stoves in the cabs of trucks. The RDAG has members from the HSE, the Road Haulage Association, the Freight Transport Association, the Association of Pallet Networks, the Institute of Occupational Safety and Health, and the Skills for Logistics body. It has discussed matters surrounding risk associated with fire and carbon monoxide poisoning in the past, and it is the HSE's intention to bring this case to its attention to reinforce lessons learnt and more widely publicise the risks.
- HSE reported that the PNLI had carried out a further investigation into the death with the company who had employed the deceased. In their conclusion it was noted that the company had failed to report the death to the PNLI and had also failed to conduct any investigation of their own into the death. Further to this, the PNLI recommended that the company fit all their fleet with heaters to prevent drivers from having to find alternative sources of overnight heat. Following the PNLI's investigation the company established a post-accident investigation team which concluded that the death was the result of a workplace accident. HSE are satisfied that the PNLI has investigated this death fully, and that they have gained adequate assurances from the company about the installation of heaters in all vehicles in their fleet.
- HSE also received a letter from the company's solicitor which refutes the claim that the truck in question did not have a heater for overnight use. HSE suspect that the driver may have been unaware of the heater

but has asked the company to make all UK-based trucks available for inspection when they are next based at Manchester airport. The letter also confirms that all drivers employed by the company have been advised not to use gas-fuelled camping stoves in the cabs of trucks for overnight heat and that the company's entire fleet of trucks will be inspected to ensure that they are safe and contain working heaters.

GMP replied as follows:

- Information has been circulated to all Road Policing Units and members of the Motorway Enforcement Team have been checking all encountered HGVs. Of the 91 trucks that had been checked prior to the date of the response, all were found to have correct and unobstructed ventilation and all drivers had been advised on the risks of using gas-fuelled camping stoves for overnight heat.
- Four drivers were noted to have in-cab gas-fuelled camping/heating equipment and the companies employing them have been notified of the risks, to which they were receptive.
- The concerns over the use of gas-fuelled camping stoves have also been circulated to the Vehicle and Operator Services Agency.

iii) Mental Health related deaths

a) A man committed suicide the day before he was due to be evicted from his rented home. Prior to his death, a warrant had been obtained from the county court for his eviction, and the matter had been discussed between the landlord's agent and the man, with the latter giving assurance that he would vacate the property. The bailiff therefore stood down on the day fixed for the eviction, but on the night before the eviction had been due to take place the man took an overdose of propanolol, leaving a note explaining his actions.

The coroner wrote to the Suicide Reduction Group (SRG) in the local primary care trust (PCT), suggesting that the Court Service and the Suicide Reduction Group work more closely together to create a risk template that would assist the SRG in identifying persons who have substantial debt and any health risks that may make them vulnerable or prone to suicide.

The SRG responded as follows:

- Two training courses being run locally are aimed at a broad range of professional and community workers. These courses enable people to be aware of the risk of suicide and to recognise those who may be vulnerable to suicide and equip them to intervene.
- It was intended that the local PCT would be actively encouraging those in the county court system to attend these courses to help them better identify and help those who may be at risk of suicide.
- Citizens Advice Bureaux (CAB) offer independent advice to people attending court as a result of financial difficulties. The PCT would negotiate with the local CAB and the county court to identify how to

advertise these services most effectively to those in need (and who may not attend the hearing).

b) A man killed himself after his wife and children left home because of his recent changes in his behaviour. On the days leading up to his death the man's behaviour had been of great concern to his friends, to whom he said he would take his life if he could not get his children back. The man had also called the police several times a day in the days preceding his death, threatening to take his life and asking for help to contact his wife and children. Officers attended the man's home on several occasions but because they could not detain him under section 136 of the Mental Health Act 1983 (MHA) because he was in the privacy of his own home, did not then attempt to obtain a warrant under Section 135 of the MHA. This was despite the fact that on the day before his death the man had shown an officer a ligature around his neck with which he was attempting to hang himself in his kitchen. On the day of his death the man rang the police stating that he was swallowing sulphuric battery acid. Emergency services were dispatched to the man's address but he died later that day in hospital.

The coroner wrote to the Greater Manchester Police (GMP) asking that they devise a programme requiring all frontline officers to attend compulsory training on their powers under the MHA, and the management and assessment of distressed individuals or those with a potential mental health disorder. The coroner also suggested that the police service take advice from the appropriate Mental Health Trust in devising this training.

The GMP responded as follows:

- Work is underway to review the current training provided to staff about mental health issues and to assess the need for further training.
- The Safeguarding Vulnerable Persons Inspector has canvassed mental health leads across Manchester to ascertain what support is available to the GMP.
- Work is also underway to review the GMP's Frontline Manual to update guidance, following identified training needs, on powers available to police under the MHA.

iv) Community healthcare and emergency services related deaths

Two people died after being seen out-of-hours by a non-UK based locum general practitioner. The coroner wrote to:

1. The Department of Health, suggesting that a review be undertaken of the operation of EU Council Directive 93/16/EEC. This Directive facilitates the free movement of doctors and the mutual recognition across the EU of their

diplomas, certificates and other evidence of formal qualifications. As part of the review the coroner suggested:

- a national protocol is established for the appraisal, admission and contracting of non-UK based doctors, and that guidance is given on this to all Primary Care Trusts (PCTs) to ensure that the National Health Service (Performers List) Regulations 2004 (Performers List Regulations) are applied robustly.
- the Department of Health implement a national database for non-UK based doctors, which would detail linguistic skills, medical competence, criminal record checks and records of malpractice, and whether the doctor is registered or has had their registration withdrawn from any PCT.

2. The Royal College of General Practitioners (RCGP), inviting them to draw up a national training and assessment programme for non-UK based doctors who have not worked in the UK before.

3. The regional strategic health authority (SHA), recommending that the authority establish that no doctor should undertake out-of-hours work unsupervised unless he or she has been through the necessary induction.

The Department of Health replied as follows:

- The Government has undertaken a pre-review of the Council Directive as part of its preparation for an EU-wide review in 2012. It is proposed that concerns about this case will be raised as part of the evidence during that review.
- The NHS Chief Executive has written to all PCTs reminding them of the provisions of the Performers List Regulations and asking them to implement recommendations made in a report published in February 2010 by Primary Care and the Royal College of General Practitioners. This report, entitled '*General Practice Out-of-Hours Services: project to consider and assess current arrangements*' makes 24 recommendations to PCTs to take urgent steps to assure themselves that "both operationally and contractually, robust arrangements [were] in place to deliver safe out-of-hours services in [their] area."
- Department of Health Ministers also announced that PCTs should review their Performers List procedures, including ensuring that performers have sufficient knowledge of English and the necessary skills to practise.
- The Medical Profession (Responsible Officers) Regulations 2010 were due to be (and indeed have been) laid in July 2010, and are due to come into force in January 2011. These Regulations establish arrangements for the introduction of "responsible officers", who will be appointed by health care organisations and certain other bodies, and will have responsibilities relating to the evaluation of the fitness to practise of doctors who work in the organisation.
- It was also announced that where a PCT refuses to admit a doctor to its Performers List, or has concerns about the doctor's ability, it should notify the General Medical Council.

- It would also look to introduce a new model contract for out-of-hours provision, which would include a built-in risk assessment of any prospective doctors who have not worked in the NHS before.
- A review of National Quality Requirements was also underway, which would develop a stronger set of national minimum standards, which all out-of-hours providers would need to meet.
- There is a virtual national list of performers and a separate list of all locum and sessional performers. Because of this it was not thought that a separate list for non-UK based doctors was required, particularly as it might unduly increase the level of checks to be performed by the PCTs.

The RCGP responded as follows:

- National training and assessment opportunities for non-UK based doctors already exist, hosted by the Postgraduate Medical Education and Training Board and the Postgraduate Deaneries. These are designed to ensure that non-UK based doctors undertake appropriate induction and assessment before being qualified or allowed to work in the UK.
- However, the RCGP also noted that this guidance was not necessarily implemented in all areas and to be truly robust the schemes would need to become mandatory. This would have funding implications for SHAs and PCTs.

The regional SHA replied as follows:

- In November 2009 the SHA audited its PCT's commissioning and contract monitoring for out-of-hours services. This audit also covered National Quality Requirements relating to induction. The response to the audit showed that there were areas requiring greater attention from PCTs, and two rounds of action plans were subsequently submitted from PCTs setting out actions taken against the indicators identified by the audit. The result of this is that all PCTs can now show evidence that they are meeting all the requirements in the action plans.
- In March 2010 all PCTs had con firmed that they had taken up t he coroner's recommendations on induction.
- In July 2010 a minimum set of standards for out-of-hours services was developed by the SHA, with clinical input, and distributed to all PCTs and out-of-hours providers for implementation.
- Between July 2010 and October 2010 a programme of peer review support team visits to all PCTs and out-of-hours providers is taking place. These visits are chaired by the RCGP and the team has PCT representation. The purpose of the visits is to help PCTs improve their out-of-hours commissioning and contracting monitoring in light of the new guidance, and for the SHA to gain greater assurance on the quality of out-of-hours provision. A regional report will be produced and disseminated on completion of the visits.

v) Deaths in Custody

A man who had been arrested for breach of the peace died in a police station cell as a result of cocaine intoxication and the development of a variant of excited delirium/acute behavioural disorder (ED/ABD). He had been sweating profusely, was unable to recognize police officers in uniform as police officers, had tried to jump out of a window to "fly" and had been extremely strong. At the police station he repeatedly asked for water, splashed water from the toilet over himself, and was wailing at the walls. A doctor was called but was not permitted to examine the man in the cell due to a concern that he might be violent. An ambulance was called and kept waiting for the same reason. The man lay on the cell floor in the prone position without moving for about twenty minutes before police and medical staff went into the cell, at which time he was found to be dead. The jury found that the doctor did not carry out a timely and adequate assessment of the man or give adequate instructions to the police. They found that the failure to recognize the signs of ED/ABD was due to the presentation of the symptoms, lack of police training, and failures of communication between police officers and the doctor. They also found that the shift change had adversely affected the man's care.

The coroner wrote to the Faculty of Forensic and Legal Medicine (FFLM), the London Ambulance Service (LAS) and the Metropolitan Police Service (MPS), suggesting that training and guidance on ED/ABD be updated and refined. She also suggested revising the procedures for transfer in police vehicles; risk assessment at police stations; observation of unfit detained persons; the role of the Forensic Medical Examiners (FME) at the police station; and for calls to and transfers of detained persons by the ambulance service to heighten awareness and to prevent recurrence. She also suggested that the (now withdrawn) Guidance Practice Guidelines for FME's be re-issued or something similar commissioned.

The FFLM responded as follows:

- A training course had been developed with the National Policing Improvement Agency which generally covers deaths in custody and includes a DVD produced by the MPS, detailing the symptoms and dangers of ED/ABD. In addition, course participants receive presentations on fitness for detention and the importance of the role of communication between police and healthcare professionals.
- A consultation published in March 2010 recommended that the above course be mandatory for all doctors who undertake clinical forensic medicine (although it should be noted that the FFLM cannot enforce any recommendations it makes).
- A revised version of '*Acute behavioural disturbance: guidelines on management in police custody*' was published in June 2008 and is available on the FFLM website.

- Research and review into deaths in custody are ongoing for the FFLM, as well as plans to work with the Independent Police Complaints Commission and the National Patient Safety Agency.

The LAS responded as follows:

- Training courses which cover ED/ABD were introduced into the LAS's student paramedic programme in February 2006, and Continuing Professional Development modules were introduced in October 2005 for current paramedics, as part of wider training on managing mental illness and violence.
- Electronic resources detailing ED/ABD have been made available on the intranet, and a series of articles released in LAS news.
- A new DVD '*Death in Police Custody and LAS Medical Advice*' was produced by the LAS in conjunction with the MPS and will be shown to all staff between June 2010 and April 2012, as well as an extract from the MPS DVD being made available to paramedics on the LAS intranet.
- A review will take place between the LAS and MPS of the safe transportation of detained persons to hospital procedure, to ascertain whether any changes are necessary. Prior to this, the LAS, MPS and FME Service have arranged to meet to discuss the Rule 43 report by the coroner in this case.
- Consideration has been given to the management of calls from the MPS about detained persons and it has become evident following this case that it is more useful when the MPS call the LAS directly rather than sending an electronic message. This will ensure that calls are fully assessed and prioritised against existing protocols – similar to the way 999 calls are treated.

The MPS responded as follows:

- The Independent Medical Science Advisory Panel of the Association of Chief Police Officers (ACPO) will be requested to appoint a leading ABD medical specialist to review the MSP programme.
- The list of symptoms of ED/ABD will be amended to make it clear that just one of the symptoms listed might indicate ABD
- A short written test on ABD and related issues has been drafted and will be implemented in the next round of Officer Safety Training
- Current guidance on transport contains more information about the use of police vehicles to transport prisoners needing medical attention
- The MPS Custody Directorate is working with Newcastle University to evaluate the health screening of people in police custody. The results will improve the initial risk assessment process.
- The Custody Directorate is developing a mandatory training package for the role of a gaoler focusing on Code C Annex H (the "4Rs") and issues regarding rousing a detainee will be highlighted

in the Organisational Learning publication (June 2010) This will be supported by changes to the "*Illness While in Custody*" poster.

- Current guidance is that where a detainee is unfit for detention and is awaiting the arrival of an ambulance the person should be subject to constant supervision, and CCTV should not be used for this "constant supervision" (ACPO guidance differs)
- The Guidance for FMEs has been withdrawn. The Custody Directorate has now appointed a Medical Director to be responsible for professional leadership of all forensic custody healthcare medical staff. The Medical Director will contribute to the determination and implementation of Police corporate strategies and business plans. The MPS Forensic Healthcare Service team will disseminate Faculty Guidance recommendations etc to FMEs by internal newsletter and personal e-mail.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner district between 1 October 2009 and 31 March 2010

Coroner district	Number of inquests in which Rule 43 reports issued
Avon	2
Bedfordshire and Luton	2
Berkshire	1
Birmingham and Solihull	4
Bournemouth, Poole and Eastern Dorset	1
Brighton and Hove	4
Cambridgeshire: North and East	3
Cardiff and The Vale of Glamorgan	7
Cheshire	6
Cornwall	7
Coventry	2
Darlington and South Durham/North Durham	1
Derby and South Derbyshire	6
Derbyshire: North	4
Devon: Exeter and Greater	6
Devon: Plymouth and South West	5
Devon: Torbay and South	1
East Riding and Hull	3
Essex and Thurrock	2
Gloucestershire	1
Greater Manchester: City	10
Greater Manchester: North	3
Greater Manchester: South	17
Greater Manchester: West	2
Greater Norfolk	4
Gwent	1
Hertfordshire	2
Isles of Scilly	1
Kent: Central and South East	1
Kent: Mid and Medway	1
Kent: North East	1
Leicestershire: City and South Leicestershire	3
Leicestershire: Rutland and North	1
Lincolnshire: West	1
Liverpool	1
London: Inner North	2
London: Inner South	3
London: Inner West	1

London: Southern	1
Merseyside	1
Milton Keynes	5
Newcastle upon Tyne	1
Northampton	1
Northumberland: North	6
Nottinghamshire	1
Peterborough	1
Portsmouth and South East Hampshire	1
Preston and West Lancashire	1
Shropshire: Mid and North West	2
Shropshire: South	2
Somerset: East	5
Somerset: West	2
South Yorkshire: Eastern	2
South Yorkshire: Western	4
Staffordshire: South	9
Staffordshire: Stoke on Trent and North Staffordshire	2
Sunderland	2
Surrey	1
Sussex: West	3
Teesside	2
Warwickshire	1
West Yorkshire: Eastern	6
West Yorkshire: Western	2
Whitehaven	1
Wiltshire and Swindon	5
Worcestershire	1
York	1
Total	**195**

Annex B

Organisations which the Ministry of Justice has been notified have not responded to the coroner within the 56-day deadline and who had neither sent the coroner an interim reply nor been granted an extension as at 28 February 2010.

- Devon Partnership NHS Trust
- Heijboer Transport, Holland
- International Medication Systems (UK) Ltd

Annex C

List of all Rule 43 reports received between 1 October 2009 and 31 March 2010

Coroner District	Report Sent to	Details	Response received	Report number
Hospital Deaths: clinical procedures and medical management				
Staffordshire: South	Stafford Hospital	To consider a review of why requests for blood tests were not carried out	Yes	2
Birmingham and Solihull	Monitor	To consider the professionalism of staff at the Heartlands Hospital in the light of a series of gross failures to provide basic medical attention to a patient	Yes	4
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider whether there are systemic weaknesses in diagnostic procedures which led to no consideration being given to whether the deceased may have had an undiagnosed underlying condition.	Yes	9
Cornwall	Royal Cornwall Hospital	To consider whether potentially life threatening procedures should either be carried out by experienced doctors or that inexperienced doctors should be directly supervised	Yes	11
Cornwall	Royal Cornwall Hospital	To consider whether when a patient is urgently referred by their GP with suspected cancer that the patient be seen by a consultant or senior grade doctor	Yes	12
Greater Manchester: South	The Alexandra Hospital, Cheadle	To consider reminding staff of the need to complete medical records in full. To consider whether it is appropriate to have only one Resident Medical Officer covering the whole hospital	Yes	13
South Yorkshire: Eastern	Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	To consider the protocols and procedures for one-to-one observations when a patient is considered to be at risk of self-harm	Yes	14

Coroner District	Report Sent to	Details	Response received	Report number
Leicestershire: City and South Leicestershire	University Hospitals of Leicester NHS Trust	To consider a review of record keeping and of the need for full and accurate completion of medical records and for appropriate communication within multi-disciplinary nursing teams	Yes	19
Greater Manchester: City	Wrightington, Wigan and Leigh NHS Trust	To consider a review of the vascular service and the need for a member of the vascular team to be on-site at Wigan Hospital	Yes	20
Devon: Plymouth and South West	Plymouth Hospitals NHS Trust	To consider a review of the supply of pressure relieving mattresses, the treatment of pressure sores and of the hospital discharge process	Yes	23
Greater Manchester: South	Meridian Health Care; Tameside General Hospital	Meridian Health Care to consider a review of its procedures for recording patient accidents; Tameside Hospital to review its communication procedures on 3 named wards	Yes	25
Greater Manchester: West	Department of Health	To consider a review of the membership of multidisciplinary meetings on treatment options for cancer patients	Yes	26
York	Bellco (Sorin Group); Edwards Life sciences; Medicines and Healthcare Regulatory Agency	To consider distinctive marking and labelling on filters for haemofiliation machines	Yes	27
Northumberland: North	Northumbria Healthcare; Highways Agency	Northumbria Healthcare to consider a review of its arrangements for care of patients at risk of Deep Vein Thrombosis after discharge from hospital; Highways Agency to consider providing barriers on the A1 southbound near Newton-on-the-Moor	Yes	29
Cardiff and The Vale of Glamorgan	Cardiff and Vale NHS Trust	To consider a review of and staff training on its risk assessments and a review of dealing with falls at Whitchurch Hospital	Yes	40
Cardiff and The Vale of Glamorgan	Cardiff and Vale University Health Board	To consider publicising more widely within the medical profession that patients taking warfarin who suffer a blow to the head should seek immediate medical attention	Yes	43

Coroner District	Report Sent to	Details	Response received	Report number
Greater Manchester: South	Trafford General Hospital	To consider whether medically trained staff only and not security guards should observe patients who are in danger of falls	Yes	45
Somerset: East	Yeovil District Hospital; General Medical Council (GMC)	Yeovil District Hospital to consider changes to procedures in its laboratory to ensure blood test results are available to treating doctors as soon as possible; GMC to consider actions taken by a doctor involved in the deceased's care and whether any disciplinary sanctions should be imposed	Partial response	47
Greater Manchester: City	Stockport NHS Foundation Trust	To consider procedures to ensure immediate action is taken when a patient is seriously injured in the course of radiology	Yes	54
Somerset: East	Royal United Hospital Trust Bath	To consider training issues arising from the failure to diagnose a ruptured patella tendon, providing more information to patients at risk of developing deep vein thrombosis and pulmonary embolism and a system of radiological review of Accident and Emergency x-rays	Yes	62
West Yorkshire: Eastern	South West Yorkshire Mental Health NHS Trust	The Chantry Unit to consider its levels and training of staff, its policy on staff roles and responsibilities, its medical records procedure and its Slips, Trips and Falls policy in relation to older people	Yes	67
London: Inner North	Department of Health	To consider issuing a national recommendation that where 500ml bags of glucose are used to prime a 50ml syringe, the unused contents are discarded as clinical waste and not left attached to the patient via a 3 way tap.	Yes	68
South Yorkshire: Western	Barnsley District General Hospital	To consider a review of procedures following patients' admission to Accident & Emergency and of communication procedures prior to their discharge	Yes	72

Coroner District	Report Sent to	Details	Response received	Report number
Greater Manchester: City	Manchester Royal Infirmary	To consider ongoing training for staff on dealing with patients with learning difficulties; a review of the communication channels between wards and the need for timely and chronologically accurate patient records	Yes	73
Greater Manchester: City	University Hospital of South Manchester NHS Trust; Southwold Nursing Home, Wythenshawe; Anchor Trust, London	To consider training for staff on the recognition, treatment, record keeping of and responsibilities in the treatment of pressure sores	Yes	76
Brighton and Hove	Brighton and Sussex NHS Trust	To consider a review of how forms indicating a patient's wishes for resuscitation can be better annotated to ensure changes are easily identified	Yes	82
Staffordshire: Stoke on Trent and North Staffordshire	North Staffordshire NHS Trust; North Staffordshire Primary Care Trust	To consider a review of the approach to continuity of care for mentally ill patients	Yes	83
Devon: Exeter and Greater	North Devon NHS Trust	To consider a review of training policies and supervision of staff	Yes	84
Whitehaven	Cumbria Partnership NHS Trust; North Cumbria NHS Trust	To consider implementing a written protocol for dealing with patients suffering from alcohol withdrawal and to amend its resuscitation policies to include the requirement to take a blood sample after a cardio-respiratory arrest	Yes	87
Greater Norfolk	Queen Elizabeth Hospital, Kings Lynn	To consider a review of its discharge arrangements to ensure both patients and their GP receive discharge letters in a timely manner	Yes	89
Staffordshire: South	Queen's Hospital, Burton Upon Trent	To consider training and levels of staff in the Emergency Assessment Unit	Yes	90

Coroner District	Report Sent to	Details	Response received	Report number
Sunderland	Department of Health; General Medical Council (GMC); Sunderland Royal Hospital	Department of Health to consider the appropriateness of using female catheters on male patients; GMC to consider whether the requirements for licence registration are sufficiently detailed to independetly validate the skills and competencies of an overseas doctor; Sunderland Royal Hospital to consider action it could take to prevent a similar incident in the future	Yes	92
Greater Manchester: City	Pennine Acute Hospital NHS Trust; Care Quality Commission	To consider a written protocol on patients' access to and use of the call bell; to consider a hospital based policy for staff on managing suspected head injuries and falls and to reinforce guidance on appropriate record keeping of these incidents	Yes	94
Bedfordshire and Luton	Department of Health	To consider a review by the Care Quality Commission and Monitor and for these bodies to consider establishing a task force for Milton Keynes Hospital to ensure it provides high quality maternity care and implements the recommendations in the Healthcare Commission's September 2009 report	Yes	96
Cornwall	Royal Cornwall Hospital	To consider carrying out a Clinical Governance Review to ensure preventative measures are put in place to prevent a post operative pulmonary embolus	Yes	100
Cornwall	Cornwall Partnership NHS Trust	To consider carrying out a Clinical Governance Review to ensure vulnerable patients are properly observed to ensure that any injuries they have sustained can be accounted for	Yes	101
Bournemouth, Poole and Eastern Dorset	Poole Hospital NHS Trust	To consider a review of the completion of referral forms to ensure there is no misunderstanding of the treatment required	Yes	117
Derbyshire: North	Chesterfield Royal Hospital	To consider implementing a radiology policy that acute x-rays for people attending the Accident & Emergency Department/Acute Assessment Unit should be read and reported on within 24 hours	Not yet due	123

Coroner District	Report Sent to	Details	Response received	Report number
Greater Norfolk	Norfolk and Waveney Mental Health; Cambridgeshire and Peterborough NHS Trust	Both Trusts to consider whether any changes are needed to policies and procedures to improve communications and discharge procedures between mental health teams when a patient is discharged from one Trust to the other	Not yet due	124
Sunderland	City Hospitals Sunderland NHS Foundation Trust	To consider changes to the procedures for monitoring a patient with diabetes and to improve record keeping	Not yet due	129
Staffordshire: South	Stafford Hospital	To consider implementing a policy for dealing with confused patients in Accident & Emergency and using bed rails on trolleys	Not yet due	131
Warwickshire	University Hospital, Coventry and Warwickshire	To consider implementing the recommendations of the Root Cause Analysis Investigation on capnography in elective endotracheal intubations	Not yet due	137
Devon: Exeter and Greater	Devon Partnership NHS Trust	To consider an immediate review of the remit and purpose of Occupational Therapy Assessments	Not yet due	138
Derbyshire: North	Chesterfield Royal Hospital	To consider training to increase awareness amongst all doctors and ward based nursing staff of the significance of decreased levels of consciousness following a fall including the National Institute for Clinical Excellence (NICE) Head Injury Guidelines	Not yet due	139
Coventry	South Warwickshire General Hospitals NHS Trust; Department of Health	To consider whether front line doctors have the competence to read ECG results accurately and to provide appropriate training	Not yet due	144
Brighton and Hove	Brighton and Sussex University Hospital	To consider a review to address errors, omissions and delays in treatment and failures in communication and the loss of patient notes	Not yet due	152

Coroner District	Report Sent to	Details	Response received	Report number
Cardiff and The Vale of Glamorgan	Cardiff and Vale University Health Board	To consider the procedure for documenting a patient's risk of self harm	Not yet due	155
Brighton and Hove	Brighton and Sussex University Hospital NHS Trust	To consider a review of the timeliness of x-rays and the non-reporting or mis-reporting of x-ray results	Not yet due	156
Essex and Thurrock	South Essex Partnership University NHS Foundation Trust	To consider a review of the procedures for treating patients with bipolar disorder	Not yet due	162
Gloucestershire	Gloucestershire Hospitals NHS Trust	To consider a review of radiology to ensure the availability of a consultant radiologist at all times.	Not yet due	173
Milton Keynes	Milton Keynes Hospital NHS Foundation Trust	To consider a review of the policies and protocols on the discharge of patients at high risk of developing pulmonary embolisms	Not yet due	176
Birmingham and Solihull	City Hospital, Birmingham	To consider introducing a policy that hospital staff report all cases of domestic violence to West Midlands Police	Not yet due	178
Staffordshire: South	Queen's Hospital, Burton upon Trent	To consider a review of the protocol and training for staff on the insertion of breathing tubes	Not yet due	188
Greater Manchester: South	Stockport NHS Foundation Trust	To consider a review of protocols on the requirement for comprehensive notes on patients' medical records; communication between members of staff and between staff and families; monitoring and supervision of junior doctors.	Not yet due	189
Hospital Deaths: other hospital deaths				
Portsmouth and South East Hampshire	Medicines and Healthcare Products Regulatory Agency	To consider advising hospitals to remove Graseby pumps and to replace them with an alternative which cannot function without pre-setting the quantity of drug to be dispensed	Yes	6

Coroner District	Report Sent to	Details	Response received	Report number
Greater Manchester: South	Greater Manchester Police; Pennine Care NHS Trust	To consider ratifying new guidelines for managing violent users of the mental health service where the Police may need to be involved	Yes	44
Greater Manchester: South	Manchester Royal Infirmary	To consider providing patients with flame retardant gowns	Yes	158
Cardiff and The Vale of Glamorgan	Cardiff and Vale University Health Board	To consider a review of health and safety reporting and checks by staff, training on caring for confused patients and the treatment of head injuries for patients taking warfarin	Yes	187
Road Deaths: highways safety				
Wiltshire and Swindon	Wiltshire County Council	To consider road markings and signage about the dip in the road on the B390 between Shrewton and Chitterne	Yes	7
Devon: Exeter and Greater	Mid-Devon District Council; Area East Highways Management; Devon Community Recycling	To consider the working practices of recycling collectors in potentially hazardous road situations, such as bends	Yes	21
Derbyshire: Derby and South Derbyshire	Derbyshire County Council	To consider redesigning the roundabout on the A53 in Buxton to improve safety for pedestrians	Yes	24
Devon: Torbay and South Devon	Torbay Council	To consider safety improvements to the corner of Palace Avenue, Paignton	Yes	33
Northampton	Northamptonshire County Council	To consider regularly checking gullies and drains in Towcester Road, Milton Malsor to prevent them becoming blocked	Yes	36
Somerset: East	Somerset Highways	To consider reviewing the section of the A3088 spanning Alvington Bridge to see if improvements should be made	Yes	38
Shropshire: Mid and North West	Shropshire County Council	To consider increasing visibility, making the junction one way and reducing the speed limit on the A41 at Rosehill, Market Drayton	Yes	55
Derbyshire: Derby and South Derbyshire	Derbyshire County Council	To consider changes to the layout of the junction of Sheffield Road with the A6135 at Barlborough	Yes	61
Northumberland: North	1) Heijboer Transport, Holland 2) Highways Agency	Heijboer Transport to consider issuing instructions that escort vehicles and lorries should always stay together; Highways Agency to consider making the A1 at Mousen Bends, Northumberland into a dual carriageway	Partial response	78

Coroner District	Report Sent to	Details	Response received	Report number
Newcastle Upon Tyne	Newcastle City Council	To consider parking restrictions in Old Sceptre Street, Newcastle Upon Tyne	Yes	86
Staffordshire: South	Highways Development Services, Stafford	To consider improvements for pedestrians at the junction of River Drive and Fazeley Road, Tamworth	Yes	88
Greater Manchester: North	Bury Metropolitan Borough Council	To consider regular inspection of Pilsworth Road, Bury for flooding	Not yet due	111
Derbyshire: North	Derbyshire County Council	To consider making the Staden Lane junction with the A515 at Buxton a stop junction; providing a rescue area for vehicles turning right on to the dual carriageway and replacing the speed limit signs with illuminated ones	Not yet due	114
West Yorkshire: Eastern	Wakefield Council	To consider on Chevet Lane, Wakefield in the direction towards Sandal, erecting a concealed entrance sign prior to the bend; introducing a maximum speed limit of 40mph; erecting a sign warning of emerging farm vehicles to be illuminated by flashing lights	Not yet due	126
Shropshire: South	Shropshire Council; West Mercia Police	To consider installing electronic flashing warning signs along the A458 at Gateacre Hill, Stanmore, Bridgenorth	Not yet due	135
Somerset: West	Network Management, Taunton	To consider a survey of the B3227 at Hillcommon to ascertain whether the camber of the road causes vehicles to veer to the wrong side of the road	Not yet due	147
London: Southern	Transport for London	To consider taking action to improve the junction for vehicles turning right onto the A217 from Northdown Road	Not yet due	148
West Yorkshire: Eastern	Wakefield Metropolitan District Council	To consider a review of the road signs and markings on Blacker Lane, Wakefield	Not yet due	170
West Yorkshire: Eastern	West Yorkshire Passenger Transport Executive; First West and North Yorkshire Ltd	To consider modifications to Leeds City Bus Station and a safety review of how buses are driven into the bus station; installation of macro lens reversing cameras on buses using the bus station, training for drivers in the use of these cameras and reversing beepers re-sited to make them more audible	Not yet due	181
Somerset: East	Somerset Highways	To consider action to prevent flooding at Sandy Lane, Over Stratton and contacting owners of adjoining land which has not been properly maintained which may contribute to the flooding	Not yet due	190

Coroner District	Report Sent to	Details	Response received	Report number
Northumberland: North	Highways Agency	To consider reclassifying the A1 in Northumberland as a strategic national route	Not yet due	193
Road Deaths: Vehicle Safety				
Staffordshire: South	DK Motorcycles	To consider refusing to sell a motor bike to someone who does not hold the appropriate licence to ride it.	Yes	125
Derby and South Derbyshire	Department for Transport	To consider a review of the safety of providing seating on buses in the area designated for wheelchair users	Yes	194
Road Deaths: driver and vehicle licensing				
Wiltshire and Swindon	DVLA	To consider a review of the sole responsibility for reporting failing health falling below driving standards resting on the driver and whether there should be an obligation on those treating the individual to have a duty to report such matters	Yes	8
Accidents at work and health and safety related deaths				
South Yorkshire: Eastern	Rotherham Metropolitan Borough Council	To consider fencing and generally how to prevent access to, or management of, the slope at Rother Country Park during snow fall to prevent it being used for sledging	Yes	15
Kent: North East	Royal Mail Group	To consider requiring members of staff who drive in the course of their work to undergo regular eye tests	Yes	16
Northumberland: North	Berwick Borough Housing Association	To consider checking and/or replacing internal doors in its properties to ensure they provide a minimum of 20 minutes fire protection	Yes	30
Greater Manchester: South	Stockport Homes	To consider a review of emergency access procedures to Conway Towers, Stockport	Yes	31
Wiltshire and Swindon	Department for Business, Innovation and Skills (BIS) ; Health and Safety Executive (HSE)	BIS to consider introducing a mandatory obligation on landlords to ensure non-gas appliances, pipe work and flues are maintained in a safe condition. HSE to consider taking a more pro-active role in checking that landlords comply with Health and Safety Regulations	Yes	32
Cheshire	Richard Keenan (UK)	To consider improving safety markings on farm machinery	Yes	34
Somerset: East	Manitou UK Ltd	To consider improving the design of fork lift trucks to prevent the joy stick operating when an operator is not in the driver seat	Yes	37

Coroner District	Report Sent to	Details	Response received	Report number
Cheshire	Cheshire Fire and Rescue Service	To consider action which could be taken to enable the Fire Service to be more proactive in providing fire safety advice to residential care home owners	Yes	42
Cheshire	British Waterways	To consider inspecting the area near the Amber Lounge (River Weaver) to increase its safety and providing life preservers and warning notices	Yes	48
Avon	Highways Agency	To consider installing a barrier along the M5 (northbound) between junctions 19 and 20 to prevent falls down the motorway embankment	Yes	49
Staffordshire: South	Cannock Chase Council; Verdant Group PLC	Cannock Chase Council to consider the introduction of wheelie bins for recycling collection; Verdant Group PLC to consider the health and safety instructions provided to refuse collectors	Yes	59
West Yorkshire: Western	West Yorkshire Fire and Rescue Service	To consider appropriate speeds for vehicles responding to an emergency when negotiating significant hazards en route	Yes	60
Greater Manchester: City	Boekestijn Transport SP. Z.o.o; Health and Safety Executive (HSE) ; Greater Manchester Police; ACPO	Boekestijn Transport SP to consider prohibiting the use of gas bottles and burner attachments in heavy goods vehicles (HGVs); HSE to issue a leaflet warning HGV drivers of such dangers and to contact Polish authorities to advise them accordingly; Greater Manchester Police to ensure the HGVs they inspect have adequate ventilation and drivers advised of the potential dangers; ACPO to consider dissemination of the dangers nationwide	Yes	74
South Yorkshire: Western	Davy Markham Ltd, Sheffield	To consider undertaking a risk assessment for unloading work to improve health and safety	Yes	75
Devon: Exeter and Greater	Department for Communities and Local Government	To consider requiring landlords to provide battery operated smoke detectors as a minimum standard in their rented properties	Yes	95
Shropshire: South	Apley Estate Office, Bridgenorth	To consider installing palisade fencing and providing grills around the entrances to the caves at Apley Estate in Bridgenorth	Yes	98
Greater Manchester: South	Peel Holdings (Management) Ltd, Manchester	To consider repairing the fencing to restrict access to the Canal Arm at Trafford Quays	Yes	120
West Yorkshire: Western	Department of Transport; Society of British Neurological Surgeons	To consider a legal requirement for quad bike riders to wear crash helmets	Not yet due	128
Sussex: West	Health and Safety Executive	To consider a review to extend guidance on the risks of scalding to include vulnerable people being cared for in their own homes	Not yet due	136
Shropshire: Mid and North West	Shropshire County Council	To consider installing a hand rail along the pathway along the River Severn between the English Bridge and Castlefields, Shrewsbury	Not yet due	140

Coroner District	Report Sent to	Details	Response received	Report number
South Yorkshire: Western	Care Quality Commission	To consider issuing national advice on the control of hazardous products and whether inspectors should check the storage of these products when visiting nursing homes	Not yet due	141
Somerset: West	Taunton Deane Borough Council	To consider making the stairs at the property at East Reach, Taunton safer or, if this is not possible, to consider whether the property remains suitable for multiple occupancy	Not yet due	145
Sussex: West	P&O Cruises	To consider modifications to the short flights of steps on P&O cruise ships, specifically an edging strip on the outside edge of the tread of steps.	Not yet due	186
Community Healthcare and Emergency Services Deaths				
Milton Keynes	Milton Keynes Primary Care Trust	To consider a review of the decision to withdraw providing the support of the tissue viability nurse service to care homes within Milton Keynes	Yes	3
Gwent	Newport City Council	To consider introducing a review procedure to re-assess the suitability of equipment provided for people with disabilities	Yes	57
Cardiff and The Vale of Glamorgan	Chief Medical Officer for Wales; Cardiff and Vale University Health Board	To consider the midwife or health visitor asking to see sleeping arrangements for new born babies	Yes	80
Cornwall	South Western Ambulance Service NHS Trust	To consider evidence from the inquest in carrying out the critical incident review	Yes	103
Cardiff and The Vale of Glamorgan	Welsh Ambulance Service NHS Trust	To consider if notifications of road closures could be sent by e-mail rather than by post or alternatively if such information could be integrated with central control/ambulance navigation systems	Yes	106
London: Inner North	Royal College of General Practitioners	To consider issuing national guidelines on the interaction between temporary and permanent GPs to prevent the over-prescribing of drugs	Not yet due	109
Cambridgeshire: North and East	Department of Health; East of England Strategic Health Authority; Royal College of General Practitioners	To consider providing guidance to primary care trusts on appointing non-UK based doctors and the checks required on training, performance and knowledge of English; quality assurance of out of hours services and written contracts, which set out minimum standards and are regularly monitored; to hold a national database of overseas doctors detailing their skills, records of malpractice, date of registration and any withdrawal of registration	Not yet due	110

Coroner District	Report Sent to	Details	Response received	Report number
Birmingham and Solihull	Birmingham City Council	To consider a policy review of care plans for patients with learning difficulties to include the risk of choking and the need for a carer to remain with a patient throughout a meal; social workers to be advised to attempt the Heimlich method when a patient is choking where possible	Not yet due	142
Derbyshire: Derby and South Derbyshire	Dean & Smedley Ltd; Derbyshire County Primary Care Trust (PCT); Newhall Surgery, Swadlingcote; Department of Health	Dean & Smedley Ltd to consider a review of pharmacy staff training; PCT to consider issuing comprehensive guidelines for GPs, community pharmacies and dentists on protocols for patient identification and to have in place a robust inspection process to ensure guidelines are followed; Newell Surgery to consider a review of its staff training and access to Practice policies and procedure protocols; Department of Health to consider issuing a national policy on patient identification and bringing forward legislation to bring primary cares facilities within the remit of the Care Quality Commission	Not yet due	146
Greater Manchester: West	Ashton, Leigh and Wigan Community Health Care	To consider a review of note recording so that health visitors are not confused about what is required	Not yet due	149
Leicestershire: City and South Leicestershire	Resuscitation Council (UK)	To consider amending its current guidelines to state that resuscitation should only be stopped if there is breathing and a pulse and should otherwise continue until the arrival of a medically qualified person or the patient regains consciousness	Not yet due	151
East Riding and Hull	Thames Valley Police; Humberside Police	To consider how to improve communication between the control rooms of two widely separated Police Forces	Not yet due	160
Berkshire	National Patient Safety Agency; Royal Pharmaceutical Society of Great Britain; The Medicines and Healthcare Products Regulatory Agency; Department of Health	To consider a review of dispensing prescription drugs to ensure every box of prescribed medication carries the generic name of the drug in a designated place; that all dispensed medication be checked by two different qualified staff before it leaves the pharmacy; a requirement that patients be given a clear written note of their prescribed medication and colour coded packaging to identify the more common or potentially harmful drugs	Not yet due	177
Greater Manchester: City	Manchester City Council	To consider a review of the policy on applications for assistance with care to require the Council to obtain reports from organisations and professionals which had previously assisted the applicant	Not yet due	195
Mental Health related Deaths				

Coroner District	Report Sent to	Details	Response received	Report number
Leicestershire: Rutland and North Leicestershire	Hinckley and Bosworth Borough Council	To consider a review of how information received is recorded in reports of Anti-Social Behaviour; To consider how this information is followed up and how a chronology of reports can be established and shared with Police and other agencies	Yes	5
Greater Manchester: City	Home Office	To consider banning the publication, supply or availability of 'Final Exit' or similar publications which provide advice on how to commit suicide	Extension granted	22
Greater Manchester: City	Greater Manchester Police	To consider devising a programme requiring all frontline officers to attend training on their powers under the Mental Health Act 1983 and on managing and assessing distressed individuals and to review its internal guidance leaflet 'Crisis Intervention and Potential Suicide Avoidance'	Yes	63
Hertfordshire	East and North Hertfordshire NHS Trust	To consider putting in place a procedure to ensure communications about important requests concerning mental health issues affecting patients are notified and acted upon prior to their discharge	Yes	66
West Yorkshire: Eastern	West Yorkshire Police	To consider refresher training for police on the provisions of Section 136 of the Mental Health Act 1983	Yes	70
South Yorkshire: Western	Sheffield Health and Social Care NHS Trust	To consider training staff to recognise the dangers of a moderate paracetamol overdose; developing a protocol between the Drug Intervention Team and Sheffield NHS Trust and to consider social workers referring patients on methadone to a doctor in the event of a paracetamol overdose	Yes	71
Devon: Exeter and Greater	Devon Partnership NHS Trust	To consider reviewing existing protocols for dealing with an urgent mental health referral	No	105
Merseyside	Merseyside Police	To consider a review of police procedures when unauthorised pedestrians on motorways are reported to them	Not yet due	108
Greater Manchester: South	The Together Trust; Stockport Metropolitan Borough Council; Greater Manchester Police; The Pennine Care NHS Trust; Stockport NHS Trust; Manchester Mental Health Care	To consider a review of the mental health service delivered by these various agencies; to ensure that all documentation is accurately completed and that a clear policy and procedure exists identifying roles and responsibilities	Not yet due	121

Coroner District	Report Sent to	Details	Response received	Report number
Teesside	Tees Esk and Wear Valley NHS Trust; Cleveland Police	To consider further training of staff at St Luke's Hospital, Middlesbrough and police officers on Section 3 of the Mental Health Act 1983 and how this impacts on the treatment of patients detained under this section of the Act	Not yet due	127
Surrey	Surrey and Borders Partnership NHS Trust	To consider how best to enable mental health information held by the Police and County Council to be available to clinicians treating patients out of hours	Not yet due	130
Brighton and Hove	Sussex Police	To consider a review of police procedures for dealing with people detained under S136 of the Mental Health Act 1983	Not yet due	132
Birmingham and Solihull	West Midlands Police; Birmingham and Solihull Mental Health Trust; West Midlands Ambulance Service; Birmingham City Council	To consider continuing efforts to secure the provision of more health based places of safety for people with mental health concerns in Birmingham	Not yet due	143
Greater Norfolk	Norfolk and Waveney Mental Health Trust	To confirm that the recommendations about risk assessments for patients with mental health issues made in the Root Cause Analysis have been implemented	Not yet due	164
Greater Norfolk	Norfolk and Waveney Mental Health Trust	To consider whether further guidance and training is required for healthcare professionals to assess when a patient with mental health problems being treated in the community should be referred to a psychiatrist	Not yet due	165
Bedfordshire and Luton	Department for Work and Pensions	To consider a review of the policy not to seek advice from a claimant's own GP or psychiatrist if they are suffering from a mental illness in determining whether a benefit claimant is fit for work	Not yet due	166
Nottinghamshire	Nottinghamshire Healthcare NHS Trust	To consider a protocol to ensure that any patient on seclusion receives an explanation for their exclusion in their own language at least once in every 24 hours and that psychiatric nurses have basic medical training on dealing with the range of medical emergencies	Not yet due	169
Cornwall	Royal Cornwall Hospital	To consider compiling a comprehensive discharge plan for vulnerable patients; greater joined up working between the various medical agencies involved in a patient's care; further guidance to nursing staff on the implications of the Mental Capacity Act 2005	Not yet due	171

Coroner District	Report Sent to	Details	Response received	Report number
Devon: Exeter and Greater	Devon County Council; Devon Partnership NHS Trust	To consider procedures for risk assessing the situation where a mental health patient who as the carer of a child has made threats to or had thoughts to harm the child and how these risks are documented and shared with other relevant agencies	Not yet due	179
London: Inner West	Department of Health; Wandsworth Borough Council	To consider a review of the guidance on the provisions of the Mental Capacity Act 2005, the Mental Health Act 1983, section 47 of the National Assistance Act 1948, Articles 5 and 8 of the European Convention on Human Rights and other public health and housing legislation to ensure plain English is used to assist social service professionals	Not yet due	182
Deaths in Custody				
Teesside	HMP Holme House; Tees, Esk and Wear Valley NHS Trust	To consider mental health care provisions; record keeping; training and communications within the prison and liaison with outside agencies	Yes	1
Milton Keynes	HMP Woodhill; Milton Keynes Primary Care Trust	To consider a review of prison medical procedures and arrangements for transferring prisoners to hospital	Yes	28
Cardiff and The Vale of Glamorgan	South Wales Probation Trust	To consider a review of prison and probation home detention curfew practices in Cardiff to ensure prisoners are released to suitable accommodation	Yes	35
Cambridgeshire: North and East	HMP Whitemoor	To consider a review of HMP Whitemoor's healthcare and observation procedures	Yes	39
Derbyshire: Derby and South Derbyshire	Ministry of Justice	To consider ensuring that all documentation relating to a prisoner is transferred when they are transferred, that identified risks are highlighted and that all paperwork is kept in one file and readily accessible 24 hours a day	Yes	41
Liverpool	HMP Altcourse	To consider keeping the Assessment, Care in Custody and Team working book in the wing record and that safer custody staff audit the book on the wing.	Yes	50
Kent: Mid and Medway	HMP Swaleside	To consider reviewing prison medical care and record keeping	Yes	52
East Riding and Hull	HMP Full Sutton	To consider improving communication between the prison wing and health centre staff	Yes	53

Coroner District	Report Sent to	Details	Response received	Report number
West Yorkshire: Eastern	HMP Wakefield; Wakefield District PCT	To consider a review of Assessment, Care in Custody and Team working procedures and review processes for prisoners with mental health issues	Yes	56
Cambridgeshire: North and East	HMP Whitemoor; Ministry of Justice	To consider a review of the procedures for and recording of checks made on prisoners confined to their cells	Yes	65
Northumberland: North	Northumberland NHS Care Trust	To consider clarifying appropriate treatment and reporting options for prisoners at HMP Acklington presenting with chest pain	Yes	69
Lincolnshire: West	HMP Lincoln	To consider putting in place a system in all prisons for the "Emotional well-being" section of prisoner reports to be checked immediately to reduce the risk of self harm when a prisoner is admitted	Yes	79
London: Inner South	Ministry of Justice	To consider a thorough medical examination of new prisoners including their past medical history; to consider procedures to ensure that concerns about new prisoners' mental health are communicated to the prison mental health team to enable a mental health assessment to be undertaken	Yes	93
London: Inner South	Ministry of Justice	To consider a thorough medical examination of new prisoners including their past medical history and to ensure that forensic medical records made prior to detention are available to prison medical staff	Extension granted	97
Preston and West Lancashire	St Helens Borough Council	To consider a review of the Council's Young Persons Service and Youth Offending Service procedures, their record keeping and the allocation of staff resources within these Services	Yes	104
Greater Manchester: North	HMP Buckley	To consider procedures for transferring and allocating prisoners within the prison estate; medical emergency response codes; first aid training for prison officers; and a re-appraisal of the availability of plastic bags within prisons	Yes	107
Greater Manchester: City	HMP Manchester	To consider a review of how information on prisoners' mental health is collected and acted on	Yes	122
Cheshire	Central and Eastern Primary Care Trust (PCT); HMP Styal	HMP Styal to consider regular inspections to identify ligature points; a review of the monitoring of observations of prisoners; consistent application of the "Incentive and Earned Privilege system"; staff training in mental health; and with the PCT the appointment of a full-time registered mental health nurse	Yes	150

Coroner District	Report Sent to	Details	Response received	Report number
Worcestershire	HMP Long Lartin; Department of Health; West London Mental Health Trust	HMP Long Lartin to consider providing mandatory mental health awareness training for discipline staff working on the segregation unit; Department of Health to review the process of admitting a prisoner from prison to hospital	Yes	154
London: Inner South	Faculty of Forensic and Legal Medicine, Metropolitan Police; London Ambulance Service	To consider a review of training on excited delirium and risk assessment both at the scene of arrest and at the police station; the use of police vehicles to transport prisoners to hospital; guidance on monitoring and observing prisoners; guidance for forensic medical examiners at the police station; guidance on calls to the ambulance service and how these should be handled	Yes	159
East Riding and Hull	Ministry of Justice	To consider a review across the prison estate to check and, where necessary, adjust light fittings in segregation and induction units which could be used as ligature points	Yes	163
Milton Keynes	Ministry of Justice	To consider a review of the timeliness of the procedure for notifying prisoners and their prison of a change in charges a remand prisoner is facing	Yes	167
Drug and Medication-related deaths				
Devon: Plymouth and South West	UCB Pharma Ltd; Martindale Pharma; Medicines and Healthcare Products Regulatory Authority	To consider providing Adrenalin, Amiodarone and Atropine to ambulance services in different coloured boxes to avoid them being confused	Partial response	17
Derbyshire: Derby and South Derbyshire	National Institute for Health and Clinical Excellence (NICE)	To consider a review of the NICE guideline that antibiotic prophylaxis should not be provided to those at risk of endocarditis	Yes	18
Greater Manchester: North	Royal Pharmaceutical Society of Great Britain	To consider restricting the use of Chloroquine	No	51
Cornwall	Drug and Alcohol Team, Truro	To consider evidence from the inquest to inform the policy review being undertaken	Yes	102
Avon	Ministry of Defence	To consider reporting a possible adverse reaction to the Hepatitis B vaccination to the appropriate drug enforcement agency	Yes	184
Care Home Deaths				

Coroner District	Report Sent to	Details	Response received	Report number
Staffordshire: Stoke on Trent and North Staffordshire	The Limes Residential Home, Stoke-on-Trent	To consider providing basic medical training to care home staff to enable them to recognise potentially life threatening conditions which may need onward referral to a qualified medical practitioner	Yes	10
Greater Manchester: South	Peak Valley Housing Association, Hyde	To consider ways to ensure there is continuous personal alarm system support in place when residents are moved from one home to another	Yes	46
Greater Manchester: South	Ravenoak, Cheadle Hume	To consider ensuring that at least 2 carers are available to assist at meal times	Yes	115
Greater Manchester: South	Grosvenor Care Cheshire	To consider a review of the care home's regimes and regulations to avoid patients being able to leave the home unnoticed	Yes	133
Greater Manchester: South	Reinbeck Residential Home, Stockport	To consider a review of risk assessments on residents, full recording of falls and the provision of bed rails for residents prone to falls	Yes	157
Milton Keynes	Care Quality Commission	To consider a review of record keeping to determine if patients are fit to be discharged at the Water Hall Care Centre, Milton Keynes.	Yes	168
Devon: Plymouth and South West District	Care Quality Commission	To consider the steps which could be taken to ensure a more rigorous and reliable system of inspection can be put in place	Yes	172
Cheshire	Southern Cross Healthcare, Durham	To consider a review of the documentation kept on bed sores to improve communication between staff and ensure appropriate treatment.	Yes	175
Staffordshire: South	Stafford Social Services	To consider a review of care plans for patients with dementia who require observation at meal times.	Yes	180
Greater Manchester: South	Tarryhill Residential Home, New Mills, Derbyshire	To consider a review of maintenance of the heating and hot water facilities at Tarryhill Residential Home	Yes	191
Service Personnel Deaths				
Devon: Plymouth and South West	Secretary of State for Defence	To consider the Ministry of Defence learning account on the use of R-WMIK Land Rovers	Yes	112
Wiltshire and Swindon	Ministry of Defence	To consider a review of current training procedures for service personnel in the Police Mentoring Team; the availability of metal detectors and whether Snatch Land Rovers are the most appropriate vehicles for the Team	Yes	153
Wiltshire and Swindon	Ministry of Defence	To consider service personnel in theatre having meetings by video conference to avoid road trips	Yes	174
Police Procedure-related deaths				

Coroner District	Report Sent to	Details	Response received	Report number
Cheshire	Cheshire Probation Service; Cheshire Police	To consider extending the terms of their Memorandum of Understanding to include the taking of statements	Yes	64
Essex and Thurrock	Essex Police	To consider improving communication with mental health services to better identify suspects with a history of mental health problems and to ensure all intelligence is communicated to the officers concerned	Yes	85
Greater Manchester: South	Greater Manchester Police	To consider a review of procedures for police to enter a property where it is known the occupant is at risk	Yes	192
Product-related deaths				
Kent: Central and South East	UN Economic Commission for Europe	To consider amending regulations for testing child car seats to include testing the impact from the side in addition to the current front and rear impact tests	Yes	81
Darlington and South Durham/North Durham	Department for Business Innovation and Skills	To consider a safety awareness campaign, improved packaging and labelling to highlight the dangers of overloading portable electrical outlet devices	Yes	99
Hertfordshire	England Hockey	To consider providing information to English Hockey clubs and schools about the importance of observing instructions which accompany helmets and to alert helmet users of the dangers of mistreating them and of the level of supervision required at practice	Yes	113
Leicestershire: City and South Leicestershire	Cardi-Solutions, Harrogate	To consider providing guidance on the need to trim excess cardiac pacing wire, including warnings on the product's packaging and ensuring this information is cascaded to all hospitals	Yes	118
Derbyshire: North	Coleman UK plc; British Standards Institution (BSI)	Coleman UK plc to consider providing a leaflet demonstrating the correct assembly of camping gas lights which could be given to those who buy refill cartridges for older style units; BSI to consider devising regulations to ensure both tents and camping gas lights carry clear instruction labels written in plain English about ventilation, assembly and usage instructions	Yes	119
Railway-related Deaths				

Coroner District	Report Sent to	Details	Response received	Report number
Peterborough	Network Rail	To consider modifications to the wicket gate and the level crossing at Fox Covert Road, Werrington, Peterborough	Yes	185
Other Deaths				
Staffordshire: South	Civil Aviation Authority	To consider keeping a national register of private pilots and aeroplanes	Yes	58
Northumberland: North	Maritime and Coastguard Agency	To consider regulating diving trips	Yes	77
Sussex: West	Civil Aviation Authority	To consider implementing the recommendations of Aircraft Accident Report 6/2009	Yes	91
Greater Manchester: South	Stockport Metropolitan Borough Council	To consider reviewing the barriers to allow emergency service access to Torkington Park, Stockport	Yes	116
Isles of Scilly	Cornwall and Isles of Scilly Primary Care Trust	To consider closer working between Her Majesty's Court Service and the Suicide Reduction Group to identify better people in substantial debt who may have health risks	Yes	134
Greater Manchester: South	Department for Education; Stockport Local Safeguarding Children Board (LSCB); Offerton High School, Stockton	To consider a review of the guidance on the treatment of asthma in secondary schools, including provision of information and first aid training, policies and procedures on the care of asthmatic students and information sharing between LSCBs and Child Death Overview Panels with the coroner system	Yes	161
Coventry	University Hospital Coventry	To consider a review of how missed appointments of patients with diabetes might be followed up and provision of training in recognising the signs of hyperglycaemia or hypoglycaemia for staff at the Foyer Hostel	Not yet due	183

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