Ministry of JUSTICE

Summary of Reports Under Rule 43 of the Coroners Rules, and Responses

July 2009

Contents

1. Introduction

With effect from 17 July 2008 the Coroners (Amendment) Rules 2008 amended Rule 43 of the Coroners' Rules 1984.

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 that amends Rule 43 can be viewed at the following link:

http://www.opsi.gov.uk/si/si2008/pdf/uksi_20081652_en.pdf

This report is the first Ministry of Justice summary bulletin. It covers reports received by the Lord Chancellor between 17 July 2008 and 31 March 2009. Future bulletins will be published twice a year.

It is not intended to release all reports and responses in full. If you wish to obtain a copy of a particular report from the Lord Chancellor you should 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.

Requests should be sent to rule43reports@justice.gsi.gov.uk or to Lynette Hill, Ministry of Justice, Coroners and Burials Division, 3rd Floor, 102 Petty France, London, SW1H 9AJ. We will acknowledge all applications.

We will aim to send reports, redacted as necessary, within 20 working days of receiving the request, or we will explain why it is not possible to release the report, either at all or within this timeframe.

The Lord Chancellor wishes to thank coroners for embracing the changes made to Rule 43, and for providing copies of the reports they have written and the responses they have received, in accordance with the new procedures.

2. Statistical summary

1. Rule 43 reports issued by coroners

Between 17 July 2008 and 31 March 2009, coroners in England and Wales issued reports under Rule 43 in a total of 207 inquests.

Rule 43 reports were most commonly issued in relation to hospital deaths, accounting for 28% of the reports issued in this period (58 reports). A further 19% of reports were issued in relation to the circumstances surrounding road deaths (39 reports), and 10% in respect of deaths involving either an accident at work or health and safety issues (22 reports).

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 17 July 2008 and 31 March 2009, by broad category

Category	**Number of inquests where Rule 43 reports issued**
Hospital deaths	58
(clinical procedures and medical management)	*(56)*
(other)	*(2)*
Road deaths	39
(highways safety)	*(30)*
(vehicle safety)	*(6)*
(driver and vehicle licensing)	*(3)*
Accidents at work and health and safety related deaths	22
Mental health-related deaths	19
Community healthcare and emergency services related deaths	19
Deaths in custody	13
Drug and medication related deaths	11
Care Home Deaths	5
Service personnel deaths	5
Police procedure related deaths	4
Product related deaths	3
Railway related deaths	2
Other deaths	7
TOTAL	**207**

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

There are currently 115 coroner jurisdictions in England and Wales. Rule 43 reports were issued by 57 of these coroner jurisdictions between 17 July 2008 and 31 March 2009, almost half of the total. The coroner for Greater Manchester South issued 18 reports, the most by a single jurisdiction during this time.

Clearly, the number of reports issued by each coroner will be to a large extent determined by the particular circumstances which surround the deaths he or she investigates. Furthermore, sometimes remedial action has been taken by the organisation concerned before the inquest is heard, which means that there is no need for the coroner to issue a rule 43 report at the time of the inquest itself.

Annex A lists the 57 coroner jurisdictions which issued Rule 43 reports, together with the number issued by each jurisdiction.

3. Organisations to which Rule 43 reports have been sent

Rule 43 reports were sent by coroners to a wide range of organisations and institutions. Table 2 shows a breakdown of the types of organisations which were the recipients of reports. On occasion coroners send reports arising from the same inquest to more than one organisation, so the actual number of reports issued to organisations is higher than the total of 207 inquests in which reports issued.

Given that the most common category of Rule 43 reports was in relation to hospital deaths, NHS hospitals and Trusts were the most frequent recipients. They received 31% of the reports issued by coroners between 17 July 2008 and 31 March 2009 (78 reports). Ministers and central government departments received 19% of the reports (48 reports), while local authorities received 14% (37 reports).

A list of all organisations who have received a Rule 43 report in the period in question is **included in Annex C.**

Table 2: Rule 43 reports issued by coroners between 17 July 2008 and 31 March 2009, by type of organisation

Type of organisation	Number of Rule 43 reports
NHS hospitals and Trusts	78
Ministers/central government departments	48
Local authorities	37
Private companies	36
Regulatory bodies and trade associations	22
Police and other emergency services	11
Prisons	7
Care and nursing homes	6
Other	5
TOTAL	**250**

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, within 56 days of the date of receiving it, give a written response to the coroner. The response has to give details of any action which has been or it is proposed will be taken, or to provide an explanation when no action is proposed.

Coroners have the discretion to grant an extension of time if an application is made.

149 responses to Rule 43 reports have been received by the Lord Chancellor in respect of the 250 reports issued between 17 July 2008 and 31 March 2009, and which were due to be with the coroner by 28 February.

As at 28 February, coroners were yet to receive responses to the remaining 101 reports. Some of the organisations had, however, been granted an extension by the coroner and some would not have yet passed the 56-day deadline at 28 February.

A list of organisations which the Ministry of Justice has not been notified have responded to the coroner within the 56-day deadline and who have neither sent the coroner an interim reply nor been granted an extension as at 28 February is at **Annex B**.

3. Trends and Rule 43 Reports which have wider implications

A list of all Rule 43 reports received between 17 July 2008 and 31 March 2009 is at **Annex C**.

As this is the first summary bulletin it is not possible to draw out many trends, but this is something that will be considered in future reports. However, many of the reports written in respect of hospital deaths mention the need for better communication and procedures within hospitals. Most reports in highway safety deaths make suggestions for changes to road layout, erection or removal of street furniture, and road markings.

The majority of the reports are very specific and relate to a local situation or organisation. However, some have a potential wider impact and these are summarised below. These summaries include only Rule 43 reports which have been received in the period covered by this bulletin and for which the response has also been received.

Any wider implications in any reports made in this period where the response has not yet been received will be included in a future bulletin.

i. Road Deaths

Highways safety

a) A cyclist collided with a stationary lorry where no warning red triangle was displayed. The coroner wrote to the Department for Transport suggesting that, as in some other European countries, placing a red triangle at some distance should be made compulsory.

The Department for Transport confirmed that such triangles were permitted but not mandatory as these are not considered to be more effective than vehicle hazard warning lights. Vehicles first used from 1 April 1986 must be fitted with such warning lights, which may be used to warn other persons of the temporary obstruction.

b) A car driver suffered fatal injuries after his car collided in darkness with a protruding metal mudguard of a crane being transported in the opposite direction on a specialised lorry and trailer. The escort was a van with flashing lights, travelling 300 metres ahead. The roof of the lorry also displayed flashing lights. The markings on the load did not

conform to those set out in the Road Vehicles (Authorisation of Special Types) (General) Order 2003. The route taken by the abnormal load at night had been authorised by and was initially escorted by the police. The coroner wrote to the Department for Transport as follows:

- The deceased would have been blinded by the flashing lights initially of the escorting vehicle and then of the lorry and he would not have seen the protruding edge of the heavy load before his eyes could have adjusted, given the relative speed and distance.
- Regulations should require properly reflective material on the protruding elements of the heavy load vehicle.
- There should be a requirement for amber warning beacons on both escorting and heavy load vehicles.
- Paragraph 225 of the 2007 edition of the Highway Code[1] should warn drivers more strongly that they may need to stop and move to the side after passing a marked escort vehicle.

The Department for Transport replied as follows:

- They emphasised the important role the police play in the management of abnormal load movements, and will take steps to make all Chief Officers of Police aware of this incident.
- They consider the management of abnormal loads by the police at a local level to be a key aspect in the safe movement of such loads.
- They understand the county force in question, in common with most other forces, now has a policy of not ordinarily allowing the movement of abnormal loads in the hours of darkness.
- They are reviewing the conspicuousness of the largest abnormal loads and their escort vehicles, and will consider extending this to other abnormal loads.
- They will consider whether new guidance or amendments to the legislation should be developed when this work reports later this year.
- They will look to strengthen the advice in the Highway Code when the next opportunity arises.

Vehicle safety

An elderly pedestrian was killed by a tipper lorry when the driver drove over her at traffic lights as the lights changed to green. The design of

---

[1] Paragraph 225 of Highway Code 2007 edition states: "Vehicles with flashing amber beacons. These warn of a slow moving or stationery vehicles (such as a traffic officer vehicle, salt spreader, snow plough or recovery vehicle) or abnormal loads, so approach with caution."

the lorry meant the driver was unable to see if a pedestrian crossed immediately below its front. The coroner wrote to the Department for Transport as follows:

- There was a blind spot if a pedestrian crossed within one metre of the cab.
- A front windscreen mirror had subsequently been fitted to the lorry but it was not compulsory if the lorry was manufactured earlier than January 2007.
- Legislation should be amended to make such mirrors compulsory whatever the date of manufacture of such lorries.

The Department for Transport replied as follows:

- They agreed that the new European legislation was not retrospective.
- A new European directive was being introduced by end of March 2009 to install new mirrors on all large vehicles first registered from 1 January 2000.
- The benefits are much greater from side mirrors than front mirrors.
- The industry advises that front mirrors are often problematic to install on older vehicles due to vibration and cab damage.
- They will encourage installation of front mirrors wherever feasible, but are unable to change national legislation to require the fitting of front mirrors because of the constraints of European law in relation to vehicle construction.

Driver and Vehicle Licensing

A lorry driver, who was suffering from undiagnosed sleep apnoea, hit a line of traffic from the rear, killing another driver in his car. The coroner requested of the Department for Transport that consideration be given to the following points:

- All lorry drivers should undergo routine medical examinations.
- The Application Form (D4) for LGV and HGV licenses should be amended to reflect the possibility of undiagnosed apnoea.
- There should be a fast-track apnoea assessment of all commercial drivers involved in accidents.
- There should be education programmes on the dangers of tiredness for drivers, similar to those for drink and drugs

- Lorry drivers should be made aware of the policy of suspending commercial drivers with apnoea rather than automatic loss of the licence.

The Department for Transport replied as follows:

- Responsibility for the diagnosis of medical conditions lies with medical practitioners. The Driver and Vehicle Licensing Authority (DVLA) regularly provides medical practitioners with guidance on matters such as sleep apnoea and would do so again in December 2008. Drivers are obliged to declare if they have a history of apnoea and specific questions are included on the form completed by the GP from age 45 and at regular intervals thereafter. An EU directive on driver licensing, when implemented, will require Group 2 licences[2] to be issued on a 5-yearly basis.
- The format and content of the D4 application form is regularly reviewed and amended as necessary, but legislation does not authorise investigation for possible and as yet undiagnosed conditions.
- DVLA does not have the authority to undertake post-accident assessment of drivers unless contributory or causative health related factors are identified and notified, often by the police. There are plans to improve further the police notification system.
- The Department's ongoing THINK! Campaign has a range of materials on driver tiredness and had a significant investment of £400K in 2008 allocated to introducing a range of new materials.
- DVLA information leaflets and guidance notes already advise drivers that when there is evidence that obstructive sleep apnoea is successfully treated it does not prevent a vocational license being held.
- A mandatory Driver Certificate of Professional Competence will be introduced for lorry drivers in September 2009, having already been introduced for bus and coach drivers. The syllabus addresses health issues, including the effects of fatigue.

ii. Railway Deaths

A man was discovered in the early morning seriously injured on a railway line. He had been hit by one of a possible 17 trains during the previous 13 hours and suffered severe injuries to his legs as well as subsequent hypothermia due to being undiscovered for some

[2] Group 2 Licence required to drive large vehicles over 3,500kgs, minibuses (9 to 16 seats) or buses

considerable time. He died some 8 hours after being taken to hospital. The coroner wrote to British Transport Police (BTP) and Devon and Cornwall Constabulary (DCC) as follows:

- Vital evidence was lost through inadequate investigation.
- This included a lack of CCTV footage at the various stations on the route and no examination of the rolling stock which might have used the route at the relevant time.
- There was no BTP record of the position of the injured man at the scene through, in the coroner's view, misplaced health and safety concerns.
- There should be clear protocols for such investigations.

BTP replied as follows:

- They acknowledged shortcomings in the investigation and have completely reviewed their fatality investigation procedures.
- Confusion had been caused by lack of clarity over which force (DCC or BTP) had primacy of the investigation. .This led to an unacceptable delay in gathering and subsequent loss of CCTV evidence. BTP accept that primacy was and is theirs in all cases of fatality on the railway.
- Although the man received severe injuries to his feet, his body remained intact. Therefore examination of the trains was unlikely to reveal anything of evidential value, especially after such a long elapse of time from the initial impact. However, BTP recognise that this decision-making process should have been documented.
- BTP has developed a revised and updated national Standard Operating Procedure which emphasises the need for a sketch plan or photograph of a body on site.
- BTP has briefed its Senior Investigating Officers and DCC to ensure there are no future misunderstandings regarding primacy and responsibility.
- All investigations are now reviewed on a daily basis by the Operations Superintendent, to ensure fast-time quality response. This includes a watchlist of those injured but not killed in similar accidents. A Force Headquarters Detective Superintendent has responsibility for reviewing fatality investigations for the force, including monitoring liaison with bereaved families.

iii. Community Healthcare and Emergency Services-related Deaths

a) A patient died at a hospital in the north west of England of anaphylactic reaction to antibiotics, having been seriously ill for many years with the lung disease, bronchiectasis. The coroner wrote to the Department of Health as follows:

- It had been clear for some years that the deceased had an allergic reaction to one or more of the medications he was given.
- In the absence of a national allergy service it was felt difficult to explore the exact origins of the allergic reaction.
- The deceased had been given cefuroximine, which had caused a serious allergic reaction, and had died shortly afterwards.
- Medical records should have been accessible at night.
- Some of the identified shortcomings had been tackled by local management.
- The lack of a national allergy service needed to be addressed.

The Department of Health replied as follows:

- They noted local measures being taken to improve record-keeping and related matters.
- North West Strategic Health Authority (NWSHA) is now the lead Strategic Health Authority for Allergy Services.
- NWSHA has been asked to develop a pilot allergy centre, to be evaluated and used as a model that could be rolled out to other Strategic Health Authority regions.
- Further support has been given to the local allergy centre mentioned by coroner.
- Further action has been taken by National Institute of Clinical Excellence and the Resuscitation Council to deal with the immediate aftermath of an anaphylactic reaction.
- Royal College of Paediatrics and Child Health have been asked to develop care pathway for children subject to allergies.
- Skills for Health were commissioned to develop National Occupational Standards for allergy.

b) A woman felt ill and rang for an ambulance. Following assessment by a GP located in the ambulance control room, the woman was advised to contact her out-of-hours GP service and as a result the ambulance was

stood down. She was found dead over a week later, when neighbours became concerned. The coroner wrote to the Welsh Assembly Government expressing his concern about the handling of calls during the out of hours period. Whilst he accepted that staff had followed their instructions correctly, the coroner considered that the services concerned should have been able to transfer calls between one another and to provide patients with correct contact numbers.

The Welsh Assembly Government responded to say that officials had been instructed officials to undertake work in the following areas:

- To ensure that callers to any of the services operating during the out of hours periods are signposted to the right service and provided with the correct telephone number.
- To support this, a directory of services will be developed.
- To consider whether it is possible to check up on callers' success in finding the right service in certain cases.
- To consider the technical feasibility of transferring calls.
- To develop an all-Wales protocol on the signposting, transfer and follow up of patients to alternative service providers during the out of hours periods.

c) A man suffering from borderline personality disorder was visited by his GP, who believed that the man's stated intention to set fire to himself was serious and could be addressed by immediate inpatient treatment. Before he could be admitted, however, it would have been necessary for him to be further assessed by a community psychiatric nurse. Before this could be done the man set himself on fire and he died of his injuries ten days later.

The coroner wrote to Department of Health and the Chief Medical Officer requesting that GPs in such situations should be able to make direct referrals to a suitable hospital without the need for a further assessment.

The Department of Health replied as follows:

- The "gate keeping" function of the community psychiatric nurse (crisis resolution/home treatment team or CRHT) was very important and should be retained.
- 335 teams now delivered 100,000 episodes of home treatment.
- If possible, patients should be treated at home, which in general they preferred.

- Section 136 of the Mental Health Act 1983 allowed the police to remove a person to a place of safety, but also outside the Act the emergency services could convey a person to hospital.
- Although no other similar case had been drawn to Department's attention, the National Confidential Inquiry into Homicides and Suicides had been asked to consider including a question relating to modes of admission and the use of CRHTs in the immediate period before death in cases of suicide reported to them.
- Details of this case would be sent to the clinical governance leads of Strategic Health Authorities so that they could consider the coroner's findings in relation to local policy implementation.

iv. Drug and Medication-related Deaths

Lignocaine (Lidocaine[3]) overdose

A patient being treated in hospital was erroneously given an intravenous bag which had 0.4% Lignocaine rather than a bag of gelofusine[4] which caused her death in December 2006. The coroner wrote to the National Patient Safety Agency (NPSA):

- He noted guidance had already been issued better to distinguish between intravenous bags containing drugs and those containing fluids.
- However, distinctive marking should be introduced to avoid confusion.

The NPSA replied as follows:

- They were aware of this and similar cases in recent years.
- In March 2007 they had issued patient safety alert *"Promoting safer use of injectable medicines"* (Alert 20).
- Greater emphasis on designing safety features had been encouraged in packaging and labelling, especially for look/sound-alike medicines.
- Evaluation of its implementation had taken place from March 2008 onwards.
- They offer advice to pharmaceutical companies on an ad hoc basis, which has reduced risks.

---

[3] Lidocaine is an antirhythmic drug used in local anaesthetic

[4] Gelofusine is a plasma substitute. It contains modified fluid gelatine which behaves in a similar way to natural plasma albumin. It is used as a short-term measure to expand and maintain blood volume after haemorrhage, acute injury or surgery, burns, serious infection, peritonitis.

- No real progress had been made in respect of intravenous infusion manufacturers, and they published a guide in March 2008 *"Design for patient safety: A guide to the labelling and packaging of injectable medicines*" with the intention of influencing the industry to adopt new design features. So far, however, manufacturers of intravenous infusions have not progressed with the suggestions.
- Further work was ongoing with European Resuscitation Council on improvements in handling of cardio-pulmonary resuscitation drugs.

v. Accidents at Work/Health and Safety-related Deaths

A householder decorating the side of a house hired a mobile platform (or zip-up scaffolding) from a company, which provided equipment and instructions. He was found by the foot of the platform and he died from cranial injuries. The coroner wrote to the Hire Association Europe (HAE), the representative body for the hire company, as follows:

- Construction of the structure required a minimum of two people with sufficient expertise and up-to-date instructions (those provided pre-dated the Work at Height Regulations 2005 [5]).
- He drew attention to the Health and Safety Executive (HSE) leaflet "*Using Work Equipment Safely",* in particular page 6 on safety responsibility.[6]
- HAE should write to its members to ensure that the 2005 Regulations and the HSE leaflet were referred to in any instruction leaflets.
- HAE should encourage its members to enquire carefully with prospective hirers as to their capability to use the equipment being hired.

HAE replied that they were willing to circulate their membership as requested, referring to the particular case (the coroner agrees if the case is anonymised).

---

[5] (SI 2005 No 735)

[6] "Hiring out work equipment – If you hire out work equipment you are responsible for ensuring that the equipment is safe to use at the point of hire. You should also make reasonable attempts to find out what the equipment will be used for and provide on how it should be used. The safe use of the equipment is the responsibility of the person who hires it".

vi. Other Deaths

A depressed man intentionally shot himself in the abdomen with an air-rifle. The police had been unable to take the rifle away from the man, even though there was clear evidence that he would try to kill himself. The coroner wrote to the Home Office suggesting that consideration should be given to the law being changed to require air rifles to be subject to licensing or banned altogether.

The Home Office responded by stating that:

- The law had been tightened up in recent years, so that the age limit was raised from 14 to 18.
- It was now an offence to carry an air rifle in public without reasonable excuse.
- Businesses selling air rifles were now required to register sales.
- There were, however, no plans to license the 4 to 7 million air rifles already owned by members of the public in order to deal with the very small minority of persons misusing them.
- Instead misuse was being targeted and offences were in sharp decline.
- Fatal injuries remained very rare.
- Without being able to comment on the exact circumstances surrounding this death, they thought powers were available to the police to keep hold of an air rifle under section 16 of the Firearms Act 1968[7].

[7] This section is as follows: Firearms Act 1968: section 16 Possession of firearm with intent to injure

It is an offence for a person to have in his possession any firearm or ammunition with intent by means thereof to endanger life or cause serious injury to property, or to enable another person by means thereof to endanger life or cause serious injury to property whether any injury to person or property has been caused or not.

Annex A

Number of inquests in which Rule 43 reports were issued by each coroner jurisdiction between 17 July 2008 and 31 March 2009

Coroner jurisdiction	**Number of inquests in which Rule 43 reports issued**
Avon	5
Berkshire	2
Birmingham & Solihull	5
Black Country	2
Blackburn, Hyndburn and the Ribble Valley	3
Bournemouth, Poole and Eastern Dorset	2
Brighton and Hove	2
Cardiff and The Vale of Glamorgan	15
Carmarthenshire	2
Cheshire, Halton and Warrington	8
Cumbria: South and East	2
Darlington and South Durham/North Durham	2
Derby and South Derbyshire	7
Devon: Exeter and Greater	5
Devon: Plymouth and South West	2
Devon: Torbay and South	1
East Riding and Hull	1
Essex and Thurrock	2
Great Yarmouth	1
Greater Manchester: City	12
Greater Manchester: North	1

Coroner jurisdiction	Number of inquests in which Rule 43 reports issued
Greater Manchester: South	18
Greater Manchester: West	2
Greater Norfolk	7
Hampshire: North East	1
Hampshire: Portsmouth and South East	3
Hertfordshire	6
Kent: Central and South East	1
Kent: North West	1
Knowsley, St Helens and Sefton	1
Lincolnshire: North and Grimsby	1
Lincolnshire: West	3
Liverpool	1
London: City	3
London: Eastern	1
London: Inner North	2
London: Inner South	4
London: Inner West	2
London: Southern	2
London: Western	1
Milton Keynes	3
Northamptonshire	3
Pembrokeshire	3
Peterborough	2
Preston and West Lancashire	1
Shropshire: Mid and North-west	2
Somerset: Eastern	1
Somerset: Western	2
South Yorkshire: Western	5
Staffordshire: South	15

Coroner jurisdiction	Number of inquests in which Rule 43 reports issued
Staffordshire: Stoke-on-Trent and North	1
Sunderland	3
West Sussex	4
West Yorkshire: Eastern	9
West Yorkshire: Western	3
Wiltshire and Swindon	7
Worcestershire	1
TOTAL	**207**

Annex B

Organisations which the Ministry of Justice has not been notified have 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 2009

Brocklehurst Nursing Home, Manchester

Centrepoint

City of London Corporation

Derbyshire County Council

North Manchester General Hospital

Somerset County Council

Somerset Primary Care Trust

South London and Maudsley NHS Hospital Trust

St Giles Trust

Taylor Electronics (Manchester) Ltd

Annex C

List of all rule 43 reports received between 17 July 2008 and 31 March 2009

Coroner District	Report sent to	Details	Response Received	Report Number
Hospital Deaths: clinical procedures and medical management				
Staffordshire: South	Queens Hospital, Burton upon Trent	To consider use of bear huggers to keep patients warm	Yes	1
Greater Manchester: South	The Alexandra Hospital, Cheadle	To consider discharge policy following bariatric surgery	Yes	9
Hertfordshire	Spire Hospital, Harpenden	Spire Hospital Harpenden and West Hertfordshire Primary Care Trust to consider providing clearer procedures following discharge	Yes	12
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	Llandough Hospital midwifery led unit to consider staffing levels and procedures in dealing with birth complications	Yes	16
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	University Hospital of Wales to consider staff training and the level of care needed for transplant patients overnight	Yes	18
Cardiff and The Vale of Glamorgan	Gwent Healthcare NHS Trust	Royal Gwent Hospital to consider length of time to investigate possible head injury	Yes	20

Coroner District	Report sent to	Details	Response Received	Report Number
Birmingham & Solihull	Monitor, Independent Regulator of NHS Foundation Trusts	Heartlands Hospital, Birmingham, West Midlands Ambulance Service and Good Hope Hospital, Sutton Coldfield to consider improving communications between health professionals	Extension granted	21
Kent: Central & South East	Department of Health	William Harvey Hospital, Ashford, to consider possible nursing staff shortages	Yes	22
Staffordshire: South	New Cross Hospital, Wolverhampton	To consider providing patient hospital transport	Yes	29
Birmingham & Solihull	Monitor, Independent Regulator of NHS Foundation Trusts	To consider amending NICE guidelines to order neurological observations routinely following falls in hospitals	Extension granted	34
West Yorkshire: Eastern	South West Yorkshire NHS Mental Health Trust	The Sycamores Unit, Ossett, to consider a review of the level of staffing	Yes	35
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	Cardiff Royal Infirmary to consider a review of administration of medication and infection control procedures	Yes	41
Hertfordshire	Healthcare Commission	To consider disseminating across Health Trusts clear guidelines and training on symptoms of diabetic ketoacidosis, and ensuring rapid advice can be obtained from the inpatient diabetic team for A & E staff	Yes	45

Coroner District	Report sent to	Details	Response Received	Report Number
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	University Hospital of Wales to consider providing supplies to ensure post-operative patients are kept at the right temperature	Yes	49
Greater Manchester: South	Stockport NHS Foundation Trust	To consider ways of communicating more effectively about infection control	Yes	52
South Yorkshire: Western	Barnsley District General Hospital	To consider reviewing guidelines on necrotising fasciitis	Yes	56
London: Inner North	University College Hospital, London	To consider reorganising delivery of upper gastro-intestinal and bariatric surgical services	Yes	62
Staffordshire: South	Cumberland House Doctor's Practice, Stone; Stafford Hospital; Autumn House Nursing Home, Stone	Cumberland House and Autumn House to consider improving medical records of doctors visiting care homes and Stafford Hospital to review the reading of x-rays	Yes	65
Greater Manchester: South	Stockport NHS Foundation Trust	Obstetrics and Gynaecological department at Stepping Hill Hospital, Stockport, to consider a review of communication procedures, note keeping and staffing levels	Yes	66
Birmingham & Solihull	Monitor, Independent Regulator of NHS Foundation Trusts	To consider a review of admission and care procedures at Heartlands Hospital, Birmingham	Yes	69

Coroner District	Report sent to	Details	Response Received	Report Number
Milton Keynes	Milton Keynes Hospital NHS Foundation Trust	To consider a review of delays in the conduct and reporting of CT scans and of arranging urgent CT scans during the night	Yes	72
Northamptonshire	Kettering General Hospital NHS Trust	To consider recording oxygen saturations on patient observation charts as part of the early warning system	Yes	73
Milton Keynes	Milton Keynes Hospital NHS Foundation Trust	To consider a review of the protocol and advice given to mothers phoning the maternity unit after discharge	Extension Granted	77
Brighton and Hove	Brighton & Sussex University Hospitals NHS Trust	To consider a review of procedures in specialist paediatric operations	Yes	93
Cardiff and The Vale of Glamorgan	School of Postgraduate Medical and Dental Education, Cardiff University; Welsh Assembly Government; General Medical Council	To consider a system to ensure adverse incidents in which doctors are involved are included on their file and considered throughout their career	Yes	103
Cheshire, Halton and Warrington	Warrington Hospital	To consider a review of treatment for hepatitis C patients to make it fully compliant with the January 2004 NICE Guidelines	Yes	104

Coroner District	Report sent to	Details	Response Received	Report Number
Cheshire, Halton and Warrington	Warrington Hospital	To consider making patients' previous notes available on the hospital computer system so they are instantly available	Yes	105
Devon: Plymouth & South West	Plymouth Hospitals NHS Trust	Derriford Hospital to consider a review of the procedures for allocating patients to nursing homes, information contained in records on patients' conditions in referral forms to nursing homes, and provision of adequate medication	Yes	107
Cheshire, Halton and Warrington	Leighton Hospital, Crewe	To consider a review of the time taken and the procedure for reporting x-rays	Yes	112
Blackburn, Hyndburn and the Ribble Valley	East Lancashire Hospitals NHS Trust	To consider the appropriateness of major surgery being undertaken at Burnley General Hospital when there is no haematology department or intensive care unit	Yes	113
Peterborough	Peterborough District Hospital	To consider a review of procedures for treatment containing potassium and the treatment of hyperkalaemia	Yes	118
London: City	General Medical Council; Nursing and Midwifery Council	To consider reviewing fitness to practise regulations following the administration of inappropriate medication	Yes	120

Coroner District	Report sent to	Details	Response Received	Report Number
Staffordshire: Stoke-on-Trent and North	University Hospital of North Staffordshire	To consider a review of nursing expertise, the training provided and safeguards in monitoring, preventing and treating sacral pressure sores	Yes	124
London: Eastern	Department of Health	To consider reviewing NICE guidelines on when CT scans should be conducted on patients with head injuries	Yes	129
Brighton and Hove	Brighton & Sussex University Hospitals NHS Trust	To consider a review of guidance provided to day patients on mobilisation and DVT risks on their discharge after day surgery	Yes	131
Shropshire: Mid and North-west	Princess Royal Hospital, Telford	To consider a review of use of locum doctors and appropriate entries on medical records	Yes	132
Greater Manchester: City	North Manchester General Hospital	To consider a review of the procedure of recording when stents need replacing and a robust recall and audit system to ensure this is done	No	137
Worcestershire	Worcestershire Acute Hospitals NHS Trust	To consider using capnography in all cases of paediatric intubation cases	Extension Granted	140
West Yorkshire: Western	Department of Health; Healthcare Commission	Eccleshill Independent Sector Treatment Centre, Bradford, to consider a review of facilities to deal with complications arising during surgical procedures	Yes	141

Coroner District	Report sent to	Details	Response Received	Report Number
Bournemouth, Poole & Eastern Dorset	Royal Bournemouth Hospital	To consider a review of the training needed and/or protocol on x-ray images being reviewed and reported on by radiologists	Yes	143
Greater Manchester: City	Christie Hospital NHS Trust, Manchester	To consider reviewing procedures for approving drug funding applications to ensure all clinicians and appropriate hospital managers/nurses are aware of them; providing a standard template and regular reviews to avoid delays; and communicating the system to patients and their families	Yes	145
Greater Manchester: South	Trafford Healthcare NHS Trust	To consider a review of consent procedures and acute pain service provision	Not yet due	150
Hampshire: Portsmouth and South East	Portsmouth Hospitals NHS Trust	Queen Alexandra Hospital, Portsmouth to consider observation procedures when patients use a vital signs monitor	Not yet due	153
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust; Welsh Ambulance Service NHS Trust; National Institute for Health and Clinical Excellence	University of Wales Hospital to consider reviewing the availability of records to ensure they are available to all involved in patient care and providing a protocol to assist triage nurses; Welsh Ambulance Service to consider a review of transmission of ambulance records to hospital staff to enable continuity of care; NICE to review guidelines on the treatment of children to include tachycardia as a significant symptom	Not yet due	162

Coroner District	Report sent to	Details	Response Received	Report Number
South Yorkshire: Western	Barnsley District General Hospital Foundation Trust	To consider a review of the way information on falls and special needs is identified and communicated to all ward staff involved in a patient's care and how best to provide this special assistance to patients; to consider a review of instructions provided to its staff on providing statements to the coroner	Not yet due	164
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	University of Wales Hospital to consider reviewing guidelines on the urgency of x-rays and staff training needs when pneumothorax is suspected and/or concerns are raised about the placing of nasogastric tubes	Not yet due	169
Greater Manchester: South	The Alexandra Hospital, Cheadle	To consider a review of staffing and the level and standard of services available	Not yet due	170
South Yorkshire: Western	Royal Hallamshire Hospital, Sheffield; Nethergreen Surgery Sheffield	To consider reviewing record keeping to ensure the follow-up of patients' treatment	Not yet due	172
Staffordshire: South	Stafford Hospital	To consider reviewing communications procedures to ensure ward staff are aware of decisions made by surgeons, to enable appropriate medication and feeding to be administered	Not yet due	173

Coroner District	Report sent to	Details	Response Received	Report Number
Preston and West Lancashire	Lancashire NHS Trust	Royal Preston Hospital to consider a review of staffing provision and the location within wards of patients with special nursing needs	Not yet due	183
Devon: Exeter and Greater	Royal College of Obstetricians and Gynaecologists	To consider a review of the protocol when a baby is born with low APGAR scores so that the placenta will be retained for examination, and to consider carrying out research into the risks and benefits of birthing pools so that advice can be evidence based	Not yet due	190
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	University Hospital of Wales to consider reviewing system for handover from the critical care unit to wards, arrangements for patients who become unwell while off the wards, and the making of cardiac arrest calls	Not yet due	193
Greater Norfolk	Queen Elizabeth Hospital, Kings Lynn	To consider a review of handover procedures, especially at weekends, and the provision of senior medical staff at weekends to provide care to seriously ill patients	Not yet due	197
Birmingham & Solihull	General Medical Council; Nursing and Midwifery Council	To consider reviewing the performance of staff who administered an overdose of drugs to patients	Not yet due	200

Coroner District	Report sent to	Details	Response Received	Report Number
West Yorkshire: Eastern	St James's University Hospital, Leeds; West Yorkshire Ambulance Service	A & E Departments at Leeds General Infirmary and St James's University Hospital to consider a review of instructions in the 'Clinical Decision Unit Protocol - Isolated Headache' document, and West Yorkshire Ambulance Service to include a pain score on record sheet	Not yet due	201
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust	To consider the level of English required before a doctor can practise	Not yet due	207
Hospital Deaths: other hospital deaths				
Greater Manchester: City	Spacelabs Healthcare Ltd; Central Manchester and Manchester Children's University Hospitals	To consider a review of maintenance and regular monitoring of hospital equipment to ensure it is working correctly	Yes	70
London: Inner South	Medicines and Healthcare Products Regulatory Agency	To consider a review of possibly defective suction unit equipment in the cardiac laboratory at King's College Hospital, London	Yes	101

Coroner District	Report sent to	Details	Response Received	Report Number
Road Deaths: Highways safety				
Lincolnshire: West	Highways Agency	To consider closing the gap in the central reservation on the A1 at junction with the road from Stoke Rochford	Yes	3
Berkshire	Wokingham District Council	To consider an extension of the crash barrier on the A392M	Yes	4
Sunderland	Sunderland City Council	To consider providing vehicular restrictions near Lyon Place, South Hylton, adjacent to River Wear	Yes	7
Somerset: Western	Government Office for the South West	To consider providing a dual carriageway on the A303 between Ilminster and Honiton	Yes	8
Derby and South Derbyshire	Derbyshire County Council	To consider providing traffic calming measures on the A511 at Woodvale, South Derbyshire, near the doctors' surgery	No	11
Staffordshire: South	Staffordshire County Council	To consider providing 'SLOW' markings on Rolleston Lane, Tutbury	Yes	14
Wiltshire and Swindon	Highways Agency	To consider providing signage and extension of solid white lines road markings on the A36 Black Dog Hill, Chapmanslade, near Warminster	Yes	17

Coroner District	Report sent to	Details	Response Received	Report Number
Birmingham & Solihull	Birmingham City Council	To consider providing a pedestrian crossing, central refuge, speed camera or speed sign at Clapgate Lane, Bartely Green, Birmingham at junction with Bell Heath Way	Extension granted	25
Greater Manchester: South	Trafford Council	To consider improvements to short-cut pathway leading to Dane Way Metrolink stop, Manchester	Yes	26
Devon: Exeter and Greater	Devon County Council	To consider providing signage markings on the B3137 at Little Silver, South Moulton	Yes	27
Greater Manchester: West	Highways Agency	To consider providing pedestrian entry restriction signs on slip roads and lighting on the M61 between junctions 3 and 6	Yes	30
Kent: North West	Kent County Council	To consider improving lighting on the A25 Main Road, Sundridge, Kent	Yes	33
Wiltshire and Swindon	Highways Agency	To consider providing improvements to hatch markings and street lighting at the Reybridge Junction on the A350	Yes	37
Peterborough	Peterborough City Council	To consider closing the central reserve gap at junction of Russell Hill, Thornhaugh with the A1	Yes	44

Coroner District	Report sent to	Details	Response Received	Report Number
Greater Manchester: South	Stockport Metropolitan Borough Council	To consider providing a barrier and reducing speed limit at Woodford Road, Bramhall Roundabout on Manchester Airport eastern link road	Yes	51
Derby and South Derbyshire	Derby City Council	To consider work to improve visibility and reduce the speed limit on Pasture's Hill, Littleover, Derby	Yes	54
West Yorkshire: Eastern	Leeds City Council	To consider what remedial work could be carried out to prevent flooding in the underpass on the A64 at Hope Inn, Burmantofts	Yes	59
Greater Manchester: South	Highways Agency	To consider providing a nearside barrier on the M60 adjacent to marker post 49.9 at Denton and replacing a lamppost at this site	Yes	60
Avon	Bristol City Council	To consider providing pedestrian crossing facilities on the A37 Wells Road at the junction with Ridgeway Lane	Yes	61
Avon	Bristol City Council	To consider providing a higher barrier to prevent pedestrians crossing the M32 slip road at the Eastgate roundabout	Yes	67
Bournemouth, Poole and Eastern Dorset	Department for Transport	To consider a review of signage and warnings on abnormal loads travelling on a public highway	Yes	74

Coroner District	Report sent to	Details	Response Received	Report Number
Staffordshire: South	Department for Transport	To consider whether red warning triangles should be made compulsory in the UK	Yes	78
Wiltshire and Swindon	Wiltshire County Council	To consider closing the gated access on the A350, on the western section of Shails Lane, Melksham	Yes	80
Avon	Somerset County Council	To consider replacing 2 manhole covers on the west-bound A38 at Washford	No	110
Hampshire: North East	Department for Transport	To consider removing the hedge in the central reservation on the A303 at Micheldever Station	Yes	114
Shropshire: Mid and North-west	West Mercia Constabulary	To consider further measures to stop excessive speeding on the A41 Tern Hill near Stormy Petrel Public House	Not yet due	156
Essex and Thurrock	Essex County Council	To consider reviewing the safety of the willow trees on Blake End Road, Great Saling to check for rot and damage, and to implement an inspection regime for trees along a highway	Not yet due	157
Staffordshire: South	Staffordshire County Council	To consider a review of additional road safety measures on the A449 northbound at Lloyd Hill, near Wombourne	Not yet due	167

Coroner District	Report sent to	Details	Response Received	Report Number
West Sussex	Department for Transport	To consider improving signage on the A23 to advise that a cycle route is available and how to get to it at start of the route at Broadfield	Not yet due	180
West Yorkshire: Eastern	Leeds City Council	To consider blocking steps from Swinnow Road, Bramley, to block access onto the A647 Stanningley by-pass	Not yet due	189
Road Deaths: vehicle safety				
Cumbria: South and East	Department for Transport	To consider a potential stability problem with the Mitsubishi Delicia motor car when driven at speed	Yes	10
Blackburn, Hyndburn and the Ribble Valley	Department for Transport	To consider that all large goods vehicles and not just those registered since January 2007 should be fitted with a wide-angle front mirror to improve visibility,	Yes	47
Avon	First Bus, Bristol	To consider providing a device on double decker buses to alert the driver of passengers stood on stairs	Yes	63
Derby and South Derbyshire	Department for Transport	To consider providing road safety education on drivers' sitting position and the correct positioning of seatbelts	Yes	88

Coroner District	Report sent to	Details	Response Received	Report Number
London: Western	Department for Transport	To consider that all large goods vehicles and not just those registered since January 2007 should be fitted with a wide-angle front mirror to improve visibility,	Yes	119
West Sussex	Department for Transport	To consider requiring that agricultural trailers should have 'under run bars' at the rear of vehicles to prevent other vehicles being able to move under the trailers in the event of a collision	Not yet due	181
Road Deaths: Driver and vehicle licencing				
Knowsley, St Helens and Sefton	Department for Transport	To consider implementing lorry driver screening for obstructive sleep apnoea	Yes	19
Cumbria: South and East	Driver and Vehicle Licensing Agency	To consider reviewing procedures regarding the re-issue of a driving licence to someone who has voluntarily surrendered their driving licence on medical grounds	Yes	133
Wiltshire and Swindon	Driver and Vehicle Licensing Agency	To consider reviewing the deemed loophole whereby motorcycle licence holders from an EU country whose test is not equivalent to the UK test can convert their licence without having to take a UK driving test	Not yet due	176

Coroner District	Report sent to	Details	Response Received	Report Number
Accidents at Work and Health & Safety-related Deaths				
London: City	Freshfields Bruckhaus Deringer LLP; City of London Corporation	To consider providing lighting or safety notices to indicate the depth of drop in light wells when buildings with such features are not occupied	Partial response	6
Hertfordshire	Hire Association Europe	To consider reviewing guidance and instructions provided to people hiring scaffolding equipment, to ensure it is compliant with the latest guidelines and that hirers are aware of the requirements for safe construction and use of the equipment	Yes	46
Sunderland	Sunderland City Council	To consider providing rescue equipment and review all aspects of safety at Hendon Beach and extending the beach safety education programme to secondary school children	Yes	53
South Yorkshire: Western	Carlton Main Brickworks Ltd, Barnsley	To consider a review of risk assessment, reporting of health and safety issues and trespass incidents, and compliance with the Quarries Regulations 1999	Yes	55
Carmarthenshire	UK Liquid Petroleum Gas	To consider a review of advice and servicing information for liquefied petroleum gas regulators installed into properties	Yes	68
Devon: Torbay and South	Health and Safety Executive	To consider the guidance/signage at unmanned swimming pools to warn of steep gradients	Yes	76

Coroner District	Report sent to	Details	Response Received	Report Number
Darlington and South Durham/North Durham	Health and Safety Executive	To consider guidance and regulations on the transportation of acetylene and other potentially explosive volatile gases	Yes	87
Pembrokeshire	Health and Safety Executive	To consider a review of solid fuel appliance regulations to bring them into line with Gas Regulations	Yes	95
East Riding and Hull	Clarke International Ltd	To consider the design and guidance of crane model CFC 100 to improve safety	Yes	99
Greater Manchester: South	Regatta Ltd	To consider reviewing the operating procedures for man-rise trucks, to avoid collisions when two are in the same aisle and having audible and visible warning systems operating on these trucks when in use at the company's Elby warehouse	Yes	115
Carmarthenshire	Carmarthenshire County Council	Pembrey Country Park to consider providing signs warning of the dangers of digging and burrowing at dunes at Cefn Sidan Beach and on its information leaflets and website	Yes	134

Coroner District	Report sent to	Details	Response Received	Report Number
Greater Manchester: City	Taylor Electronics (Manchester) Ltd	To consider requirements for cherry picker machines to be maintained and serviced in accordance with manufacturers' instructions, for all second-hand machines to be accompanied by operating manual and instructions, appropriate safety equipment and signage, and for HSE guidance to be provided and reviewed if needed	No	138
Greater Norfolk	North Norfolk District Council	To consider providing further warning notices about the dangers of the sea at Cromer	Not yet due	155
Berkshire	Auto-Cycle Union Ltd	To consider whether Motocross tracks can be members and, if so, whether minimum standards of safety equipment can be imposed before users are allowed to use the track	Not yet due	158
Milton Keynes	Sikh Arts and Cultural Association	To consider a review of the provision of briefing, instructions on safety equipment and marshals along the route of its Birmingham to Southall cycle ride	Not yet due	163
Cheshire, Halton and Warrington	Jeyes UK; The Environment Agency; The British Metals Recycling Association	To consider a review of procedures for the proper storage, transport and safe disposal of hazardous waste	Not yet due	175

Coroner District	Report sent to	Details	Response Received	Report Number
London: City	Mayor of London	To consider providing lifebelts or flotation aids on the River Thames near Grant's Quay Wharf and London Bridge	Not yet due	182
Cardiff and The Vale of Glamorgan	RWE National Power Generation; AMEC Power and Process; Association of Electricity Producers	Aberthaw Power Station to consider reviewing safety responsibilities and plans	Not yet due	191
Pembrokeshire	Department for Transport	To consider extending the Merchant Shipping (Means of Access) Regulations 1988 to include fishing vessels	Not yet due	192
London: Inner West	Department for Work and Pensions	To consider formalising banning the use of semi-automatic quick hitches to attach buckets to excavators	Not yet due	195
West Yorkshire: Eastern	Wakefield and District Housing	To consider advising tenants about the dangers of hot water and the signs indicating problems; encouraging them to report problems urgently; and staff attending such call-outs to check that water has not entered the immersion heating terminal housing unit	Not yet due	199
Avon	Weston Super Mare Golf Club	To consider providing a barrier or restraint on the footpath alongside the golf club where the reinforced wall is made of Gabion baskets	Not yet due	202

Coroner District	Report sent to	Details	Response Received	Report Number
Community Healthcare and Emergency Services Deaths				
Derby and South Derbyshire	Derbyshire Health United	To consider the suitability of out of hours software to diagnose small children, and the transfer of information between call handlers	Yes	5
Greater Manchester: City	Department of Health	To consider providing a national allergy service funded by the NHS	Yes	31
Greater Manchester: South	Bramhall Health Centre, Stockport	To consider logging all telephone calls and placing details of prescriptions given as a result of telephone contact on patients' notes	Yes	48
Cheshire, Halton and Warrington	5 Boroughs NHS Partnership, Warrington	To consider improving medical notes and implementing a regular system of audit	Yes	57
London: Inner North	Islington NHS Primary Care Trust; Rubicon Drinks Ltd; Food Standards Agency	Islington NHS Primary Care Trust to consider a review of provision of paediatric allergy clinics to raise awareness of food ingredients, and to ensure an up to date source of adrenaline injections; Rubicon Ltd and Food Standards Agency to consider a review of food packaging requirements regarding allergies	Yes	64

Coroner District	Report sent to	Details	Response Received	Report Number
Greater Manchester: South	Stockport Metropolitan Borough Council	Social Services to consider reviewing guidance on the use of more than one mattress on beds with guard rails	Yes	81
Greater Norfolk	Norfolk Community Healthcare	Norwich and Norfolk Hospital and Norfolk Community Healthcare to consider a review of communication between them of patients' needs	Yes	82
West Yorkshire: Western	Department of Health	To consider the system for admission into psychiatric care to remove the need for further assessment by a community psychiatric nurse	Yes	83
Greater Manchester: North	Rochdale Adult Care Services	To consider installing domestic sprinkler systems or monitored smoke alarms in homes of vulnerable adults under their care	Yes	85
Pembrokeshire	Welsh Assembly Government	To consider a review of the after hours service to enable call handlers to transfer calls to the correct service or provide the correct number to call	Yes	94
Staffordshire: South	Berrymans Lace Mawer Solicitors	To consider a review of pharmacy procedures to ensure the correct checking of prescribed medicines before they are dispensed and the correct sealing of bags once checked	Yes	100
London: Inner South	Southwark Health and Social Services	To consider a review of policy and practice on referrals	Yes	111

Coroner District	Report sent to	Details	Response Received	Report Number
Blackburn, Hyndburn and the Ribble Valley	Blackburn with Darwen Borough Council	To consider obtaining legal advice on the application of confidentiality law to persons under 18 who are the subject of court orders; to consider a review of lines of responsibility within the Youth Offending Team to reduce the number of staff involved in a young person's care and to review the mental health assessment protocol when a young person indicates suicidal intention	Not yet due	160
Great Yarmouth	Messrs Mills and Reeve, Solicitors, Norwich	To consider the relationship between the ambulance service and hospital staff, and the process of transmitting ambulance records to A & E staff to enable continuity of care	Not yet due	161
West Yorkshire: Eastern	Wakefield Metropolitan District Council	Queen Elizabeth Rehabilitation Unit, Wakefield to consider reviewing its staffing levels	Not yet due	179
Liverpool	Liverpool Primary Care Trust	To consider reviewing the health visitor framework for home visits to include a request to inspect sleeping arrangements for new born babies and to provide information on co-sleeping, and to record if the request is refused	Not yet due	184
Greater Manchester: South	Guinness Northern Counties, Oldhan	To consider providing round-the-neck pendant alarms for residents in warden controlled accommodation at Edgeley, Stockport	Not yet due	198

Coroner District	Report sent to	Details	Response Received	Report Number
Cardiff and The Vale of Glamorgan	Gwent Healthcare NHS Trust	To consider issuing all community and district nurses with a standard list of equipment to be carried on their rounds	Not yet due	204
Greater Manchester: South	Stockport Homes; Stockport Primary Care Trust; Bridge Care Services Ltd, Marple; Carecall, Stockport; Stockport Metropolitan Borough Council;	To consider ensuring that Carecall operators have more information on clients so they can better understand why alarms may be activated and appropriate care offered, and Social Services and the Primary Care Trust to consider carrying out possible fire risk assessments on vulnerable adults in their care	Not yet due	205
Mental Health-related Deaths				
Staffordshire: South	South Staffordshire and Shropshire Healthcare NHS foundation Trust	To consider providing more face to face contact in psychiatric assessment and providing non-emergency beds	Yes	13
Staffordshire: South	South Staffordshire and Shropshire Healthcare NHS foundation Trust	To consider providing supported accommodation for psychiatric patients	Yes	15
South Yorkshire: Western	South Yorkshire Police	Custody officers to consider referring to a police surgeon someone indicating suicidal risk who is taken into police custody, and routinely providing nursing staff in large custody areas	Yes	32

Coroner District	Report sent to	Details	Response Received	Report Number
London: Southern	South London and Maudsley NHS Trust	Maudsley Hospital to consider improving procedures on what action to take when a patient leaves without permission when admission is being contemplated	No	43
Derby and South Derbyshire	Derbyshire Mental Health NHS Trust	To consider reviewing rota for social workers and time limits for response to calls made to the service	Yes	91
Greater Norfolk	NHS Norfolk; Norfolk and Waveney Mental Health NHS Foundation Trust	To consider a review of delays in referrals to the mental health team and the provision of cover when the primary nurse is unavailable for patients with eating disorders	Yes	102
West Sussex	Sussex Constabulary; Sussex NHS Partnership Trust; Priory Hospital Brighton and Hove;	Sussex Police Call Centre to consider a review of the recording of domestic violence Incidents; Sussex Partnership Trust to consider a review of procedures regarding transfer of notes between hospitals; The Priory Hospital, Brighton and Hove, to consider a review of records kept and their policy and procedures on action to be taken by staff who receive information on possible harm to self or others	Yes	106
Cheshire, Halton and Warrington	5 Boroughs NHS Partnership, Warrington	To consider a review of mental health services procedures, communications and referrals	Yes	117

Coroner District	Report sent to	Details	Response Received	Report Number
Lincolnshire: West	West Lincolnshire Primary Care Trust	To consider including depression as a possible side effect of the drug memantine	Yes	122
Greater Manchester: City	University of Manchester	To consider reviewing the roles of student tutors, procedures for contact with family/next of kin concerned about a student's welfare, procedures for follow up of welfare concerns about students living in university accommodation, and the need for clear access routes to mental health advice and treatment for students	No	125
Greater Norfolk	Norfolk & Waveney Mental Health NHS Foundation Trust	To consider whether the recommendations in Root Cause Analysis Report have been fully implemented	Yes	126
Staffordshire: South	Good Hope Hospital, Sutton Coldfield	To consider reviewing communications with agencies in Staffordshire in cases where there are mental health issues	Yes	127
London: Inner South	St Giles Trust; Centrepoint	To consider a review of the protocols and systems to exchange information between each other and other agencies to minimise risks for clients with mental health issues	No	128

Coroner District	Report sent to	Details	Response Received	Report Number
Greater Manchester: City	Manchester Mental Health and Social Care Trust	To consider reviewing the system of prioritising patients waiting for beds, including whether there are adequate beds available for the number of patients needing detention, and to consider reviewing their criteria for placement out of area	Yes	135
Hertfordshire	Hertfordshire Partnership Trust	To consider, together with the Exceptional Treatment Panel and the Joint Commissioning Team, providing clear information on the process of consideration for funding, the criteria for funding and clear reasons for refusing of such funding for exceptional treatment	Yes	144
Devon: Exeter and Greater	Devon Partnership NHS Trust; Devon and Cornwall Constabulary	Devon Partnership NHS Trust to consider a review of the systems in place to provide care to patients detained under section 3 of the Mental Health Act 1983; Devon and Cornwall Constabulary to consider its procedures for pursuing Missing Persons Reports	Yes	148
Hertfordshire	Barnet, Enfield & Haringey Mental Health NHS Trust	To consider a review of the arrangements for co-ordination between health trusts and the allocation of care co-ordinators, together with a review of comprehensive risk assessments and care programmes to facilitate discharge into the community	Not yet due	149

Coroner District	Report sent to	Details	Response Received	Report Number
Greater Manchester: City	University Hospital of South Manchester; Borchardt Medical Centre, Withington	Wythenshawe Hospital to consider urgently referring patients indicating potential self-harm for a psychiatric assessment, and Borchardt Medical Centre, Withington, to ensure that responsibilities for referrals are clearly set out to avoid confusion	Not yet due	188
London: Inner West	Nursing and Midwifery council	To consider the apparent inadequate selection, training and qualifications of some registered mental health nurses trained at some London universities	Not yet due	194
Deaths in custody				
West Yorkshire: Eastern	Ministry of Justice	New Hall Prison to consider a survey of old cellular accommodation to identify and then rectify possible ligature points	Yes	42
Cheshire, Halton and Warrington	GSL UK Ltd; Cheshire Constabulary	To consider a review of detention officers' awareness of PACE provisions	Yes	58
West Yorkshire: Eastern	H M Prison Wakefield	To consider a review of medical management of prisoners with long term medical conditions	Yes	75
Hertfordshire	Ministry of Justice	Mount Prison, Hertfordshire to consider redesigning shower doors and frames in its cells to remove rigid bars which could be used as ligature points	Yes	92

Coroner District	Report sent to	Details	Response Received	Report Number
Cheshire, Halton and Warrington	H M Prison Risley	To consider obtaining GP records for prisoners and noting prisoners' records when an Assessment, Care in Custody and Teamwork (ACCT) is opened	Yes	96
Greater Manchester: West	Home Office	To consider providing a readily available set of emergency keys for cells in police custody suites	Yes	98
West Yorkshire: Eastern	West Yorkshire Police	To consider a review of policies, practices and procedures carried out in all custody suites, and personnel competence within its area	Yes	108
Durham & Darlington	H M Prison Frankland	To consider a review of electronic cell call system, night staff procedures, personal officer scheme and first aid training	Yes	121
Greater Manchester: City	H M Prison Manchester	To consider a review of the protocol for exchange of information between the Police and Prison Service regarding prisoners; Manchester Prison to review use of defibrillators, and the Prison Service to consider a review of protocols to ensure foreign nationals can make contact with their families as speedily as possible	Yes	139

Coroner District	Report sent to	Details	Response Received	Report Number
Staffordshire: South	South Staffordshire Primary Care Trust; H M Prison and Youth Offender Institute, Brinsford	Brinsford Prison and Young Offenders' Institute to consider a review of information given to new arrivals about visiting orders, and South Staffordshire PCT to consider a review of information on entries on medical records	Partial response	142
Greater Manchester: City	H M Prison Manchester	To consider providing interpreters who speak prisoners' first language; providing defibrillators in all parts of the prison; providing extra support to prisoners at times of possible additional stress; follow up missed medical appointments and review protocol on responding to emergencies so responders know the type of emergency they are attending	Not yet due	165
Northamptonshire	Ministry of Justice	To consider a review of the number of secure beds provided for prisoners suffering with a mental illness	Not yet due	171
Greater Manchester: City	H M Prison Manchester	To consider a review of prison medical records procedures, to extend the scope of first reception health screen and appointment processes for medical appointments and to ensure staff have appropriate training to identify addictions	Not yet due	196

Coroner District	Report sent to	Details	Response Received	Report Number
Drug and Medication-related Deaths				
Staffordshire: South	National Patient Safety Agency	To consider producing distinctive markings on intravenous drug bags to avoid those with similar names being confused	Yes	23
Lincolnshire: West	The British Pain Society	To consider providing guidance to doctors about possible detrimental affects of pethadine tablets and oramorph liquid in patients liable to snoring	Yes	24
Greater Manchester: South	Stockport Community Drug Team	To consider providing daily prescriptions when it is known a client may not take medication as prescribed	Yes	39
Greater Norfolk	Department of Health	To consider mandatory Criminal Records Bureau checks on dental staff with access to controlled drugs, and whether further guidance should be provided to dentists on how to protect drugs from being obtained by their staff unlawfully	Yes	84
Derby and South Derbyshire	Addaction	To consider a policy ensuring a regular review of methadone users' needs and prescriptions to reduce their ability to accumulate large quantities of methadone	Yes	90
Somerset: Eastern	Somerset Primary Care Trust	To consider a review of the records maintained by community nurses to ensure these are available to others within the team	No	109

Coroner District	Report sent to	Details	Response Received	Report Number
Sunderland	Northumbria Police	To consider timescale for implementing and disseminating the protocol between the Police and North East Ambulance Service regarding medical assessment of people who are drunk and to consider first aid refresher training for police officers in respect of non-detained persons	Yes	130
Cardiff and The Vale of Glamorgan	Royal College of Psychiatrists	To consider requiring that all methadone prescriptions should be dispensed and taken on pharmacy premises to reduce the availability of methadone in the community and methadone related deaths	Not yet due	185
Cardiff and The Vale of Glamorgan	Royal Pharmaceutical Society of Great Britain; Royal College of General Practitioners	Royal Pharmaceutical Society to consider reminding pharmacists about the protocols on dispensing, labelling and providing medicine information leaflets and to review the availability of online patient information leaflets; Royal College of General Practitioners to remind GPs about the protocols on amending prescriptions after dispensing	Not yet due	186
Cardiff and The Vale of Glamorgan	Cardiff & Vale NHS Trust; Tesco Stores Ltd	To consider reviewing the availability of drugs and from where these are obtained by pharmacists to prevent drug abuse by pharmacists. Cardiff & Vale NHS Trust to ensure staff are aware of the need to provide all relevant information in the statements they make to the Police	Not yet due	187

Coroner District	Report sent to	Details	Response Received	Report Number
Black Country	Home Office	To consider restricting the supply of potassium cyanide	Not yet due	206
Care Home Deaths				
Staffordshire: South	Rowans Care Homes Ltd	Burton Court, Burton upon Trent to review how a client on blended menu obtained non-blended food item	Yes	2
Greater Manchester: South	Marple Dale Nursing Home, Stockport	To consider improvements to care plans and medication records	Yes	38
Greater Manchester: South	Hyde Nursing Home, Glossop	To consider improvements to information and care procedures	Yes	40
Greater Manchester: City	Brocklehurst Nursing Home, Manchester	To consider reviewing policy on who should have responsibility for patients' mobilisation and whether appropriate training has been provided, and to ensure an audit trail is completed in line with any policy implemented	No	136
Hampshire: Portsmouth and South East	Dunwood Manor Nursing Home, Romsey	To consider the information given by care home staff when residents with special dietary/feeding needs are admitted to hospital	Not yet due	152

Coroner District	Report sent to	Details	Response Received	Report Number
Service Personnel Deaths				
Wiltshire and Swindon	Ministry of Defence	To consider the use of electronic counter measures on vehicles used in operational zones	Yes	50
Wiltshire and Swindon	Ministry of Defence	To consider how to take forward the lessons learned following the crash of the Hercules XV179 in Iraq in September 2005	Yes	86
Black Country	Ministry of Defence	To consider a review of use of army 'green' vehicles for non-operational/civilian purposes	Yes	123
Devon: Plymouth and South West	Ministry of Defence	To consider armouring the underside of Viking personnel carriers to improve protection from mine strikes	Not yet due	159
Wiltshire and Swindon	Ministry of Defence	To consider reviewing instructions to rotary crews; bringing a modified pigtail into service; the repositioning of the grab handles; fitting of an Automatic Data Recorder and ensuring the cockpit voice recorder is enabled at all times	Not yet due	177

Coroner District	Report sent to	Details	Response Received	Report Number
Police Procedure-related Deaths				
Greater Manchester: South	Greater Manchester Police; Peak combined service Ltd, Hyde; Thameside Metropolitan Borough Council; Highways Agency	To consider a review of police and security personnel procedures in dealing with incidents at Ashton Moss entertainment complex; the availability of alcohol in the Thameside Metropolitan Borough council area, and fencing on the M60 motorway adjacent to Ashton Moss entertainment complex	Yes	71
London: Southern	Association of Chief Police Officers; Ministry of Justice; Metropolitan Police	To consider whether incidents of self harm or attempted suicide in prison custody should be noted on the Police National Computer to enable officers who may come into contact with the person to provide appropriate care	Partial response	79
Somerset: Western	H M Inspector of Constabulary	To consider keeping statistics on crimes or suspected crimes which involved high speed pursuits or responses by Police vehicles	Yes	146
London: Inner South	Metropolitan Police; Metropolitan Police Authority	To consider a review of command structure, communications systems, radio discipline, location and identification information, and rules of engagement for surveillance and firearms officers	Not yet due	154

Coroner District	Report sent to	Details	Response Received	Report Number
Product-related Deaths				
Essex and Thurrock	SCA Hygiene Products	To consider a review of the safety of their incontinence pads, which appear difficult to extinguish if they catch fire	Extension granted	116
Devon: Exeter and Greater	Roma Medical, Bridgend	To consider a review of the braking system on the Shoprider Deluxe Mobility Scooter	Yes	147
Northamptonshire	Department of Communities and Local Government; Persimmon PLC	DCLG to consider providing regulations requiring that mantelpieces should be permanently fixed, Persimmon PLC to consider review of company procedures regarding fire place installation	Not yet due	151
Railway-related Deaths				
Devon: Exter and Greater	British Transport Police; Devon and Cornwall Police	To consider a clear protocol for investigating injury/death on a railway line	Yes	28
West Sussex	Department for Transport	To consider amending the Highway Code to require pedestrians to keep dogs on a lead when crossing level crossings and to provide signs near such crossings indicating that dogs must be kept on leads	Not yet due	178

Coroner District	Report sent to	Details	Response Received	Report Number
Other Deaths				
Greater Manchester: South	Ellen Smith (Tours) Limited	To consider improving records of passengers' next of kin and contact details	Yes	36
Derby and South Derbyshire	Home Office	To consider licensing air weapons and whether it is appropriate for these to be available to the general public	Yes	89
Lincolnshire: North and Grimsby	North Lincolnshire Council	To consider taking control of Ashby Ville waters to enable them to be operated as a managed public facility with a better focus on safety	Yes	97
West Yorkshire: Western	Department of Health	To consider screening babies for beta haemolytic streptococcus group B infection	Not yet due	166
Hampshire: Portsmouth and South East	Portsmouth City Council	To consider a review of protocol on locking public conveniences, to include a manual check to ensure that no-one is still inside when they are locked for the night	Not yet due	168
Greater Norfolk	Malawi Department of Civil Aviation; International Civil Aviation Organisation, Montreal; National Transport Safety Board, Washington DC	To consider providing resources to enable investigations into air accidents to be carried out to the highest possible standard wherever they occur; Malawi Department of Civil Aviation to consider carrying out thorough investigations in fatal air accidents	Not yet due	174

Coroner District	Report sent to	Details	Response Received	Report Number
Staffordshire: South	Jobcentre Plus, Telford	To consider relaxing the requirement for claimants with considerable transport difficulties to have to attend Jobcentre Plus regularly to claim continuing benefits	Not yet due	203

Produced by the Ministry of Justice

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