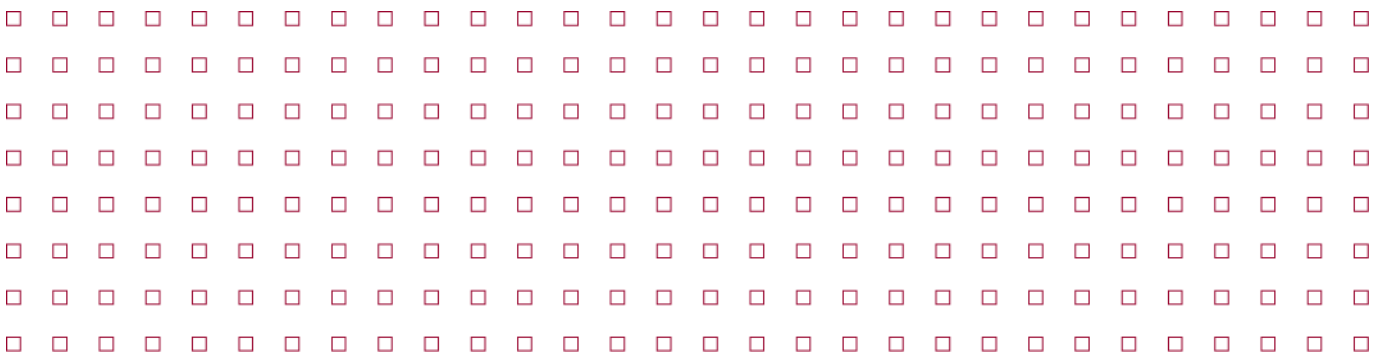
CHIEF CORONER

Summary of Reports to Prevent Future Deaths (formerly Rule 43 Reports)

First Report: For period – 1 April 2013 - 30 September 2013

December 2013



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1. Introduction

This is the first report from the Chief Coroner on Reports to Prevent Future Deaths (PFD reports), formerly known as Rule 43 Reports, and covers the period from 1 April to 30 September 2013. Responsibility for the Reports transferred from the Ministry of Justice to the Chief Coroner on 1 April 2013. During this period, Rule 43 Reports were replaced by PFD reports on the implementation of the Coroners and Justice Act 2009 (the 2009 Act) which came into force on 25 July 2013. Under Schedule 5 paragraph 7 the coroner has a statutory duty to issue a report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The Schedule can be viewed at http://www.legislation.gov.uk/ukpga/2009/25/schedule/5

The importance of PFD reports is emphasised by their upgrading from a rule (Rule 43 of the Coroners Rules 1984) to part of the 2009 Act. Significantly, a coroner's discretion to make a report under the old rules has become a duty to make a report where a concern is identified. In order to issue a report, the coroner must have 'considered all the documents, evidence and information that in the opinion of the coroner is relevant to the investigation' (Regulation 28(3) Coroners (Investigations) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made). This should normally lead to a PFD being issued once the inquest has concluded. However, it is possible for a PFD to be made before an inquest is heard (so long as the above pre-condition is satisfied). Such an approach would be possible if the coroner is satisfied, prior to the inquest, that there is unlikely to be more material to arise on the matter of concern or the coroner believes that there is an urgent need for action without delay.

Where a coroner has a duty to issue a report, it must state the coroner's concerns, and that in the opinion of the coroner, action should be taken to prevent future deaths. The report is a recommendation that action should be taken, but not what that action should be. The coroner must send the report to the person who the coroner believes has the power to take such action. The recipient then has 56 days to respond. A response must contain details of the action proposed, with a timetable, or reasons why no action will be taken. A copy of the report and the response must be sent to the Chief Coroner; reports and responses are now published on the internet. The Chief Coroner has issued guidance to coroners on PFD reports and provided a standard form which can be viewed at http://www.judiciary.gov.uk/about-the-judiciary/office-chief-coroner/pfd-reports/index

As part of his statutory remit the Chief Coroner can review and consult on areas of concern highlighted by reports and where feasible recommend additional action in the form of advice to government agencies or individuals. Once a response is received, a coroner has no further role.

The Chief Coroner wishes to thank coroners for providing copies of both the reports and responses received.

2. Statistical Summary

2.1. PFD reports issued by coroners and trends

Between 1 April 2013 and 30 September 2013 coroners in England and Wales issued 241 PFD reports.

Table 1: The number of PFD reports issued by reporting period

Reporting period	PFD reports issued
17 July 2008 – 31 March 2009	207
1 April 2009 – 30 September 2009	164
1 October 2009 – 31 March 2010	195
1 April 2010 – 30 September 2010	175
1 October 2010 – 31 March 2011	189
1 April 2011 – 30 September 2011	210
1 October 2011 – 31 March 2012	233
1 April 2012 – 30 September 2012	186
1 October 2012 – 31 March 2013	235
1 April 2013 – 30 September 2013	244
Total	**2038**

As in previous summary bulletins produced by the Ministry of Justice, the majority of reports issued during the period resulted from hospital deaths (87 reports). The remainder of the reports were divided principally between community health care and emergency services deaths (43 reports) and road deaths (29 reports). This period saw the highest number of reports issued in any six month period.

Table 2: PFD reports issued by coroners between 1 April 2013 and 30 September 2013, by broad category

Category	**Number of inquests where PFD reports were issued**
Hospital deaths	**87**
Road deaths	**29**
(Highways safety)	*27*
(Vehicle safety)	*2*
Deaths in custody	**24**
Care home deaths	**13**
Mental health related deaths	**10**
Community health care and emergency services related deaths	**43**
Accidents at work and health and safety related deaths	**5**
Alcohol, drug and medication related deaths	**7**
Police procedures related deaths	**4**
Product related deaths	**3**
Railway related deaths	**2**
Service personnel deaths	**1**
Other	**13**
Total	**244**

2.2. Number of PFD reports received from each coroner area

Between 1 April 2013 and 30 September 2013 PFD reports were issued by 72 of the coroner areas within England & Wales.

The Coroner for Manchester South issued the largest number of reports (12) for a single area, followed by Shropshire South (11) and Leicester City (9).

Annex A lists the coroner areas which have issued PFD reports during the period and the numbers issued.

2.3. Organisations in receipt of PFD reports

Table 3 provides a breakdown of the organisations in receipt of PFD Reports. A coroner will send copies of their report to multiple organisations, if the recommendations cover more than one area of responsibility. This means that the number of organisations receiving a report is higher than the number of reports made.

A list of all organisations which have been sent a PFD report is included in the table at **Annex B**.

Table 3: PFD reports issued by coroners between 1 April 2013 and 30 September 2013, by organisation type

Type of organisation
NHS hospitals and Trusts
Central Government departments
Regulatory bodies and trade associations
Community Health Care & Emergency Services
Local Authorities
Private companies
Prisons
Care and nursing homes
Other

2.4. Responses to reports

Under Rule 29 of the Coroners (Investigations) Regulations 2013, organisations are required to respond to PFD reports sent to them. The recipient of a report is required to provide a response within 56 days of the report being sent. The response should provide details of any actions which have been or will be taken, or provide an explanation when no action is deemed necessary or appropriate.

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

2.5. Emerging Trends

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

Just over a third of reports issued in this period relate to deaths in hospitals; this is now an established trend. These reports frequently identify concerns over policies or in relation to note taking, staffing, training, communication and the recording of medication. Coroners have reported directly to the Department of Health where they have identified concerns which may have national implications or they feel information could usefully be disseminated to all NHS Trusts. In addition, coroners are now required to send copies of all

health-related reports to the Care Quality Commission which is responsible for ensuring that the concerns raised in reports are properly dealt with.

As in previous summaries, mental health related deaths and deaths in custody feature prominently. A number of reports focus on communication issues particularly between different agencies and departments within hospitals and the importance of training for staff responsible for caring for patients at risk of self-harm.

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

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

3. PFD reports - wider implications

A list of PFD reports received by the Chief Coroners' office between 1 April 2013 and 30 September 2013 is at **Annex C**.

The vast majority of reports are very specific to a local situation or organisation. However, there are a small number which have wider implications. Two examples from the period are set out below.

Case 1

A prescription was taken to the pharmacy by the wife of the deceased for 84 Prednisolone 5mg tablets. The medication that was dispensed was correctly labelled but the medication and accompanying packaging was actually for Prochlorperazin 5mg tablets. The pharmacy described this as an act of human error, most likely from whoever was responsible for picking the box of medication from the pharmacy shelf. However it has been acknowledged that the checking arrangements by the qualified pharmacist failed to pick up this error.

The cause of death at the conclusion of the inquest was natural causes. However the coroner felt that the evidence heard at the inquest highlighted the need for a report to be made. The Coroner asked NHS England and the Medicines and Healthcare Product Regulatory Agency to consider:

- Whether straightforward pharmacy errors still appear to be occurring at a basic level.

- If future packaging of drugs may be something that can avoid future errors.

In their response, NHS England stated:

- The Patient Safety Team recognises these risks and we are working with the community pharmacy contractors to increase the numbers of patient safety incident reports that the national reporting and learning services receive to improve our understanding of the problem. Analysis of reports that we have received indicates that more needs to be done to reduce these types of incidents.

- Double checks help to identify and correct dispensing errors and have been promoted in previous Design for Patients Safety guidance from the National Patients Safety Agency. NHS England will continue to promote this practice wherever possible.

- There is research evidence that the use of bar code technology, linked to patients medicine records and electronic transfer of prescriptions could reduce moderately severe dispensing errors by 60%. We agree

that much more use should be made of this type of technology in dispensaries to improve patient safety and NHS will work to that effect.

- Significant improvements have been made to the design of medicines labelling and packaging to help minimise mis-selection errors. But in our view safer dispensing systems are required in addition to improvement and labelling and packaging.

- NHS England will undertake a review of incident data and research and engage with stakeholders and prepare a Patient Safety Alert for possible publication as soon as possible. The Alert will better describe the risks arising from dispensing medicines and safer practices to minimise these risks.

In their response, the Medicines and Healthcare Product Regulatory Agency stated:

- To reduce the likelihood of error in the future we have published guidance for the pharmaceutical industry on judicious use of colour on packs to reduce the similarity of pack presentations.

- Other tools can be used to aid the correct selection of product include the use of Tallman lettering. This involves the use of capital letters within the name of the medicine to help differentiate names otherwise look alike when written down. Taken together with the use of colour and incidental capital letters can improve the way in which the names of the medicines as accessed from the labelling.

- We will take steps to see what changes could be introduced to the packaging of these medicines to help those in pharmacies to more easily pick the correct drug and reduce the incidence of mis-selection going forward.

Case 2

In March 2011 there was a fatal helicopter crash at Honister pass in the Lake District. The incident occurred at night in poor weather conditions. The helicopter was operated and registered on the Hungarian Civil Register. The investigation brought to light a number of serious airworthiness issues, none of which could have been linked directly to the crash. However those issues could given time have caused a serious malfunction with catastrophic consequences. The question of oversight, standards and maintenance appears directly related to foreign registration issues.

The Coroner asked The Secretary of State for the Department of Transport to consider:

- Reviewing the arrangements which apply to the operation of helicopters based and flown in this country which are registered in other countries, including the issue of record keeping, maintenance and airworthiness.

In his response, the Secretary of State for the Department of Transport stated:

- The pilot was flying an Aerospatiale SA.341G Gazelle, which crashed in a valley during a night flight in meteorological conditions that included reduced visibility and low cloud. The pilot was not qualified to fly in these conditions or at night.

- The helicopter was registered in Hungary and therefore is operated under the oversight of the Hungarian Civil Aviation Authority and in compliance with European rules for airworthiness. It is the owners/operators responsibility for ensuring that the helicopter is operated in accordance with these rules and that the pilot has the necessary qualifications to operate the flight in all conditions.

- The department is aware that there are a number of helicopters based and operated in the UK that are registered in other countries. The department is working with Civil Aviation Authority (CAA) to understand whether there are similar issues with other foreign helicopters as part of the UK State Safety Programme.

- The department has asked the CAA to conduct inspection/surveys on other foreign registered Gazelle aircraft, notably from Serbia and Hungary. This work is ongoing and remains a priority for the department. The CAA has been in touch with both the Hungarian and Serbian Authorities and are working together to improve the oversight of these helicopters.

Annex A

Number of inquests where PFD reports were issued by each coroner area from 1 April 2013 to 30 September 2013

Coroner area	Reports issued
Avon	**4**
Berkshire	**2**
Birmingham and Solihull	**3**
Black Country	**1**
Blackburn, Hyndburn and Ribble Valley	**4**
Bournemouth, Poole and Eastern Dorset	**2**
Bridgend and Glamorgan Valleys	**3**
Brighton and Hove	**4**
Leicestershire: Rutland and North	**2**
Cardiff and Vale of Glamorgan	**7**
Cheshire	**2**
Lancashire: East	**1**
Cornwall	**3**
Coventry	**4**
Cumbria: North and West	**4**
Cumbria: South and East	**3**
Darlington and South Durham	**4**
Devon: Plymouth and South West	**1**
Dorset: West	**1**
East Riding and Kingston upon Hull	**2**
Exeter and Greater Devon	**6**
Gloucestershire	**4**
Gwent	**1**
Hertfordshire	**4**
Kent: North East	**1**
Leicester City and South Leicestershire	**9**
Lincolnshire: Central	**2**
Lincolnshire: South	**3**
Liverpool	**5**
London: City	**1**
London: East	**4**
London: Inner North	**4**
London: Inner South	**5**
London: Inner West	**7**
London: North	**5**
London: South	**7**
London: West	**1**
Manchester: City	**6**
Manchester: South	**12**

Coroner area	Reports issued
Manchester: North	**2**
Manchester: West	**6**
Mid Kent and Medway	**2**
Milton Keynes	**4**
Norfolk	**3**
North Lincolnshire and Grimsby	**3**
North Wales: East and Central	**4**
North Yorkshire: East	**1**
Northumberland: North	**1**
Nottinghamshire	**2**
Oxfordshire	**1**
Portsmouth and South East Hampshire	**3**
Shropshire: Mid and North-West	**3**
South Yorkshire: East	**4**
South Yorkshire: West	**5**
Staffordshire: South	**11**
Stoke-on-Trent and North Staffordshire	**2**
Sunderland	**2**
Sussex: West	**4**
Teesside	**2**
West Yorkshire: East	**6**
Hampshire: North East	**1**
Wiltshire and Swindon	**2**
Worcestershire	**1**
Buckinghamshire	**2**
Carmarthenshire	**2**
Ceredigion	**1**
Derbyshire North	**4**
Newcastle upon Tyne	**1**
North West Wales	**2**
Somerset Western	**2**
Surrey	**8**
Kent North West	**1**
Total	**244**

Annex B

List of PFD reports received between 1 April 2013 and 30 September 2013

Coroner Area	Organisation	Summary	Response Received	Report
Accidents at work and health and safety related deaths				
South Lincolnshire	(1) South Lincolnshire Clinical Commissioning Group (2) East Lincolnshire Clinical Commissioning Group	To consider improvements to practices on how seasonal workers can gain access to the general practitioner services.	Yes	1
North Wales (East and Central)	Carrington Doors	To consider instating a more rigorous training plan and health & safety procedure in place when working at height.	Yes	2
Leicester City and South Leicester	PPR Transport	To consider a review of current procedures, risk assessments on lifting operations.	Yes	3
Hertfordshire	Fire & Rescue Service Development Division	To consider whether defibrillators should generally be available during future training events.	Yes	4
North West Wales	Health and Safety Executive	To consider implementing regulation/guidance to operators.	Yes	5
Care home deaths				
Surrey	(1) Care Quality Commission (2) South East England Fire Rescue Service	To consider whether pro-active clothing should be more readily available in care homes whose residents may include smokers.	Yes	6
Black Country	Care Quality Commission	To consider the failings of the care home mentioned in the report and implementing an improvement plan.	Yes	7

Coroner Area	Organisation	Summary	Response Received	Report
Teesside	Roseville Care Home	To consider a review of staff practices and procedures	Yes	8
Leicester City and Leicester South	The Manor Residential & Nursing Care Home	To consider improvements to communication between care home staff and other health care professionals	Yes	9
South Yorkshire (West)	Lower Bowshaw View Nursing Home	To consider improvements to record keeping and patient assessments	Yes	10
Manchester West	Pennine Care Trust	To consider improvements to the quality of patients notes and record keeping.	Yes	11
Gloucestershire	(1) Care Quality Commission (2) Gloucestershire Social Services	To consider a review of the care arrangements at the care community.	Yes	12
Leicestershire: Rutland and North	Primelife Ltd	To consider whether there is need for a system to check that the sling has been correctly connected, which is adhered to by the staff.	Yes	13
Manchester: South	Stockport MBC	To consider implementing a central register for all care home residents.	Yes	14
Manchester: South	(1) Mayfield Care Home (2) Care Quality Commission (3) Clinical Care Commissioning Group	To consider introducing a system for prompt re-assessment and transfer of patients whose condition is deteriorating rapidly.	Yes	15
Surrey	Affinity Care Home	To consider incorporating the use of the defibrillator on the premises.	Yes	16

Coroner Area	Organisation	Summary	Response Received	Report
Staffordshire: South	Chaseview Care Home	To consider a review of: • The ratio of staffing to residents. • The training and experience of staff. • The fitting and positioning of alarms. • Training of staff/monitoring/recording of checks on alarms to ensure they are functioning • The ability of staff to maintain 15 minute observations on residents given the need to also attend to other residents.	Yes	17
Manchester West	Oaks Residential Homes	To consider a review of: • Staffing levels • Risks assessments and the management of risks in relation to each patient in particular after a fall or accident. • Training for all staff.	Yes	18
North Yorkshire: (East)	Secretary of State for the Department of Health	To consider a review of the staff ratios in care homes and establishing national guidelines or regulations.	Yes	19
Community health care and emergency services related deaths				
Staffordshire South	Stafford and Surrounds Clinical Commissioning Group	To consider if there can still be some continuing medical/psychiatric involvement once patients are referred to the EWISS service.	Yes	20
South Yorkshire (West)	Secretary of State of Health	To consider a national shared protocol to ensure consistency between all trusts in the management of the drug, Amiodarone.	Yes	21
West Yorkshire (East)	Beeston Health Centre, Leeds	To consider a review of process and procedure for updating patient records which is kept under regular review	Yes	22

Coroner Area	Organisation	Summary	Response Received	Report
Manchester South	(1) Royal College of General Practitioners (2) Royal College of Nursing	To consider a review of training needs within the district nursing team.	Yes	23
Cardiff and the Vale of Glamorgan	National Institute for Health and Care Excellence	To consider a review of the summarising and the transfers of notes to computer when a new patient joins a GP surgery.	Yes	24
West Sussex	Fairlight Nursing Home	To consider a review of the process and procedure in regards to care after admission.	Yes	25
Leicester City and Leicester South	Leicestershire Partnership NHS Trust	To consider a review of the processes and procedures for …and reassess training needs and requirements of staff.	Yes	26
Manchester West	Department of Health	To consider reviews of • Ambulance categorisation • dissemination of information amongst the clinical commissioning groups and other organisations within the health service • Communication between the ambulance services and the Healthcare professionals to distribute clear information on the provision of the Ambulance Service.	Yes	27
Mid Kent and Medway	Kent & Medway NHS and Social Care Partnership Trust	To consider whether a system could be implemented to ensure that all avenues are pursued in attempts to contact such persons: - relatives or friends where known.	Yes	28
Manchester South	Department of Health	To consider whether improvements can be made to the current practice which define a clear pathway for the referral of patients by a GP to the mental healthcare environment.	Yes	29

Coroner Area	Organisation	Summary	Response Received	Report
Powys, Bridgend and Glamorgan Valleys	(1) ABMU Health Board (2) The Monkstone House Care Home (3) The Grove Medical Centre	To consider a review of the process and procedure regarding the level of communication between the care home district nurses and the out of hours GP.	Yes	30
County Durham and Darlington	Tees Esk and Wear Valley NHS Foundation Trust	To consider a review of the process and procedures for discharging patients.	Yes	31
South Yorkshire (East)	Askern Road Surgery	To consider introducing a system for monitoring patients response to pain control management.	Yes	32
Cheshire	Wirral and Cheshire NHS Foundation Trust	To consider to a review of processes and procedures in relation to the adequate and regular assessment of patients.	Yes	33
Avon	Avon and Wiltshire Mental Health Trust	To consider patient's confidentiality arrangements between the trust, family and friends. Also to consider whether or not agencies should be involved when a patient disengages e.g. primary care of the local police.	Yes	34
North Wales (East & Central)	Welsh Ambulance Services NHS Trust	To consider a review into the current working practices with a view to there being greater sound isolation for staff to seek to eliminate background noise and improve the quality and consistency of communication between callers and advisors.	Yes	35
South Yorkshire (West)	LNT Software Helios 47 (owners of Herries Lodge Care Home Sheffield)	To consider introducing a cohesive management system and fully trained staff supervised at all times, and consider adequate patient care plans.	Yes	36
Cheshire	(1) NHS England Castlefields Health Centre	To consider introducing a robust system in place for dealing with patient safety and that doctors and medical staff within the practice are fully trained to respond to such alerts and act upon them appropriately.	Yes	37

Coroner Area	Organisation	Summary	Response Received	Report
West Yorkshire (East)	Saga Homecare	To consider a review on the training protocols and care plans to ensure that carers would always notwithstanding client wishes, call the emergency services and ensure ambulance attendance.	Yes	38
Exeter and Greater Devon	Devon Partnership Trust, Wonford House Hospital	To consider a review of the interaction of all the agencies involved in the local criminal justice system and health providers for safeguarding vulnerable adults	Yes	39
Shropshire, Telford and Wrekin	Bryn Melyn Care Home	To consider implementing a more robust record keeping system.	Yes	40
North East Kent	Kent Police Headquarters	To consider introducing a robust procedure for dealing with potential suicides.	Yes	41
Carmarthenshire and Pembrokeshire	Minister of State for the Armed Services	To consider how care can be effectively managed and delivered, and a review of current protocols on joint-working with the NHS.	Yes	42
Brighton and Hove	(1) The Wellesbourne Health Centre (2) General Medical Council (3) Sussex Community NHS Trust (4) Clinical Quality and Primary Care	To consider the way new patients are registered with GP surgeries and the process and procedures that follow.	Yes	43
Exeter and Greater Devon	Devon Partnership Trust, Wonford House Hospital	To consider whether or not more could have been done to assist and support the deceased.	Yes	44
Central Lincolnshire	East Midlands Ambulance Service NHS Trust	To consider process and procedures when receiving 999 calls.	Yes	45

Coroner Area	Organisation	Summary	Response Received	Report
Manchester South	(1) Department of Health (2) North West Ambulance Service (3) Manchester Medical Services (4) Salford Royal Hospital Trust	To consider whether there should be local (if not national) written policies on how NHS trusts are placed on pre-alert by independent medical providers and for this to be clearly distributed to all concerned as a matter of urgency.	Yes	46
Manchester South	Stockport Council	To consider what training is given to the home support workers, what systems are in place to check that the workers carry out their functions properly, effectively and safely, also what checks are in place to ensure that those systems are working correctly.	Yes	47
Rutland and North Lincolnshire	South Central Ambulance Service NHS Foundation Trust	To consider amending the training manuals and guidelines to provide for the training of paramedics to assist a birth by providing gentle traction to the baby's head and/or gentle internal manipulation of the baby whilst in the vagina.	Yes	48
Avon	Mental Health Service Avon	To consider whether more funding should be provided in relevant cases	Yes	49
Cumbria: North and West	Devon Partnership Wonford House Hospital	To consider introducing a system whereby changes in prescription are monitored by care co-ordinators to ensure that they have been put into effect.	Yes	50
Leicester City and Leicester South	Leicestershire Partnership Trust	To consider a review of the communication between the community crisis team and the mental health team.	Yes	51
Liverpool	Adult Services, Liverpool City Council	To consider why a robust system to review, management and audit were not in place to ensure the annual review of care plans .	Yes	52
London: Inner North	Royal College of General Practitioners	To consider increasing the awareness and guidance of (SAD) to all GP's.	Yes	53

Coroner Area	Organisation	Summary	Response Received	Report
London: Inner West	Secretary of State for the Department of Health	To consider reassessing the accelerated training of the district nurses and those trusts that continue to use the Graseby syringe drivers.	Yes	54
London: North	Secretary of State for the Department of Health	To consider providing guidance to mental health providers and voluntary agencies, providing support to the community.	Yes	55
London: North	Secretary of State for the Department of Health	To consider when a health need assessment is to be undertaken in addition to the guidance already in place: • There is sufficient notice of the assessment given to those who are to attend and a clear explanation of the process is given. • That an impact assessment is made following the outcome of the assessment.	Yes	56
London: North	Secretary of State for the Department of Health	To consider implementing guidance to doctors and health care workers in the community to provide effective safeguards for checking medication in the community.	Yes	57
Shropshire: Mid and North	Community Health Services, Shropshire	To consider a review of: • The contact procedure and how and when it should applied. • The handover period before the regular housing support officer goes on holiday.	Yes	58
Surrey	Surrey and Borders Partnership NHS Trust	To consider the lack of communication by the mental health services with the GP.	Yes	59
West Yorkshire (East)	Leeds Student Medical Practice	To consider implementing a system immediately whereby the relevant dosage of drugs are entered on patient's records.	Yes	60

Coroner Area	Organisation	Summary	Response Received	Report
Manchester West	Pennine Care Trust	To consider a review of: • How the quality of patient notes is assessed and procedures to ensure that there are substantial improvement in the quality of record keeping. • Methods of and recording of communication with GPs.	Yes	61
Norfolk	Norfolk and Suffolk NHS Foundation Trust	To consider ensuring patients continue to be seen and are reviewed if their community mental health nurse is suddenly unavailable due to sickness or indeed any other reason.	Yes	62

Deaths in custody

South Yorkshire: East	HMP Doncaster	To consider the benefit of additional training for staff in identifying and managing increased risk.	Yes	63
Leicestershire: Leicester City & South	National Offender Management Service	To consider the recommendation made in the report by the prison and probation ombudsman that when a prisoner has been assaulted the head of healthcare should ensure that a brief mental health assessment is completed and the findings recorded.	Yes	64
Durham: Darlington and South	HM Prison Service	To consider a review of process and procedures with the intention of avoiding similar fatalities in the future.	Yes	65
Norfolk	Serco Group PLC	To consider whether prisoners housed in the older prisoner unit have appropriate access to speech and language therapist who can provide assessments to those with swallowing difficulties and make necessary recommendations as to their medical management.	Yes	66
Buckingham	HMYOI Aylesbury	To consider a review of training needs for health care and wing staff relating to mental health awareness and referrals.	Yes	67

Coroner Area	Organisation	Summary	Response Received	Report
West Yorkshire (Eastern)	National Offender Management Service	To consider: • Upon receipt of a pre-sentence report and or OASYS document, such report should be read and the appropriate action taken. • Implementing continuous CCTV monitoring of all residential wings at HMP Leeds. • Vetting all newspapers before distribution to the inmates.	Yes	68
Manchester City	(1) Manchester Mental Hospital (2) Prisons and Probation Ombudsman (3) HMP Manchester	To consider a review of relevant provisions and the need for appropriate reasonable caution in opening an ACCT.	Yes	69
Buckinghamshire	HMYOI Aylesbury	To consider a review of mental health training and awareness for staff.	Yes	70
Oxfordshire	NHS England	To consider national training of mental health professions within the prison service.	Yes	71
London West	(1) Home Office (2) MOJ (3) British Airways	To consider: • A review for the arrangement for auditing compliance and ensuring only accredited DCO's perform escorting and removal functions under the Immigration and Asylum act 1999. • Introducing detailed and specific measures requiring contractors to provide non discriminatory escorting and custodial services ensuring any cultural and staffing issues are addressed. • Rigorous review of approved methods of restraint, and especially the use of force in overseas removals. • A review into the actions of the cabin crew and in particular failure to intervene to administer first aid.	Yes	72

Coroner Area	Organisation	Summary	Response Received	Report
Dorset: West	National Offender Management Service	To consider implementing a system to ensure that key staff have all of the relevant information available to them to make adequate risk assessments in future to ensure inmates at risk of self harm and suicide are quickly identified.	Yes	73
Staffordshire South	Prisons and Probation Ombudsman	To consider a system that actively follows up recommendations following investigations.	Yes	74
Dorset	(1) NOMS (2) Dorset Healthcare University NHS Foundation Trust	To consider a review of training needs for prison staff.	Yes	75
Wiltshire and Swindon	HMP Erlestoke	To consider implementing a protocol where information can be shared across other institutions effectively.	Yes	76
London: Inner West	(1) National Offender Management Service (2) London Ambulance Service (3) HMP Wandsworth	To consider a protocol between prisons and the LAS so that the prison knows what information is required by the LAS to enable the LAS to appropriately prioritise calls to the prison.	Yes	77
London: Inner West	(1) London Ambulance Service (2) HMP Wandsworth (3) National Offender Management Service	To consider a protocol between prisons and the LAS so that the prison knows what information is required by the LAS to enable the LAS to appropriately prioritise calls to the prison.	Yes	78
Durham: Darlington & South	HM Prison Service	To consider whether there should be a clear policy and guidance as to how a staff member should react when they are made aware of family concerns with information being passed to one nominated department which can take ownership of the matter and ensure that concerns are properly, adequately and expeditiously investigated.	Yes	79

Coroner Area	Organisation	Summary	Response Received	Report
Worcestershire	(1) HMP Hewell (2) Worcestershire Health and Care NHS Trust (3) HMP Bristol	To consider taking steps to ensure that all members of staff are fully familiar and trained in the requirements of the policy documents.	Yes	80
Cardiff and the Vale of Glamorgan	HMP Cardiff	To consider that all prison governors are open, honest and transparent.	Yes	81
Leicester City and South Leicestershire	(1) Leicestershire and Rutland Probation (2) West Mercia Probation Trust	To consider improving communication between different agencies.	Yes	82
Exeter and Greater Devon	HMP Exeter	To consider whether close monitoring and surveillance by prison officers would assist in the prevention of any untoward interference with prisoners during periods when the prisoners can leave their cells.	Yes	83
Surrey	HMP Send	To consider a protocol ensuring that all prison staff understand the importance of recording 'triggers' and the need to review the 'trigger' section of the ACCT, when they assume responsibility for , or make decisions relating to prisoner who is on ACCT.	Yes	84
London: Inner West	(1) London Ambulance Service (2) Metropolitan Police	To consider a review of current process and procedure.	Yes	85
Staffordshire: South	HMP Dovegate	To consider a redeployment of staff, so more are available on the drug treatment wing.	Yes	86

Drug and medication related deaths

London Inner North	(1) Metropolitan Police Service (2) London Ambulance Service	To consider a review of the current training for the Metropolitan Police to help officers to differentiate between extreme agitation and excited delirium. The London Ambulance Service to amend its protocol and training to recognise extreme agitation as a medical emergency and prioritise appropriately.	Yes	87

Coroner Area	Organisation	Summary	Response Received	Report
Coventry and Warwickshire	Whitefriars Housing	To consider the current process and procedures in place and the requirement for systems to prevent future reoccurrence.	Yes	88
West Yorkshire (East)	(1) CEO MHRA (2) Food Standards Agency	To consider whether any measures can be taken to publicise the fact that the use of DNP to assist weight reduction is extremely dangerous and may well lead to death.	Yes	89
London Inner West	Medicine and Healthcare Products Regulatory Agency	To consider a review of the regulations pertaining to the sale of laxatives.	Yes	90
Birmingham and Solihull	Jurys Inn Hotel Birmingham	To consider a review of this case and what lessons, if any, should be learnt.	Yes	91
Berkshire	Secretary of State for the Department of Health	To consider changing the packaging for the drug (Prednisolone).	Yes	92

Hospital deaths (Clinical Procedures and medical management)

Cumbria: North and West	University Hospitals of Morecambe Bay NHS Foundation Trust	To consider taking action regarding the procedures and policies in place when patients are to be discharged from the Accident and Emergency Department following attendance after overdose or acts of apparent self harm.	Yes	93
London: Inner North	The Whittington Hospital NHS Trust	To consider a review of the standard of medical records and surgical reviews.	Yes	94
Cumbria: South and East	Furness General Hospital, Barrow-in-Furness	To consider the level and extent of communication between hospitals and local GPs.	Yes	95
Staffordshire: South	New Cross Hospital, Wolverhampton	To consider whether doctors in the emergency department at New Cross hospital are taking sufficient notice of initial readings and to see whether additional training is required in this regard.	Yes	96

Coroner Area	Organisation	Summary	Response Received	Report
Birmingham and Solihull	University Hospital Birmingham NHS Trust	To consider a review of current procedure in relation to surgeons checking instruments before they operate.	Yes	97
Leicestershire: Leicester City and South	University Hospitals of Leicester NHS Trust	To consider a review of current policies and procedures that relates to the storage and therefore the availability of ED records both within the department and on the wider hospital wards.	Yes	98
Surrey	CEO SABP NHS	To consider • Implementing Risks Assessments and Care Plans to include follow up appointments pending a patient's discharge from a secure psychiatric ward. • Implementing procedure, practices and training of AMHPs.	Yes	99
Manchester City	Pennine Acute Hospitals	To consider a review of the way the trust conducts case review investigations following fatal incidents.	Yes	100
London Inner South	South London and Maudsley NHS Foundation Trust	To consider the recommendations in the MAP CAG Executive serious incident investigations report of 4/5/2013.	Yes	101
Derbyshire North	Department of Health	To consider the need for modifications to chairs in NHS establishment to reduce the risk of people sliding off them.	Yes	102
London South	Croydon University Hospital NHS Trust	To consider amending and reinforcing guidance to line managers when they suspend a member of staff who has special skills to ensure appropriate cover	Yes	103
Leicester City and South Leicestershire	University Hospitals Leicester NHS Trust	To consider a review of the admission and discharge procedure currently in place.	Yes	104

Coroner Area	Organisation	Summary	Response Received	Report
Sussex: West	Sussex Partnership Trust	To consider: • Implementing an observation policy and to give clear guidance to staff with regards who can make the decision to reduce a patient's level of observation and in what circumstances a doctor must be consulted. • Implementing a more robust recording in notes system of the actual items removed from patients' bedrooms.	Yes	105
Derbyshire North	Chesterfield Royal Hospital NHS Foundation Trust	To consider introducing nutritional care plans for patients considered at high risk of malnutrition.	Yes	106
Blackburn, Hyndburn and Ribble Valley	East Lancashire Hospitals NHS Trust	To consider introducing a system to ensure that where INR is at a dangerous level and that communication is dealt with urgently.	Yes	107
Sunderland	Department of Health	To consider a review of the guidelines in respect of giving oxygen to patients.	Yes	108
Brighton and Hove	Sussex Partnership NHS Trust	To consider implementing care plans once patients have been discharged.	Yes	109
Manchester City	UHSM NHS Foundation Trust	To consider reviewing guidance and protocols for head injury cases.	Yes	110
Manchester City	Pennine Acute Hospital NHS Trust	To consider a review of current record keeping process and procedures.	Yes	111
Gloucestershire	Gloucestershire Hospitals NHS Foundation Trust	To consider a protocol for clinicians to request an emergency CT scan.	Yes	112
North Wales (East and Central)	Wrexham Maelor Hospitals	To consider a review of protocol and procedures.	Yes	113
North Lincolnshire and Grimsby	Northern Lincolnshire and Goole Hospitals NHS Trust	To consider a review of the procedure where elderly patients with swallowing/nutritional needs are returned to the care of nursing homes.	Yes	114

Coroner Area	Organisation	Summary	Response Received	Report
London East	National Institute for Health and care Excellence	To consider reviewing the NICE guidelines on the treatment of head injuries.	Yes	115
Manchester South	Stockport NHS Foundation Trust	To consider taking action to ensure that lines of communications and decision makings processes are more clearly set out and understood by various specialties and disciplines.	Yes	116
Liverpool	Mersey care NHS Trust	To consider the recommendations of the internal review.	Yes	117
Milton Keynes	Milton Keynes General Hospital	To consider a review of process and procedure.	Yes	118
London East	Queens Hospital, Walthamstow	To consider a review of the systems in place which are meant to ensure there is no risk of anaphylactic shock in relevant cases.	Yes	119
Coventry	University Hospital Coventry & Warwickshire	To consider a review of the training needs for medical staff.	Yes	120
Staffordshire South	Stafford Hospital	To consider making improvements to the address recording system in the haematology department in particular and the hospital as a whole	Yes	121
London Inner South	(1) University Hospital Lewisham (2) NHS Lewisham Commissioning Group	To consider a review of obstetric services.	Yes	122
Liverpool	University Hospital Aintree NHS Foundation Trust	To consider a local agreement on the criteria for carrying out tests, taking into account the special circumstances under which prison medical staff work.	Yes	123

Coroner Area	Organisation	Summary	Response Received	Report
London Inner South	(1) The Maudsley Hospital (2) Commissioning for Mental Health, London Borough of Lewisham	To consider entering discussions between parties, consulting the college of emergency medicine, and if appropriate GP commissioning group, to identify and agree an acceptable maximum period of time to wait for a MH Act assessment. Also agreeing plans to ensure that independent doctors and AMHP will be available in that time for those patients attending A&E departments	Yes	124
London South	Oxleas NHS Foundation Trust	To consider further guidance and training on the treatment of patients who are found unresponsive.	Yes	125
London South	South London and Maudsley NHS Trust	To consider changes to advice to improve the recording of important decisions and that follow up arrangements are made clear and are adequately documented.	Yes	126
Teesside	James Cook University Hospital	To consider a review of the current record keeping procedure in place.	Yes	127
Surrey	St Peters Hospital Trust	To consider extending existing protocols for informing patients whose CRP levels show significant infection.	Yes	128
Derbyshire North	Chesterfield Royal Hospital NHS foundation Trust	To consider introducing a system to try and ensure regular review of patient observation charts by a qualified nurse.	Yes	129
Blackburn, Hyndburn and Ribble Valley	East Lancashire Hospitals NHS Trust, The Royal Blackburn Hospital	To consider introducing a system to ensure that all people who attend at the A&E department and who may be suffering from neutropenic sepsis are referred to the on call oncologist immediately.	Yes	130
Milton Keynes	Milton Keynes General Hospital	To consider introducing a more robust process for ensuring that the emergency department consultants review the radiology report.	Yes	131
West Sussex	Western Sussex Hospital NHS Trust	To consider implementing additional training for staff.	Yes	132
Exeter and Greater Devon	Devon Partnership, Wonford House Hospital	To consider a review of the system of named nurse allocation and the attendant chain of responsibilities for inpatient care.	Yes	133

Coroner Area	Organisation	Summary	Response Received	Report
Brighton and Hove	Brighton & Sussex University Hospital NHS Trust	To consider a review of the discharge process/arrangements and procedures.	Yes	134
Milton Keynes	Department of Health	To consider issuing a direction to all hospitals that in future observations should be carried out by trained nurses.	Yes	135
Cornwall	Royal Cornwall Hospital	To consider the facts of the case and whether there is a need to tighten the time limits for patients being admitted to Treliske hospital via their GP rather than through the emergency department.	Yes	136
South Lincolnshire	United Lincolnshire Hospital, Lincoln County Hospital	To consider implementing a protocol where the oncologists are immediately informed when their patients are admitted as emergencies under the care of the hospital clinicians.	Yes	137
Coventry and Warwickshire	University Hospitals Coventry & Warwickshire NHS Trust, University Hospital	To consider a review in respect to the admission process and procedures.	Yes	138
West Yorkshire (East)	Head of Obstetrics, The General infirmary	To consider the various recommendations of the report.	Yes	139
Bridgend and Glamorgan Valleys	(1)The Royal Shrewsbury (2) St Nicholas House	To consider a review of the process and procedure where patients require two hourly turning.	Yes	140
South Yorkshire (West)	Department of Health	To consider Implementing a computerised system, to ensure automatic referral to the relevant senior doctor.	Yes	141
City of London	St Bartholomew's Hospital	To consider a review of process and procedures.	Yes	142
Staffordshire South	Queen's Hospital, Burton Upon Trent	To consider having more fresh air (through open windows) as opposed to recycled air through air conditioning.	Yes	143

Coroner Area	Organisation	Summary	Response Received	Report
Liverpool	Aintree Hospitals NHS Trust	To consider what steps can be put in place to remind a member of the nursing staff of the level of risk to a patient of a fall	Yes	144
Manchester South	Stockport NHS Foundation Trust	To consider a review of the training needs required for medical and nursing staff.	Yes	145
South Yorkshire (West)	Barnsley Hospital NHS Foundation Trust	To consider introducing one form used by medical and midwifery staff within the hospital to reduce miscommunication and workload.	Yes	146
London Inner South	(1) Kings College Hospital (2) Care Quality Commission (3) Chief Inspector of Hospitals	To consider a review of staffing levels within the hospital.	Yes	147
Manchester West	5 Boroughs Partnership NHS Foundation Trust	To consider whether a review can be undertaken of overnight staffing levels on wards within the trust.	Yes	148
Manchester North	(1) Pennine Acute Trust (2) Chief Medical Officer England & Wales	To consider having guidelines as to the standard of competence or training of those carrying out the procedure.	Yes	149
Gwent	Aneurin Bevan Health Board	To consider reviewing the process and procedure when carrying out observations on patients.	Yes	150
Bridgend and Glamorgan Valleys & Powys	Cwm Taf Health Board	To consider a review of the admission process and procedure.	Yes	151
South Lincolnshire	United Lincolnshire Hospitals	To consider a review of procedures in the emergency department.	Yes	152

Coroner Area	Organisation	Summary	Response Received	Report
Mid Kent and Medway	Kent & Medway NHS Social Care Partnership	To consider a review of the discharge procedure and care plans for patients.	Yes	153
Leicester City and South Leicestershire	Resuscitation Council (UK)	To consider introducing appropriate certificates/accreditations for advance paediatric life support with a requirement to demonstrate that the requisite skills have been maintained.	Yes	154
London Inner South	Royal College of General Practitioners	To consider a review of training for all staff.	Yes	155
London East	East London NHS Foundation Trust	To consider notification to general practitioners on admissions of their patients into hospital by way of clear protocol.	Yes	156
Berkshire	Priory Secure Services Ltd	To consider a review of the current record keeping procedure and the communication level amongst medical staff.	Yes	157
Cardiff and the Vale of Glamorgan	Cardiff & Vale University Health Board	To consider implementing a more robust record keeping system of patients notes.	Yes	158
Cardiff and the Vale of Glamorgan	Cardiff & Vale University Health Board	To consider a review of training needs for staff members.	Yes	159
Cardiff and the Vale of Glamorgan	Cardiff & Vale University Health Board	To consider a review of current protocol for junior medical staff.	Yes	160
Derbyshire: North	Kingsway Hospital	To consider a review of the current issue in relation to the administration team.	Yes	161
Devon: Exeter and Greater	Secretary of State for the Department of Health	To consider a review of the resuscitation policy.	Yes	162

Coroner Area	Organisation	Summary	Response Received	Report
Devon: Plymouth and South West	Cornwall Partnership NHS Trust and Isles of Scilly PCT	To consider a review of the current protocol.	Yes	163
Hampshire: Portsmouth and South East	Portsmouth Hospital NHS Trust	To consider a review of training and awareness for all ward staff.	Yes	164
Hampshire: Portsmouth and South East	South Health NHS Trust	To consider a review of the current protocol for the administration and recording of the oral medication given to patients.	Yes	165
Hertfordshire	Care Quality Commission	To consider whether hospitals and adult care services are liaising appropriately, especially for patients who are "*out of area*" so that discharge plans can be properly formulated.	Yes	166
London: East	Newham University Hospital	To consider implementing a referral policy/guidance that is clearly defined.	Yes	167
London: South	NHS SE London	To consider • Conducting a proper and full investigation into the matter, • Implementing any actions that will minimize this situation reoccurring.	Yes	168
London: Inner West	St Marys Hospital	To consider a review of: • Procedures with respect to identifying acute myocarditis. • Procedures to ensure that complete observation of patients are made and recorded, particularly in the case of children during the weekends and silent hours. • Procedures to ensure that induction of new staff focuses on the importance of communication between staff.	Yes	169

Coroner Area	Organisation	Summary	Response Received	Report
London: Inner West	Capio Nightingale Hospital	To consider implementing: • A procedure to ensure that complete observations of patients are made and recorded where required. • A procedure to ensure the adequacy of the assurance mechanism it has in place for the conduct of clinical observations. • A procedure that ensures it's a safe environment for its patients. • Training programme for all staff on both conduct of observations and the assurance regime.	Yes	170
Manchester: North	Pennine Acute NHS Trust	To consider a review of the referral process after discharge.	Yes	171
Manchester: South	Tameside General Hospital	To consider a review of training requirements for staff in relation to communication.	Yes	172
Manchester: West	Lancashire Teaching Hospital	To consider a review of systems and procedures of referral of X-Ray results by senior clinician in the department requesting the X-Rays.	Yes	173
Manchester: West	Five Boroughs Hospitals	To consider a review of the record/note taking process.	Yes	174
Nottinghamshire	Doncaster and Basselflaw Hospital Trust	To consider a review of training requirements for staff in relation to communication	Yes	175
Staffordshire North and Stoke on Trent	University Hospital of North Staffordshire	To consider: • Whether dementia patients and particularly those at risk of falls should be nursed in bed as close as possible to nursing stations in order to provide maximum supervision. • Wherever possible nursing staff observing patients mobilising unaided who are at risk of falls should attend to them as a matter of urgency.	Yes	176
Shropshire: Mid and North	Telford Hospital Trust	To consider implementing a more robust record keeping system.	Yes	177

Coroner Area	Organisation	Summary	Response Received	Report
Staffordshire: South	South Staffordshire and Shropshire NHS Trust	To consider a review of record keeping and sharing of information with other trusts.	Yes	178
South Yorkshire (East)	Rotherham District General Hospital	To consider a review of the current protocol and procedure in place for ensuring that only those qualified to do so take patient observations.	Yes	179
Mental health related death				
Dorset	Community mental Health Team, Weymouth	To consider a review of process and procedures.	Yes	180
Cornwall	Plymouth Community Health Care	To consider a robust system that ensures patients are not lost in the system when they move from one area to another.	Yes	181
Norfolk	Norfolk and Suffolk NHS Foundation Trust	To consider the implementation of a single electronic health record system.	Yes	182
Ceredigion	Hywel Dda Health Board HQ	To consider whether there is a real and immediate risk of a detaining psychiatric patients.	Yes	183
West Sussex	Sussex Partnership NHS Partnership Trust	To consider reviewing care plans currently in place.	Yes	184
Cardiff and the Vale of Glamorgan	Cardiff and Vale University Health Board	To consider whether GP’s should in their referral letters to neurologists provide details of potentially relevant information regarding depression.	Yes	185
Avon	Avon and Wiltshire Mental Health Partnership Trust	To consider the implementation of a robust system for patient care plans.	Yes	186

Coroner Area	Organisation	Summary	Response Received	Report
Manchester South	(1) Trafford Crisis Resolution and Home Treatment Team (2) Improving Access to psychological therapies	To consider that if a follow–up with or referral to IAPT (or any other organisation) is deemed appropriate upon discharge from CRHTT then such an appointment should be arranged before or upon discharge.	Yes	187
London: Inner West	(1) London Ambulance Service (2) Metropolitan Police Service	To consider: • That the LAS review the training that is delivered to the EMTs in particular to ensure that the EMTs understand that primacy remains with the LAS even when a patient that they have been called to see has been arrested. • That the LAS extend their current process of review of PRFs to include all such forms generated from consultation where the police are present or have been called by the LAS for assistance. • That the NSPIS computer system includes an option “viewed through wicket” as part of drop down box where detained persons checks are recorded. • That the MPS urgently re-audit the compliance of custody staff with PACE C Annex H by evaluation of CCTV as well as custody records.	Yes	188
Hampshire: North East	C&AMHS	To consider a review of the current discharge protocol in place.	Yes	189

Other

Cardiff and the Vale of Glamorgan	Vale Health Board	To consider a review of the current policy.	Yes	190
Cumbria: North and West	Secretary of State – Department for Transport	To consider the arrangements which apply to the operation of helicopters based and flown in this country which are registered in other countries, including the issue of record keeping, maintenance and airworthiness.	Yes	191

Coroner Area	Organisation	Summary	Response Received	Report
Lincolnshire: North and Grimsby	Stagecoach East Midlands	To consider a review of current training records and update training where necessary.	Yes	192
Blackburn, Hyndburn and Ribble Valley	Jesta Capital Corporation	To consider reviewing safety regulations for customers using the car park.	Yes	193
Manchester City	CEO Network Rail	To consider a review of current CPR training standards and requirements.	Yes	194
Manchester: South	Secretary of State for Department and Health	To consider whether nursing homes could hold the dressing for use by various patients.	Yes	195
North West Wales	Secretary of State for Transport	To consider a review of: • The existing survey and inspection procedures. • An effective and accessible system to record and provide information to surveyors. • Existing instructions requiring a photographic record of the vessel's principal features.	Yes	196
Darlington and Durham	Homes and Community Agency	To consider current process and procedure.	Yes	197
Blackburn, Hyndburn and Ribble Valley	Secretary of State for Culture, Media and Sports	To consider implementing the recommendations of the Leveson report in full.	Yes	198
Manchester South	Chrysalis	To consider introducing a clear policy and ensuring that staff deliver the required dose of medication.	Yes	199
Carmarthenshire and Pembrokeshire	Pembrokeshire County Council	To consider sharing information with other agencies and review the training needs for staff members.	Yes	200

Coroner Area	Organisation	Summary	Response Received	Report
Hertfordshire	Minister of State for Universities and Science	To consider whether there could be more preparation for youngsters before they go to university as to their expectations and what can be offered to them.	Yes	201
London Inner North	(1)First Response Hospital Service (2) London Borough of Tower Hamlets	To consider a review of safety measures currently in place.	Yes	202
Cornwall	Cornwall One Stop Shop	To consider whether the hostel in question and other hostels understand the need to ensure that their patrons can gain access to their accommodation when they return home late at night and possibly under the influence of alcohol.	Yes	203
London South	Archbishop of Canterbury	To consider implementing guidance when using church houses as event venues.	Yes	204
Birmingham and Solihull	Secretary of State for the Department of Health	To consider whether more awareness could be made available in respect to epilepsy.	Yes	205
Police procedures related deaths				
Liverpool	Merseyside Police	To consider a review of current training procedures.	Yes	206
Manchester City	Greater Manchester Police	To consider a review of protocol and policies for taking reports of missing persons to ensure , so far as possible that the correct information is recorded and relayed and to undertake a random audit to establish the levels of compliance.	Yes	207
Surrey	(1) Metropolitan Police Service (2) Home Secretary	To consider a review of policies and procedures for officers conducting searches.	Yes	208

Coroner Area	Organisation	Summary	Response Received	Report
Staffordshire: North and Stoke on Trent	Staffordshire Police	To consider a review of: • Whether the training of special constables should include better awareness of police policies for dealing with similar situations. • The existing policy and whether it should be amended to encompass not only persons who are apparently incapable through drink but also those apparently incapable through drink, drugs or who otherwise appear to be incapable by any means (for example illness or glue sniffing).	Yes	209

Product related death

London South	The Prime Minister and First Lord of the Treasury	To consider liaising with the relevant ministries to see if some further provision can be made to control the information available on the internet which not only informs but in some cases actively encourages vulnerable persons to take action to harm or indeed kill them.	Yes	210
Staffordshire: South	Department of Business Innovation and Skills	To consider whether there should be formal regulation or firm advice to provide clear warnings of the dangers on packaging.	Yes	211
Gloucestershire	Towergate Smart Motor Insurance	To consider a review of current insurance policies and GPS monitoring kits installed in cars.	Yes	212

Railway related death

Hertfordshire	Network Rail Infrastructure Limited	To consider the following recommendations: • An investigation to make cost effective improvements to the visual warnings of approaching trains. • To amend your guidance on risk mitigations to take into account of possible improvements for the visibility of an approaching train at a level crossing. • To make a comprehensive set of risk reduction measures available to level crossing managers.	Yes	213

Coroner Area	Organisation	Summary	Response Received	Report
London: North	Transport for London	To consider: • Installing alarms on the platform to track gates at London Underground Stations. • Issuing members of staff or other personnel with key-fobs to deactivate the alarm when using the gate.	Yes	214

Road (Highways Safety)

Cumbria: South and East	Secretary of State for Transport	To consider a review of reporting medical conditions to the DVLA.	Yes	215
Newcastle upon Tyne	(1) Durham County Council (2) Specialist Collision Unit (3) Ministry of Justice	To consider a controlled crossing and/or appropriate warning/alert to approaching drivers of the crossing and potential pedestrian presence.	Yes	216
Lincolnshire: Central	Lincolnshire County Council	To consider: • Whether a speed restriction is imposed in the vicinity of the junction in order to slow traffic down. • Erecting an electronic sign on either side of the junction to warn of the inherent danger created by emerging vehicles.	Yes	217
Sunderland	(1) Sunderland City Council (2) Northumbria Police	To consider the feasibility of installing an audible warning in the cab or other features of gritting process to ensure that it is effective, continuous and inspected.	Yes	218
Wiltshire & Swindon	Royal Society for the Prevention of Accidents	To consider increasing public awareness in relation to bicycle mechanics.	Yes	219
Portsmouth and South East Hampshire	Hampshire County Council	To consider installing traffic calming/speed reductions measures on a particular section of the road	Yes	220

Coroner Area	Organisation	Summary	Response Received	Report
Kingston upon Hull	Highways Department	To consider a fundamental review of green lanes.	Yes	221
Gloucestershire	British Board of Agreement	To consider a review of the interpretation of BBA certificate number 06/H120 issued in respect of milepave.	Yes	222
London North	Traffic & Highway Network Management Department	To consider a review of the traffic management system and pedestrian crossing signals.	Yes	223
Lancashire East	Highways Agency	To consider the installation of barriers against embankments of certain sizes.	Yes	224
Staffordshire South	Staffordshire County Council	To consider carrying out a survey of the scene and if further safety measures are required.	Yes	225
Brighton & Hove	Brighton & Hove City Council	To consider placing a warning sign preferably self illuminating triggered by passing vehicles.	Yes	226
Staffordshire South	Staffordshire County Council	To consider a review of current procedures in relation to potential flooding on roads.	Yes	227
Cumbria North and West	Cumbria County Council	To consider a review of the current safety structure in place and whether it should be updated.	Yes	228
Avon	Highway Services, Western Super Mare	To consider erecting a more suitable barrier by means of stronger posts or another sort of barrier to prevent vehicles entering the main flow of water.	Yes	229
West Somerset	Avon & Somerset Constabulary	To consider working hours in an enclosed environment	Yes	230
Exeter and Greater Devon	Devon County Council	To consider improving the highway drainage system.	Yes	231

Coroner Area	Organisation	Summary	Response Received	Report
London Inner South	(1) Secretary of State for Transport (2) Secretary for Education (3) Southern Gas Networks (4) Transport for London (5) LBS Highway Authority (6) Mouchel (7) Children Services (Education) LBS	To consider: • Whether an accident such as this was preventable by the erection of temporary phased lights. • Whether children are aware of the risks of wearing headphones when crossing and the trajectory of turning lorries.	Yes	232
Nottinghamshire	Nottinghamshire County Council	To consider a review of the speed limit and road markings, and should this be applied along the entirety of Rufford Lane.	Yes	233
Coventry and Warwickshire	Coventry City Council	To consider having regular reviews into the effectiveness of the Hale Street Junction scheme.	Yes	234
West Somerset	Somerset County Council	To consider whether or not the painting of intermittent white lines on either side of the carriageway might alert drivers more readily that they are likely to be leaving the motorway.	Yes	235
North Lincolnshire and Grimsby	North Lincolnshire Council	To consider erecting protective barriers to prevent future collisions.	Yes	236
South Yorkshire (East)	Regeneration & Environment	To consider whether the scheme of work will reduce road traffic related injuries.	Yes	237
Milton Keynes	Milton Keynes Council	To consider a thorough safety investigation specific to each location in collaboration with the roads policing team.	Yes	238

Coroner Area	Organisation	Summary	Response Received	Report
London: Inner South	Secretary of State for the Department of Transport	To consider whether more awareness should be given to cyclists of the dangers of wearing headphones whilst riding on public roads.	Yes	239
East Riding of Yorkshire & Kingston Upon Hull	East Riding of Yorkshire Council	To consider whether the weather station could be moved to an alternative site.	Yes	240
Northumberland: North	Northumberland County Council	To consider installing an Armco or similar barrier where the road bends or where there is particular steep fall into the field or burn below.	Yes	241
Road (Vehicle Safety)				
North Wales (East and Central)	(1) The Association of British Insurers (2) DVLA (3) VOSA	To consider the uncontrolled sale repair of insurance write offs.	Yes	242
Surrey	Secretary of State for Transport	To consider whether there should be an age restriction on tyres used by private, commercial or public vehicles.	Yes	243
Service personnel deaths				
Kent: North West	Ministry of Defence	To consider whether the RMPSIB investigation was sufficiently rigorous enough and that the scope of the NSI was too restrictive.	Yes	244

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