DAC BEACHCROFT

Prevention of Future Deaths Reports in inquests - recurring themes for health and social care

April 2024

Contents

Introduction

Having received positive feedback about the usefulness of our reports on themes we have identified from Prevention of Future Deaths Reports (PFDs) issued by coroners to health and social care providers in 2021 and 2022, we have repeated the exercise this year in relation to PFDs issued in 2023.

The purpose of PFDs is to bring about positive change by promoting learning from deaths. However, the issues raised in PFDs are rarely unique to the particular organisations involved in an inquest and - to capitalise fully on the power of PFDs to drive improvements in care - the lessons learned from those cases need to be shared across the system.

To help shine a light on the current picture, and how that compares with our findings in previous years, we've looked at themes emerging from over 250 PFDs issued by coroners in connection with the provision of health and social care over the course of 2023.

Recap on PFDs

Coroners have a duty to issue a PFD to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The coroner's function is to identify areas of concern, not to prescribe specific solutions.

As explained in the Chief Coroner's guidance about PFDs, when deciding whether they must issue a PFD, coroners should focus on the current position: *"Coroners should consider evidence and information about relevant changes made since the death or plans to implement such changes. If a potential PFD recipient has already implemented appropriate action to address the risk of future fatalities, the coroner may not need to make a report to that body."*

Coroners are expected to send PFDs within 10 working days of an inquest concluding, with recipients having 56 days to provide a written response.

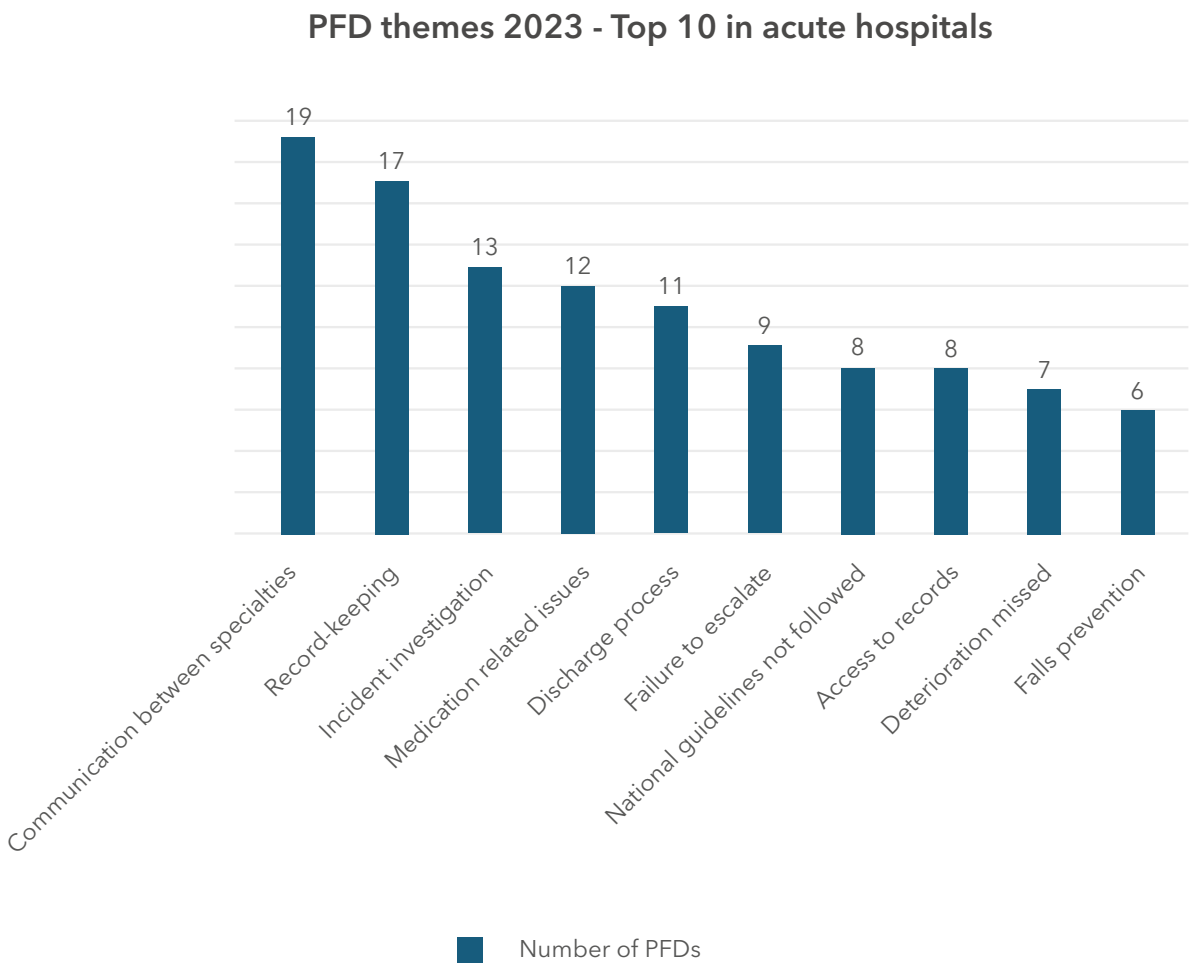
A copy of the PFD is sent by the coroner to the deceased's family and is made available for anyone to read online via the Chief Coroner's website (which was our source of PFDs for this report).

Importantly for health and social care providers, a copy of the PFD is also sent to the CQC, which may lead to further regulatory scrutiny.

Acute hospital care

We looked at 100 PFDs issued to providers over the course of 2023 where the concerns related to acute hospital care.

The graph below illustrates the 'Top 10' issues raised by coroners in these PFDs:



Further details of what we found in relation to PFD themes for acute hospitals are set out below:

Communication between specialties

Issues with ineffective communication were in the 'Top 3' PFD themes for acute hospital providers for the third year running. What was striking in relation to the 2023 PFDs compared with previous years we'd looked at, however, was the extent to which these concerns focused particularly on communication between the different specialties involved in the provision of acute care, with 19% (19 cases) of the acute hospital PFDs we looked at raising issues about communication between specialty teams.

Examples included: lack of communication where more than one specialty is involved in the care - e.g. *"There is little evidence to date of effective communication between multi-disciplinary teams from different specialisms when a patient is on more than one treatment pathway"*; specialty teams being unaware of one another's input; referral pathways between specialty teams being unclear or not followed - e.g. *"I am concerned that the surgical registrar referral pathway is not being utilised despite previous incidents in which its use was highlighted as necessary"*; lack of clarity about which specialty team has overall responsibility for the patient - e.g. *"… there was confusion between the doctors as to who was responsible for the patient, in light of her dual orthopaedic and medical needs"*; and issues with working relationships between specialties - e.g. *"There is limited evidence to date of improved communication, and a stronger working relationship, between the stroke team and the neurosurgical team at the Trust".*

Record-keeping

The next most frequently occurring PFD theme we identified for acute hospital providers related to record-keeping, with 17% (17 cases) of PFDs in 2023 raising this as a concern. This is the third year running that we have found record-keeping to be in the 'Top 3' themes for acute hospitals.

Examples included: omissions in clinical records, such as the treating doctor's notes failing to record major presenting symptoms; inconsistencies in records, such as a contradiction between nursing notes and prescription charts about how much medication was administered; fluid balance charts poorly completed - e.g. *"Clinical records were poorly maintained, resulting in an unclear picture of fluid administration"* and *"...there was no effective, reliable recording of intravenous fluids administered to patients in the emergency department";* details pertaining to a different patient being included in the deceased patient's records; the rationale for clinical decision-making not being recorded - e.g. *"Neither the trust decision to discharge…nor clear safety-netting advice to carers was recorded in the clinical record"* and records being of a generally poor standard - e.g. *"The Trust's clinical records were of a particularly poor standard which impeded the Trust's governance investigation".*

Linked with record-keeping, we also noticed a rise in cases where access to records was flagged to acute hospital providers as a concern in 2023, including issues relating to the incompatibility of records systems used by different teams/services inhibiting the sharing of information about patients, with access to records issues coming up in 8% (8 cases) of the acute hospital PFDs we looked at.

Incident investigations

Also holding its place in the 'Top 3' PFD themes for acute hospital providers was the topic of incident investigations, which was raised by coroners in 13% (13 cases) of acute hospital PFDs in 2023.

Examples included poor quality incident investigations - e.g. one investigation report was described by the coroner as *"erroneously exculpatory"*, another as being *"of a generally poor standard"* including *"a failure to challenge the statements of clinicians where there were obvious contradictions between statements made and the medical record"* and, in another case, the coroner expressed concern that *"the lack of robust critical analysis and investigation of the clinical decision making and care provided... has caused a delay to, and led to missed opportunities to learn lessons that are vital to patient safety".* The PFDs we looked at also raised concerns about failing to undertake an incident investigation at all or significant delays in doing so - e.g. in one case the coroner highlighted *"...a lack of insight within the senior management team of the importance of undertaking a comprehensive investigation into unexpected deaths within their organisation..",* with some coroners expressing increasing frustration about the lack of improvement here: *"I have issued a number of Prevention of Future Deaths Reports relating to investigations and governance and yet these concerns continue".*

Looking ahead, it will be interesting to track the impact on PFDs of the introduction of the new 'Patient Safety Incident Response Framework' (PSIRF), which has replaced the previous Serious Incident Framework for organisations providing care under the NHS Standard Contract, particularly given that PSIRF promotes a range of learning responses which do not necessarily have to involve producing an investigation report in the way coroners have been used to. Reflecting the fact that most of the deaths subject to PFDs in 2023 would have occurred prior to the introduction of PSIRF, we found little direct reference to PSIRF in these PFDs, although in one case the coroner commented in the PFD that: *"There is limited evidence of progress in implementing the national Patient Safety Incident Response Framework at the Trust".* This is likely to be an area coroners will continue to keep a close eye on.

Other recurring PFD themes we identified for acute hospitals in 2023 included: medication related issues (12 cases, including several examples of anticoagulant medications being stopped/not re-started or given incorrectly, lack of alerts on electronic systems about medications not being administered, and records systems which *"do not speak to each other"* leading to medication transcribing errors); discharge processes (11 cases, including patients being discharged without medical review, discharge without prescribed medications or follow-up appointment, lack of advice on discharge about points of access if concerns arise, and discharge documentation being unclear about ongoing care needs); failure to escalate (9 cases, including high NEWS scores not prompting escalation of care, inaccurate NEWS scores resulting in missed opportunities to escalate for medical review, escalation to ITU delayed or not discussed as it should have been, and junior staff not knowing when to escalate concerns); national guidelines not followed (8 cases, including not following Royal College of Emergency Medicine guidelines about consultant review of patients re-presenting in A&E within 72 hours and several examples of NICE guidelines not being followed, including in relation to timing of surgery for hip fractures); deterioration missed (7 cases, including failing adequately to monitor patients, not providing adequate supervision to an F1 doctor and lack of continuity of medical or nursing care); and falls prevention (6 cases, including not enough staff to deliver enhanced level care and falls risk assessments not taking account of all available information).

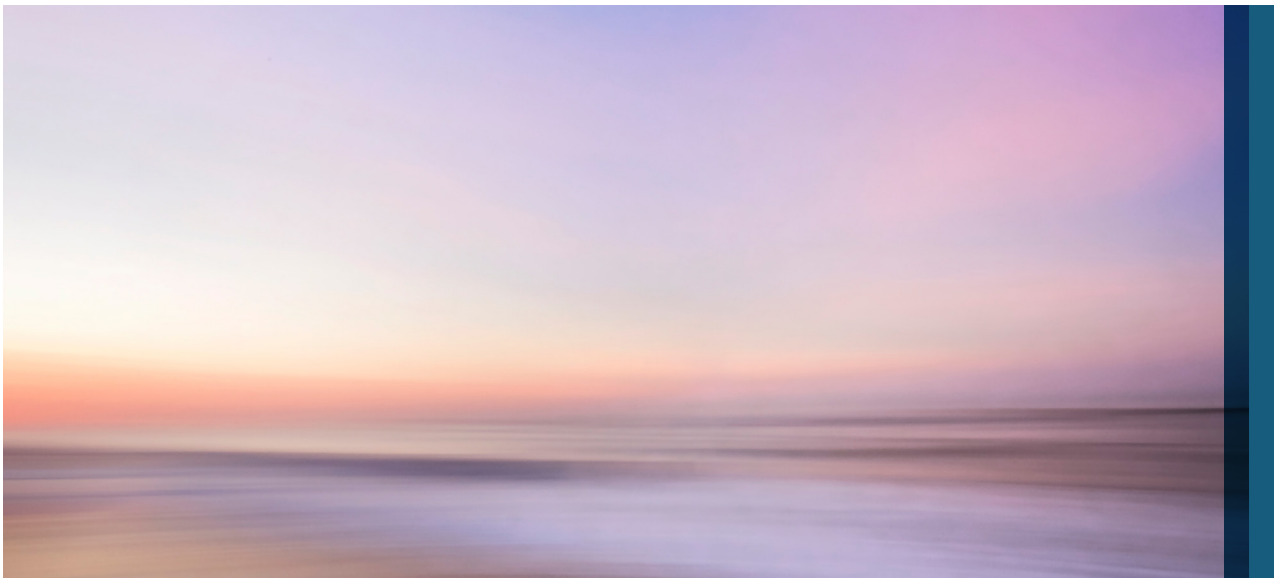
We also noticed a couple of emerging themes we think are worth highlighting even though they didn't make the 'Top 10' for this category. There were 5 PFDs which flagged lack of clinical cover over weekends/public holidays as a concern, including cases involving lack of specialist consultant input over those periods. Also, concerns about insufficient adjustments being made for patients whose ability to communicate is affected by their mental health or a learning disability came up in 3 cases and it is possible that we may see such issues being raised more frequently in PFDs going forward.

How does this compare with previous years?

Looking at the overall number of PFDs, whilst we had seen a drop in the number of PFDs issued to acute hospital providers in 2022 (55) compared with 2021 (93), that number was back up in 2023 (100), suggesting no downwards trend here.

The 'front runners' in terms of themes - i.e. communication, record-keeping and incident investigation - were unchanged for acute hospital providers in 2021, 2022 and 2023. Medication related issues came a close fourth place in both 2022 and 2023. Meanwhile, concerns relating to discharge processes, escalation of care and falls prevention have featured in the 'Top 10' themes in all three of the years we've looked at.

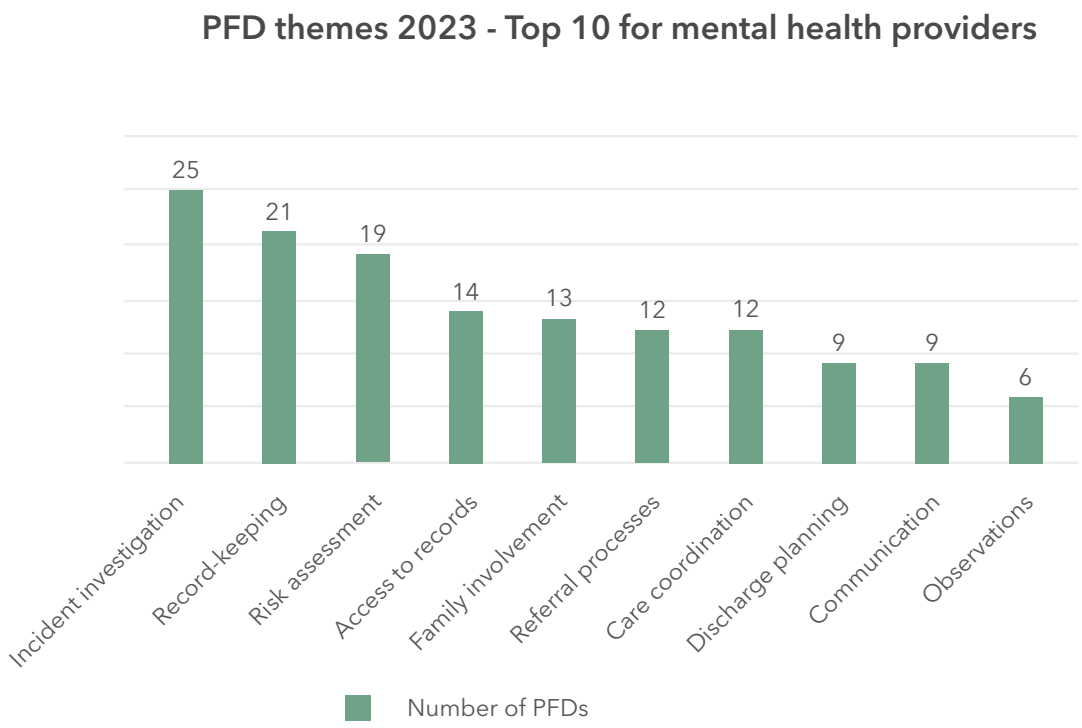
Broadly speaking, therefore, PFD themes for acute hospital care have remained relatively consistent.



Mental health

We looked at 85 PFDs issued over the course of 2023 where the concerns related to providers of mental health care.

The graph below illustrates the 'Top 10' issues raised by coroners in these PFDs:



Further details about these mental health related PFD themes are set out below:

Incident investigation

New to the 'Top 3' PFD themes for mental health providers in 2023 was incident investigation, with this issue having ranked in fourth place in both 2022 and 2021. This was raised by coroners as a concern in 29% of PFDs (25 cases) we looked at.

We found many instances of coroners expressing concerns in PFDs issued to mental health providers about the general sufficiency and robustness of their incident investigations. In one case, for example, the coroner highlighted *"… an evident lack of overall strategic direction to investigations and learning"* and, in another, the coroner remained concerned that: *"… the Trust's investigation was insufficient, lacked robustness and did not fully engage*

with the duty of candour". In another PFD, the coroner put it like this: *"If staff are either unwilling, or are not given the opportunity, to reflect on what went wrong in an open and honest manner, then the Trust cannot seek to learn from events at the earliest opportunity, and these issues of concern will persist, leading to further deaths"*. In several PFDs, coroners expressed frustration with the lack of improvement here, for example: *"I have previously issued a number of Prevention of Future Deaths Reports relating to quality and timeliness of investigation"*.

Other examples of concerns raised in relation to incident investigations by mental health providers included: investigations being *"significantly"* or *"substantially"* delayed; concerns identified by the coroner not having been picked up by the incident investigation - e.g. in one PFD the coroner stated that the failure properly to investigate *"...led to the wholly untenable situation where errors in care were uncovered for the first time at inquest…"*; issues relating to the reliability of investigation reports, such as one investigation which *"lacked any meaningful degree of critical analysis of events"*; failing to involve key staff and/or the deceased's family in the investigation process; and delays implementing actions arising from investigations - e.g. in one case the Trust was *"…not able to identify a single action point that had been completed to date".*

As discussed in relation to PFDs issued to acute hospital providers, it will be interesting to track the impact of PSIRF on PFDs, especially as this promotes a range of learning responses which may be different from the 'serious incident' investigation reports coroners have been used to. Whilst the hope is that the move to PSIRF will mean a greater focus on learning and improvement, rather than just 'going through the motions' of producing investigation reports, there is no guarantee that it will put an end to coroners' concerns about how providers learn from deaths, as illustrated by one of the 2023 PFDs issued to a mental health Trust which had conducted a Patient Safety Incident Investigation under PSIRF which the coroner found to be *"materially incomplete"* and *"a lost an opportunity to understand concerns of the family".* Going forward, it seems likely that coroners will continue to want to see some form of written evidence that providers have learned the necessary lessons from a death. In one of the PFDs we looked at, for example, the coroner was told there had been a 'hot debrief' following the death, however *"no notes were made of that"* and so *"nobody…found out what the decision maker's thinking had been".*

Record-keeping

Record-keeping was the next most frequently occurring theme we identified in PFDs issued to mental health providers in 2023 (having been knocked off the top spot it occupied last year), with coroners raising concerns about this in 24% (21 cases) of PFDs we looked at in this category.

Issues raised by coroners included concerns about poor quality record-keeping, such as *"significant examples of cut and paste"* (which came up in 3 cases) and *"a failure generally to keep proper records"*. There were also examples of failing to record the reasons for clinical decision-making (e.g. a decision not to re-assess someone) and of records not accurately or fully reflecting interactions with the patient. A lack of records regarding MDT discussions and handovers was another recurring issue, as was omitting to include significant risk-related information in records (e.g. about a recent suicide attempt).

Closely related to this theme, we noted 5 examples of PFDs issued to mental health providers where coroners expressed concerns about staff not reading clinical records, rather than about the records themselves. In one case, for example, a staff member was *"… candid about the fact he did not have enough time to review patients' records before MDT meetings, this is a grave concern"* and, in another, the coroner highlighted: *"…wholesale inconsistency in healthcare professionals reviewing medical notes before appointments, assessments, or handovers"*.

Also related to this, we noticed an emerging theme about access to records, including issues with services using different record-keeping systems and the adverse impact of this on the sharing of information about significant developments and risk. This came up in 16% (14 cases) of the mental health provider PFDs we looked at. Examples included concerns about lack of records access between the NHS and independent sector providers - e.g. in one case the coroner highlighted that there was *"no clear pathway for details of any private psychiatrist consultations to be shared with those in either the acute or mental health inpatient settings"* and, in another case, there was *"no quick method to obtain NHS records on admission to a private hospital"*. There were also multiple examples of coroners flagging the need for services to move to compatible systems of electronic records to reduce the risk of key information being missed/not shared, including the coroner highlighting in one case: *"…any delay in ensuring all notes are available electronically is potentially harmful to patients"* and in another: *"…information sharing between service providers using different data bases is difficult"*.

Risk assessment

Issues relating to risk assessment were raised by coroners in 22% (19 cases) of PFDs issued to mental health providers in 2023.

One of the most commonly occurring concerns here was about risk assessments not being reviewed or updated in light of significant events or changes in the patient's presentation. In one PFD, for example, the coroner noted: *"If risk assessments are not being properly completed or updated, then there is an obvious risk of deaths occurring in the future, as a result of insufficient recording of risk".* Another coroner put it like this: *"…the risk assessment effectively became redundant by virtue of the failure to update it".*

There were also several examples of coroners raising concerns about lack of risk assessment prior to the patient moving between different mental health teams or before being discharged from a service. One coroner, for example, highlighted that the patient *"…did not receive a comprehensive risk assessment prior to her discharge from the Home Treatment Team"*. Similarly, there were some examples of concerns being raised about inadequate risk assessment before granting leave/ allowing a patient off the ward.

In last year's report, we queried whether we might see a fall in the number of PFDs raising concerns about risk assessments in light of the publication in September 2022 of the NICE guideline on 'Self-harm: assessment, management and preventing recurrence', which advises against the use of risk assessment tools and scales to predict future suicide or self-harm. Perhaps reflecting this, there were only a couple of PFDs in which use of risk assessment tools was specifically referred to. However, risk assessment in the broader sense of factoring risk into decision-making about what type of care/level of input the patient needs continues to feature in the 'Top 3' most frequently occurring themes for mental health providers.

Other recurring PFD themes for mental health providers in 2023 included: family involvement (13 cases - e.g. failing to seek relevant information from family which could *"bridge the gap in communications between various health agencies involved in someone's care"*, not involving families in discharge planning, and families not being *"…sufficiently, effectively and meaningfully listened to or understood when they voice concerns"*); care coordination (12 cases - e.g. several PFDs raised concerns about lack of care coordinator resource, including caseloads being too heavy); referral processes (also 12 cases - e.g. lack of understanding between teams about referral pathways, referrals not being actioned and referral information not being fully considered); discharge planning (9 cases - e.g. patient discharged without planned follow-up, discharge report not fit for purpose, no involvement of other agencies or family in discharge process); communication (9 cases - including communication issues between teams/services - e.g. *"The evidence demonstrated communication between the specialist teams was not effective and this caused delays"* and communication issues within teams - e.g. *"The decision that the deceased should not be allowed unescorted leave was not communicated to all members of staff working in the unit"*); and observations (6 cases - e.g. observation records not reflecting any level of therapeutic engagement with the patient, a reduction in frequency of observations not being in line with Trust policy and observation sheets not filled out adequately or at all).

Gaps in mental health service resource is another key theme which emerges, particularly when also taking into account PFDs issued to organisations at a national level, such as the Department of Health and Social Care. From that wider pool, we identified 15 PFDs where lack of mental health service resource was raised by coroners as an concern. These included 5 PFDs in which coroners highlighted lack of access to psychological therapies, including long waits for CBT and a lack of availability of psychological therapies tailored to those with autism. There were also 4 PFDs in which coroners expressed concerns about the shortage of acute psychiatric bed capacity, with one coroner describing *"a chronic lack of resources to treat seriously mentally ill patients"*. Meanwhile, another 4 PFDs expressed concerns about the lack of appropriate provision for those with autism, with one coroner summarising the issue as follows: *"Sadly this case exposes the total inadequate level of community provision for the care and treatment of those with suffering with Autism. This is a national problem and sadly leads to many experiencing unnecessary admissions to inpatient mental health facilities and also A&E attendances"*.

How does this compare with previous years?

The overall number of PFDs we identified as having been issued to mental health providers was up in 2023 (85) compared with both 2022 (56) and 2021 (72).

The most striking change was the rise in cases where coroners expressed concerns relating to incident investigations, which jumped from the fourth most commonly occurring theme for mental health providers in both 2022 and 2021 to the top spot in 2023, featuring in not far off a third of PFDs in this category.

Meanwhile, record-keeping and risk assessment have held onto last year's position in the 'Top 3' themes for mental health providers. Other consistently recurring themes related to family involvement, discharge planning and care coordination, which have been in the 'Top 10' themes for mental health providers across all three years we've looked at.

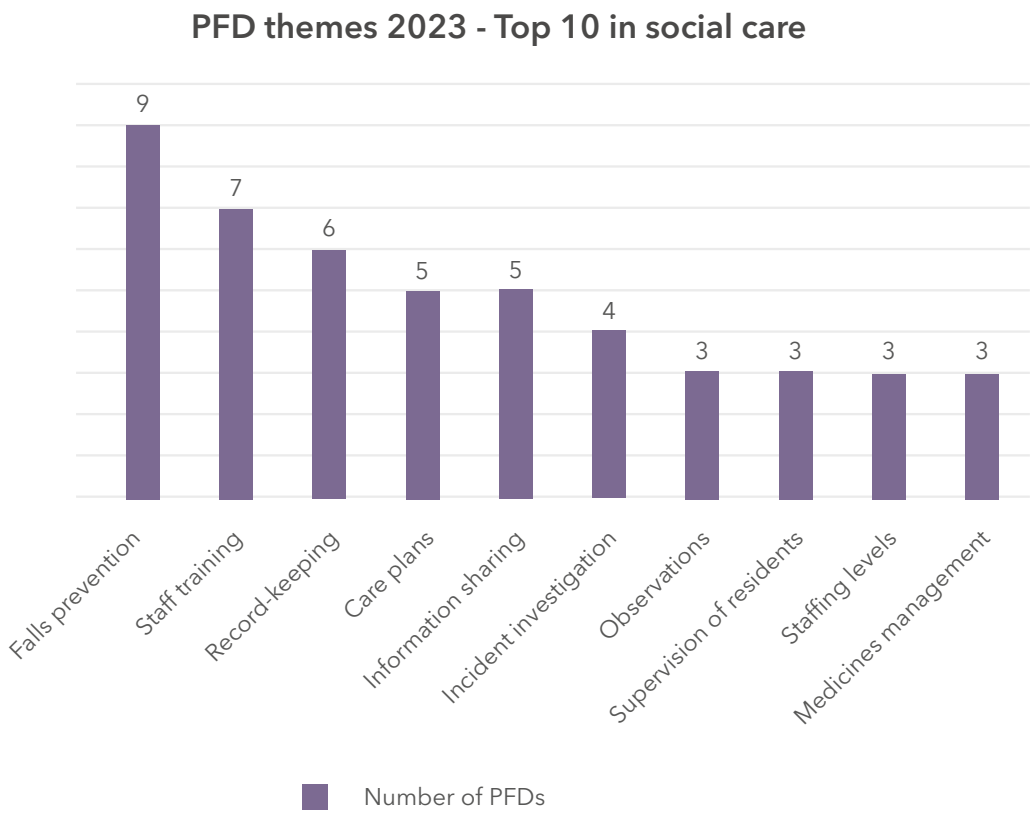
New to the 'Top 10' for mental health providers was the issue of access to records and the impact of different services/teams not easily being able to share information with one another. Given the national push towards greater digitisation and integration of records, this is a theme we could continue to see more of.

Social care

We looked at 25 PFDs issued to adult social care providers, including care homes, domiciliary care and supported living, over the course of 2023.

In terms of the factual context these PFDs arose from, there were some recurring scenarios, with 13 cases involving deaths following falls (equating to over 50% of the social care PFDs we looked at) and 4 choking incidents.

The graph below illustrates the 'Top 10' issues raised by coroners in these PFDs:



Further details of what we found are set out below:

Falls prevention

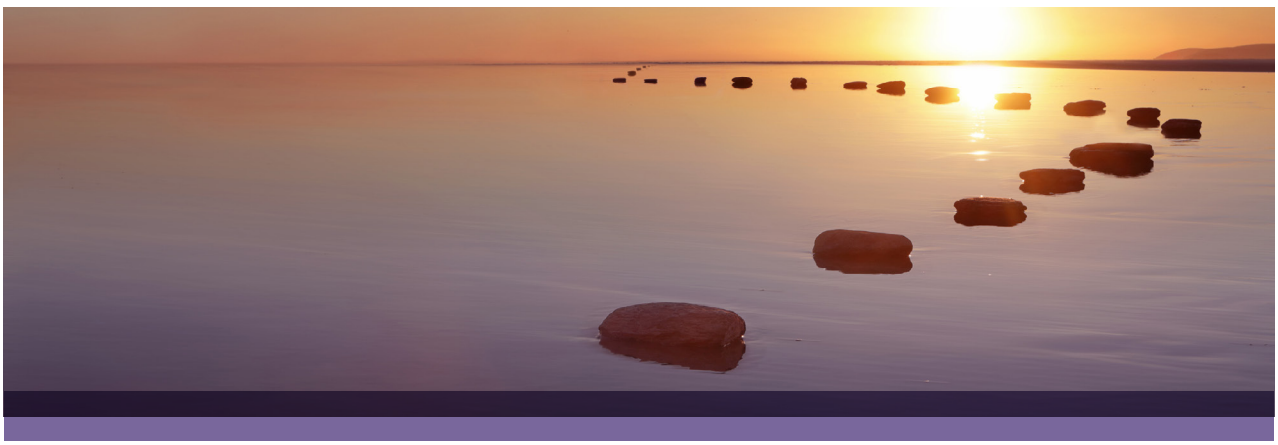
Falls prevention was the most frequently occurring area of concern we identified in PFDs issued to social care providers in 2023, reclaiming the top spot this theme occupied in 2021, and featuring in 36% (9 cases) of the PFDs we looked at in this category. This is perhaps unsurprising given that over half of the PFDs issued to social care providers were cases involving deaths following a fall.

Several of these cases involved not having adequate falls prevention measures in place (e.g. issues with sensor mats) or falls risk assessments not being reviewed in the aftermath of falls. There were also issues flagged in relation to lack of learning to reduce future falls risks - e.g. *"An action plan in respect of preventing future deaths from falls/falls prevention/the learning following these events was not presented at Inquest"*.

Staff training

Staff training came up in 28% (7 cases) of the social care related PFDs we looked at.

Examples included concerns about inadequate staff training in moving and handling residents - e.g. *"There was little evidence before the court that the new carer had received any or any adequate training or shadowing experience".* There were also concerns about inadequate staff training relating to falls risks - e.g. *"Staff training in relation to falls risk remained outstanding at the date of the Inquest for the majority…of staff at the care home"*.



Record-keeping

Also making the 'Top 3' themes for social care providers in 2023 was record-keeping, which came up as a concern in 24% (6 cases) of PFDs we looked at.

Examples included a case involving records of resident checks having been edited/falsified, another where there was limited documentation about pressure care and another where *"Some of [the resident's] observations were recorded on a piece of paper and were not logged in his Care Records. The Manager only became aware of gaps in the records following concerns raised by the family."*

Other themes we identified from PFDs relating to social care included: care plans (5 cases - e.g. failing to update/review care plans to reflect significant developments or care plans missing key information such as a requirement for the person to be on a blended diet); information sharing between services (5 cases - e.g. incorrect or incomplete information being shared with ambulance staff for a resident being taken to hospital); incident investigations (4 cases - e.g. inadequate investigation leading to missed opportunities to learn lessons, including a case where: *"There has still been no internal review carried out following [the resident's] death which was unexpected"*); observations (3 cases - e.g. patient checks not carried out as frequently as they should have been); supervision of residents (3 cases - e.g. lack of clarity about which staff member was responsible for supervising residents); staffing levels (3 cases - e.g. staffing levels not sufficient to provide the level of monitoring residents needed to keep them safe); and medicines management (3 cases - e.g. a resident being left unsupervised with medication).

How does this compare with previous years?

The overall number of PFDs we identified as having been issued to social care providers in 2023 (25) was not dissimilar from previous years (23 in 2022 and 35 in 2021).

There has been some movement in terms of the 'Top 3' themes for social care providers, with the most commonly occurring theme in 2022 - i.e. delays seeking medical attention - not featuring in the 'Top 10' this time round. Instead, concerns relating to falls prevention took the top spot in 2023, as they did back in 2021. Other than that, however, the 'Top 3' looked as it did in 2022, with issues relating to staff training and record-keeping having retained their position.

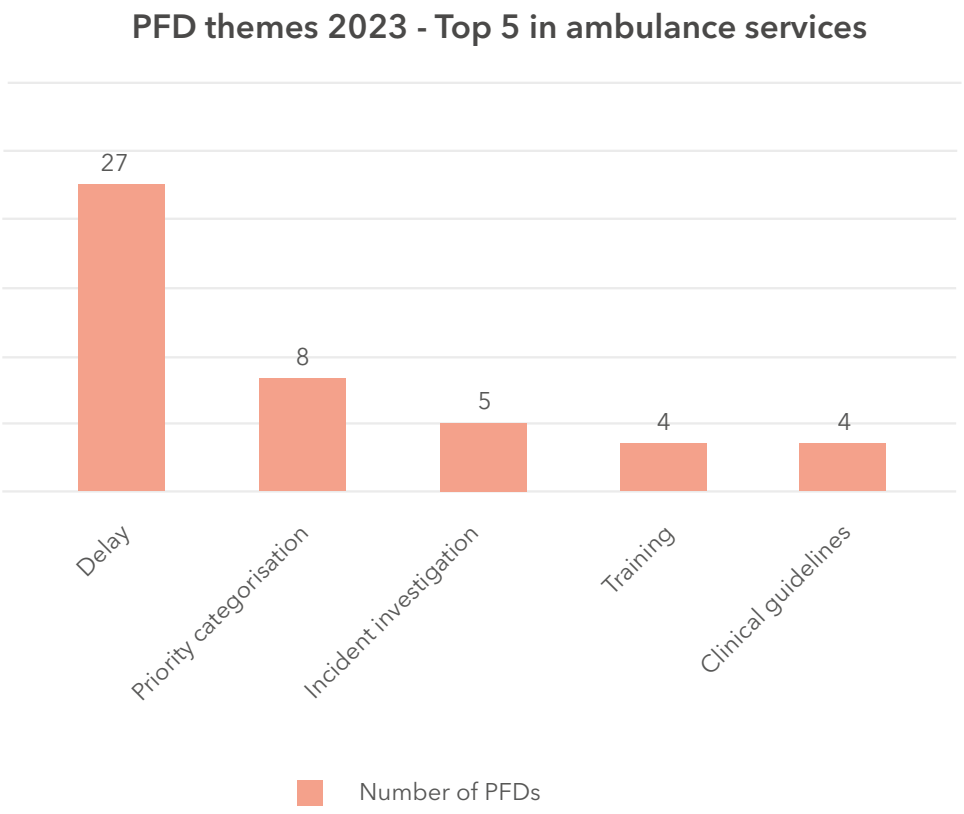
Given that the overall number of PFDs issued to social care providers is relatively low, it is difficult to draw any firm conclusions from the less frequently occurring themes we've identified, although themes relating to incident investigations and care plans have been in the 'Top 10' for social care providers in all three years we've looked at.

Ambulance services

We looked at 42 PFDs issued by coroners in 2023 in relation to ambulance services. This included PFDs issued to Ambulance Trusts themselves and also PFDs issued to a range of bodies connected with the provision of ambulance services at a national level, such as the Department of Health and Social Care, reflecting the fact that many of the issues arising for ambulance services are impacted by wider systems pressures.

In terms of the factual context these ambulance PFDs arose from, it was notable that around 30% of them (13 cases) involved someone who had suffered a fall (a similar proportion compared with 2022). A further 21% of these PFDs (9 cases) involved people experiencing cardiac issues such as heart attacks and around 11% (5 cases) involved overdoses.

The themes emerging from PFDs relating to ambulance services were less varied than for the other types of care provision covered in this report, so we have a 'Top 5' (rather than a 'Top 10'), as shown in the graph below:



Further details of what we found are set out below:

Delay

A high proportion (64% - 27 cases) of the 2023 PFDs we looked at in relation to ambulance services raised concerns about delays and, specifically, about ambulances attending significantly outside target response times. Often, people were having to wait many hours longer than they should have done, with coroners finding in some of these cases that the person would likely have survived if the ambulance had attended within the target response time. This was very similar to the picture that emerged from PFDs issued in relation to ambulance services in 2022.

We found that over a third of PFDs in which ambulance delay was raised as a concern involved people who had suffered a fall, with coroners highlighting the particular risks for elderly frail people associated with having to wait long periods for an ambulance to take them to hospital after a fall - e.g. *"Long lie after a fall, especially in the elderly often results in a terminal kidney injury and death. Consideration should be given to review of how these types of emergency call are managed and thereafter monitored".*

One coroner who issued a PFD covering 3 separate deaths where there had been long ambulance delays in each case stated: *"I want to be clear that these three deaths are not isolated cases. They are just an illustration of the sorts of cases this area has dealt with regularly over the last two years or so"*.

It is clear from these PFDs that coroners are very much aware of ambulance delays being a national problem with multiple causes, including gridlock in the wider system, with discharges from hospital delayed due to lack of social care provision in the community, leading to Emergency Departments overflowing and ambulances stuck outside hospitals waiting to hand patients over. One coroner summarised the problem as follows: *"The root cause for ambulance delays was found to be the lack of social care provision…, whether care packages or beds in care homes…This means that wards are accommodating patients who would otherwise be discharged. The hospital wards being full beyond capacity, means that emergency departments are unable to move patients out of emergency beds into the wards. This means in turn that the emergency department is full and unable to receive patients from ambulances. This leads to the handover delays, and consequently response delays…".*

As well as being a key factor in ambulances not being available to respond to calls within target response times, long waits in ambulances outside ED also featured as a specific issue of concern in 9 of the PFDs we looked at.

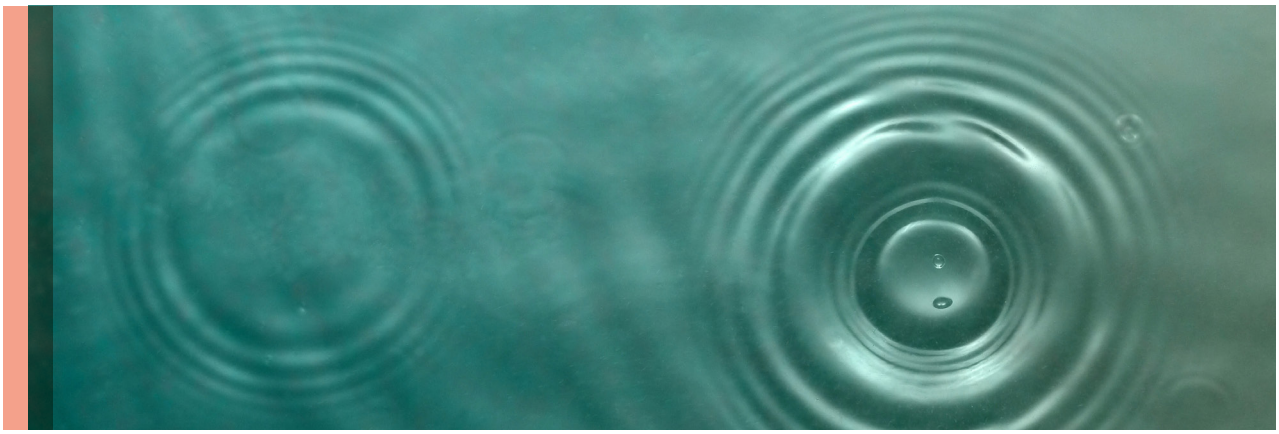
Whilst acknowledging the system-wide nature of the problem here, many of these PFDs reflect frustration amongst coroners about the lack of progress in reducing ambulance delays. As one coroner put it: *"Deaths are occurring and will continue to occur as a result of delayed ambulance attendances caused by these multifactoral issues"*.

Priority categorisation

The next most frequently occurring theme in PFDs relating to ambulances services was about priority categorisation of calls, which came up in 19% (8 cases) of PFDs we looked at.

This included coroners raising issues about the algorithms used to determine priority categorisation in certain clinical scenarios - e.g. prioritisation systems not differentiating between low risk and high risk overdoses where treatment may be time-critical and not taking anticoagulation medication into account in bleed cases.

There were also a number of PFDs which focused on issues relating to clinical reviews of system-generated priority categorisations - e.g. *"I was informed at the inquest that on occasion a clinician … will intervene to undertake a further assessment to determine whether the response should be expedited. However, this appeared to be an ad hoc arrangement not underpinned by local policy or guidelines."*



Incident investigation

Issues with incident investigations came up in 11% (5 cases) of ambulance-related PFDs we looked at. The concerns here related mainly to investigations not identifying learning or making recommendations for improvement. In one case, for example: *"An investigation took place but the staff did not identify any learning".*

Other themes arising in ambulance service PFDs included issues relating to training (4 cases - e.g. gaps in paramedic training on the management of particular presentations) and issues relating to clinical guidelines/protocols on specific conditions (4 cases).

How does this compare with previous years?

The overall number of PFDs relating to ambulance services in 2023 (42) was higher than in 2022 (26).

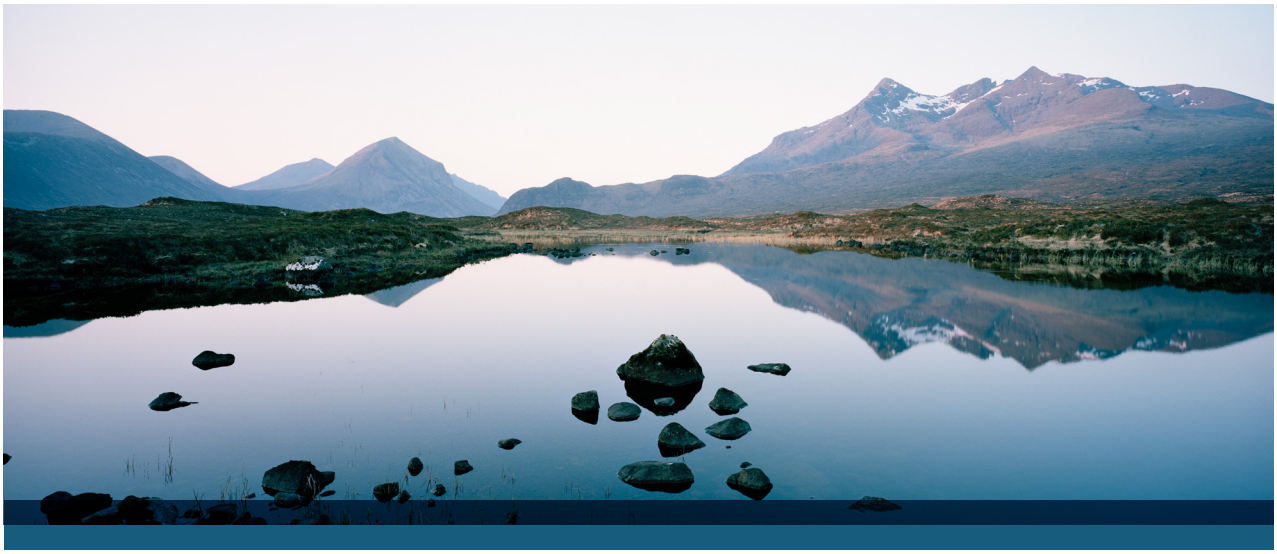
However, the themes emerging were remarkably similar, particularly in terms of the proportion of PFDs relating to ambulance delays (64% in 2023 and 65% in 2022). Issues arising around priority categorisation, staff training and clinical protocols were also very similar in 2023 compared with the previous year. The only notable change in 2023 was the issue of incident investigations coming up more frequently.

Reflections

Having now looked at themes arising from PFDs issued to health and social care providers for the third year running, we were struck by how consistent the overall picture has remained. For acute hospital providers, record-keeping, incident investigations and communication were the most frequently occurring themes in all three years we've looked at. For mental health providers, risk assessment has been in the 'Top 3' each year, with discharge planning, family involvement and care coordination also coming up consistently. In terms of social care providers, the picture is again broadly similar, with 2023's most commonly occurring themes of falls prevention, staff training and record-keeping having also been in the 'Top 10' themes for social care providers in both previous years. Finally, for ambulance services, delays in attending within target response times has continued to be by far the most frequently arising PFD concern.

We were also struck by how frequently PFDs issued in 2023 raised concerns about incident investigation, with this featuring amongst the most commonly occurring themes for all four types of provider, coming up in around 18% of all PFDs we looked at. The prevalence of this theme relates back to the core purpose of PFDs, which is about learning from deaths, and also links in with the Chief Coroner's guidance to coroners that they may not need to issue a PFD at all if the potential recipient has already taken appropriate action to address the risk of future deaths.

It remains the case that the best way to avoid a PFD is to provide sufficient reassurance to the coroner that enough is already being done to address any areas of concern through existing incident response and governance processes. Looking ahead, coroners will no doubt be keeping a close eye on the impact of PSIRF in terms of how reassured, or otherwise, they feel.



How we can help

Our large national team of inquest lawyers have a wealth of experience in supporting providers and individuals across the health and social care sector through the inquest process - from relatively straightforward hospital deaths to very complex Article 2/jury inquest cases involving multiple parties and deaths in state detention, including assisting with the preparation of evidence to address Prevention of Future Deaths Report risks.

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