DAC BEACHCROFT

PREVENTION OF FUTURE DEATHS REPORTS IN INQUESTS - WHAT ARE THE RECURRING THEMES?

APRIL 2023

Contents

INTRODUCTION

This time last year we published a report on themes we identified from Prevention of Future Deaths Reports (PFDs) issued by coroners to health and social care providers in 2021. Having received positive feedback about the usefulness of that exercise, we have repeated it this year in relation to PFDs issued during the course of 2022.

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 individuals/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.

Whilst the total number of PFDs issued by coroners has now started to be included in the annual 'Coroners Statistics', and whilst the PFDs themselves continue to be published online, there is still little in the way of central analysis of PFD themes/trends to support the sharing of lessons learned from deaths nationally.

To help shine a light on the current picture - and how that compares with our findings the year before - we've looked at themes emerging from over 160 PFDs issued by coroners in connection with the provision of health and social care over the course of 2022.

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.

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

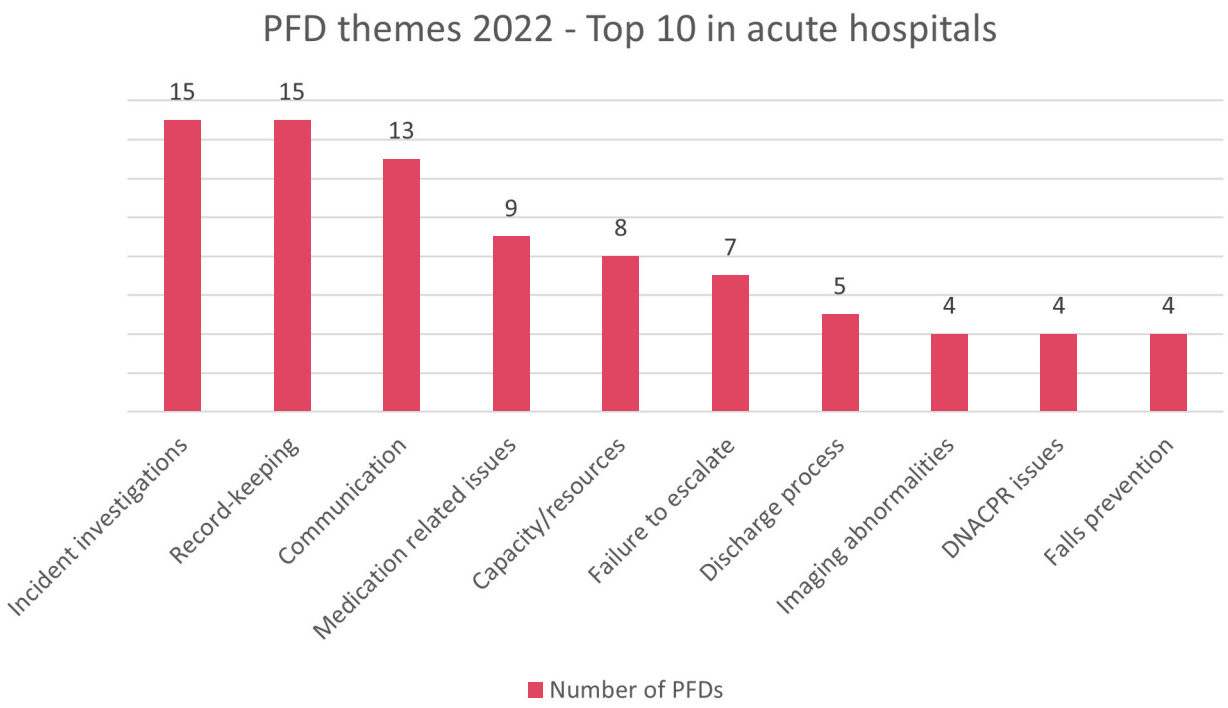
A copy of the PFD is sent by the coroner to the deceased's family and is made available for anyone to read online via the Chief Coroner's website.

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 55 PFDs issued to providers over the course of 2022 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:

Incident investigations

A significant proportion - 27% (15 cases) - of the 2022 acute hospital PFDs we looked at included concerns from coroners about how providers carried out investigations into patient deaths and learned lessons from them.

In a number of cases, coroners were strongly critical of incident investigation processes, including, for example, one investigation report being found to contain *"basic and obvious errors"* whilst another was *"flawed in a number of serious ways"*. A common issue here related to investigations not covering all relevant areas of concern as found by the coroner - e.g. a *"lack of investigative rigour"*. Other themes included not giving due weight to the family's concerns and not following through on action plans. There were also some cases where no incident investigation had taken place, but the coroner felt it should have done - in one case, for example, the hospital *"…did not successfully identify and escalate this death through its governance procedures as a serious incident for investigation until the issue was raised by the coroner"*.

These PFDs demonstrate that coroners place a lot of emphasis on the importance of robust incident investigation as a key element of the drive to minimise preventable death. As one coroner put it: *"Prompt, rigorous and effective investigations of clinical incidents are essential to deriving learning and improving patient safety, thereby reducing the risk of future deaths"*.

Record-keeping

The same proportion - 27% (15 cases) - of PFDs issued to providers of acute hospital care in 2022 raised concerns relating to record-keeping.

Examples included - poor standard of record-keeping exacerbating lapses in communication within the treating team, handover records being incomplete, lack of contemporaneous record of factors taken into account in clinical decision-making such as when prescribing medication, the need for a clinical review not being documented and therefore not happening and electronic systems failing to flag up abnormal results.

Communication

Another frequently occurring concern for providers of acute hospital care in 2022 - raised in around 24% of these PFDs (13 cases) - related to ineffective communication within and between teams and other services.

Examples included - lack of communication within treating teams (e.g. miscommunications between nursing, junior and consultant staff leading to concerns not being considered before discharge), ineffective communication between different specialities involved in a patient's care, communication issues between hospital and community teams (e.g. not involving district nurses in discharge planning) or between primary and secondary care (e.g. delayed or lost information about the need for further investigations). In one PFD, for example, the coroner highlighted a *"significant breakdown in communication, trust and respect between primary and secondary care"*.

Other recurring PFD themes for acute hospitals in 2022 included: medication related issues (e.g. prescribing medications that were contra-indicated, including several cases involving anticoagulation); pressure on capacity/resources across various areas of acute care provision (e.g. in paediatric ED, pathology and orthopaedic wards); failure to escalate the care of deteriorating patients (e.g. inadequate response to early warning scores and delays acting on abnormal blood tests); concerns about discharge processes (e.g. test results or most recent observations not checked prior to authorising discharge); imaging abnormalities not being picked up/acted on (e.g. no flag on the system for abnormal radiology results); concerns relating to lack of understanding around DNACPR (e.g. inappropriate withholding of CPR following a choking incident); and falls prevention (e.g. falls risk assessment not being updated following a fall in hospital).

How does this compare with the previous year?

Looking at the overall number of PFDs, we noticed a drop in the number of PFDs issued to providers of acute hospital care in 2022 (55) compared with 2021 (93). The reasons for this are unclear and it will be interesting to see if that trend continues in subsequent years.

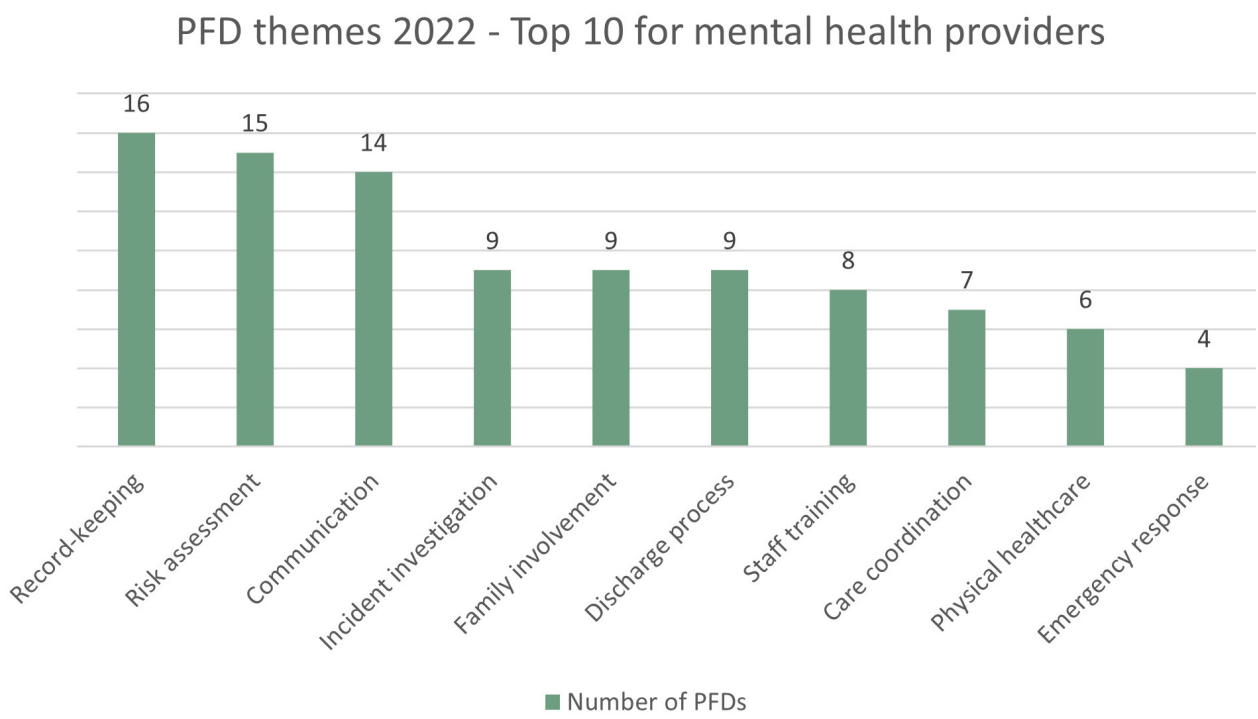
However, the 'front runners' in terms of themes - i.e. incident investigations, record-keeping and communication - were unchanged for acute hospital providers in 2022 compared with the previous year. Whilst the proportion of PFDs raising record-keeping issues remained fairly static (27% compared with 25% the previous year), the proportion of PFDs in which coroners raised concerns about incident investigations (27% up from 17%) and communication (24% up from 16%) increased.

PFD themes new to the 'Top 10' for acute hospital providers in 2022 included concerns about medication related issues, imaging abnormalities and DNACPR decision-making. Meanwhile, some themes from the previous year's 'Top 10' (e.g. staff training and equipment availability) did not feature this time.

MENTAL HEALTH

We looked at 56 PFDs issued over the course of 2022 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:

Record-keeping

Record-keeping takes the top spot in our review of PFD themes for mental health providers in 2022, with coroners raising concerns about this in almost 29% of PFDs (16 cases). Commonly occurring issues included not adequately documenting important information from mental state assessments or CPA discussions, not making a record of disclosures (e.g. about possession of a knife) and poor contemporaneous documentation about clinical decision-making (e.g. not recording the rationale for decisions such as granting unescorted leave or not referring someone to the MDT). There were also cases where coroners raised concerns about inaccuracies in clinical records, as well as issues with information being recorded in different places, giving rise to a risk of information being missed (e.g. no single inpatient/outpatient record or information contained in both electronic records and handwritten handover sheets).

Risk assessment

As was the case the previous year, a significant proportion of PFDs issued to mental health providers in 2022 - around 27% (15 cases) - raised concerns relating to risk assessment. The most commonly occurring issues here were about assessments of suicide/self-harm risk not being reviewed or updated in light of the disclosure of new information (e.g. about specific suicide plans) or following recent instances of self-harm or the occurrence of a trigger event.

On this theme of risk assessment, it is worth noting that the deaths that were the subject of these 2022 PFDs would have occurred prior to 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. Whilst not all PFD concerns relating to risk assessments will have been specifically connected with the use of such risk assessment tools/scales (that level of detail is difficult to ascertain from the PFDs alone), the NICE guideline could lead to a drop in the frequency with which issues around risk assessment are raised in PFDs.

- **Communication**

  25% of PFDs (14 cases) issued to mental health providers in 2022 raised concerns about communication within or between different teams/services involved in the person's care. Examples of inadequate communication within clinical teams included not handing over information about recent incidents of ligaturing or drug-taking and not sharing risk-related information in CPA or discharge meetings. In terms of communication across different teams/services, examples included patient data not able to be shared across electronic systems, communication between primary care and mental health services (e.g. a GP having difficulty contacting the mental health team for an urgent review) and lack of effective lines of communication between different disciplines (e.g. between neurology and psychiatric teams where the patient had epilepsy).

The next most frequently occurring PFD themes for mental health providers were incident investigations, family/carer involvement and discharge processes, each of which came up in 16% of PFDs (9 cases). In relation to incident investigations, the concerns raised by coroners included incomplete action plans and lack of learning from incidents, key staff not being interviewed as part of the investigation process and areas of concern identified by the coroner not having been covered by the incident investigation. Meanwhile, issues relating to family/carer involvement (or rather lack of it) centred in several cases around confusion amongst staff over the rules around patient confidentiality and when information can and cannot be shared, as well as a number of cases where not involving family members in assessment processes and after-care plans led to information gaps which coroners found a cause for concern. In terms of discharge processes, concerns raised by coroners included not discussing patients in MDT/professionals' meetings prior to discharge and lack of review process for discharge decisions.

Other themes that came up in mental health related PFDs included: staff training (although there was no real pattern in terms of staff training gaps identified, with these ranging from the effects of particular drugs to aspects of missing persons policies); care coordination/oversight of care (e.g. lack of clarity about oversight of care following discharge to ensure safety-netting and insufficient care coordinator resource); physical healthcare in mental health settings (e.g. several cases of failing to carry out VTE risk assessments); and issues with response to medical emergencies (e.g. delays administering CPR or calling paramedics).

Gaps in mental health service resource across the country is another key theme which emerges, particularly when also taking into account PFDs issued to national-level organisations on this issue, such as the Department of Health and Social Care. From that wider pool, we found 14 PFDs where lack of mental health service resource was identified by coroners as an issue, including lack of capacity in older age psychiatry and psychology services. Three PFDs expressed concerns about the lack of appropriate provision for those with autism and similar concerns were raised in another three cases about the lack of CAMHS resource nationally to support young people struggling with their mental health. As one coroner put it: *"Despite the increase in numbers accessing CAMHS there has not been any relative increase in resources to meet this demand and therefore the current position is unsustainable and it is putting many young people's lives at risk".*

How does this compare with the previous year?

In terms of the most frequently occurring themes, the picture in 2022 looked very similar to the previous year on communication (25% in 2022 compared with 28% in 2021) and risk assessment (27% in 2022 compared with 28% in 2021). New to the top 3 in 2022, however, were a significant number of concerns expressed to mental health providers about record-keeping.

Meanwhile, although involvement of family/carers was knocked off the top 3 in 2022, this theme continued to come up relatively often. The picture in relation to incident investigations, staff training, discharge processes and care coordination was also not markedly different in 2022 compared with the previous year.

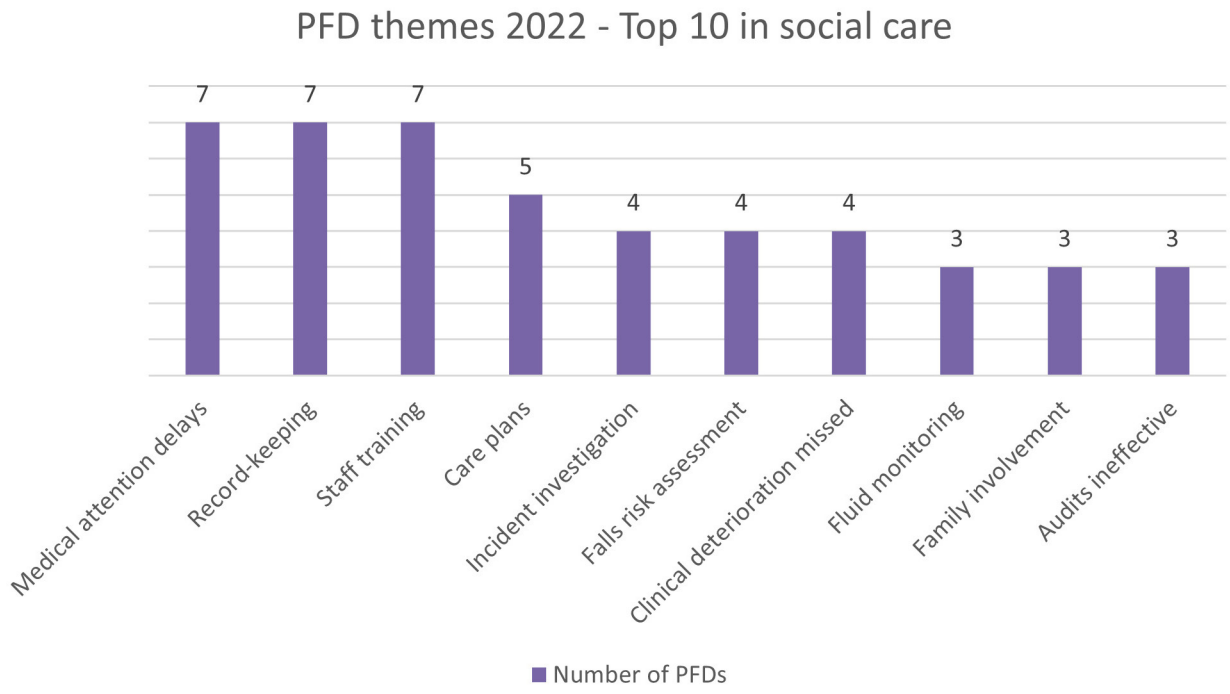
New to the top 10 themes for mental health providers in 2022 compared with the previous year, however, were concerns relating to the physical healthcare of patients in mental health settings and response to medical emergencies.

SOCIAL CARE

We looked at 23 PFDs issued to adult social care providers, including care homes, domiciliary care and supported living, over the course of 2022.

In terms of the factual context these PFDs arose from, there were some recurring scenarios, with 7 cases involving deaths following falls (equating to around 30% of the social care PFDs we looked at), 4 involving choking on food and a further 4 sepsis related deaths.

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



Further details of what we found are set out below:

Delays seeking medical attention

New to the 'Top 10' for PFDs issued to social care providers in 2022 were concerns about delays seeking medical attention. This was a theme in 30% of social care related PFDs (7 cases). Examples included delays calling for an ambulance in emergency situations (e.g. following a choking incident) and delays seeking review by a doctor where the resident had become acutely unwell, with those cases associated in several instances with care staff failing to pick up on the person's clinical deterioration (e.g. not recognising signs of sepsis in the elderly).

Record-keeping

Level-pegging with medical attention delays in PFDs issued to social care providers in 2022 was the theme of record-keeping, which again came up in 30% of cases. Examples included pressure sores not being documented, no record being made of a family's concerns, a resident being described in the records as 'content' throughout the day with no reference to her deteriorating condition, medication records lost or missing. In another case, the records in general were described as *"abysmal"* and in another case missing handover notes led the coroner to comment that *"Managers of nursing homes should make checks sufficiently often to ensure the records required to be kept actually exist"*.

Staff training

Staff training similarly came up in 30% of the social care related PFDs we looked at. One of the most commonly occurring issues here was lack of first aid training for care staff, meaning they were not equipped to deal with medical emergencies. As one coroner commented: *"The evidence of the carer demonstrated a lack of training, skills and understanding in being able to reasonably identify a medical emergency and how to respond to a medical emergency"*. In other cases, the staff training issues raised were more broad-brush, for example: *"Training/education, support & supervision of care staff including the provision of clear escalation procedures was inadequate"*.

Other themes we identified from PFDs relating to social care included: care plans (e.g. care plan appearing to be a 'cut and paste' from another resident's plan; staff not aware of important information in care plans regarding dietary requirements; reviews of care plans either not done or done by someone unsuited to the task); incident investigation (e.g. no investigation or 'ineffective investigation' into the incident leading to death; no evidence of a commitment to learn from the incident); falls risk assessment (e.g. falls risk assessments not reviewed/updated following recent falls); clinical deterioration missed (e.g. carer failing to identify that a resident was unconscious; staff not understanding signs of sepsis); fluid monitoring issues (e.g. inaccurate recording of fluid intake); involvement of family (e.g. family should be informed of incidents/falls, especially where the resident lacks capacity); and audits (e.g. care plans not regularly audited by senior staff; audit activity not picking up significant issues with care).

How does this compare with the previous year?

Given that the overall number of PFDs relating to social care was relatively low, it is difficult to draw firm conclusions from a comparison with the previous year. However, there was a shift in terms of the top 3 themes in 2022, with falls prevention having been knocked off the top spot it held the previous year and relatively more issues arising in relation to escalation for medical review and staff training in 2022 compared with the year before.

Overall though, similar themes emerged in both years, including in relation to record-keeping, care plans, incident investigations and assessing falls risks.

Looking at the picture as a whole, the PFD themes we identified in 2022 indicate a shift towards more of a focus by coroners on how care staff respond to medical emergencies, as illustrated by the recurring themes around delays seeking medical attention, care staff failing to pick up on people becoming acutely unwell and gaps in first aid training.

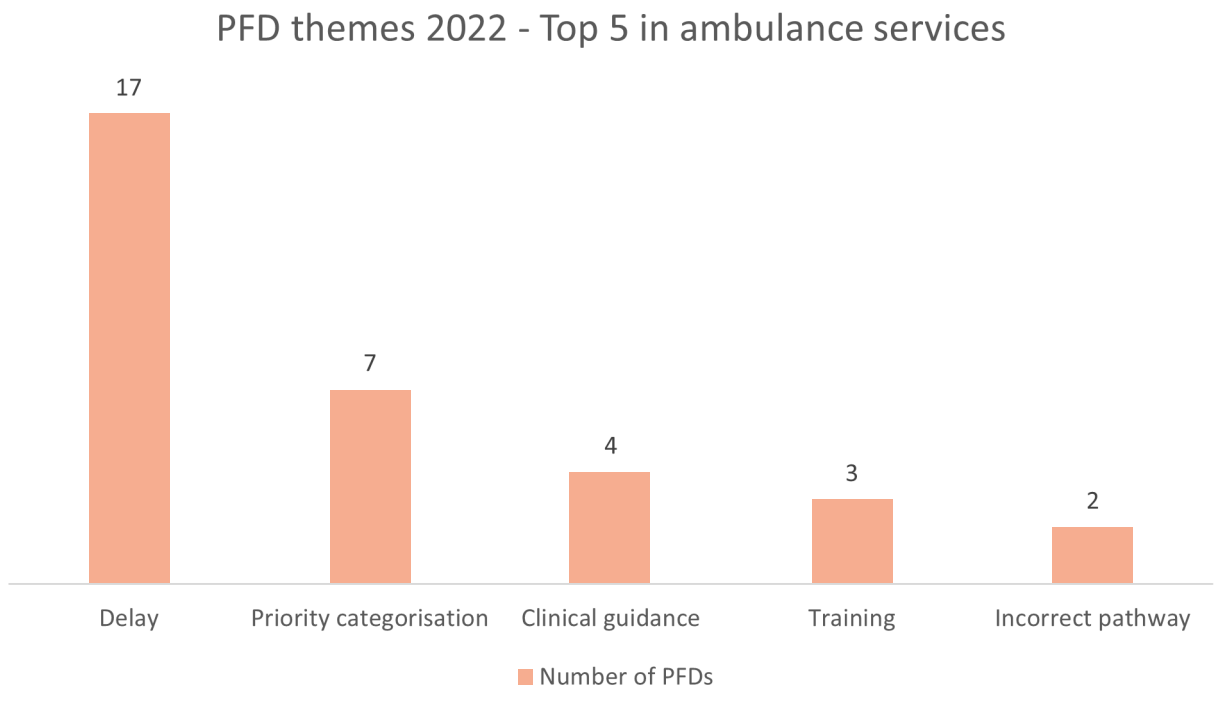
AMBULANCE SERVICES

In this year's report, we have also identified themes emerging from PFDs relating to ambulance services.

We looked at 26 PFDs issued by coroners in 2022 in relation to ambulance services. Reflecting the fact that many of the concerns raised related to ambulance delays which are often connected with system pressures nationally, we looked both at PFDs issued to Ambulance Trusts themselves (11 PFDs) and also at PFDs issued instead to a range of bodies connected with the provision of ambulance services at a national level (15 PFDs), such as the Department of Health and Social Care and the Association of Ambulance Chief Executives.

In terms of the factual context these PFDs arose from, there were numerous different clinical scenarios involved, although it was notable that 8 cases - equating to 30% of the ambulance related PFDs we looked at - involved patients (usually elderly) who had suffered a fall. There were also 2 cases involving acute behavioural disturbance, 2 involving abdominal haemorrhage and 3 cases involving transfers between hospitals.

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 (65% - 17 cases) of the PFDs we looked at in relation to ambulance services raised concerns about ambulance response times and delays. Often, patients were having to wait many hours longer than they should have done, with coroners finding in some of these cases that such delays were a contributory factor in the death.

The evidence in these cases tended to focus on ambulance delays being a national problem, with multiple causes, including gridlock in the wider system, with ambulances often stuck at hospitals waiting to hand patients over.

One coroner summarised the system-wide nature of the issues here by stating in the PFD that the problem is not due to shortage of ambulances or staff but *"a wider issue linked with the lack of resources in primary, secondary and social care. This results in demand for ambulances outstripping supply and a backlog of ambulances waiting to hand over patients at A&E departments because of a shortage of A&E beds, which in turn is because of a shortage of hospital beds, which in turn is because of shortages in social care".*

Overall, there appears to be an appreciation by coroners of the likely causes of ambulance delays, but they are frustrated by the lack of potential solutions, as they continue to express concern that more lives will be put at risk in the meantime.

Priority categorisation

The next most frequently occurring theme in PFDs relating to ambulances services - coming up in 27% of PFDs (7 cases) - related to the priority categorisation allocated to calls in particular scenarios.

This came up a couple of times in the context of priority categorisation where an elderly patient has suffered a fall involving significant trauma, with the coroner asking the recipient of one PFD to *"Confirm whether there are any plans to review the categorisation of elderly patients who suffer falls and are more likely to be affected by the risks associated with lengthy periods of immobility."*

Question marks over the appropriate priority categorisation were also raised by coroners in the context of drugs overdoses requiring time-critical treatment and in cases of head injury where the patient is on blood-thinning medication.

Clinical guidelines

In 15% (4 cases) of the PFDs we looked at in relation to ambulance services, coroners raised issues about the need to review guidelines/ protocols dealing with some specific scenarios, including mental-health related incidents, cases where the patient has a learning disability/ communication issues and breech presentations in labour.

Other themes arising in ambulance related PFDs included: selecting incorrect protocol/pathway (e.g. incorrect pathway followed for hospital transfer to HDU) and staff training (e.g. in relation to acute behavioural disturbance and epilepsy medications).

REFLECTIONS

As the Chief Coroner states in his guidance note on Prevention of Future Deaths Reports: *"PFDs are vitally important if society is to learn from deaths"*. With this in mind, what key messages can be taken from our review of the PFDs issued to health and social care providers in 2022 and what does the future hold?

As was the case last year, the most frequently occurring themes across the PFDs we looked at in 2022 tended to centre around basic aspects of safe care such as good record-keeping, effective communication and learning from incidents.

Whilst the 'Top 10' PFD themes for each area of health and social care we looked at did show some changes of emphasis in 2022 compared with those from the previous year, the overall picture was not markedly different. Specifically, the three most frequently occurring PFD themes for acute hospitals (incident investigations, record-keeping, communication) remained the same compared with the previous year. For mental health providers, it was a similar picture too, with communication and risk assessment coming up most frequently. In social care, there was a shift in the themes coming up most often, with the emergence of delays seeking medical attention as one of the most common areas of concern. Meanwhile, this was the first time we had looked specifically at themes for ambulance services, and ambulance delays came up very clearly as the theme most concerning coroners in 2022.

It remains the case that the best way to avoid a PFD is to provide sufficient reassurance to the coroner that enough has already been done to address any areas of concern through existing incident response processes - as the Chief Coroner's guidance note states: *"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"*. There is significant change around the corner here, with the existing Serious Incident Framework in the process of being replaced by the Patient Safety Incident Response Framework (PSIRF), which will give providers of NHS funded care more flexibility to decide their response to patient safety incidents, depending on their own risk profile and opportunity for learning, meaning that producing an investigation report will no longer always be the default response.

This could have a knock-on effect for inquests and it remains to be seen what the impact of PSIRF will be on how reassured (or otherwise) coroners are about whether sufficient lessons have already been learned under the new system. Coroners are likely to need careful reassurance that the increased flexibility of response is not synonymous with reduced rigour in the investigation of and learning from deaths.

Another significant development on the horizon for health and social care providers is the proposed introduction of the CQC's new single assessment framework, which will include a requirement to demonstrate a learning culture in which *"…lessons are learned to continually identify and embed good practices"*, underlining that learning from deaths will also continue to be a key focus for the CQC going forward.

PFDs continue to provide powerful leverage for change in health and social care and, the more widely learning from them can be shared across the system, the greater their potential positive impact will be.

HOW CAN WE 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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