DAC BEACHCROFT

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

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INTRODUCTION

The steady flow of Prevention of Future Deaths Reports (PFDs) issued by coroners to health and social care providers continues, but what can we learn from them?

PFDs can provide powerful leverage for change, with the Chief Coroner's guidance note on PFDs describing them as "*vitally important if society is to learn from deaths*". How providers learn from deaths also continues to be a key focus for the CQC.

Whilst all PFDs issued by coroners are accessible online, there is currently no central analysis of PFD themes/trends to help support the sharing of lessons learned from deaths nationally.

To provide a snapshot of what these themes might be, we've looked at 200 PFDs issued by coroners to providers of health and social care over the course of 2021.

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.

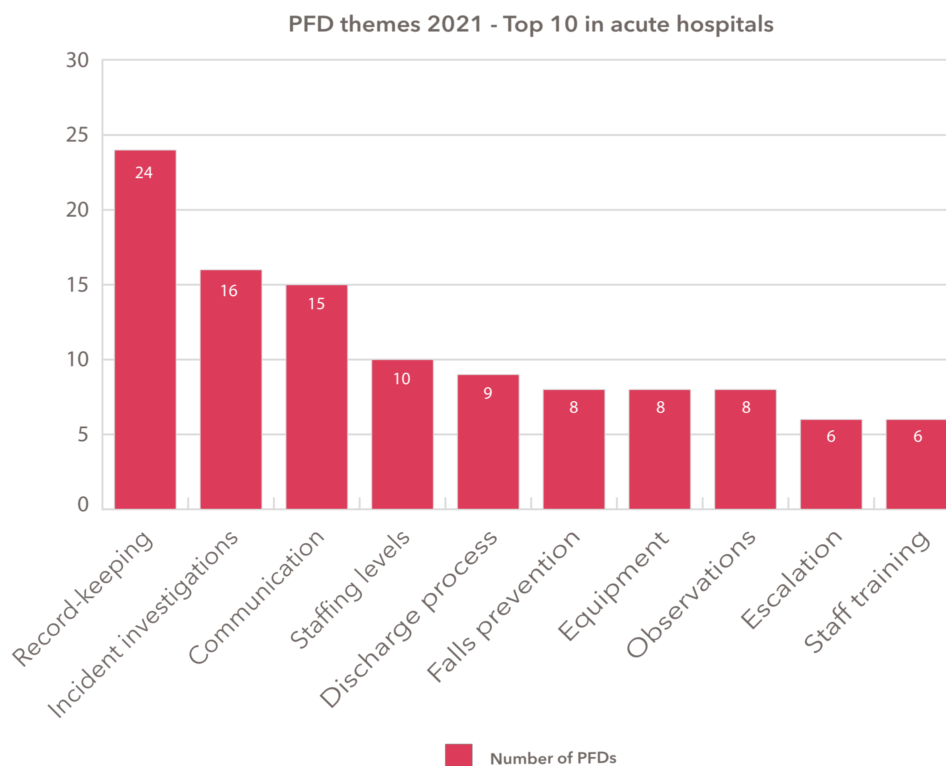
Coroners are expected to send PFDs within 10 working days of an inquest concluding, with recipients having 56 days to provide a written response.

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 follow up on the concerns raised.

ACUTE HOSPITAL CARE

We looked at 93 PFDs issued to providers over the course of 2021 where the concerns related to acute hospital care.

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



Focusing on the most frequently-arising of these concerns, further details of what we found are set out below:

Record-keeping

A significant proportion - 25% - of PFDs directed to providers of acute hospital care in 2021 raised concerns about record-keeping.

The issues highlighted by coroners covered a wide range of record-keeping misdemeanours, including lack of information about why particular clinical decisions were taken (e.g. when diverting from a previous plan of care), gaps in documentation making it difficult for other staff to ascertain what treatment had been given and when (e.g. discharge records inaccurate or incomplete), staff not making contemporaneous records (e.g. where there were insufficient IT facilities for entering records electronically), lack of systems for recording decision-making in clinical meetings (e.g. radiology meetings) and instructions for a patient's care (e.g. required level of observations) not being recorded in the notes.

- ### Serious incident investigations

  Around 17% of the acute hospital PFDs we looked at included concerns from coroners about how providers carried out investigations into patient deaths and learned lessons from them.

  A common problem here was failure to implement action plans from incident investigations in a timely way, plus incident investigations not picking up concerns found at inquest (e.g. about bed rails policies, sepsis response) and various deficiencies in incident investigation processes, including not sufficiently involving families, staff giving evidence at inquest not having seen the investigation findings and incident reports omitting to consider the reasons behind what went wrong. As the coroner in one of these PFDs said: "*I am concerned that the continual delays in investigating adverse incidents, sharing learning and implementing actions following the same, create risks to patient safety*".

- ### Communication between teams

  Another frequently occurring PFD concern for providers of acute hospital care - raised in around 16% of cases - related to ineffective communication within and between teams and other services.

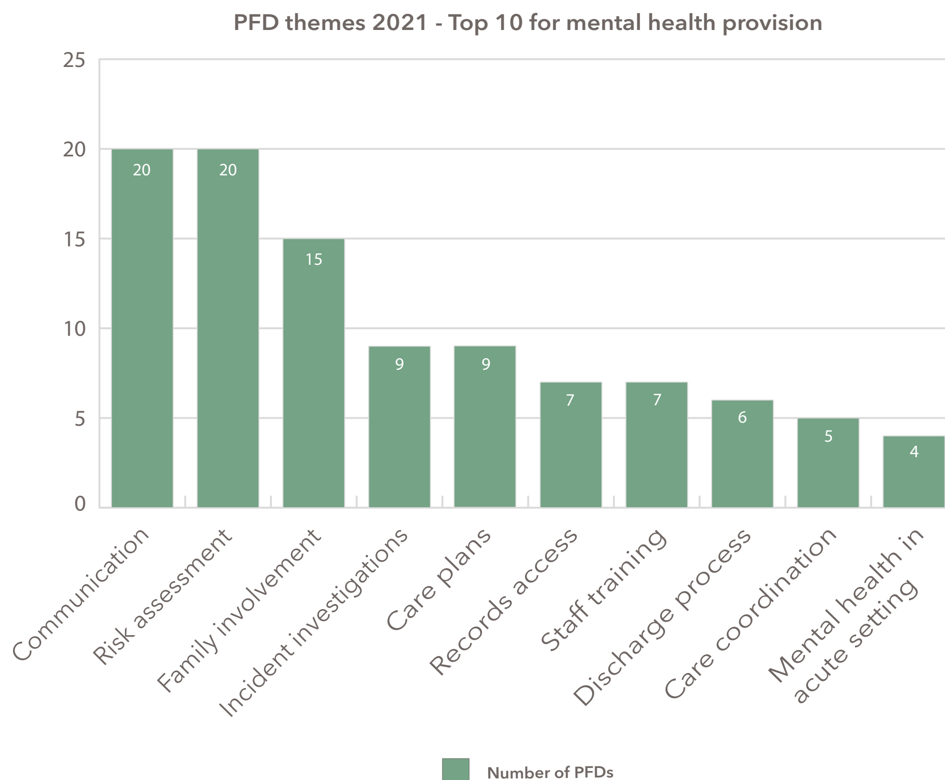
  Examples included - miscommunication between staff as to a patient's plan of care (e.g. the level of observations required or the need to keep the person nil-by-mouth), ineffective communication between different specialities involved in a patient's care (e.g. between critical care and microbiology or between orthopaedic and plastic surgery teams), unclear lines of communication with primary care (e.g. regarding monitoring of prescribed medications or not sharing pathology results with the GP), plus poor communication about a patient between different Trusts (e.g. not giving a full picture when seeking advice from a specialist hospital).

Other recurring PFD themes for acute hospitals included: staffing levels (e.g. insufficient staff levels in ED, dietetic team, microbiology, radiology, too much reliance on agency staff); discharge processes (e.g. gaps/delays in discharge summaries, lack of senior review before discharge); falls prevention (e.g. lack of adequate or any falls risk assessment, falls risk 'downgraded' without documenting rationale); equipment issues (e.g. issues with availability of equipment such as zimmer frames, falls alarms and adequacy of equipment such as CTG monitors and stents); patient observations (e.g. required frequency/duration of observations not carried out, 1:1 supervision needed but not resourced); escalation (e.g. failure to escalate patient deterioration to more experienced/senior clinician); and issues with staffing training (e.g. staff not up-to-date with mandatory training).

MENTAL HEALTH

We looked at 72 PFDs issued over the course of 2021 where the concerns related to provision of mental healthcare (inpatient and community provision).

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:

Communication across services

To quote the coroner in one of the PFDs we looked at: "*One of the most common concerns I hear at inquest is the difficulty with communication between separate organisations*". That coroner was not alone, with around 28% of mental health related PFDs we reviewed from 2021 raising issues with communication across different services. Recurring themes included inadequate communication between inpatient and community mental health teams or between the CMHT and home-based treatment team, lack of communication between mental health and primary care services leading to missed opportunities and failing to share risk-related information between different services within the mental health system.

- **Risk assessment**

  A significant proportion of mental health related PFDs we looked at - again around 28% - raised concerns relating to risk assessment. One of the most commonly occurring issues here was risk assessments not being updated to reflect material incidents/events. There were also a number of concerns about risk assessments not being sufficiently rigorous, with missing information and management plans, as well as cases involving a lack of comprehensive risk review ahead of discharge from hospital or before downgrading the person's risk status. There were cases too where the coroner felt the wrong balance had been struck between therapeutic positive risk-taking and keeping people safe.

- **Family involvement**

  In around 20% of mental health related PFDs we looked at, the coroner raised concerns about lack of family involvement. The most commonly occurring issue here was not heeding/taking on board warnings or concerns from family/carers about risks, with the coroner in one PFD saying, for example: "*When a family member sought to share concerns, these were rebuffed*". There were also issues with lack of family/carer involvement in the discharge process and lack of staff understanding about the impact of the duty of confidentiality on the extent of permitted communication with families.

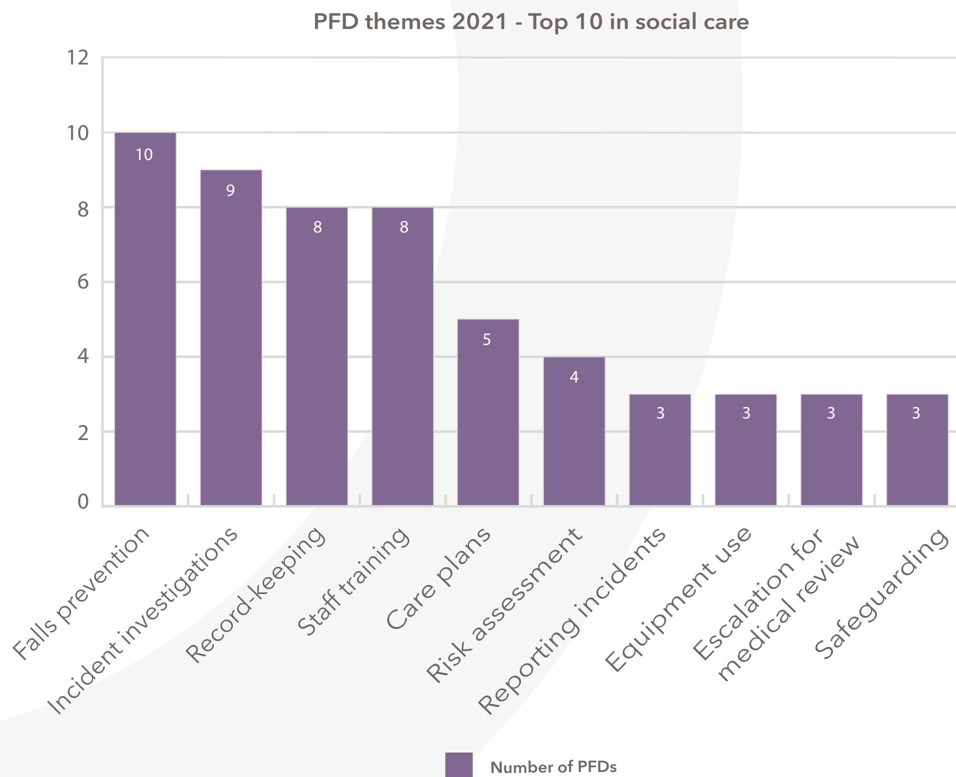
Another theme that came up a number of times centred around the quality of internal serious incident investigations. This issue came up in 12% of mental health related PFDs we looked at - not dissimilar from the 17% of cases where this was raised with acute hospital providers (see above), with coroners particularly keen to highlight instances where incident investigations are not fulfilling their purpose of learning lessons for the future. One incident investigation report, for example, was found by the coroner to contain "*several factual errors and misinterpretations*" and another "*failed to challenge false assumptions made at the time*", whilst another "*…promised action but nothing effective has been produced*".

Other themes we saw coming up in a number of mental health related PFDs included: care plans (e.g. lacking contingency plans or not updated following incidents); lack of reciprocal patient records access between different healthcare providers (such as between acute and mental health Trusts); staff training issues (e.g. lack of staff awareness in specialist areas such as dementia or autism); discharge processes (e.g. lack of multi-agency planning prior to discharge from hospital); care coordination issues (e.g. no care co-ordinator/lead practitioner in overall charge of the person's care); and issues with supervision of mental health patients in acute settings such as the emergency department.

SOCIAL CARE

We also looked at 35 PFDs issued to adult social care providers, including care homes, domiciliary care and supported living providers, over the course of 2021.

As there were fewer social care related PFDs compared with those relating to acute hospital care or mental health provision, it was more difficult to pick up strong themes. However, a number of recurring issues stood out, as illustrated in the graph below:



Falls prevention

Over a quarter (around 28%) of the social care related PFDs we looked at expressed concerns relating to falls prevention measures, including: falls prevention equipment (e.g. sensor mats) not being used or not being used properly; falls risk assessments not being updated when they should have been - e.g. following further falls - and not consistently complying with falls/ mobility care plans. Despite a lot of focus in the sector over the years on falls risk reduction strategies, it is clear from this that coroners in 2021 were still feeling that more needs to be done here.

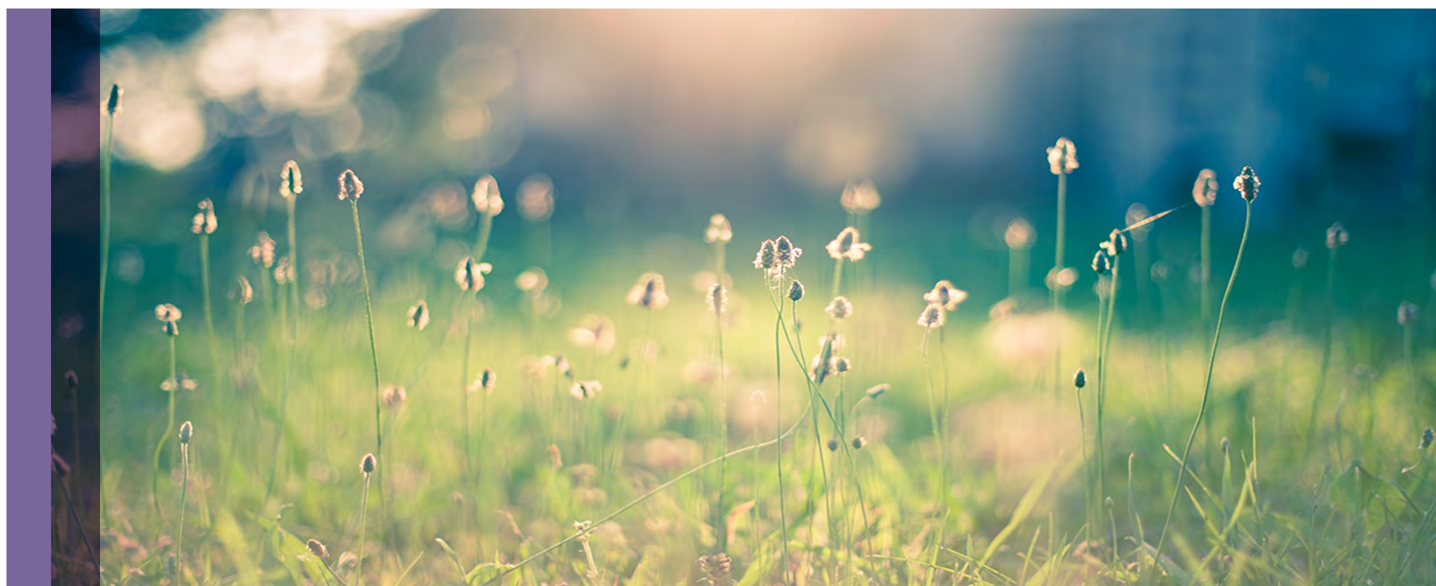
- ### Incident investigations

  Meanwhile, as was the case with both acute hospital care and mental health provision, a significant proportion of concerns in social care related PFDs - 25% - were about internal incident investigation processes. For example, in one case, the serious incident review process was described by the coroner as "*deficient and ineffective*" and in another, the coroner was not confident that lessons would be learned because of a culture amongst senior staff of "*obfuscation and denial*". There were also issues raised about internal investigations not having been sufficiently robust to pick up concerns raised at inquest and cases that should have triggered a serious incident review but didn't, meaning missed opportunities to learn.

- ### Record-keeping

  Deficiencies in record-keeping was another commonly occurring PFD theme here, coming up in around 22% of cases we looked at. Examples included important records not being kept by staff - e.g. in relation to food intake, exercise, vital observations - or gaps in records, such as lack of detail about well-being or failure to note episodes of wandering at night or falls, with record-keeping described by the coroner in one case as "*inconsistent and sometimes non-existent*".

Other issues that came up a number of times in PFDs relating to social care included: staff training (e.g. gaps in staff training on a range of issues such as DNACPR, dietary matters, recognising head injury); care plans (e.g. not updated to reflect incidents or specialist advice); risk assessments (e.g. choke risk tool inaccurately completed); incident reporting (e.g. discrepancies in falls incident reporting); escalation for medical review (e.g. confusion over when to escalate when someone becomes acutely unwell); equipment (e.g. lack of compliance with instructions for specialist equipment use); and safeguarding (e.g. safeguarding alert should have been raised).



REFLECTIONS

Although the Chief Coroner's guidance note on PFDs emphasises that they are "*not intended as a punishment*", the reality is that health and social care providers would generally rather avoid a PFD if possible because they tend to highlight - in a very public way - concerns about how their services operate which can potentially lead to further regulatory scrutiny, principally from the CQC, as well as press scrutiny and reputational damage with commissioners. Ensuring robust internal investigation systems and investing time in preparing evidence for the coroner about lessons learnt and changes made (or planned within a clear timeframe) should go a long way towards reassuring coroners that enough is already being done to address any concerns, without the need to issue a PFD. As illustrated by the high proportion of PFDs in 2021 where concerns were raised about poor internal investigation processes, however, there remains considerable room for improvement here.

Other key recurring themes across all the PFDs we looked at tended to centre around basic principles of safe care - in particular, good record-keeping, communication and assessment of risk. Learning lessons for the future in these areas can in practice be a real challenge because providers are continually grappling at the same time with stretched resources, pressured staff and a health and care system which is not as digitally advanced or as integrated as it could be.

However, having a feel for the themes most commonly coming up in PFDs across the country may go some way to helping health and social care providers pinpoint areas of risk to minimise the chances of receiving a PFD where possible and, most importantly, to learn from them when they do happen.

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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