PSIRF and coronial processes: Supporting learning and improvement while meeting inquest needs

NHS England recently met with the Chief Coroner to explore how the Patient Safety Incident Response Framework (PSIRF) and coronial processes can work more effectively together. The discussion focused on a shared goal: ensuring coroners receive the information they need for inquests while preserving PSIRF's core principle of fostering a learning culture within healthcare.

Background on PSIRF

Following more than four years of development, testing and evaluation, PSIRF was introduced to the NHS in England in August 2022, and became mandatory within the NHS Standard Contract from April 2024. PSIRF replaced the Serious Incident Framework (SIF), addressing weaknesses in incident response highlighted by patients and families, health professionals, regulators, academics and Parliament.

PSIRF moves away from a single, linear method - Root Cause Analysis (RCA) -towards a systems-based approach, widely regarded across safety-critical industries as best practice for learning and improvement. RCA often oversimplified complex events and failed to identify interacting systemic factors, leading to narrow and ineffective actions. In contrast, PSIRF enables proportionate responses using varied evidence-based methods to generate learning, fostering openness and a culture of continuous improvement. While this approach strengthens the ability to learn from incidents, it has also introduced new challenges in how healthcare providers interact with coronial processes.

Current challenge

The challenge between PSIRF and inquests arises because the two processes serve fundamentally different purposes. PSIRF is designed to support organisational learning and improvement, and deliberately excludes activities such as apportioning blame, determining liability, assessing preventability, or identifying cause of death. PSIRF learning responses take a "window on the system" approach, exploring how work happens in everyday practice rather than focusing solely on a single incident.

In contrast, coroners are legally required to answer four statutory questions, including how someone came by their death. This often involves establishing causation and examining the circumstances surrounding a specific death. This difference means PSIRF outputs, which focus on systemic insights rather than direct causation, may be less directly useful for coronial purposes.

Some coroners, accustomed to Serious Incident investigation reports that provided clear chronologies and RCA now find that PSIRF outputs while richer in systemic insight are lacking the causation detail they expect.

Action

Both NHS England and the Chief Coroner agreed on the importance of continued collaboration to ensure that relevant information can be shared to support both processes.

Because PSIRF and inquests serve different purposes, evidence gathering for a PSIRF learning response and for an inquest must remain distinct so that each achieves its intended aim. This means coroners may need causation to be established through other means and should no longer expect or require an RCA in place of a learning response, as this is no longer the nationally endorsed approach.

Importantly, PSIRF outputs, including the rationale for the chosen response and any improvement actions, can provide valuable context about wider circumstances and system changes. Coroners may continue to use learning response outputs as supplementary information when available; however, these should not be relied upon as the primary or sole evidence for an inquest.

By working together, both parties can uphold the integrity of the coronial process while fostering a culture of learning and improvement across healthcare.