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Shared Insights

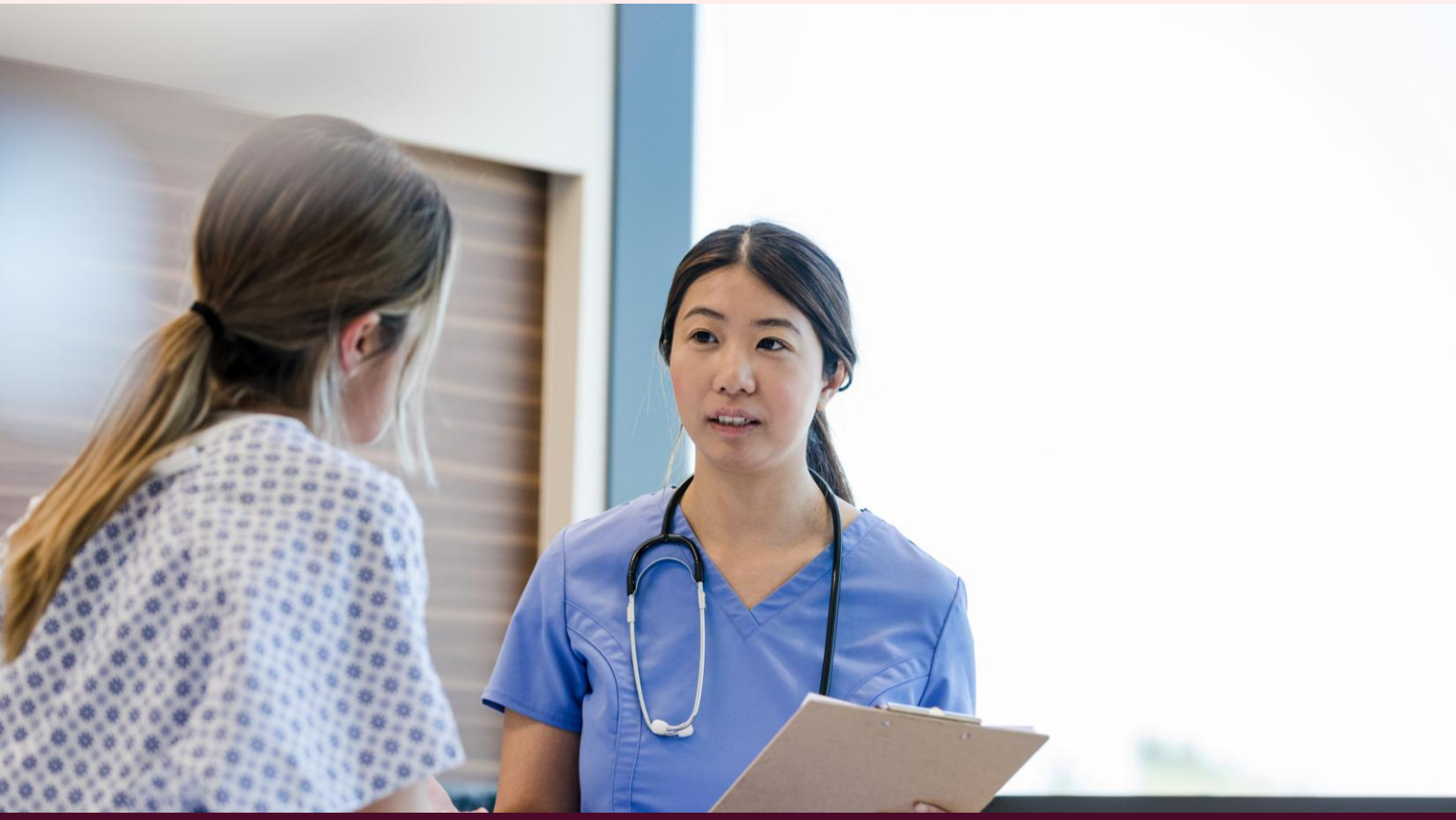
The impact of the Patient Safety Incident Response Framework (PSIRF) on preparing for inquests

Speakers

Katie Viggers, Professional Development Lawyer, Browne Jacobson
Mr Graeme Irvine – HM Senior Coroner for East London
Lauren Mosley – Head of Patient Safety Incident Response Policy, NHS England
Dr Stef Cormack – Head of Patient Safety, Sandwell and West Birmingham NHS Trust
Conor Lees – Head of Legal Services, Sandwell and West Birmingham NHS Trust

NHS England

NHS Sandwell and West Birmingham NHS Trust



Browne Jacobson

Introduction

PSIRF became mandatory for all health services contracted under the NHS Standard Contract, including NHS-funded care delivered by independent healthcare providers, in April 2024. It replaced the Serious Incident (SI) framework. The change in approach to investigations under PSIRF has resulted in some practical challenges to the way in which information and organisational learning evidence is presented to the coroner for inquests.

Chaired by **Amelia Newbold,** Risk Management Lead, this Shared Insights session discussed how the PSIRF and coronial processes can work more effectively together to ensure that coroners receive the information they need for inquests while preserving PSIRF's core principle of fostering a learning culture within healthcare.

Bringing together perspectives from across the system, we explored some of the key challenges and, importantly, shared positive and practical examples of how a collaborative approach across both learning and coronial processes can ensure that relevant information is shared effectively.

Contents

How we can help

- Our specialist team can provide advice and support to help with the impact of PSIRF. Areas we can help you with include:
- Deep dives of claims/inquests to assist with identifying your risk profile.
- Representation and support in relation to investigations involving patient safety incidents (inquests, regulatory investigations, police investigations).
- The documentation and storage of records produced in respect of responses other than PSII.
- Supporting healthcare providers and staff through the inquest and health litigation processes.
- Training on other areas relevant to PSIRF including statement writing and duty of candour.

We have also developed a PSIRF inquest toolkit designed to support all those involved in responding to a patient safety incident under PSIRF and in-house legal teams preparing for an inquest.

Please contact Amelia Newbold or Katie Viggers if you would like more information about how we can support your organisation.

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PSIRF overview and interactions with the coronial process

Katie Viggers – Professional Development Lawyer, Browne Jacobson

What is PSIRF?

PSIRF is now mandatory for all health services contracted under the NHS Standard Contract, including NHS-funded care delivered by independent healthcare providers. It replaced the Serious Incident (SI) framework.

Under the SI framework, only incidents meeting a particular threshold were investigated, meaning that less serious incidents were not subject to formal review. Investigations were often long and drawn-out processes. Under PSIRF, providers now determine what learning response is appropriate following a patient safety incident, based on their Patient Safety Incident Response Plan (PSIRP). The PSIRP is specific to individual organisations and sets out what incidents will be reviewed and how. The response might take the form of a Patient Safety Incident Investigation (PSII), a swarm huddle, a structured review or another learning method, depending on the nature of the incident.

PSIRF also moves away from Root Cause Analysis (RCA) and endorses a system-based approach, which examines components of a system (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and their interdependencies (i.e. how they influence each other) and how those interdependencies may contribute to patient safety, rather than attributing a single root cause.

This change in approach is positive for improving patient safety incident responses and organisational learning, but it has come with some challenges – particularly in relation to the inquest process.

What is an inquest?

An inquest is a fact-finding inquiry led by a coroner. An inquest must take place where there has been a violent or unnatural death, where the cause of death is unknown or where the person died in custody or state detention, including detention under the Mental Health Act. The coroner must determine by law who the deceased was, where, when and how they died.

The tension between PSIRF and the coronial process

PSIRF and inquests serve fundamentally different purposes. PSIRF is designed to support organisational learning and excludes apportioning blame or identifying cause of death. By contrast, the coronial process is required to determine how someone died, which involves establishing causation and examining the circumstances surrounding a death.

Previously, some coroners relied heavily on SI reports, as they often included a clear chronology of events, statements or comments from clinicians, actions or inactions that may have caused or contributed to the death and a “root cause”. However, whilst a chronology might form part of a learning response under PSIRF, a “cause of death” statement should not.

The result is a potential evidential gap for inquests. Providers are now having to carefully consider what evidence is required for an inquest, and how they will obtain and present it to the coroner.

A recent newsletter published by NHS England confirmed that NHS England met with the Chief Coroner to explore how the PSIRF and coronial processes can work more effectively together. The agreed position is that evidence gathering for a PSIRF learning response and for an inquest must remain distinct so that each achieves its intended aim.

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NHS England's perspective

Lauren Mosley – Head of Patient Safety Incident Response Policy, NHS England

Lauren confirmed that NHS England met with the Chief Coroner to address the emerging tensions between PSIRF and inquests. A newsletter was published following that meeting setting out the key agreed positions. The overarching principle is that each process (PSIRF and the coronial inquiry) should remain distinct. PSIRF outputs can be helpful supplementary material for the coroner but should not be the primary source of inquest evidence.

The Chief Coroner was hugely supportive of the two processes remaining distinct but capable of supporting each other where needed. NHS England has been clear for some time that witness statements are not required under PSIRF, and that a PSIRF learning response may not contain a detailed chronology or causation analysis. What a PSIRF learning response does produce may nonetheless be helpful to a coroner as supplementary material, but it should not be treated as the primary source of evidence for the inquest.

The challenge is made greater by the fact that not every organisation has a dedicated legal team, and in some cases the legal and patient safety functions overlap. NHS England is seeking to encourage a supportive process, where inquest evidence, including witness statements, is collected separately from the PSIRF learning response.

Lauren emphasised that the most important practical step is to work well with coroners locally. The challenge is significantly reduced where there is an open and established conversation about PSIRF and where the right supplementary information is being provided to the coroner when needed.

Some organisations have developed standard guidance and templates for submitting evidence to the coroner. Structured approaches and open discussion to enable the right information to be shared in the right way and at the right stages are enormously valuable.

The Coroners' perspective

Mr Graeme Irvine – HM Senior Coroner for East London

The role of the coroner is twofold. The first role is to answer the four statutory questions – who died, when, where and how. The fourth question, how the person died, is concerned with any acts or omissions that were causative of the death. The coroner's second role is under Regulation 28 of the Coroners (Investigations) Regulations 2013 – the Prevention of Future Deaths duty, which is a very useful vehicle for prompting meaningful organisational reflection.

There are other processes in addition to PSIRF that run parallel to inquests (e.g. Independent Office for Police Conduct investigations) and similar tensions can arise with these. Parallel investigations have different aims and priorities and do not always run smoothly alongside an inquest.

Addressing the evidence gap

PSIRF usually involves a review of documentation and conversations with staff, but those conversations are often not written down. This does not remove the coroner's need for written material. In Mr Irvine's jurisdiction, two Trusts were involved in the PSIRF pilot, and he knew from the outset that there would be an evidential gap.

It is key for the patient safety team to work closely with the legal team to identify what the coroner is going to need for the inquest and to fill the gap proactively.

Causation evidence

The SI report, for all its limitations, was a relatively convenient package for coronial purposes. Organisations must now think carefully about how to provide the evidence that was often included in an SI report – particularly in terms of causation evidence.

Mr Irvine was candid that PSIIs and other PSIRF outputs can sometimes be lengthy and dense documents making them difficult to use in a coronial context.

The human dimension

Mr Irvine noted that coroners are human beings, so organisations should expect some frustration if a coroner feels that the documentation provided is inadequate or does not address the court's needs.

Mr Irvine receives approximately 2,500 referrals a year. His starting question is always whether a case raises something beyond the ordinary, and in particular whether it raises a patient safety concern. Providers need to communicate with coroners as early as possible and provide a realistic timeframe for PSIRF outputs as well as an indication of the additional documentation they can expect.

If a consensus cannot be reached about causation by the healthcare organisation, the coroner may need to commission independent expert evidence. It is important for an organisation to notify a coroner early if it is unable to reach a consensus about causation.

A practical approach

Conor Lees – Head of Legal Services,
Sandwell and West Birmingham NHS Trust

Conor explained that at his Trust, the legal team works closely with the patient safety team which is something he regards as critically important from an inquest perspective. He reflected that the evidential gap between PSIRF and the coronial process is not entirely new – gaps existed under the SI framework too.

The key advantage at Sandwell and West Birmingham NHS Trust is the close working relationship between the legal and patient safety teams, and the legal team's involvement in the PSIRF implementation group. This gave the legal team an informed and detailed understanding of how the framework would work in practice. When local coroners made contact to ask about the Trust's approach, they were well placed to respond.

The evidential gap is significantly easier to manage where there is an established, open working relationship with the local coroner.

Developing the template

The Trust developed a template "inquest report", designed to present information about a death / patient safety incident to the coroner in the most useful and accessible way. One of the practical challenges of PSIRF is that it can result in a mixture of outputs: a swarm huddle produces very little structured documentation, while a full PSII report is extensive. The inquest report is a way of bringing together a range of information, including PSIRF outputs, into a single, coherent structure.

The template includes:

- Patient and incident details.
- A record of the Duty of Candour process.
- Type of PSIRF response conducted.

- **Chronology of the patient safety incident** – a focused chronology of the incident itself, rather than a full clinical history. It covers sufficient preceding history and the immediate impact of the incident, with the detailed wider clinical background provided in other evidence to the coroner, e.g. witness statements.
- **Investigation findings and conclusions** – a structured summary of each concern or issue identified by the investigation, the findings and conclusions in relation to each, including contributing and influencing factors, and any learning or improvement points.
- **Impact on outcome** – this section is deliberately distinct and specifically addresses causation. For each issue identified, it considers how, if at all, the problem, error, weakness or omission impacted the outcome for the patient including whether, on the balance of probabilities, the patient would still have died but for it. Conor described this as the Trust's way of taking control and being proactive about the causation question. The opinions that inform this section can be drawn from a variety of clinical specialties.
- **Areas for improvement and safety actions** – an amalgamated list of safety actions with details as to who has responsibility/oversight, target dates for completion and progress updates. This works well with coroners in the context of Prevention of Future Deaths reports and provides families with a clear picture of what is being done, by whom and by when.

One important pitfall to avoid is treating the template as a standalone document. It is not: it is designed to supplement the other evidence provided to the coroner, not to replace it.

A practical approach

Dr Stef Cormack – Head of Patient Safety, Sandwell and West Birmingham NHS Trust

Stef is a critical care paramedic by background and has a strong affinity with systems thinking and contributing factors. She is firmly in the camp that found RCA unsatisfying, and PSIRF's approach resonates with her.

Completing the “inquest report” template requires active investigative work. Staff have to go searching for information, ask additional questions and draw on subject matter expert opinions from a range of clinical specialties. The template provides a way of collating that information into something concise that works for both coroners and families. PSIIs are very long documents and families often want their questions answered relatively quickly and without wading through pages of dense text. The template allows the team to focus on the contextual background and the contributing factors in a clear, accessible way.

The “impact on outcome” and “safety actions” sections require the team to address causation issues and to demonstrate what has been done to minimise risk of reoccurrence. Stef is conscious of the need to provide the coroner with what they need, not just what the organisation has focused on for its own local learning. She attends inquests regularly, given her comprehensive knowledge of each case, and the team approach has meant that far fewer clinical witnesses are called to give oral evidence.

It is the work that goes behind the template that is key: those conversations, those reviews, the questions that arise along the way. The template is the means of presenting that work clearly.

Discussion and questions

Witnesses at inquests

A delegate raised the question of witnesses being called to give oral evidence where they were involved in a learning response, such as a structured judgment review, rather than in the substantive care of the patient. It was discussed that coroners often call the author of a learning output, whether that be a PSII or a swarm huddle to give organisational learning evidence The coroner will want to understand, what meaningful reflection the organisation has genuinely undertaken as part of the Prevention of Future Deaths duty.

We recommend that organisations are proactive in identifying the best witness to speak to your organisational learning and putting that person's name to the Coroner at an early stage - the Coroner will usually take on board the organisation's suggestions . Sometimes that will be the PSII investigator and sometimes it will be a Clinical Director or senior Consultant or Nurse - as always, this will be case specific.

Causation and pre-inquest admissions

There is a contrast between the open, collaborative culture of PSIRF and the environment of the coroner's court, where specific questions about individual acts and omissions must be answered directly. A delegate highlighted the tension between the culture of psychological safety that PSIRF is designed to foster and the realities of the coroner's court.

The coroner may ask a trust or organisation whether it has made an admission on causation and sometimes that is a legitimate question that needs to be faced. Appropriate pre-inquest admissions can shorten an inquest significantly, reduce the witness list and make the proceedings more straightforward for everyone involved, including the family.

Disclosure of PSIRF materials

Organisations have a duty to disclose documents that are relevant to the four statutory questions that the Coroner needs to answer.

All of the documents generated during the PSII investigation are potentially disclosable - some Coroners will expect to see all of it, others will take a different approach and will be happy just to receive the final PSII. The safest approach is to disclose the PSII and let the Coroner know what other documents you are holding. If the Coroner wants to see that documentation they can request it.

Staff reflections in particular are a difficult issue - there is no legal "safe space" for reflections but usually Coroners don't push for these to be disclosed. You can read more about the duty to give disclosure here: Chapter 12: Disclosure of documents - Courts and Tribunals. Staff reflections, or statements, are not recommended forms or methods of information gathering for learning responses under PSIRF.

If a coroner considers an underlying PSIRF document to be material to the inquest and asks for it to be disclosed, there needs to be a very good reason not to provide it. Deliberately withholding documentation from a coroner would be a criminal offence.

There was also some discussion about disclosure of draft documents to the Coroner. Usually, the final version of the report will be disclosed. However, the drafts are potentially disclosable - they are not covered by legal privilege and so if the Coroner or the family ask for them then they will be disclosable. Draft documents can be important in cases where the final version is significantly changed from the first drafts for example, when the Coroner or the family's solicitor is trying to unpick why initial shortcomings have been watered down in the final draft.

It is important to remember that disclosure to the coroner is the first stage of a two-stage process. The coroner does not automatically disclose all material to all interested parties. When providing material to the coroner, organisations should be explicit about whether they are asking the coroner not to disclose it more widely, and the reasons for that request.

Engagement with families

There was considerable discussion about the best ways to involve and engage families in the PSIRF process with some organisations producing family friendly reports following AARs or a template to record the findings from an AAR or other learning response. The use of Family Liaison Officers (FLOs) was also considered very helpful.

The Patient Safety Incident Response Standards talk about those affected (i.e. both patients/families and colleagues) being given an opportunity to review the learning response report while it is still in draft. This is where the engagement and involvement piece of PSIRF really supports the process .

Resources

- NHS-Futures-newsletter-on-PSIRF.pdf
- Essential guidance for healthcare providers on PSIRF and inquests
- Patient safety incident inquest report template (Sandwell and West Birmingham)
- PSIRF & inquests: Navigating the evidential gap
- PSIRF inquest toolkit
- Coroners' Question Time
- Guide to preparing and evidencing organisational learning
- Guide to the inquest process for witnesses

Contact us

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PATIENTS PEOPLE POPULATION

NHS Sandwell and West Birmingham NHS Trust

PATIENT SAFETY INCIDENT INQUEST REPORT

Patient Details	
Name	
Date of Birth	Click or tap to enter a date.
Date of Death	Click or tap to enter a date.
Hospital Reference (RXK)	

Patient Safety Incident Details	
PSIRF Priority Type	Choose an item.
Patient Safety Incident Type	Choose an item.
PSI Reference Number	
PSI Date/Date range	Click or tap to enter a date. **to** Click or tap to enter a date.
PSI Location/Clinical Specialty(ies)	

Patient Safety Incident Investigation(s)			
Sandwell & West Birmingham NHS Trust			
Investigation Type	Choose an item.		
Investigation Report?	Choose an item.	**Date of Report (where applicable)**	Click or tap to enter a date.
External/Other			
Investigation Type	Choose an item.		
Investigation Report?	Choose an item.	**Date of Report (where applicable)**	Click or tap to enter a date.

Report Details			
This report has been approved by: **Relevant Clinical Division(s)** ☐ **Safety Action Group** ☐ **Legal Services** ☐			
Author		**Job Title**	
Signature		**Date**	Click or tap to enter a date.

Purpose of Report
To supplement the evidence provided to the Coroner by the Trust for the purposes of the Inquest investigation, and to summarise the investigations, findings, conclusions, learning points and actions which form the Trust's response to the relevant Patient Safety Incident(s) under the Patient Safety Incident Response Framework ("PSIRF").

Introduction and Background

Summary of patient safety incident, to include:

- *Patient demographics, relevant/recent clinical and social history*
- *Presenting complaint for the treatment episode during which patient safety incident occurred, details of assessment, diagnosis, treatment plan and care provided/intended*
- *Broad description of patient safety incident – where and how it occurred, immediate impact and actions/outcome, anything relevant that was unknown at the time*
- *Noting that this triggered an incident report and when that was carried out*
- *Brief explanation of how the incident led to specific investigation(s) under Trust PSIRF framework/protocols*

Duty of Candour

Stage 1 (verbal notification)
Description of how Stage 1 DoC was carried out, by whom (job title/role) and which persons (patient/family member(s)/friend(s)/carer(s)) were informed

Stage 2 (written notification)
Details of when Stage 2 DoC was carried out, by whom (job title/role) and to whom (patient/family member(s)/friend(s)/carer(s)) the letter was sent/given

Stage 3 (investigation outcomes)
Details of when Stage 3 DoC was carried out, by whom (job title/role), to whom (patient/family member(s)/friend(s)/carer(s)) and via what method (letter/copy investigation report/meeting etc.)

Chronology (Patient Safety Incident)	
Detailed clinical chronology of the patient safety incident, including sufficient preceding relevant history and details of the immediate impact of the incident (n.b. this does not need to be a full chronology of the treatment episode or wider clinical background history, as this will be detailed elsewhere in evidence provided to the Coroner; the focus should be on the patient safety incident which prompted the PSIRF investigation(s) that have been carried out)	
Date/Time	**Description**

Investigation Findings and Conclusions		
Item Number	**Description of Concern/Issue identified by investigation(s)** *Describe each Clinical/Service delivery problem, error, weakness or omission*	**Findings/Conclusions** *Describe the investigation findings regarding each Concern/Issue, including any contributing/influencing factors, learning and/or improvement points*
1		
2		
3		
4		
5		
6		

Impact on Outcome		
Item Number	**Concern/Issue identified by investigation(s)**	**Impact on Outcome** *Describe how (if at all) each Clinical/Service delivery problem, error, weakness or omission impacted the outcome for the patient, including where applicable any immediate harm, restriction of treatment options or their effectiveness, and whether on balance of probability the patient would still have died but for the problem, error, weakness or omission.* *"On Balance of Probability" means that something is 'more likely than not' – i.e. greater than 50% likelihood of occurrence.*
1		
2		
3		
4		
5		
6		

Areas for Improvement and Safety Actions

Describe each Area for Improvement identified from the conclusions of the investigation(s) into the Patient Safety Incident, and the agreed Safety Actions to be carried out by the Trust

Item No.	Area for Improvement	Agreed Safety Action(s)	Expected Improvement/Measure of Success	Responsibility for Oversight (Division/Individual)	Target Date for Implementation	Date action(s) completed or note of ongoing action/progress/trajectory
1					Click or tap to enter a date.	
2					Click or tap to enter a date.	
3					Click or tap to enter a date.	
4					Click or tap to enter a date.	
5					Click or tap to enter a date.	
6					Click or tap to enter a date.	

Additional Information
Include here any additional information you think the Coroner needs to be aware of, particularly with regard to the Trust's response to, and learning/improvements from, the Patient Safety Incident(s), but which does not fit into any of the sections above.

For further information about any of our services, please visit **brownejacobson.com**