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Prevention of future deaths reports: A guide for independent providers

14 April 2025 Katie Viggers

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Katie Viggers, healthcare lawyer at Browne Jacobson, explains why it's essential for independent providers to understand the significance of prevention of future deaths reports.

Prevention of future deaths (PFD) reports, also known as Regulation 28 reports, are issued by coroners and serve an important public health function by encouraging effective responses to identified patient safety risks. They are a mechanism for learning and development to prevent future fatalities.

A coroner must issue a PFD report when they have a concern that circumstances creating a risk of further deaths continue to exist. The coroner must also be satisfied that action should be taken to prevent the occurrence or continuation of the identified risk of death or reduce the risk of future deaths created by those circumstances.

The threshold is relatively low and subjective. It's not necessary for the concerning circumstances to have caused the index death, while merely having a concern there are circumstances posing a risk of future deaths is sufficient.

PFD reports must be issued to a person, including an organisation, who the coroner believes can take remedial action. Where a report is sent to an organisation, the coroner should identify a senior person with the power to take action. For healthcare providers, this will typically be the chief executive or the chief medical officer.

A coroner can't make recommendations as to what action should be taken. It's the recipient's responsibility to decide what action – if any – to implement in response to the concerns.

PFD reports are publicly available and often attract media attention.

Response times and requirements

Upon receiving a PFD report, an organisation has 56 days to respond, though extensions are possible.

Recipients should carefully review the concerns raised, identify actionable steps and seek to implement changes to prevent recurrence. Ideally, this task should be undertaken by a multidisciplinary team, including clinicians, risk managers, patient safety and quality assurance specialists, to ensure a comprehensive response.

The response must include a timetable for the actions taken or proposed. It should be thorough and demonstrate a commitment to addressing the issues highlighted by the coroner.

If no action is deemed necessary, the reasons for this must be clearly stated in the response. It's uncommon and potentially unwise for a provider to take no action in response to a PFD report unless the coroner has misunderstood the position or the required remedial action is beyond the provider's control, in which case the coroner should be informed accordingly.

A badge of dishonour

A coroner can't sanction an organisation that fails to respond to a PFD report. For that reason, the chief coroner recently started publishing a list of organisations that haven't responded.

This list serves as a badge of dishonour, publicly naming non-complying entities. Non-responses not only attract negative attention but also suggest a lack of accountability and commitment to patient safety, which can have repercussions on a provider's reputation.

There is, however, evidence indicating the non-response list may not always be accurate, and we are aware of some healthcare organisations that have been mistakenly included.

Georgia Richards, who leads the Preventable Deaths Tracker, also highlighted that the chief coroner plans to update the list every six months, meaning those who provide a response after being named won't automatically be removed.

Can a healthcare provider mitigate the likelihood of receiving a PFD report?

In short, yes. In most inquests, coroners request organisational learning evidence from the healthcare provider. This is because, when considering whether to make a PFD report, coroners are required to focus on the current position at the date of the inquest rather than death.

The coroner should consider evidence and information about relevant changes made since the death or plans to implement improvements. If a healthcare provider has already implemented appropriate action to address the risk of future fatalities, a PFD report may not be necessary.

It's therefore important for healthcare providers to undertake an internal review of the death swiftly. Details of the findings, identified learnings and improvement actions should be provided to the coroner in advance of the inquest.

It's advisable for any investigation to be conducted in accordance with the Patient Safety Incident Response Framework (PSIRF).

Issues likely to arise in PFD reports

Due to increasing demands on NHS resources, patients often seek private healthcare support while waiting for NHS assistance or are placed with independent providers as they await an NHS bed – particularly relating to mental health care.

These cases have revealed issues such as inadequate communication or information sharing between the independent provider and NHS. There have also been concerns over unclear referral processes between private practitioners and the NHS, especially for mental health crisis support.

Independent providers should establish protocols with the NHS to ensure timely information exchange, continuity of care and effective patient handover. Referral pathways to local NHS services should be clarified for independent practitioners, especially for crisis care services.

Several PFD reports have highlighted a lack of clear protocols for escalating deteriorating patients and insufficient arrangements for transferring patients to NHS hospitals with intensive care facilities in emergencies.

It's imperative that independent providers establish clear policies and guidelines to ensure clinicians and healthcare staff can identify and appropriately escalate deteriorating patients in a timely manner.

Providers should offer regular training and implement mechanisms to identify patients at risk of deterioration. Additionally, it would be prudent to appoint a clinician responsible for facilitating admissions to local NHS hospitals equipped with intensive care support.

Providers should conduct regular reviews of their protocols and guidance documents to ensure a comprehensive set of up-to-date policies addressing all necessary areas. The review should include references to national and international guidelines and policies, which evolve frequently. Appropriate mechanisms should also be implemented to ensure clinicians adhere to both organisational and national guidelines.

Another perennial issue at inquests is poor record keeping. Regular audits to identify and address gaps, along with staff training, are some of the ways providers can assure coroners that improvements have been made.

Finally, insufficient post-death reviews can give rise to concerns. Common issues include a lack of meaningful communication with bereaved families, not involving families and relevant clinicians in patient safety investigations and failing to identify key learning opportunities. Healthcare providers should ensure families and key personnel are appropriately engaged and involved in post-death reviews, in accordance with PSIRF guidance.

Final thoughts

PFD reports serve as crucial tools for enhancing patient safety in healthcare. In the event of an unexpected or sudden death, independent providers should promptly conduct a comprehensive review, involving all relevant parties, to identify learning and implement remedial action.

These findings should be provided to the coroner as soon as possible. If a PFD report is issued, providers should consider the concerns raised, implement remedial measures and deliver a thorough response to the coroner within the 56-day time limit to avoid being named on the list of non-responses.

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