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Reports to Prevent Future Deaths: Themes related to acute hospitals and emergency services

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A Report to Prevent Future Deaths (PFD report) must be issued by a coroner if they have a concern that circumstances creating a risk of death will occur or continue to exist in the future. In a healthcare context, PFD reports can serve as a valuable tool for enhancing public health, welfare, and safety. Healthcare organisations can gain insights and make improvements from both PFD reports addressed directly to them and those issued to similar service providers. We also recognise, that despite it not being their purpose, they can often feel like a punitive measure.

We have reviewed 25 PFD reports that were issued to healthcare organisations between October and December 2024, and analysed them to identify common themes and issues arising nationwide. The review focuses on trends related to acute hospital providers and emergency services.

Summary

A PFD report can refer to multiple issues or risks (not necessarily directly connected to the death) that have arisen out of one inquest. We identified 34 key issues arising from the 25 PFD reports we looked at. The key issues can be broken down into five main themes or categories:

- Record keeping, communication and information sharing
- Resources and staffing
- Post-death investigation and duty of candour
- Guidance, policies, training and knowledge
- Clinical practice/procedure

The stats below summarise how frequently each issue arose:

- Record keeping, communication and information sharing: 9
- Resources and staffing: 8
- Post death investigations and duty of candour: 8
- Guidance, policies, training and knowledge: 5
- Clinical practice or procedure: 4

Record keeping, communication and information sharing

This issue arose in nine of the PFD reports. Typically, the concern was that the patient's notes did not sufficiently record all the necessary information, e.g.

- Operation notes not recording a complication that arose during surgery, meaning other staff were unaware of it.
- Maternal risks identified on admission not being recorded or shared with the maternity unit and all those providing intrapartum care.
- A lack of contemporary nursing and medical notes from various stages of treatment, meaning it was not possible to identify staff responsible for critical treatment decisions or to locate a contemporaneous account of the rationale behind those decisions.

- Record keeping by the nursing team not recording the fluctuations in presentation relevant to the diagnosis of intracranial hypotension, or to enable a review of the patient's condition prior to discharge.

Other concerns in this area included:

- Staff being assisted by other staff when writing records in retrospect following a neonatal death and contemporaneous handwritten notes being destroyed.
- Delays in accessing a patient's hospital record and history when they are taken to hospital by a paramedic depending on the method of booking in and triage, especially if there are delays in patients being assessed, e.g. when patients are placed in cohorting areas.

There were also system-based concerns in this area, such as:

- Conflicting evidence and confusion amongst staff on how to request a CT pulmonary angiogram scan and whether clinician-radiologist liaison is required.
- Inconsistent hospital discharge notes across a Trust, risking essential patient information being unavailable when a patient is transferred to a new setting.
- The summary care record not showing care plans (e.g. Frequent Attender Care Plans) that are in place for individuals.
- Different wards and departments within one hospital utilising different record keeping and prescribing systems (including paper based and electronic), leading to fragmented systems lacking integration.

Communication and record-keeping are perennial factors in coronial proceedings. Regular auditing of the quality of record-keeping is a very helpful tool to ensure the coroner receives a more 'global' view and can often prove to be a reassuring factor.

Resources and staffing

Resources and staffing encompassed staff and resource shortages, insufficient service provision, and long waiting or response times.

Excessive ambulance response times were highlighted in two PFD reports, and in both situations the delays were, in part, attributed to handover delays at acute hospitals due to a lack of A&E beds.

Other resource and staffing concerns included:

- Lack of theatre availability leading to cancelled operations and fatal outcomes. In this inquest, the Trust had already reviewed its patient prioritisation procedures and emergency theatre use, but still faced times when they had to cancel elective surgeries to accommodate the high number of emergency surgeries. The Trust had Standard Operating Procedures in place and there were no imminent plans for theatre expansion at the hospital, so their position was that categorisation and access to emergency theatres had been maximised with current resources. The PFD report was therefore sent to the Department of Health and Social Care, as the coroner acknowledged that while the Trust was doing its best, the issue would likely recur.
- A labour ward being full and understaffed, with some midwives caring for two women even without covering breaks and the Labour Ward Co-ordinator having to provide 1:1 care for a woman in labour, rather than fulfilling her role of assisting the team. Due to the extreme busyness of the ward, no practitioner noticed the abnormal CTG trace of the baby (who subsequently died) and no ad hoc support was provided to the newly qualified midwife caring for the mother.
- Chronic understaffing of an ambulance service due to ongoing recruitment and retention challenges, despite the service taking all reasonable steps to meet staffing requirements. This PFD report was sent to the Secretary of State for Health and Social Care and NHS England. The coroner acknowledged that the ambulance service is already involved in a wide improvement programme aimed at increasing capacity, which is monitored by NHS England and the Trust's commissioners. Consequently, there is limited scope for the ambulance service itself to further enhance service provision.
- Delayed patient discharges due to insufficient social care provision, leading to hospital admission congestion and delayed medical assessment, diagnosis and treatment.
- Insufficient bedside/departmental ultrasound scanning for abdominal pain in young people at any time, but especially out of hours.
- No nurses with learning disability training being available at a hospital during weekends and holiday periods.

It is vital for healthcare organisations to demonstrate at an inquest the work they have done or are doing towards maximising the resources it has, and to evidence where further potential work falls out of their control.

Post death investigations and duty of candour

In six inquests, coroners were either concerned that an inadequate post death investigation had been conducted by the healthcare body, or insufficient learning/remedial action had been implemented following the patient's death. In one inquest, an internal investigation into the death was still pending at the time of the inquest, meaning there was insufficient evidence to assure the coroner that the identified care issues had been addressed. In another inquest, there was a concern that the hospital Trust had not appropriately referred the neonatal death to the coroner and had been slow to disclose evidence relevant to the death.

Reasons for concerns about the quality and robustness of post death investigations included:

- Not involving a key member of staff in the initial After Action Review (AAR). It is not clear from the PFD report why this was, but an action from the initial AAR was not then included in the amended/subsequent AAR. The coroner was concerned by this and wanted to know what had happened to the action and whether it had been considered.

It is difficult to comment on this particular issue without further information or context, however in our experience, it is fairly common for Trusts to complete post death investigations without input from key staff. Further, outcomes from investigations are often not shared with staff in order to test the accuracy of the investigation and its conclusions. This can also make preparation for and attendance at an inquest particularly challenging. We would encourage Trusts to ensure key staff involved are appropriately involved in post-death investigations / reviews.

- A Serious Incident Report (conducted under the previous Serious Incident Framework) failing to identify a series of healthcare errors in the deceased's treatment. Further, management failings at the Trust meant that the death was not reported to a Coroner until four years afterwards, by which time the deceased's body had been cremated denying the court an opportunity to gather relevant evidence through autopsy.

The delay in reporting the death to the coroner in this case is unusual and extreme. However, failing to identify healthcare errors in post-death investigations does occasionally occur. Legal teams often find it challenging to determine if healthcare failings have been overlooked, as they rely mainly on clinical and investigation teams for identification. Implementing more robust reviewing methodologies could help address any such gaps.

- The investigation report not addressing the central issue, namely the lack of enhanced nursing observations that led to the patient's fall in hospital, resulting in injuries that contributed to the patient's death. The investigation report stated that enhanced observations had been identified as needed but did not expand on what actions were taken, if any, to obtain enhanced observation nor what actions had been taken after the death to ensure enhanced observations for patients that require them.

It is difficult to comment on this matter without more detail regarding the specific case. It does appear, however, that the post-death investigation lacked critical information. It is important to note that if the investigation was conducted under the Patient Safety Incident Response Framework (PSIRF), the primary focus should be on identifying opportunities for learning. There may have been no relevant lessons to be drawn from the central contributory issue, making it appropriate for the report to concentrate on other areas of learning. PSIRF is not necessarily intended to focus on causation or contributory factors.

Guidance, policies, training and knowledge

Most of the risks in this area were at a national level. Concerns included:

- A lack of awareness amongst doctors that they could challenge an ambulance call handler's categorisation of a 999 call and could seek a review of the patient by a clinician within the ambulance service. A PFD report was issued to NHS England about this.
- Both Trust guidance/training and national guidelines not requiring the skin to be disinfected before immunisation. However, the coroner was of the view that reducing the bacterial count would lower the risk of bacteria being introduced into deeper tissues during an injection, and so issued a PFD to the UK Health Security Agency, the Department of Health and Social Care and NHS England.
- There being no national guidance to help primary care clinicians decide whether to extend anti-coagulation medication post-surgery to lower the risk of fatal DVT in elderly immobile patients. The PFD report was issued to the National Institute for Health and Care Excellence.
- Doctors (including hospital doctors and GPs) having insufficient knowledge and awareness of retrocaecal appendicitis, particularly in children. The PFD report was sent to the Royal College of General Practitioners, the Royal College of Paediatricians and Child Health, the Royal College of Surgeons and Royal College of Radiologists.

One PFD identified a risk on a local level, which was that Trust staff were unaware of and not following Trust guidance in respect of (1) urea and electrolytes monitoring when administering intravenous fluids and (2) management of hypokalaemia.

It is important that healthcare organisations regularly undertake reviews of their own policies and guidance documents. This should include reference to national / international guidelines and policies which are frequently evolving.

Clinical practice or procedure

Issues relating to clinical practice or procedure were identified in four PFDs. These were as follows:

- 1:1 enhanced nursing observations, required because of the patient's confused and agitated state, not being performed – leading to the patient falling and sustaining injuries that contributed to his death.
- Neither the discharge nurse nor the ambulance staff alerting a doctor to the patient's significant deterioration in condition prior to discharge, and the patient arriving home in a physically poor condition.
- An assessment of whether the patient was "fit to sit" and wait to be seen by hospital staff in A&E was not appropriately undertaken or documented.
- Concerns that appropriate steps were not taken when a patient left the hospital before assessment due to long waiting times, with no evidence of a capacity assessment being performed or secondary investigations considered during the wait.

Conclusion

This analysis has highlighted several themes within acute hospital care and emergency services. The insights gained from these PFD reports provide a valuable opportunity for continuous learning and improvement, ultimately contributing to better healthcare outcomes and patient safety. We are anticipating the release of the new 10-year NHS Plan and are interested to see the government's plans regarding significant issues such as workforce shortages, making better use of technology and the transition of care from hospitals to community settings.

We will shortly be conducting a review of mental health related PFD reports and will share our findings in due course.

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