DAC BEACHCROFT

Spotlight on Prevention of Future Deaths Reports

Published 26 February 2018

Summary

What can we take from the steady flow of Prevention of Future Deaths Reports (PFDs) issued by coroners in relation to patient care?

How do these fit into the wider learning from deaths landscape?

To help answer these questions, we have taken a closer look at hospital-related PFDs published over the last 8 months to see if any common themes emerge and, if so, what is in the pipeline for tackling them.

Context

Coroners have a statutory duty to issue a PFD report to any person or organisation where, in the opinion of the coroner, action should be taken to prevent future deaths. The report is sent to whoever the coroner believes has the power to take such action and the recipient then has 56 days to respond.

A copy of the PFD report is sent to the deceased's family and is made available for anyone to read on 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 - e.g. by way of an unannounced inspection.

Perhaps unsurprisingly, therefore, health and social care organisations would generally rather avoid a PFD report if possible, although these can provide powerful leverage for change.

What can we learn from PFDs?

To see if any common themes emerge, we have looked at all PFDs relating to 'hospital deaths' published on the Chief Coroner's website over the last 8 months (since the beginning of June 2017 until now). This involved reviewing 150 PFDs published in respect of hospital-related deaths over this period.

Whilst some of these recent PFDs related to discrete issues (e.g. lack of national guidance on haemodialysis fistula bleeds and adding jaundice to the paediatric early warning score), clear patterns emerge in terms of similar issues coming up again and again.

Recurrent PFD themes include:

Lack of evidence about actions taken

The best way to allay a coroner's concerns about future risks is to ensure that any potential failings in systems/care connected with a death are properly investigated and that actions taken/improvements made can be properly evidenced.

Our review of PFDs indicates that, even where appropriate investigations have been done, organisations do not always 'follow through' in terms of demonstrating that findings and recommendations have been translated into change.

Reflecting this, around 13% of the PFDS we looked at involved the coroner either wanting more information about the actions being taken to address investigation findings or expressing dissatisfaction with the standard of investigations done, including:

- Failure to implement recommended changes or to give a timescale for change (e.g. "*Evidence was given by the Trust that a Serious Incident Report had identified areas of concern but no changes had been implemented and it was not clear when any of the suggested changes would actually be made*"); and
- Investigations not identifying any learning opportunities at all (e.g. "*… the witness did not accept that any lessons could be learnt from the investigation surrounding the death of the deceased*").

Robust internal investigation systems and time invested in preparing evidence about lessons learnt/changes made should go a long way towards reassuring coroners (and, in turn, the CQC) that enough is already being done to minimise future risks, without the need to issue a PFD report.

Communication failures preceding suicides

Suicide risk reduction also stands out as one of the most prevalent themes in recent PFDs. 44 of the 150 hospital-related PFDs published over the last 8 months have involved people who took their own lives.

It is striking that over 50% of these PFDs related to concerns about inadequate communication, often involving valuable information about the patient's history/current presentation being missed - e.g. ward not contacting social work team or previous care provider, lack of detail in risk assessments/care plans and poor systems for service users getting messages to the team. Failing to take on board concerns expressed by family members was another recurrent theme.

The fact that so many PFDs are continuing to flag poor communication as an issue suggests there is considerable scope for further change here.

Failing to prevent falls

A further major source of concern expressed in PFDs relates to falls prevention, with 10% of the hospital-related PFDs we reviewed being about this.

Lack of appropriate equipment to reduce the risk of falls was a particular focus of concern - e.g. lack of sensor mats, non-slip footwear. Lack of adequate supervision/observations also came up in a number of PFDs.

By way of comparison, we also looked at 16 PFDs published over the same period in relation to 'Care Home Health Related Deaths' and found that 56% of these raised concerns about falls prevention, including not following falls care plans and equipment issues.

It is clear from this that coroners still feel that more needs to be done to reduce falls risks.

Failing to recognise/escalate patients who are becoming critically unwell

Over 10% of the PFDs we looked at involved concerns about signs that patients were becoming critically unwell being missed and delays escalating their care.

Similar concerns can be seen repeatedly in these PFDs - e.g. NEWS observations not being accurately recorded and/or escalated, sepsis guidelines not being followed, lack of senior review and inadequate handover processes.

The ongoing prevalence of PFDs in this area illustrates that, despite numerous national patient safety initiatives (e.g. early warning score systems and sepsis pathways), there is still plenty of scope for further improvement. This ties in with work currently being undertaken by the HSIB - see below.

Learning from deaths landscape

How do these PFD themes fit into the wider learning from deaths landscape?

2018 is likely to see a stronger-than-ever focus on how healthcare providers learn from deaths.

In particular we will see the further embedding of the national Learning from Deaths Framework introduced last year, which now requires Trusts to publish details of how many deaths were more likely than not due to problems in care, plus details of lessons learned/improvements made as a result of investigations into deaths.

We will also start to see the fruits of the work undertaken by the Healthcare Safety Investigation Branch (HSIB) since it became operational in April last year. The HSIB chooses cases for investigation according to their potential for national/systemic learning and there is a notable overlap between the areas the HSIB has chosen for investigation so far and the issues which have been concerning coroners - e.g. provision of mental health services in emergency departments and issues with recognising/responding to critically unwell deteriorating patients. In relation to the latter, the HSIB echoes various PFDs when it says: "A *significant number of patient safety incidents are reported each year relating to the clinical recognition and response to very unwell or deteriorating patients. There are various strategies in place to help reduce risk such as the National Early Warning Score (NEWS). Despite this, the problem persists suggesting that there are opportunities for further improvement*".

Going forward, it will be vital for organisations to be able to demonstrate to coroners that they have taken the national learning from these HSIB investigations on board.

How can we help?

Our large national team of healthcare regulatory 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.

The support we can provide includes:

- Initial scoping to explore likely outcomes, level of support needed and next steps;
- Advice on Duty of Candour - thresholds and approach;
- Assisting with witness preparation, both at operational level and at strategic level to address Prevention of Future Deaths Report risks;
- Attendance at pre-inquest review hearings, which may cover matters such as inquest scope, juries and expert evidence;
- Representation at final inquest hearings, including witness support throughout.

We can also provide bespoke training on all aspects of inquests, including updates on the latest legal developments and guidance for clinicians/SI investigators on report-writing and giving evidence.

If you need advice in relation to any matter relating to inquests, please contact Peter Merchant on: +44(0)113 251 4806 or pmerchant@dacbeachcroft.com.

Authors

Peter Merchant
Leeds
+44 (0)113 251 4806
pmerchant@dacbeachcroft.com

Belinda Dix
Winchester
+44 (0)1962 70 5544
bdix@dacbeachcroft.com

Robyn Reed
Leeds
+44 (0) 113 251 4742
roreed@dacbeachcroft.com

DAC BEACHCROFT