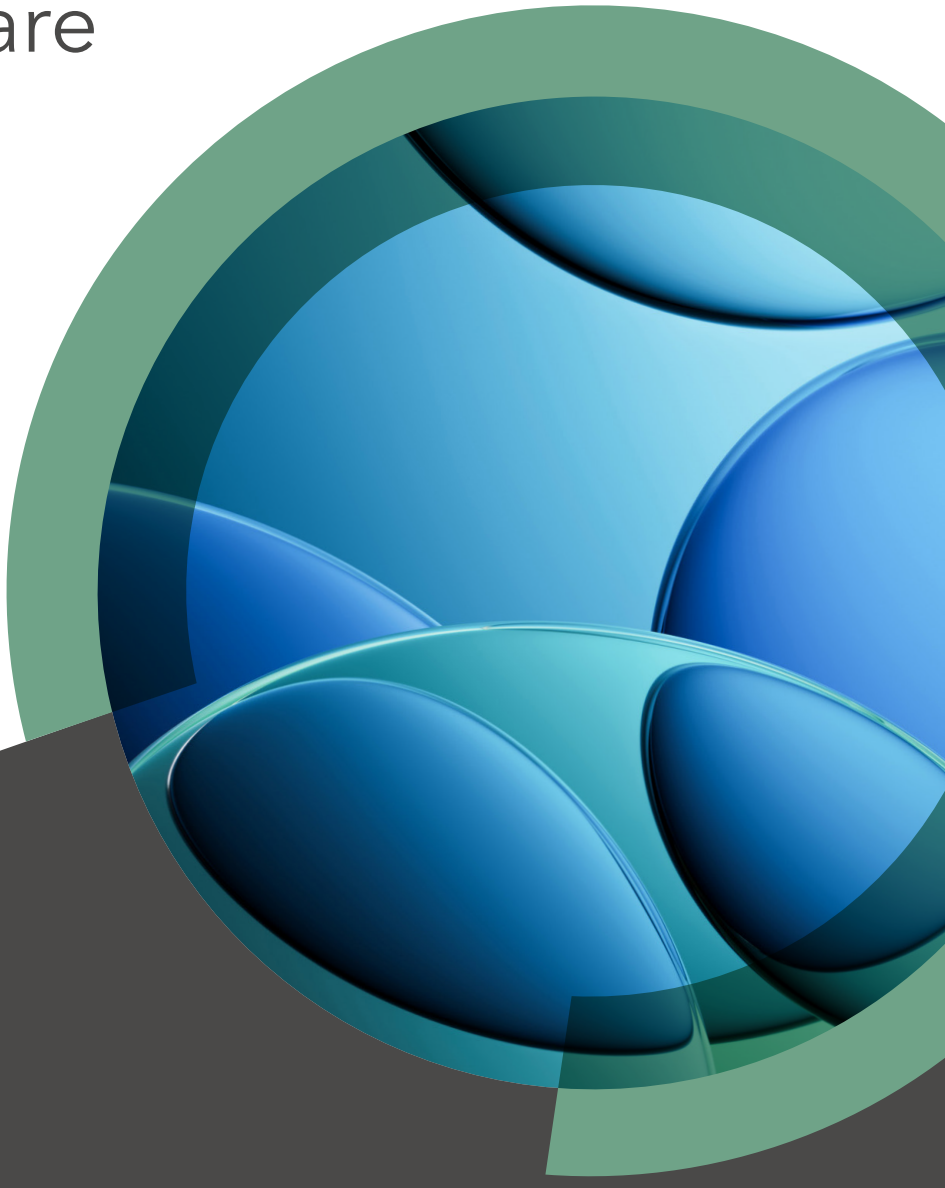
DAC BEACHCROFT

Prevention of future deaths reports in inquests - recurring themes for health and social care

April 2026



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Introduction

This is the fifth report in our annual series looking at themes we have identified from prevention of future deaths (PFD) reports issued by coroners to health and social care providers.

The aim of PFD reports is to promote learning from deaths, but the areas of concern coroners raise in them are rarely unique to the particular organisations involved and sharing recurring themes may therefore help drive improvements in care more widely.

To shine a light on the current picture, and how that compares with our findings in relation to previous years (2021, 2022, 2023 and 2024), we have looked at themes emerging from over 300 PFD reports issued by coroners in connection with the provision of health and social care over the course of 2025.

Recap on PFD reports

Coroners must issue a PFD report to any person or organisation who may have the power to take action where anything revealed by the coroner's investigation into a death gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist and, in the opinion of the coroner, action should be taken to prevent the occurrence or continuation of those circumstances or to reduce the risk of death created by them. The coroner's function is to identify areas of concern, not to prescribe specific solutions.

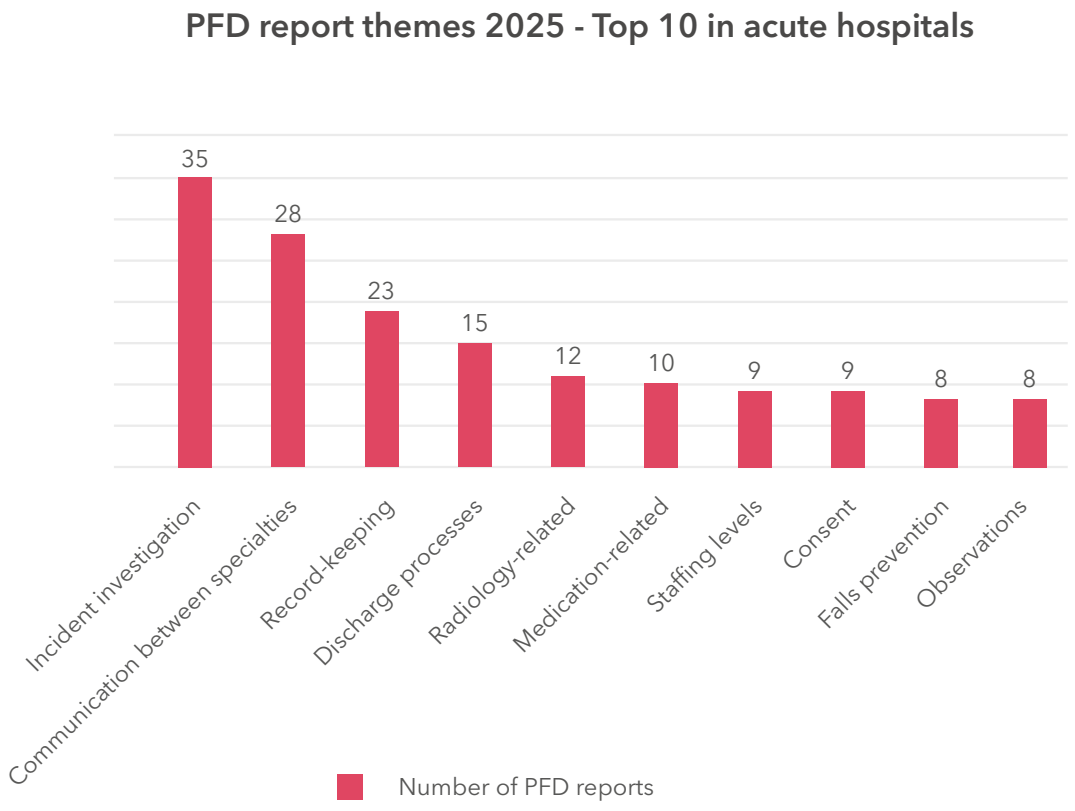
PFD reports should usually be sent out within 10 working days of an inquest concluding, with recipients then having 56 days to provide a written response setting out the action taken/proposed to be taken, or explaining why no action is proposed. To encourage compliance, the Chief Coroner now publishes every 6 months a list of those who have not responded to a PFD report within the stipulated timescale.

A copy of the PFD report is sent to the deceased's family and is also made publicly available online via the Coroners' Courts section of the Courts and Tribunals Judiciary website (which was our source for this report). Importantly for health and social care providers, a copy of the PFD report is also sent to the CQC, potentially leading to further regulatory scrutiny.

Acute hospital care

We looked at 142 PFD reports issued to providers over the course of 2025 where the concerns related to acute hospital care. This was the highest number of PFD reports we have identified in this category so far (the next highest being last year's figure of 139).

The graph below illustrates the 'Top 10' issues raised by coroners in these PFD reports:



Further details of what we found in relation to PFD themes for acute hospitals are set out below:

Incident investigation

The most frequently occurring PFD theme we identified for acute hospital providers in 2025 was incident investigation, with almost a quarter (35 cases) of PFD reports raising this as an area of concern. This is the fifth year running that we have found incident investigation to be in the 'Top 3' themes for acute hospitals and the second time it has occupied the top slot as the most commonly occurring theme (the first time being in 2022).

In many of these cases, the coroner's concerns focused on acute hospital providers not undertaking any investigation or other appropriate learning response in relation to the death and therefore failing to learn lessons - e.g. in one case, the coroner noted that much of the change following the death *"was coming very late, and as a response to the impending (or active) inquest, not as a result of learning from the tragic events in question"*, in another the concern was that *"The error has not been investigated to establish why it happened and how to prevent a reoccurrence"* and, in several cases, the coroner expressed concern about governance failures leading to incidents not being identified as *"worthy of investigation through the Patient Safety Framework"*. Other concerns focused on issues with the quality of investigations - e.g. one coroner was *"concerned there is not greater scrutiny of witness accounts as part of the Trust's investigation process"*, whilst another found that investigations conducted by the Trust in relation to the death were *"unskilled, superficial, brief, failed to identify issues and left the family without answers"*. The remainder of the cases in this category raised concerns about failures to implement actions or embed learning arising out of investigations - e.g. *"The coroner is concerned that in not completing the above recommendations arising out of the patient safety review, the Trust is placing patients at risk of early death"*.

The fact that incident investigation was such a prominent theme in PFD reports issued to acute hospitals in 2025 may suggest that the introduction of the Patient Safety Incident Response Framework (PSIRF) has not as yet done much to allay coroners' concerns about the extent to which providers learn effectively from deaths, as was expressly stated by coroners in some instances - e.g. *"I am not satisfied that the work on PSIRF to date has truly addressed the issues in respect of [the] Trust's investigations"*.

Communication between specialties

Concerns about ineffective communication were also in the 'Top 3' PFD themes for acute hospital providers for the fifth year running. In line with our findings in previous years, these issues focused particularly on communication between different specialties involved in the person's care, with 20% (28 cases) of the acute hospital PFD reports we looked at from 2025 raising issues about this.

A number of the concerns in these PFD reports related to lack of communication between specialty teams within the same organisation - e.g. in one case *"There was no document exchange or communication between the gastroenterology team and the cardiology team meaning that [the patient] was then forgotten about",* in another, the coroner raised a concern about *"accuracy of hand over communications between clinical staff in respect of patients returning to the main ward from HDU"* and in another, there was a *"lack of adequate communication between different health care professionals on the maternity unit"*. Other PFD reports raised issues with communication across hospitals, including liaison between treating teams and specialist centres - e.g. *"Consideration should be given to reviewing the process of managing and treating patients with multiple health conditions, being treated across different hospital trusts, to ensure greater coordination, collaboration and optimal treatment"*. There were also examples of concerns being raised about communication between hospitals and primary care - e.g. in one case *"Neither the results, nor the discharge summary were sent to the GP in time for the appointment. The inquest heard that the A&E doctor did not know how to share such information with the GP".*

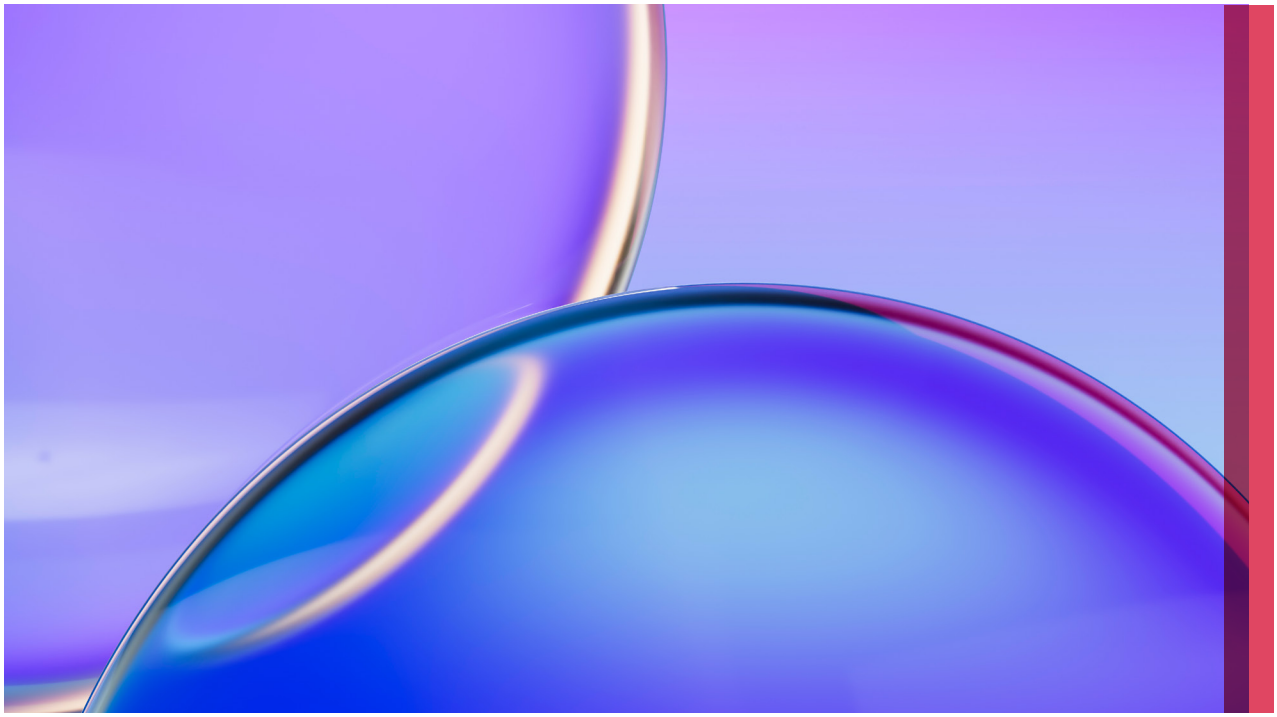
Record-keeping

Also holding its place in the 'Top 3' PFD themes for acute hospital providers was the topic of record-keeping, which was raised by coroners in 16% (23 cases) of acute hospital PFD reports in 2025.

Examples included failure to record the rationale for decision-making - e.g. *"The records of the decision-making process concerning CT scan requests are not comprehensive so as to provide a clear account"* or to adequately document consent discussions or best interests decisions. There were also a number of concerns raised about specific areas of record-keeping such as medicines administration or patient observations - e.g. *"the failure to document procedures and observations as well as advice given from third parties could lead to clinicians who take over care for a patient not having a full picture and leading to risks to patients in the future"*. However, the main focus of concern for coroners on this topic in 2025 seems to have been poor standards of basic record-keeping generally, with examples including the following: *"The evidence revealed that there were deficiencies in basic record keeping"; "The medical records did not contain all of the pertinent and relevant information and some were illegible causing difficulty in interpretation"; "The auditing of records does not seem to have identified the repeated failures to record required information"; "there was clear and consistent evidence of poor documentation throughout the medical records, from admission to the emergency department continuing through to the resuscitation attempts"; and "Throughout this investigation I was presented with inconsistent, unreliable and incomplete medical records. This significantly hindered my ability to investigate the death and creates a risk of future patient harm"*.

Although not itself making the 'Top 10' themes for acute hospital providers, coroners continued to raise concerns more broadly about the related issue of access to records, with this having come up in 10 PFD reports when also taking into account those issued to national bodies such as the Department of Health and Social Care, including concerns about teams within the same organisation having difficulties accessing one another's records - e.g. one coroner stated: *"I am concerned that this, and other hospitals elsewhere in the country, continue to operate with information being stored and shared between professionals in a fragmented and disjointed way"*. There were also concerns expressed about the inability of separate Trusts to access one another's records - e.g. in one case there were *"occasions when [the patient] was reviewed by clinicians without the full clinical picture due to the inability of separate hospital trusts to access each other's medical records"*. In another case, the coroner raised a concern about difficulties with accessing primary care records: *"Emergency Departments…do not have reliable access to patients' primary care records"* meaning that *"clinicians are frequently treating acutely unwell patients without full access to their recent medical history"*.

Other recurring PFD themes we identified for acute hospitals in 2025 included: discharge processes (15 cases, including several instances of discharging patients without any appropriate follow-up arrangements, discharging without input from relevant specialty teams and information provided by the hospital on discharge being inaccurate/incomplete); radiology-related issues (12 cases, including coroners raising concerns about the accuracy of radiological reporting, particularly out-of-hours, and also CT scan delays - e.g. *"The lines of escalation where a request for a CT scan is not accepted by the radiology department are not clearly known or understood at ward-level, even by consultants"*); medication-related issues (10 cases, including concerns about administration of prescribed medications being delayed/missed and prescribing errors involving opiates); staffing levels (9 cases, including lack of staff in ED - e.g. *"I heard repeatedly that on the night [the patient] attended, the… emergency department was understaffed, and that it remains understaffed of doctors, nurses, and even a healthcare assistant who could take basic observations"*); consent (9 cases, including concerns about patients not being provided with sufficient information regarding different treatment options or not having risks adequately explained to them); falls prevention (8 cases, many of which focused on issues with falls risk assessments - e.g. *"No subsequent action has been taken by the ward to address the gaps in the falls risk assessment and management process when patients are admitted from care homes"*); and observations (8 cases, including concerns about patient observations not being done when they should have been and hospitals not having an electronic system for recording observations despite *"the potential for such systems to…facilitate trend analysis particularly in the context of a deteriorating patient, and reduce the potential for errors"*).



Finally, a theme which emerges prominently when looking at a combination of PFD reports issued to acute hospital providers and those issued to national bodies such as the Department of Health and Social Care is that of 'corridor care' and long waits in Emergency Departments, which was raised by coroners as a concern in 9 cases. One coroner, for example, noted that *"it is not uncommon to find patients in corridors when they need to be monitored"* and another that *"overcrowding in A&E is a national concern"*, whilst another highlighted an *"inherent risk of death arising from patients remaining for lengthy periods in areas not designed or intended for undertaking observations and providing care"*. In a further case, the coroner summarised the position as follows: *"When there are no ward beds to transfer patients to, they stay in A&E and A&E is not set up to deliver the care that, particularly elderly and complex medical, patients require. Nursing staff are having to treat double the number of patients that the department is designed to accommodate and patients who require care and treatment outside of their expertise. This means that patients are not receiving the appropriate level of care"*. This theme of lack of patient flow through Emergency Departments comes up again later in this report in the context of the closely related topic of ambulance delays.

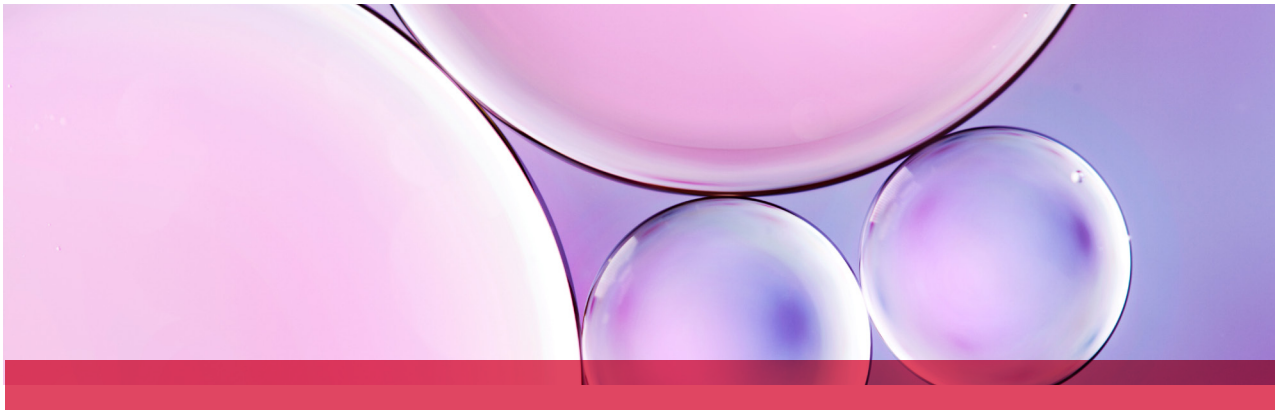
How does this compare with previous years?

The overall number of PFD reports we identified as having been issued to acute hospital providers in 2025 (142) was the highest out of all five years we have looked at, continuing the upwards trend since 2022.

The three most commonly occurring themes for acute hospital providers - incident investigation, communication between specialties and record-keeping - have remained unchanged throughout the five years (although not always in the same order).

Concerns relating to discharge processes and falls prevention have also featured in the 'Top 10' themes every year. Meanwhile, all but one of the remaining themes we identified in 2025 have appeared at least once in previous acute hospital 'Top 10s', with the only theme that has not made the 'Top 10' list until now being 'consent'. The emerging focus on ED 'corridor care' will also be a theme to keep an eye on moving forward.

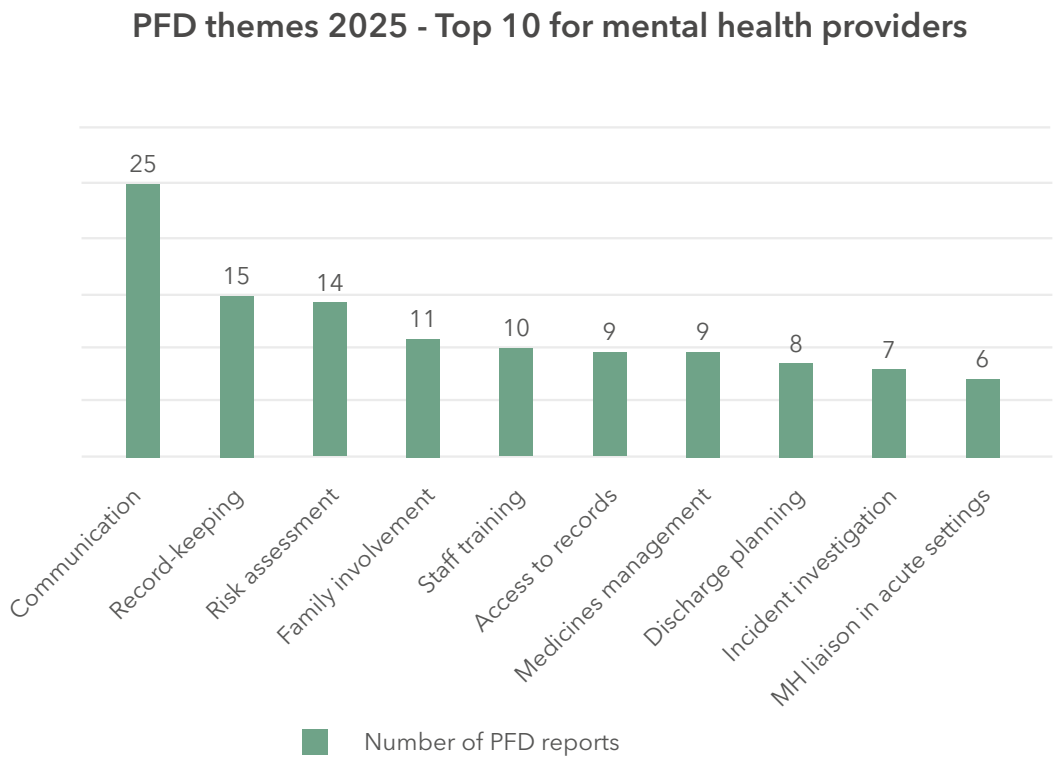
Overall, therefore, PFD report themes for acute hospitals have remained remarkably consistent over the five years we have been looking at them.



Mental health

We identified 73 PFD reports issued over the course of 2025 where the concerns related to providers of mental health care.

The graph below illustrates the 'Top 10' issues raised by coroners in these PFD reports:



Further details about these mental health related PFD themes are set out below:

Communication between services

The most frequently occurring theme we identified in PFD reports issued to mental health providers in 2025 was communication, with coroners raising concerns relating to this in over a third (25 cases) of PFD reports in this category. This theme last occupied the top slot in our analysis of PFD reports for mental health providers in 2021.

These concerns focused mainly on communication between different services involved in the person's care - e.g. in one case, the coroner highlighted that *"There are no policies, guidance or any shared understanding between services of what might be relevant*

information to be shared and when". An issue which came up repeatedly related to lack of information sharing between mental health teams and primary care - e.g. one PFD report stated, *"The coroner is concerned that the lack of coordination and communication between primary and secondary care providers may place patients at risk of early death"*. Concerns were also raised about lack of communication between mental health teams and the police - e.g. *"A member of the mental health team believed [the patient] was not medically fit for discharge but failed to voice this to medical staff or police"* or prison services - e.g. in one case there was *"A complete failure to identify and share risk pertinent information between prison and healthcare staff"*. The issue of communication between NHS and private psychiatric services also came up - e.g. NHS consultants *"may not be aware that the patient is also receiving private psychiatry"*.

In a number of cases, problems with communication between services went hand-in-hand with the closely related theme of difficulties accessing one another's records, with concerns about records access having been raised by coroners in 9 cases. In one case, for example, the services involved in the person's care all had information which was potentially relevant to her mental health, but none had the whole picture because *"different IT systems were being used for record keeping in different services"* meaning there was *"a lack of a single patient record"*. Several of these PFD reports focused on mental health teams not being able to access primary care records and vice versa - e.g. one coroner raised a concern that *"mental health crisis staff do not appear to have appropriate access to the primary care mental health System One records and there is a risk that vital information is not being shared"*.

Record-keeping

The next most frequently occurring area of concern raised by coroners with mental health providers in 2025 was record-keeping, with this coming up in 21% (15 cases) of PFD reports in this category. This was the fourth year running that record-keeping has been in the 'Top 3' for mental health providers.

This included concerns about records of patient care being of generally poor quality - e.g. in one case there was *"evidence of the 'cutting and pasting' of entries including [the patient's] initial 72-hour care plan containing details of another patient entirely"* and, in another, *"The mental health Trust record-keeping did not contain all relevant information relating to the care …there were omissions relating to symptoms and potential signs of deterioration and compliance with medication"*. An issue which came up in several cases was failing adequately to document assessments - e.g. one coroner highlighted that *"failure to properly record the details of a risk assessment can lead to inadequate information sharing and the possibility of someone who relies upon the records gaining the wrong impression"*. Failing to document the rationale for decisions about the patient's care was also raised as a concern - e.g. *"The Single Point of Access meetings which occur on a daily basis by way of triaging referrals do not provide written records of the discussions had and decisions made. This means that there is no written justification for decisions made or written actions and therefore these…do not form part of any health record for the patient which would be relevant to the overall management"*.

Risk assessment

Issues relating to risk assessment were raised by coroners in 19% (14 cases) of PFD reports issued to mental health providers in 2025, making this the fifth year running that risk assessment has been in the 'Top 3' PFD themes for mental health providers, although there were fewer instances of this being raised in 2025 compared with the previous year when the theme of risk assessment occupied the top slot.

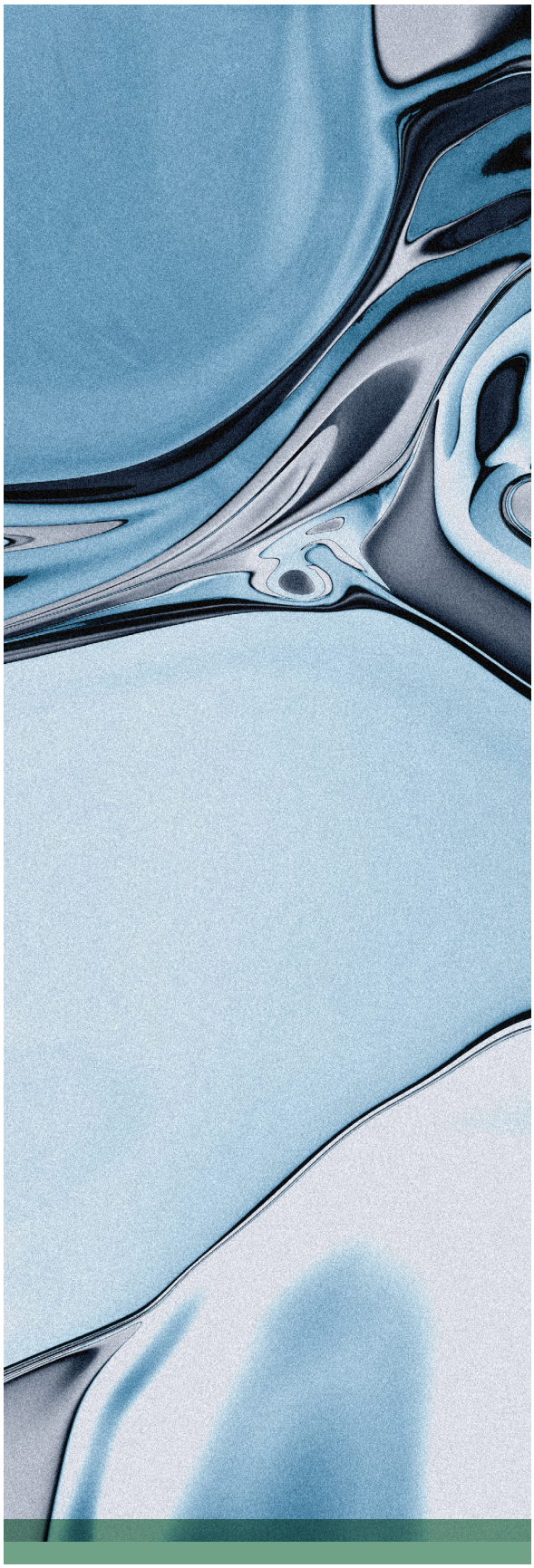
Many of these concerns related to failures to assess risks adequately or to record assessments of risk - e.g. in one case, *"what documentation there was stated there were risks but did not fully assess the risks"* and *"when giving evidence at the inquest, numerous members of staff were vague in their understanding of risk assessment"*. In another case, *"Despite there being a recognised risk to self and to others, both of which the Deceased himself said he could not control, there is no evidence of any risk assessment documentation being completed"*.

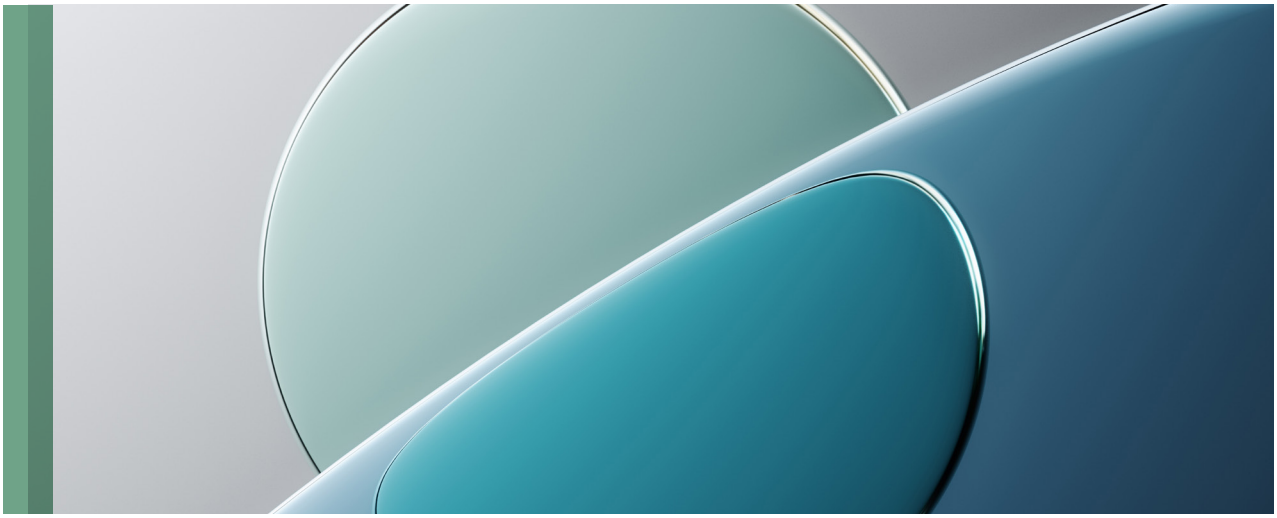
There were also examples of coroners raising issues relating to risk assessment training for staff - e.g. one coroner was *"concerned that within the…CMHT the training around risk assessments and the auditing of compliance with risk assessment policy is not adequate"*, whilst another stated that *"[The] Trust should review its provision of training for agency staff, in particular in respect of risk assessments"*.

Other recurring PFD themes for mental health providers in 2025 included: family involvement (11 cases, including several examples of failing to liaise with family/carers to gather collateral information about the patient's mental health - e.g. *"[Her] parents were not spoken to by mental health professionals about their daughter's circumstances when they would have been able to provide valuable information about her research into and planning around ending her life"* or about discharge arrangements - e.g. *"There was insufficient communication and liaison with family members, including explaining [the patient's] condition and risks on discharge and providing support to his partner as a carer")*; staff training (10 cases, including concerns about lack of staff training on a range of topics such as assessing risk and life support/first aid - e.g. *"There is no system that prevents staff that are non-compliant with mandatory training, including basic life support training, from being able to work on [the Trust's] in-patient wards"*); medicines management (9 cases, including medication administration errors due to confusion over

prescription doses and issues relating to the level of monitoring/contact when medications are changed or stopped); discharge planning (8 cases, including several examples of concerns being raised about failure adequately to involve community mental health services or family members in discharge planning - e.g. in one case there was *"a failure to appropriately liaise with the deceased's family and, specifically, [the patient's] mother to establish the suitability and safety of a discharge to her address"*); incident investigation (7 cases, including several cases of coroners raising concerns about inadequate/ ineffective post-death investigations, including failing to identify key issues with the care which only came to light at inquest - e.g. *"the findings in the SWARM huddle document contradicted evidence of key witnesses"*); and issues relating to mental health liaison in acute settings (6 cases, which focused mainly on mental health liaison teams in Emergency Departments not carrying out required assessments or doing so ineffectively and/or failing to take action to address risk - e.g. in one case, *"There was a significant delay in the mental health team attending to [the patient] in the Emergency Department, despite the urgency of his condition. When the mental health team did attend, they…did not escalate their concerns or communicate effectively with medical staff or police"* and, in another, the coroner highlighted that *"The mental health liaison nurse asked the acute Trust nurse to undertake the risk assessment for [the patient's] mental health. This is the role and purpose of mental health liaison")*.

Lack of resources in mental health services was another a key area of concern in 2025, particularly when also taking into account PFD reports issued to national-level organisations (such as the Department of Health and Social Care) on this theme. From this wider pool, we identified 13 PFD reports where lack of resources was raised as an issue, including concerns about overly lengthy waiting times for autism assessments, gender dysphoria clinic appointments and psychotherapy input. By far the most common area of concern here, however, related to lack of psychiatric inpatient





beds (6 cases), with one coroner highlighting that *"a lack of available in-patient beds for high-risk mental health patients who…cannot be managed safely in the community, is a chronic and on-going situation…nationally"*. In several of these cases, coroners expressed particular concern about the unsuitability of Emergency Departments as holding places for patients in mental health crisis - e.g. one coroner referred to *"The severe shortage and availability of beds in mental health facilities resulting in vulnerable patients being left in the Emergency Department for days increasing the risk of self harm and death"*, with those involved being described as *"victims of a system which cannot do what is being asked of it". Similarly, another coroner found "there is still far too much use of A&E space for those in mental health crisis, pending finding a dedicated mental health placement"*, with another highlighting that *"The patients cannot be detained under the Mental Health Act 1983 whilst in the emergency department. There is a significant risk that some of them are being detained unlawfully, without recourse to the legal safeguards provided by the Mental Health Act 1983."*

How does this compare with previous years?

The overall number of PFD reports we identified as having been issued to mental health providers in 2025 (73) was lower than in the two previous years we have looked at (85 in 2024 and 86 in 2023).

There has continued to be a high degree of consistency in terms of themes for mental health providers, with concerns relating to risk assessment having been in the 'Top 3' across all five years we have looked at. Meanwhile, the themes of communication between services, family involvement, incident investigation and discharge processes have retained their position in the 'Top 10' for mental health providers every year.

Overall, however, we have noticed a slightly greater variation in PFD report themes for mental health providers compared with acute hospitals. For example, communication between services was by some margin the most frequently occurring area of concern in 2025 despite not having made the 'Top 3' in the two previous years. Also, concerns relating to incident investigation were lower down the 'Top 10' list in 2025 compared with previous years.

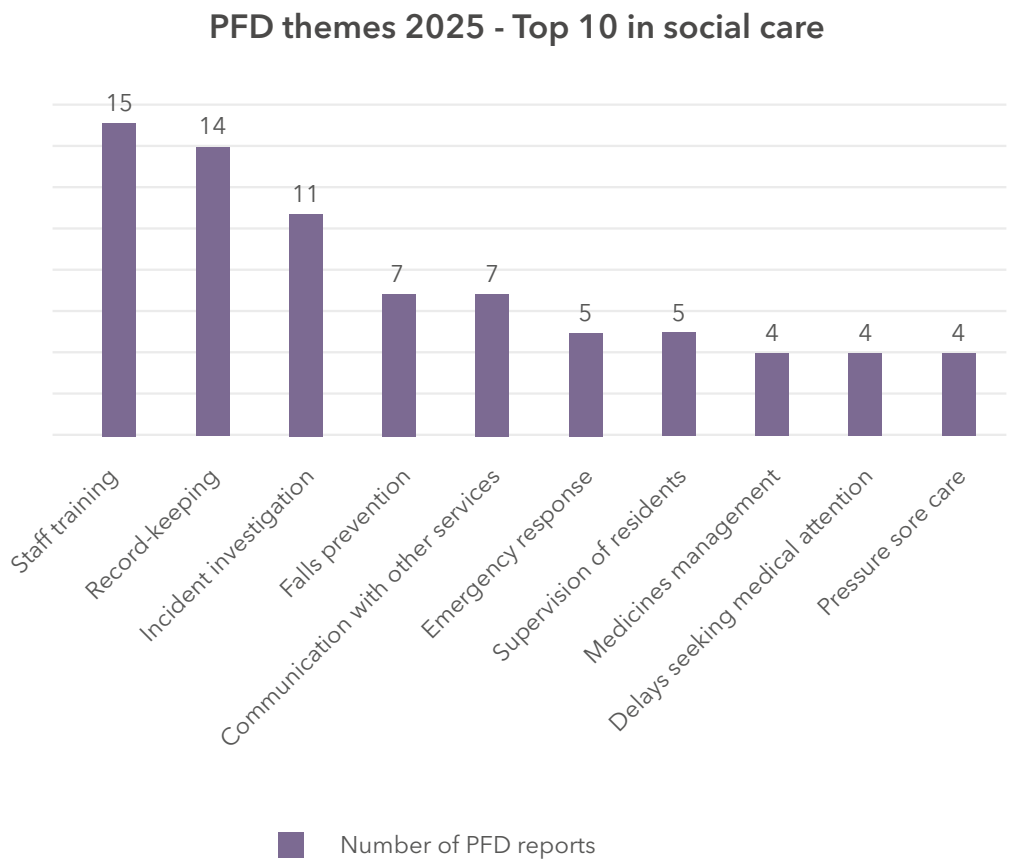
New to the 'Top 10' for mental health providers this year were concerns relating to mental health liaison services in Emergency Departments, which is a theme we could see more of in the future given how closely it ties in with the national shortage of inpatient psychiatric beds, which was a prominent area of concern for coroners in 2025, as it had been the previous year also.

Social care

We looked at 41 PFD reports issued to adult social care providers, including care homes, domiciliary care and supported living, over the course of 2025. This is the highest number of PFD reports we have identified in this category so far.

In terms of the factual context these arose from, there were some recurring scenarios, with 13 cases involving deaths following falls (almost a third), 5 choking incidents and 4 related to pressure sores.

The graph below illustrates the 'Top 10' issues raised by coroners in these PFD reports:

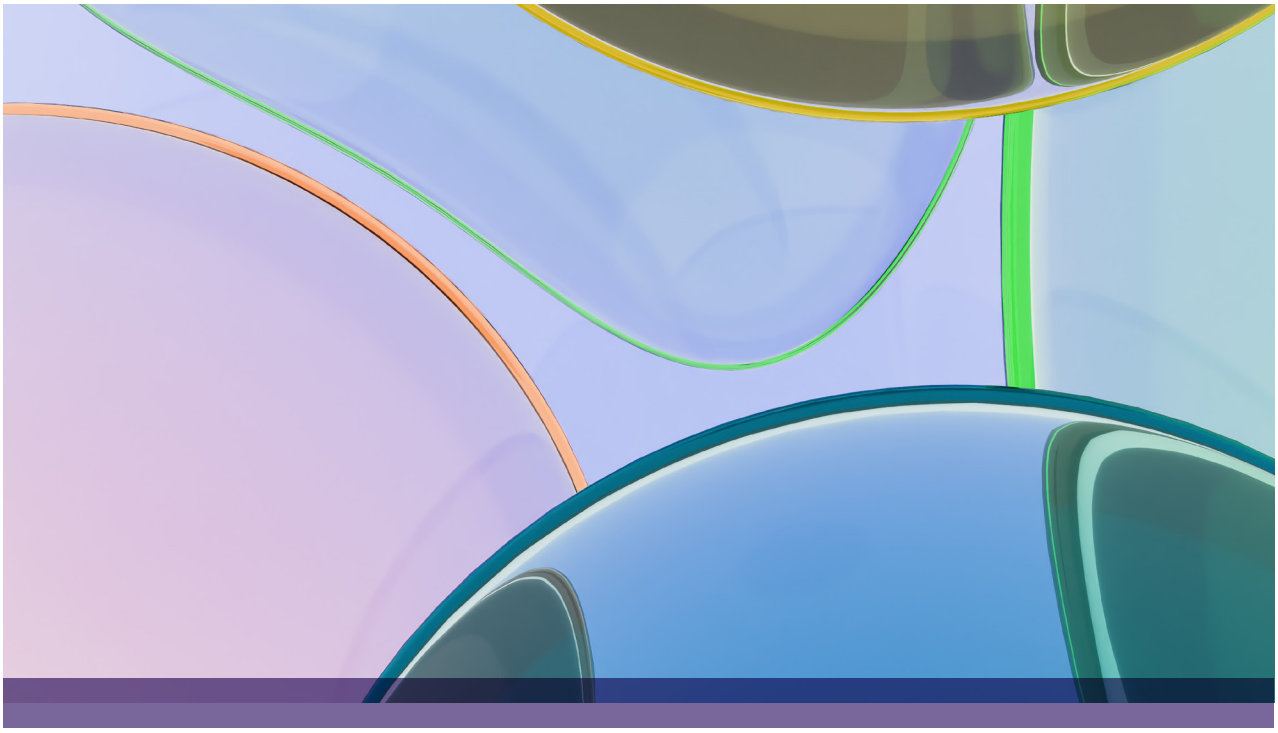


Further details of what we found are set out below:

Staff training

Lack of adequate staff training was the most frequently occurring area of concern we identified in PFD reports issued to social care providers in 2025, featuring in 37% (15 cases) of the PFD reports we looked at in this category. This was the fourth year running that staff training has been in the 'Top 3' themes for social care, but the first time it has occupied the top slot.

These concerns related to various aspects of care delivery - including insufficient training about 1:1 care, basic observations, using computerised records systems, completing care plans, pressure sore management and de-escalation. Specific issues were raised about training for agency staff - e.g. *"it could not be confirmed if the agency staff had undergone an induction"*. There were also concerns raised in relation to lack of staff training about falls risk assessment - e.g. in one case *"The court would like to know what steps are being taken to ensure that all relevant staff have received, understood and consistently act upon suitable and sufficient training in the assessment of falls risk"*. The area coroners raised most frequently in this context, however, was lack of staff training around responding to emergency situations such as residents becoming unresponsive and needing resuscitation - e.g. *"At the time of [the resident's] death, of the several staff members that responded to her choking emergency, only one staff member…had currently valid training in life support, but still undertook CPR ineffectively without being corrected by other staff. Evidence was also given that no simulated emergency drills were ever performed, and some staff were never aware their training had expired"*.



Record-keeping

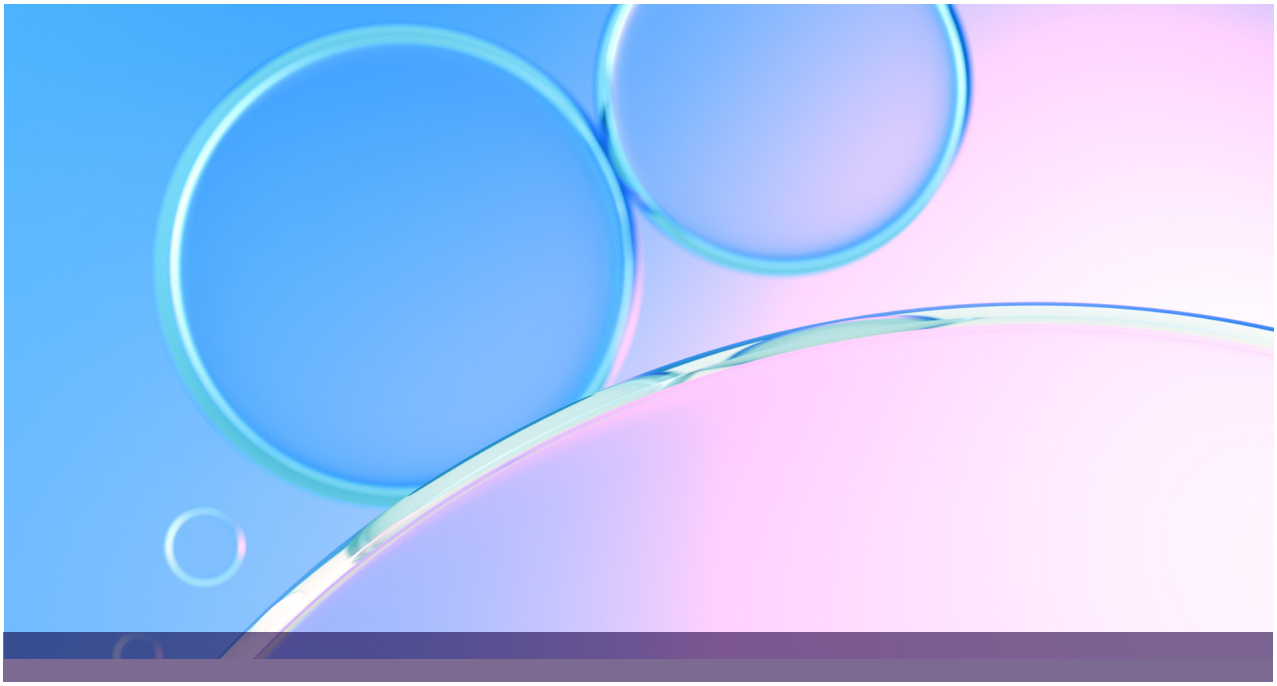
Record-keeping was raised as a concern in 34% (14 cases) of PFD reports issued to social care providers in 2025, having made the 'Top 3' most frequently occurring themes in all five years we have looked at.

Concerns about poor quality or incomplete documentation were raised by coroners in relation to numerous aspects of care, including failure to record significant events such as a fall, gaps in documentation relating to pressure sore prevention/care and failure to record the rationale for important decisions such as changing the diet recommended by the SALT team. There were also examples of documentation not adequately reflecting the fact that the person's condition was deteriorating - e.g. *"The care home records were inaccurate and did not correctly reflect the deterioration in [the resident's] condition after the fall"*. In many of these cases, however, coroners raised concerns about poor record-keeping more generally - e.g. one coroner noted *"There were candid acceptances that documentation was not completed to an accepted standard and there were gaps in the records. This is not the first inquest where acceptances were made, therefore I remain concerned that this is an ongoing issue despite evidence that this has been addressed with an auditing system"*. In another case, *"Key records were not kept or were lost or destroyed"* and, in another, the coroner expressed concern that *"Entries were limited and it was impossible to fully understand from the notes what had been observed and what had happened and at what point"*.

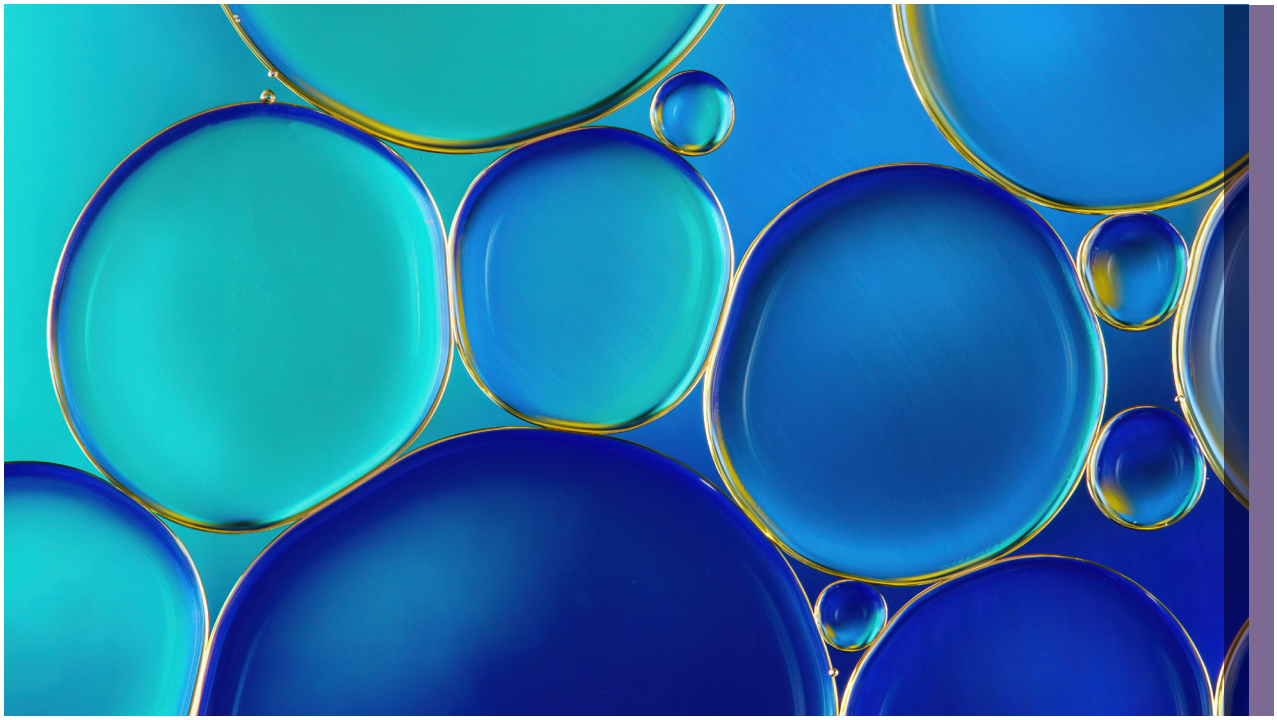
Incident investigation

Issues relating to incident investigation were raised by coroners in 27% (11 cases) of PFD reports issued to social care providers in 2025. The last time this theme made the 'Top 3' for this category was in 2021.

In a number of these cases, the coroner's concern focused on there not having been any internal investigation or other learning response undertaken by the care provider - e.g. in one case, *"The evidence highlighted that there was no mechanism for lessons to be learned from deaths which occur during or following admission to the Nursing Home"*. In others, there had been an investigation but this was found by the coroner to have been flawed/inadequate, therefore hampering opportunities to learn - e.g. in one case, the coroner found that the care provider had *"carried out a flawed investigation after this incident, pushing blame onto an innocent individual and thereby avoiding highlighting systemic failures and learning"*. Another coroner was concerned that the care home had *"no detailed guidance on how an investigation should be conducted within its organisation"* and that there was *"no routine investigation training for managers"*. There were also examples of action plans arising from incident investigations not having been completed or audited, meaning the coroner was not sufficiently reassured that lessons had been learned.



Other themes we identified from PFD reports relating to social care in 2025 included: falls prevention (7 cases, with many of these concerns focusing on issues with falls risk assessments - e.g. *"The falls risk assessment documentation was incomplete and did not appear to have been updated after falls had occurred"* or failure to implement falls risk mitigation measures - e.g. *"Despite risks being assessed, and mitigation measures identified, staff would regularly fail to implement the latter"*); communication with other services (7 cases, including failure by care providers to provide key information to others involved in the person's care such their GP or mental health team); emergency response (5 cases, the majority of which involved inadequate emergency responses to choking incidents such as not attempting CPR when required or doing so ineffectively - e.g. *"Chest compressions were only commenced over ten minutes after [the resident] was found to have stopped breathing"*. Notably, in three of these cases, coroners highlighted a lack of staff understanding about DNACPR orders not applying in the event of choking because of this being a potentially reversible cause of death); supervision of residents (5 cases, including concerns around failure to provide required levels of 1:1 care - e.g. *"Agreeing to provide care for an individual in circumstances where it is known that the level of care that person requires to keep them safe cannot be provided, creates a risk that future deaths could occur as a consequence of inadequate care and supervision"*); medicines management (4 cases, including concerns relating to the administration of prescribed medications - e.g. in one case where the care home had been unable to obtain from the pharmacy medication prescribed by an out-of-hours GP, the coroner expressed concern that *"the failure to either promptly administer the antibiotics or seek further medical care for him was a significant failing on the part of the care home"*); delays seeking medical attention (4 cases, which focused on failures to arrange for the person to receive clinical input in a timely way in light of their deteriorating condition - e.g. in one case, *"The falls policy regarding the need to seek medical advice where a resident on anticoagulation had a fall that had been unwitnessed did not seem to be widely understood by staff or adhered to on all occasions"*); and pressure sore care (4 cases, including concerns about delayed referral to tissue viability and failure to follow policies/ care plans relating to management of pressure sores - e.g. in a case where the GP had stressed the importance of frequent repositioning by domiciliary carers, the coroner found no evidence *"that repositioning had been undertaken"* or *"that there was any understanding of the need for repositioning to mitigate against the development of pressure sores"*).



How does this compare with previous years?

The overall number of PFD reports we identified as having been issued to social care providers in 2025 (41) was the highest so far (with the next highest having been the previous year's figure of 39).

Across the five years we have looked at, there has been a fair degree of consistency in terms of themes for social care providers. In particular, record-keeping has been in the 'Top 3' themes every year, whilst falls prevention and staff training have always been in the 'Top 10'. In addition, concerns relating to incident investigation, care plans and delays seeking medical attention have been in the 'Top 10' themes in four out of the five years.

We have, however, tended to see slightly more variation in themes for social care providers from year-to-year compared with other categories of provider. For example, whilst the theme of incident investigation was this year's third most commonly arising area of concern, it did not make the previous year's 'Top 10'. Also, the theme of responses to medical emergencies has emerged mainly over the last couple of years but did not feature as prominently prior to that.

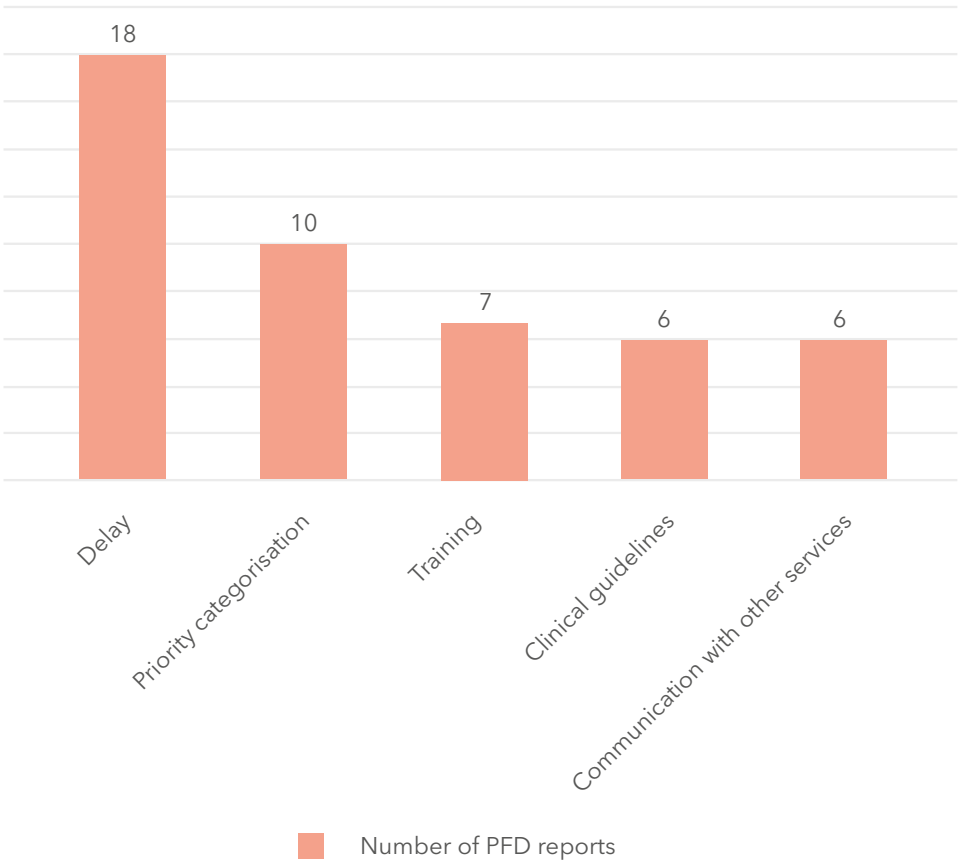
Ambulance services

We identified 40 PFD reports issued by coroners over the course of 2025 in relation to ambulance services. This included PFD reports issued to Ambulance Trusts themselves, as well as reports issued to a range of bodies connected with the provision of ambulance services at a national level, such as the Department of Health and Social Care, reflecting a recognition by coroners of the wider systems pressures impacting ambulance services.

In terms of the factual scenarios these ambulance-related PFD reports arose from, 20% (8 cases) involved cardiac issues, 13% (5 cases) involved sepsis and a further 13% (5 cases) involved falls.

As in previous years we have looked at, the themes emerging from PFD reports relating to ambulance services were less varied than for the other types of care provision covered in this report, so we have a 'Top 5' (rather than a 'Top 10'), as shown in the graph below:

PFD themes 2025 - Top 5 in ambulance services



Further details of what we found are set out below:

Delay

Concerns relating to delays in ambulances attending were raised by coroners in 45% (18 cases) of the PFD reports we looked at in relation to ambulance services in 2025.

The focus of these concerns was on ambulances missing target response times, often by many hours. In some of these cases, the ambulance delay was found to have denied the person the opportunity of potentially life-saving treatment.

Coroners expressed frustration at the seemingly intractable nature of this problem - e.g. one coroner stated *"My concern is that the prevalence and extent of such delays has become beyond intolerable and is leading to many acutely unwell patients in the community waiting for such prolonged periods for emergency care, dying directly & indirectly as a consequence"*.

What was particularly striking this year, however, was the consistency with which coroners highlighted Emergency Department handover delays as the cause of the problem, with all but one (94%) of the PFD reports in which ambulance delay was raised as a concern making express reference to ambulances being stuck outside hospitals waiting to hand patients over to over-stretched Emergency Departments. One coroner, for example, found that *"Response times for ambulances attending acute medical incidents continue to be impacted by severe delays in patient handovers at acute hospitals preventing ambulances and their crews returning to service"*, whilst another coroner put it like this: *"The delays getting patients from the Emergency Department (ED) into wards, causes delays taking patients from ambulances into ED, and a knock-on delay getting ambulances back out into the community. These delays persist despite the current actions to mitigate"*.

This was acknowledged in many PFD reports to be a 'whole system' problem - e.g. one coroner expressed concern about *"Insufficient social care provision leading to large numbers of patients in hospital who are otherwise fit for discharge, thereby impeding patient flow through hospital, there being a direct link between inadequate social care provision and ambulance delays"*.

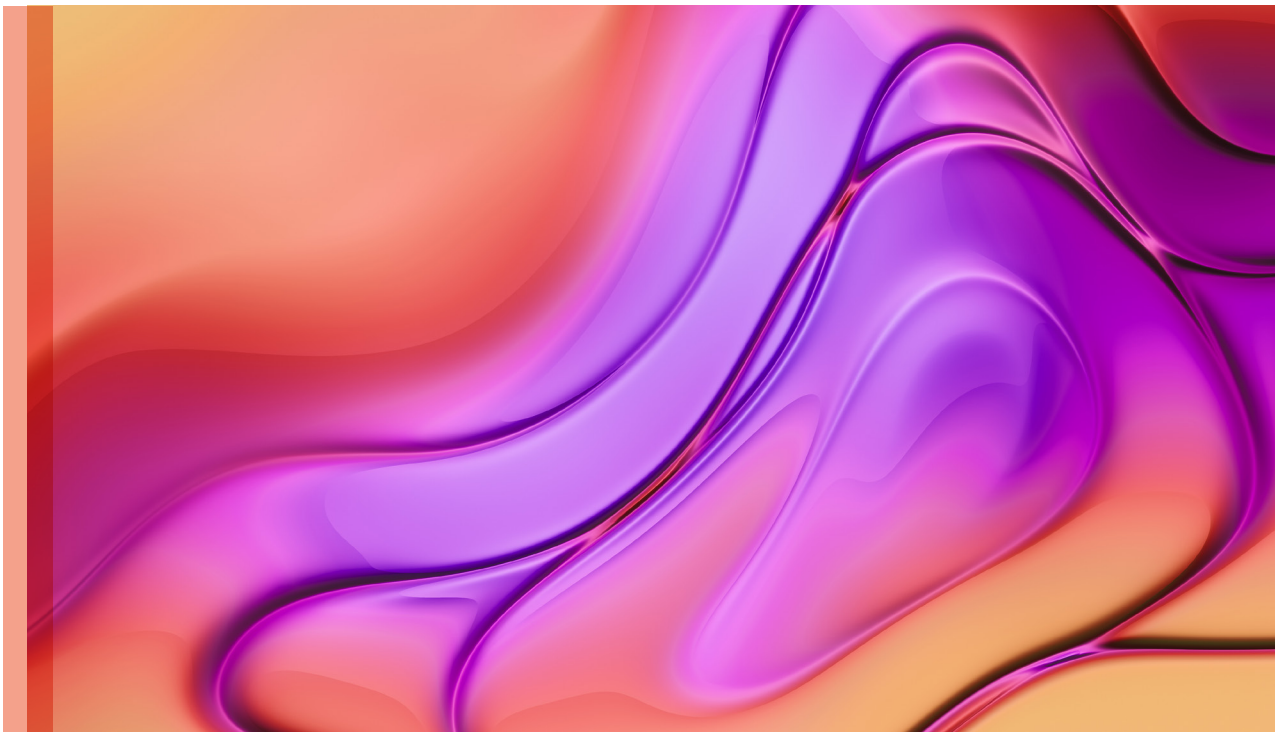
Priority categorisation

The next most frequently occurring theme in PFD reports relating to ambulance services in 2025 was about the priority level allocated to calls, which came up in 25% (10 cases) of the PFD reports we looked at.

This included concerns about ambulance requests being incorrectly categorised in terms of priority - e.g. in one case a request for paramedic back-up was incorrectly categorised because of a failure to recognise the patient's deteriorating condition.

There were also concerns raised about priority categorisation in particular clinical scenarios, including issues with algorithms for assessing newborns and whether the priority categorisation system for those suffering heart attacks or mental health crises is sufficiently nuanced - e.g. one coroner highlighted that *"The triage pathway includes some options for mental health situations but these are limited"*.

There were also concerns raised about the limited circumstances in which the highest priority ambulance response can be allocated under current systems - e.g. *"I am informed that only those callers who are unconscious and clearly in the throes of dying are afforded a Red Ambulance. This limited categorisation puts at risk patients who are severely unwell and are also close to being in an unrecoverable condition"*.



Training

Issues relating to training came up in 18% (7 cases) of ambulance-related PFD reports we looked at from 2025.

This included concerns about lack of training for ambulance staff/paramedics in relation to a number of specific clinical conditions, including aortic aneurysms, strokes and obstetric emergencies - e.g. one PFD report highlighted that *"it is not mandatory for paramedics to receive specific training on obstetric emergencies, including breech delivery, either in their foundation training/education or as part of continuing professional development"* and another coroner raised concerns about lack of training in relation to clinical guidelines on the management of children - *"There is insufficient continuing professional development for operational staff in respect of the assessment of sick children and young people, with frontline staff having limited knowledge and understanding of the Children and Young Persons clinical guideline".*

Meanwhile, lack of training in relation to assessing mental capacity came up in two PFD reports - e.g. one coroner found that the attending paramedics had *"failed to undertake a thorough capacity assessment"* and was *"concerned that the training they had received, both whilst students and subsequently, had not been adequate to equip them to undertake adequate capacity assessments".*

Other themes arising in PFD reports relating to ambulance services included: clinical guidelines (6 cases, including national guidelines not being followed - e.g. in relation to breech delivery or children and young people's care - or highlighting gaps/inadequacies in current guidelines/protocols, such as in relation to mental capacity assessments); and communication with other services (6 cases, including lack of information sharing between specialty clinical teams and ambulance services to flag particular conditions - e.g. one coroner stated *"I have not been provided with any Protocol between the services to ensure safety planning in these circumstances that would ensure that front line paramedics are made aware that they are dealing with a seriously unwell mental health patient who is at high risk living in the community"* and issues with communication between ambulance services and the police - e.g. in one case *"There is a concern also about how information was shared between the police and ambulance service. Both police officers said that, had they been aware of the extent of ambulance delays, they may have considered other options, notably, conveying [the patient] to hospital in a police car").*

How does this compare with previous years?

The overall number of ambulance-related PFD reports we identified in 2025 (40) was lower than the previous year (51 in 2024), but similar to the year before that (42 in 2023).

In terms of themes identified from these PFD reports, these were largely consistent with previous years, with issues relating to delay and priority categorisation having maintained their position throughout as the two most frequently occurring themes for ambulance services and issues relating to clinical guidelines having consistently made the 'Top 5'. Meanwhile, the theme of staff training has also come up regularly, although this was the first year it has made the 'Top 3' for ambulance services.

Although the proportion of ambulance-related PFD reports focusing on the theme of delay was lower than in previous years (45% in 2025, compared with 55% in 2024 and 64% in 2023), this was still the main focus of concern. What was particularly striking this year about the cases in which delay was raised as an issue, however, was the high degree of consistency (i.e. all but one case) with which coroners expressly highlighted ambulances getting stuck outside hospitals awaiting handover to ED as the central problem.

Reflections

We have now looked at themes arising from PFD reports relating to the provision of health and social care over five consecutive years, so we have a significant pool of data to draw from. What can we take from this?

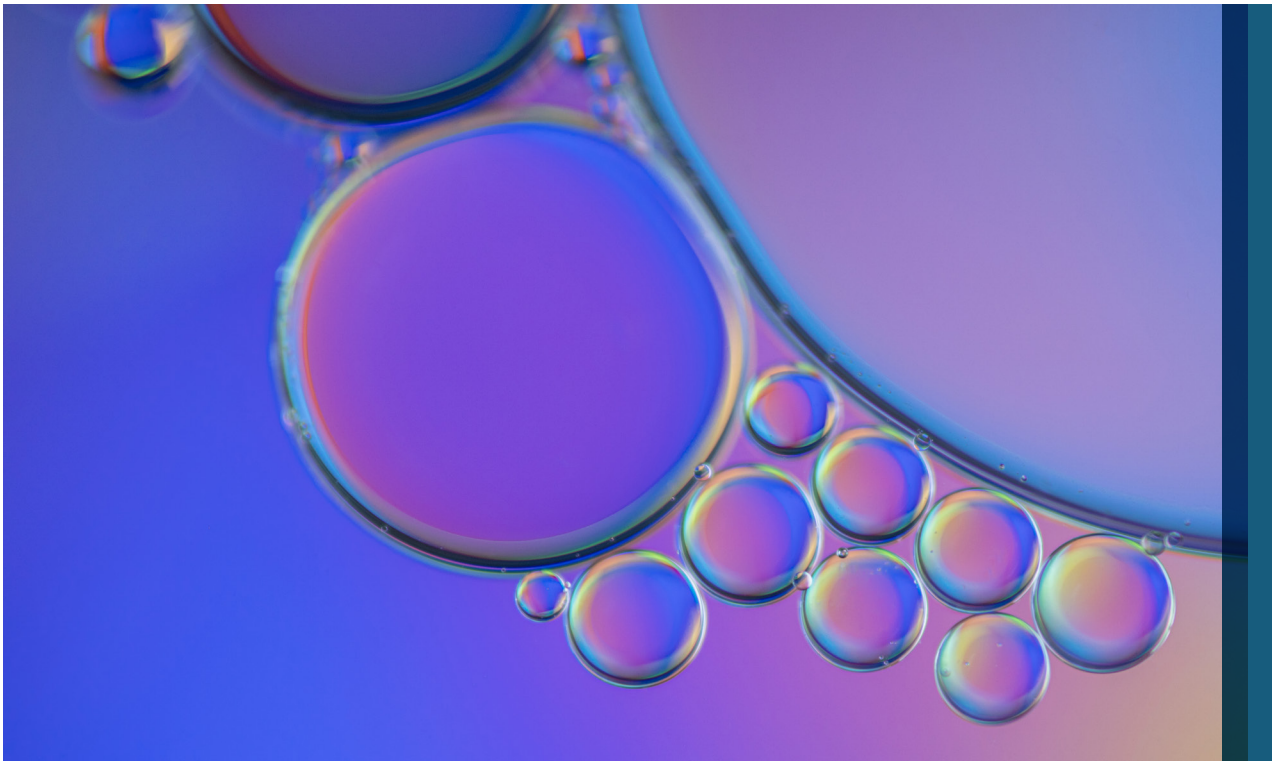
Looking first at overall numbers, 2025 saw a slight fall in the number of PFD reports we identified as having been issued to health and social care providers compared with 2024, but the figure was still higher than in the three years before that, with the overall direction of travel being upwards. However, the pattern in terms of numbers has varied depending on the type of provider, with 2025 having seen fewer PFD reports issued in relation to mental health and ambulance services compared with the last couple of years, but the highest number so far for both acute hospital providers and social care.

In terms of the areas of concern raised in these PFD reports, there has continued to be a high level of consistency over the five years we have looked at. This is most clearly the case for acute hospital providers, with their 'Top 3' themes - incident investigation, communication and record-keeping - having remained unchanged throughout. For other types of provider, at least one theme has consistently appeared in their 'Top 3' across all five years - i.e. risk assessment for mental health, record-keeping for social care, and delay/priority categorisation for ambulance services.

What about the umbrella view in terms of any PFD themes the different provider types have in common? Concerns relating to communication between teams/services have featured prominently across the board throughout the five years, as have concerns about poor record-keeping. With the ongoing sector-wide push towards fully digital, integrated records systems, it will be interesting to see whether coroners' concerns on these issues

are allayed over time. Similarly, concerns about how providers investigate and learn from deaths have continued to be high up the list of issues in PFD reports for all types of provider, which is perhaps not surprising given that, if the coroner is assured at the time of the inquest that enough has already been done to address any areas of concern through existing learning responses, a PFD report will not usually be required in the first place.

Turning back to 2025 specifically, if we had to pick a 'stand out' theme, it would probably be concerns relating to over-stretched Emergency Departments, because this came up in a number of different guises, whether in relation to the risks inherent in ED 'corridor care', the inappropriateness of ED as an environment for holding mental health patients awaiting a psychiatric bed or the impact on availability of ambulances due to so many being stuck outside hospitals waiting to hand patients over. It will be interesting to track whether this continues to be a particular focus of concern for coroners going forward.



How can we help?

Our large national team of inquest 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, including assisting with the preparation of evidence to address Prevention of Future Deaths Report risks.

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