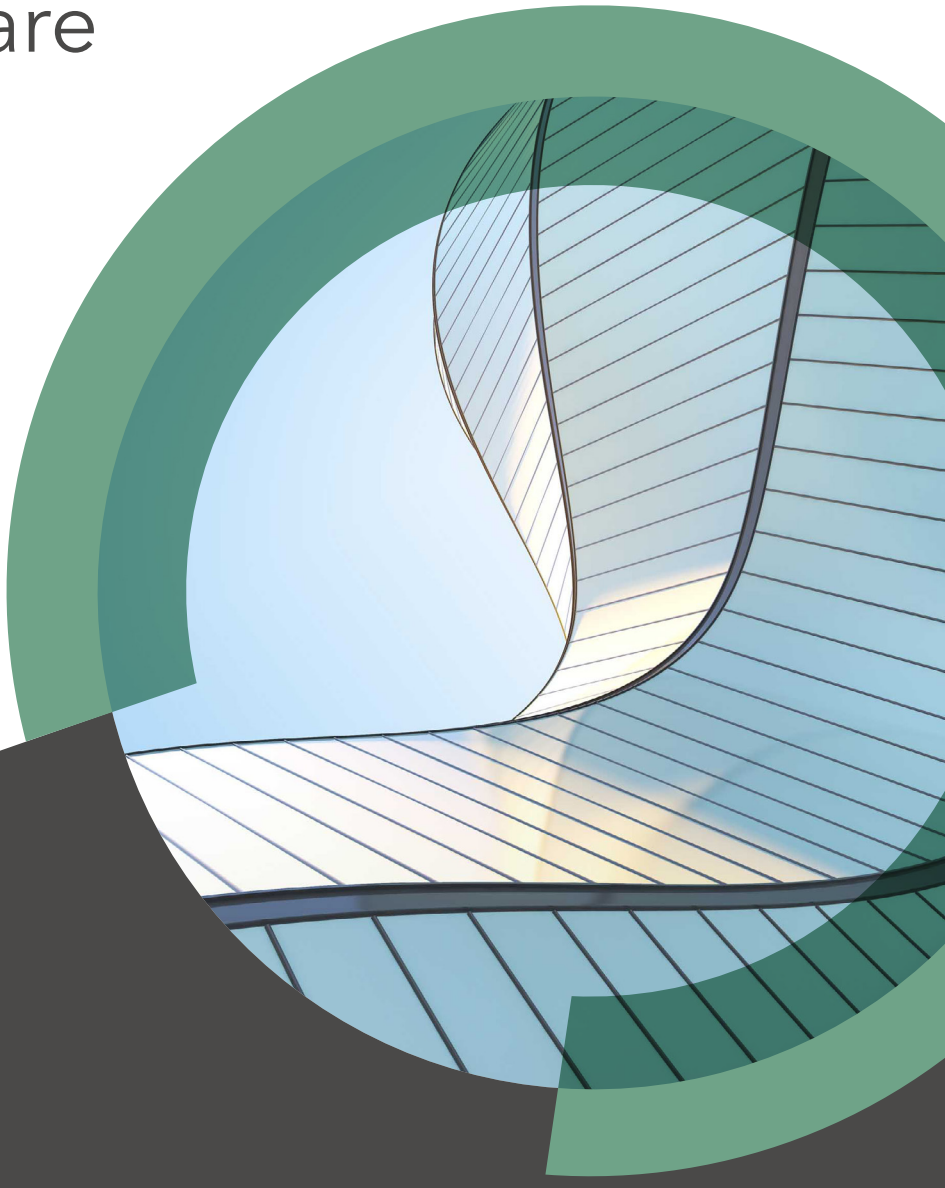
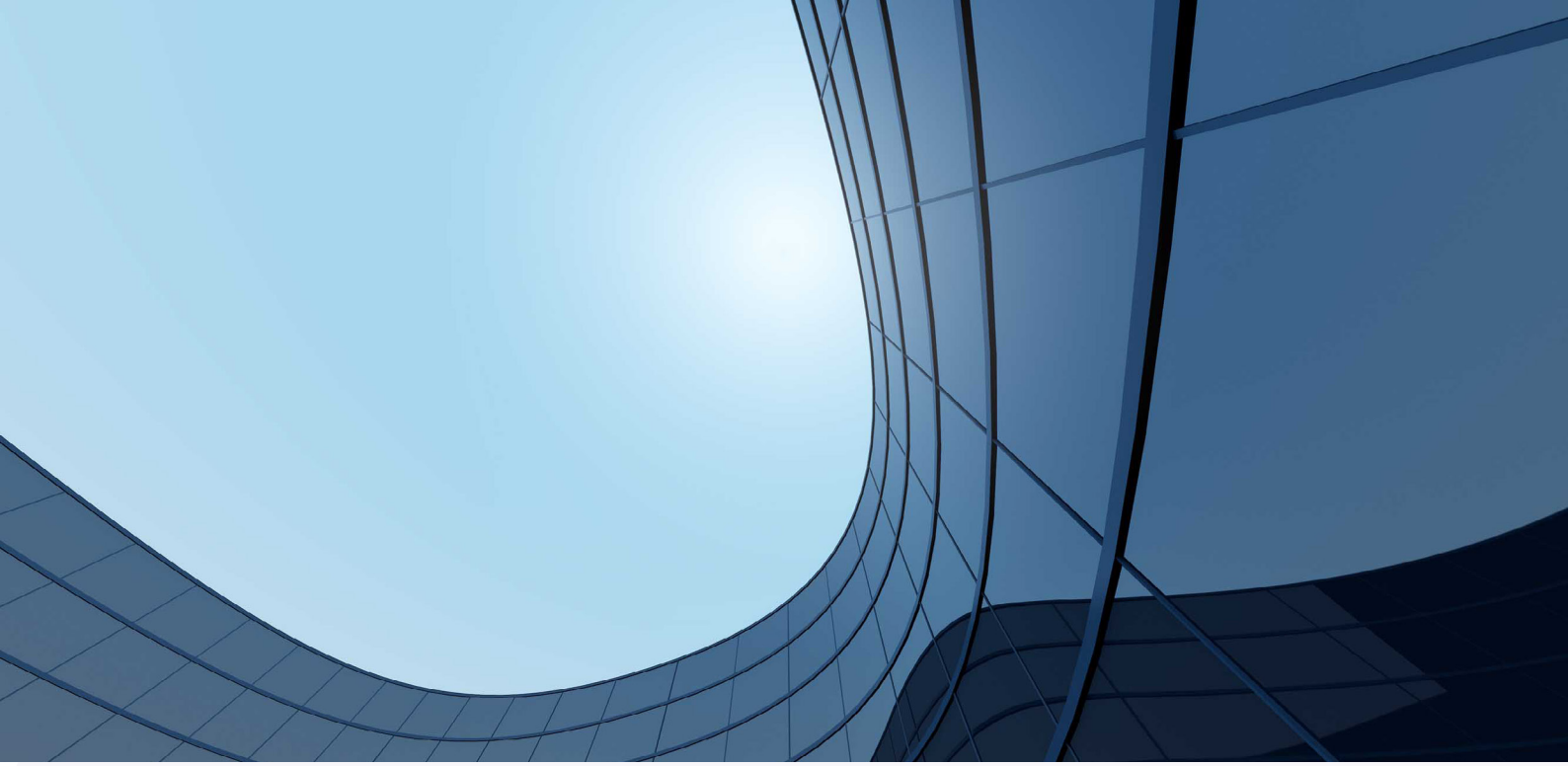
DAC BEACHCROFT

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

April 2025





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Introduction

Welcome to the fourth 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 in an inquest. Sharing themes from PFD reports 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 and 2023), we have looked at themes emerging from over 330 PFD reports - the highest number we have identified to date - issued by coroners in connection with the provision of health and social care over the course of 2024.

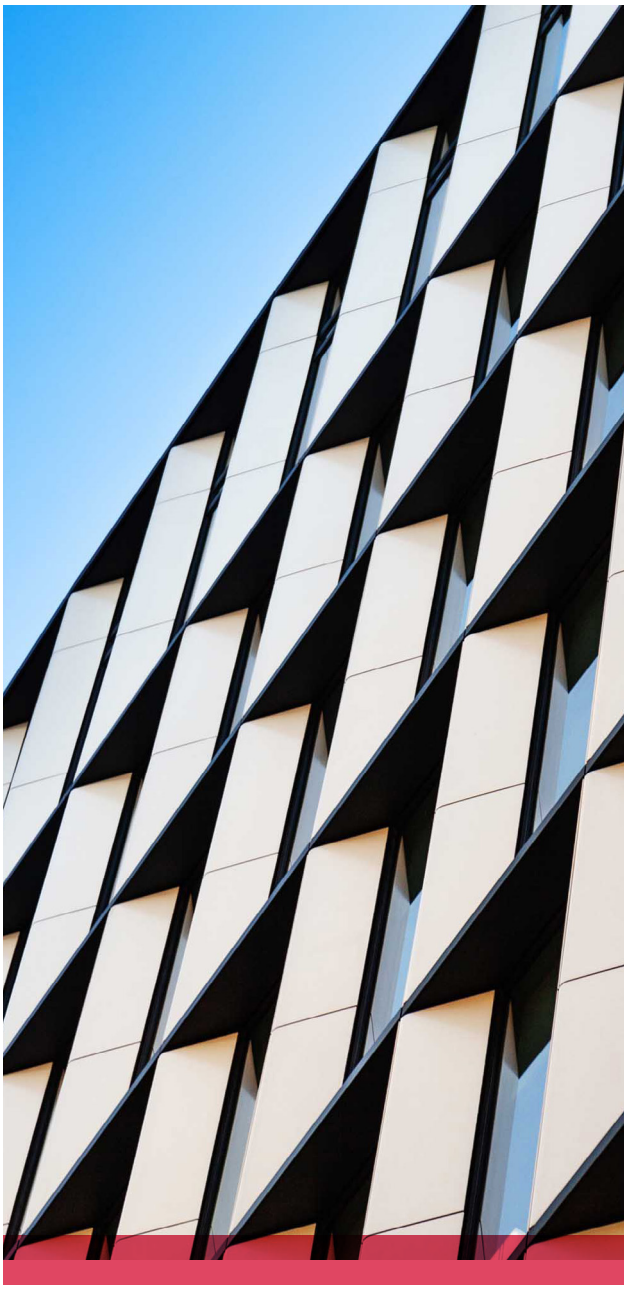
Recap on PFD reports

Coroners must 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 coroner's function is to identify areas of concern, not to prescribe specific solutions.

PFD reports should usually be sent within 10 working days of an inquest concluding, with recipients having 56 days to provide a written response setting out the action taken/proposed to be taken, or explaining why no action is proposed.

A copy of the PFD report is sent to the deceased's family and is also made publicly available online via the Chief Coroner's 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, which may lead to further regulatory scrutiny.

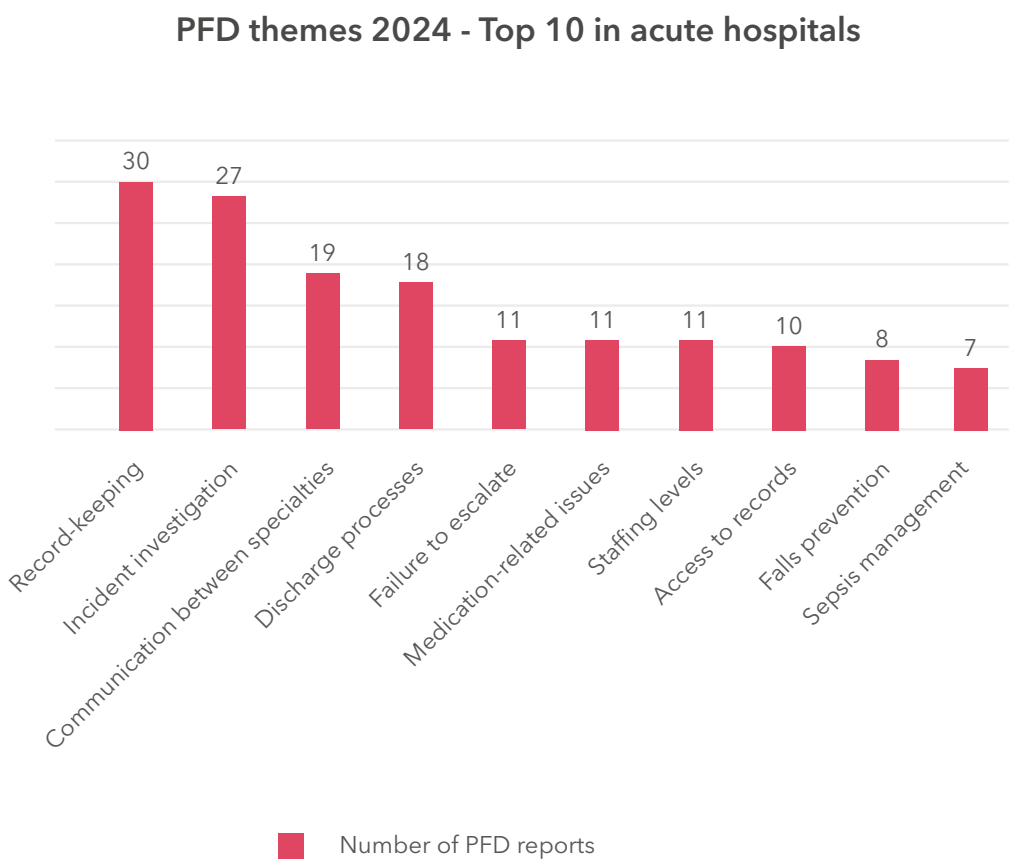
In a recent development aimed at encouraging compliance by 'naming and shaming' the organisations involved, the Chief Coroner's website also now includes a list of those who have failed to respond to a PFD report within the stipulated period.



Acute hospital care

We looked at 139 PFD reports issued to providers over the course of 2024 where the concerns related to acute hospital care. Compared with the previous three years, this was by some margin the highest number of PFD reports we have identified in this category (the next highest being the last year's figure of 100).

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:

Record-keeping

The most frequently occurring PFD theme we identified for acute hospital providers related to record-keeping, with 22% (30 cases) of PFD reports in 2024 raising this as a concern. This is the fourth year running that we have found record-keeping to be in the 'Top 3' themes for acute hospitals and the second time it has occupied the top slot for most commonly occurring theme (the first time being in 2021).

Examples included: documentation missing key details - e.g. *"Documentation (clinical and nursing) was incomplete and did not detail key/important information"*; failure to record the rationale for decision-making - e.g. *"There was no documentation from the ICU consultant setting out their rationale for not examining [the patient] at that point and for declining to admit him at that point"* and, in another case, *"where staff could be identified, no contemporary account of their rationale for making treatment decisions could be located"*; oral conversations or handovers not documented - e.g. *"Handovers and key conversations between staff, both nursing and medical staff, in ED and with Paediatric staff are not routinely documented"* and *"the notes did not fully represent the discussions and assessments that took place, which creates risk";* care plans containing out-of-date information - e.g. *"hospital notes revealed evidence of the routine "copying and pasting" of out-of-date care plans by previous doctors";* fluid balance charts not completed; records not written contemporaneously - e.g. *"the majority of the notes which were adduced in evidence as to the events and treatment…were completed retrospectively on the next day";* and records of a generally poor standard - e.g. *"clinical records were either of a poor standard or were non-existent"*.

Linked with this, in last year's report we identified access to records as an emerging theme, and this continued to be the case in 2024, having been raised in 7% (10 cases) of the acute hospital PFD reports we looked at, including issues relating to the incompatibility of electronic records systems used by different teams/services inhibiting the sharing of information about patients - e.g. teams within the same organisation not being able to view one another's records: *"Plans to introduce electronic patient records to which all medical teams have access are still at an early stage and no date has been identified for moving over to a single electronic notes system"* or inability to access GP records *"due to differing IT systems"* which *"caused difficulties in providing effective and timely care to patients"*.

Incident investigation

Also holding its place in the 'Top 3' PFD themes for acute hospital providers was the topic of incident investigation, which was raised by coroners in 19% (27 cases) of acute hospital PFD reports in 2024.

Examples included: issues with the quality of investigations, such as not involving key clinical staff or not identifying failings in the care, including one investigation report described by the coroner as *"unfit for purpose"* and a case where staff accounts were not captured at an early stage - *"The Trust cannot begin to rectify patient safety issues, if they do not understand exactly what has happened and why"*; delays completing investigations - e.g. *"the concern is that lessons cannot be learned in a timely fashion if patient safety investigations are so significantly delayed"* or failure to investigate at all - e.g. *"There was no full investigation undertaken… other than a desktop report, the quality of which was questionable"*; and actions identified in investigations not having been implemented - e.g. *"The failure to act in a timely manner when learning and actions have been identified (especially when the timetable has been set by the organisation itself) is incomprehensible".*

Although PSIRF (the 'Patient Safety Incident Response Framework') - which promotes a range of learning responses not necessarily requiring an investigation report as coroners have been used to - has had some time to bed in since our last report, it is unclear to what extent, if at all, the advent of PSIRF has allayed coroners' concerns around how health and social care organisations learn from deaths. Based on the terminology used in the 2024 PFD reports, it appears these involved a mix of old-style 'serious incident' investigations and cases where PSIRF was applied, and there are examples of coroners expressing concerns in relation to both types of process. For example, *"Despite this incident activating the PSIRF process which resulted in the completion of an After Action Review ("AAR"), the Trust did not identify any sub-optimal aspects to [the] care. Accordingly, I have a concern regarding the failure of the Trust's governance systems to…identify and reflect upon failings in care".*

Communication between specialties

Issues with ineffective communication were also in the 'Top 3' PFD themes for acute hospital providers for the fourth year running. In line with last year's findings, these concerns focused particularly on communication between the different specialties involved in the provision of acute care, with 14% (19 cases) of the acute hospital PFD reports we looked at raising issues about communication between specialty teams.

Examples included: lack of joined-up approach between different specialties involved in the patient's care - e.g. *"despite the complexity of his case there was no evidence of a multi-disciplinary discussion/approach to assess his position fully"*; lack of clarity about who was in overall charge of the care - e.g. *"no one consultant was in overall charge of her care, which meant that the issues identified in this case were not picked up on"*; liaison with specialist centres - e.g. *"there is no clear guidance on how specialist and non-specialist teams should work together effectively to ensure consistent, high-quality care for these patients";* and issues with communication between different specialties about a patient's presentation and progress - e.g. *"Where, as here, more than one team was involved in a patient's care, there was no clear system in place to ensure that the teams involved communicated with each other about the progress they were making with the patient, and about any appointments missed by the patient".*

Only just missing out on a spot in this year's 'Top 3' for acute hospitals was the theme of discharge processes, which was raised by coroners in 13% (18 cases) of PFD reports in this category. A significant proportion of these cases involved issues about discharge summaries lacking detail or containing inaccurate information - e.g. in one case, the coroner was concerned that *"no audit as to the sufficiency of detail contained in discharge summaries appears to have been undertaken"* and, in another, the discharge summary *"did not include relevant or sufficient information about treatment in the community needs"*. Other issues raised in relation to discharge processes included the patient not being physically assessed by a doctor prior to discharge and failure to provide families/carers with safety-netting advice prior to the patient's discharge - e.g. *"The family were not provided with information upon discharge as to what signs to look out for and what steps to take if [the patient] was to deteriorate"*.

Other recurring PFD themes we identified for acute hospitals in 2024 included: failure to escalate care (11 cases, including instances of miscalculating NEWS scores, not referring patients for critical care advice as per policy and lack of clear protocol for escalating deteriorating patients); medication-related issues (11 cases, including issues relating to anticoagulant prophylaxis, prescribing of medication to which the patient was allergic and leaving medication in pots by the bedside); Staffing levels (11 cases, which focused in particular on insufficient staffing in Emergency Departments, including two PFD reports specifically highlighting lack of doctors in ED and another two highlighting lack of paediatric nurses in ED - e.g. *"the emergency department was, and continues to be, overwhelmed with patients with insufficient staff to care for, monitor and manage those patients")*; falls prevention (8 cases, including not undertaking a falls risk assessment on ward transfer and enhanced observations being identified as needed but not put in place;) and sepsis management (7 cases, several of which focused on failing to identify sepsis, including where the presentation was atypical).

An emerging theme worth flagging even though it did not make the 'Top 10' for this category relates to concerns about lack of staff understanding about mental capacity, which came up in 5 PFD reports issued to acute hospitals, including cases involving vulnerable patients who left hospital without their capacity to make decisions about discharge being properly explored. In one case, for example, the coroner commented, *"I am concerned that the concepts of 'having capacity' and 'not being vulnerable' are being elided"*.

How does this compare with previous years?

Looking at the overall number of PFD reports issued to acute hospital providers, there was a significant increase in 2024 (139) compared with all three previous years we have looked at - 2021 (93), 2022 (55) and 2023 (100). It will be interesting to see whether this upwards trend continues.

Despite this higher number of PFD reports, the most commonly occurring themes for acute hospital providers - record-keeping, incident investigation and communication - have remained unchanged across all four years we have looked at (albeit not always in the same order - each of these themes has had a turn occupying the top slot).

Meanwhile, concerns relating to discharge processes, escalation of care and falls prevention have featured in the 'Top 10' themes in all four years too.

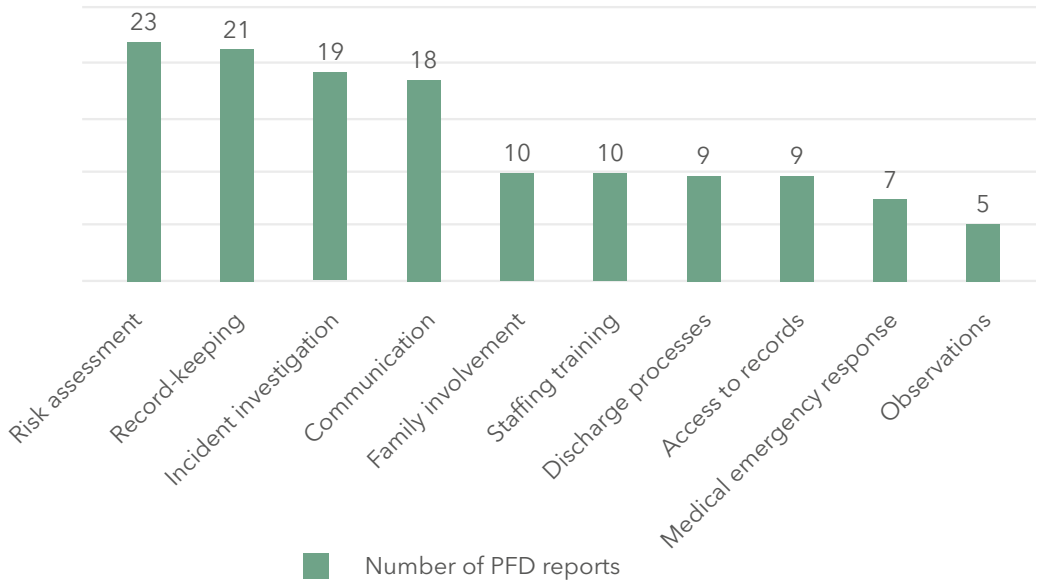
Overall, therefore, PFD report themes for acute hospital care have continued to be notably consistent.

Mental health

We looked at 85 PFD reports issued over the course of 2024 where the concerns related to providers of mental health care. (This was a similar overall number compared with the previous year, when we identified 86).

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

PFD themes 2024 - Top 10 for mental health providers



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

Risk assessment

Issues relating to risk assessment were raised by coroners in 27% (23 cases) of PFD reports issued to mental health providers in 2024. This is the fourth year running that risk assessment has been in the 'Top 3' PFD themes for mental health providers, but the first time it has occupied the top slot as the most commonly occurring theme.

In several of these PFD reports, coroners expressed concerns about inadequate exploration of suicide risk - e.g. *"I am concerned that the importance of exploring the suicide question does not feature highly enough in the consciousness of…staff",* including a number of cases where there was felt to be an over-reliance on the person's denial of suicidal intent - e.g. in one such case, the coroner stated, *"insufficient consideration appeared to have been given to the risk of impulsive suicide with instead assessment focussing on his denial of increased active suicidal intent"* and, in another, *"Despite clear guidance from NICE in September 2022 relating to the need for a holistic formulation of risk to self, two…teams involved in [the patient's] crisis care failed to carry out a holistic formulation of the risk he posed to himself… [His] risk was deemed to be low because "the main factor around risk is that he denied any risk to self and denied any suicidal thoughts". This simplistic assessment of risk is not compliant with the NICE guidelines."*

There were also several examples of coroners raising concerns about lack of risk assessment before discharge from hospital or a service - e.g. *"There was no evidence of any adequate formulation of risk prior to [the patient's] discharge from hospital…and no evidence of any adequate risk formulation prior to [his] discharge from the community mental health team".* There were also instances of coroners expressing concern about failure to update risk assessments following significant events and approaches to risk assessment more generally - e.g. in one case, the coroner highlighted a *"continuing practice/culture of minimising the importance of a ward specific risk assessment"* and, in another, the coroner was *"concerned that staff do not fully understand how to assess and manage risk".*

Record-keeping

Record-keeping was the next most frequently occurring theme we identified in PFD reports issued to mental health providers in 2024 (occupying the same second-place position as last year), with coroners raising concerns about this in 25% (21 cases) of PFD reports we looked at in this category.

An issue that came up in a number of these cases was failure to record the rationale for decisions made about the person's care, including not recording the reasons for deciding against hospital admission - e.g. in one case the coroner highlighted a failure to record *"professional opinions reached on the prospect, or not, of readmission for in-patient treatment together with the final decision and rationale".* Another recurring concern related to omitting key information from records - e.g. cases involving failure to document information about self-harm risk or the outcome of referrals, with the coroner stating in one case, *"There were issues with record keeping across the board".*

Closely related to the theme of record-keeping, access to records came up as an issue in 9 cases, with the emphasis being on access to information held by other mental health services involved in the person's care - e.g. mental health team records not being accessible

by a crisis line team in one case and a talking therapies team in another. Concerns were also raised in relation to records access as between NHS and independent sector mental health services, with one coroner stating, *"Consideration should be given to ensuring a system is in place to allow the sharing of medical information between practitioners across Trusts and also between NHS and Private providers"*.

Incident investigation

Issues relating to incident investigation made it into the 'Top 3' PFD themes for mental health providers for the second year running in 2024 . This was raised by coroners as a concern in 22% (19 cases) of PFD reports we looked at.

Examples included investigations failing to cover key aspects of the care, including not identifying concerns arising at inquest and issues not being addressed in action plans - e.g. one incident investigation *"failed to uncover all the matters arising at inquest and, some of the matters that it did uncover do not have correlating items of work listed in the action plan"*. Coroners also raised concerns about failing to involve families in the investigation process - e.g. a post-death review *"did not involve any level of consultation with [the patient's] family to consider whether there were any areas of concern they had which might direct elements of the review"*. One of the most frequently arising issues, however, related to not having implemented actions recommended by incident investigations and failures to embed change, which in some cases came to light at inquest through the factual witness evidence - e.g. *"live witnesses who gave evidence during the course of the inquest did not demonstrate that learning had filtered down to the front-line staff"*.

As we noted previously in relation to acute hospital care, it is difficult to assess whether or not the introduction of PSIRF has helped to allay coroners' concerns about how providers learn from deaths because it is often not clear from PFD reports what type of learning/ investigation process was followed at the time. However, the fact that incident investigation continued to be one of the most frequently occurring areas of concern in PFD reports issued to mental health providers in 2024 suggests that any substantial impact of PSIRF is yet to be felt.

Other recurring PFD themes for mental health providers in 2024 included: communication (18 cases - e.g. ineffective communication between mental health services in the community about the person's care and issues with information sharing between mental health services and GPs or the police, as well as several cases involving lack of communication between NHS and independent sector mental health services); family involvement (10 cases - a number of these focused on lack of opportunity for families to share their concerns, as well as failing sufficiently to involve families in safety planning, with the coroner in one case commenting, *"Lack of engagement with families is a story that I have heard often in inquests"*); staff training (10 cases - e.g. lack of staff training on a range of issues including dual diagnosis pathways, out-of-area admissions, hard-to-engage patients and assessing risk); discharge processes (9 cases, including several involving lack of safety plan or planned support on discharge from inpatient admission); medical emergency response (7 cases, focusing on concerns about the speed/effectiveness of responses to inpatients needing emergency medical attention - e.g. following ligature incidents or physical health issues requiring urgent escalation - including delays calling for an ambulance, such as a case involving *"significant confusion…as to who should call a medical emergency and how information should be relayed to the ambulance service"*); and observations (5 cases - e.g. 1:1 observations not being conducted as they should and issues with completion of observation charts, including cases of recording that observations had been conducted when they had not).

Lack of resources in mental health services was another a key area of concern in 2024, particularly when also taking into account an additional 20 PFD reports issued to national-level organisations on this theme (such as the Department of Health and Social Care). From this wider pool, we identified 26 PFD reports where lack of resources was raised with mental health providers and/or with national-level bodies as a concern. These included 4 PFD reports relating to children's mental health services, including 'unacceptably long' waiting times for CAMHS assessments and a lack of placements for high risk children with complex needs, and 4 PFD reports relating to autism/ADHD services, including shortage of placements for those with complex needs and waits for autism assessments, with one coroner highlighting that *"the demand for the service greatly exceeds the current supply"*. There were also 2 PFD reports focusing on lengthy waiting lists for psychological therapies. By far the most frequently arising concern here, however, centred on lack of psychiatric inpatient beds, which accounted for over half the PFD reports (14 cases) where lack of mental health resources came up as an issue. In one case, for example, *"The inquest heard evidence that a shortage of mental health beds nationally meant that the situation that arose here of a placement out of area many miles from home was not unusual and that private beds were being used on a regular basis due to a shortage of NHS beds"*. Other PFD reports expressed concerns in similar terms - e.g. referring to *"a nationwide shortage of inpatient mental health beds"*, *"bed capacity remains an ongoing problem"* and *"a shortage of suitable psychiatric hospital bed spaces becoming available in a timely way"*, including one coroner stating that the chronic, national shortage of mental health beds *"was described to me as a crisis"*.

How does this compare with previous years?

The overall number of PFD reports we identified as having been issued to mental health providers in 2024 (85) was very similar to the year before (86 in 2023) and higher than the two years prior to that (56 in 2022 and 72 in 2021).

Notably, the 'Top 3' themes we identified for mental health providers - i.e. risk assessment, record-keeping and incident investigation - also remained unchanged from the year before, albeit in a different order, with this being the first time risk assessment has taken the top slot.

There was a lot of consistency across other themes too, with communication, family involvement, and discharge processes having been in the 'Top 10' themes for mental health providers across all four years we have looked at. We noted, however, that care coordination did not make this year's 'Top 10' as it had in all previous years.

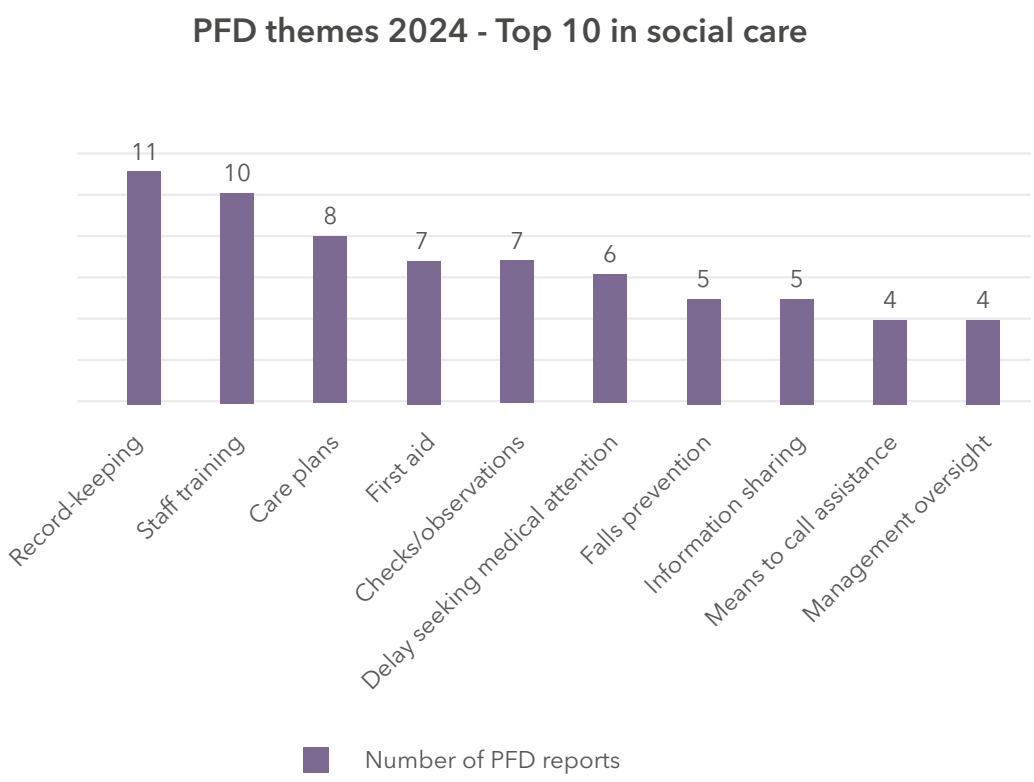
Themes which emerged strongly this year, and which we may see more of in the future, included inadequate responses to medical emergencies for psychiatric inpatients and also the national shortage of inpatient mental health beds.

Social care

We looked at 39 PFD reports issued to adult social care providers, including care homes, domiciliary care and supported living, over the course of 2024.

In terms of the factual context these PFD reports arose from, there were some recurring scenarios, with 14 cases involving deaths following falls (over a third of the social care PFD reports we looked at) and 8 choking incidents (a fifth of cases).

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:

Record-keeping

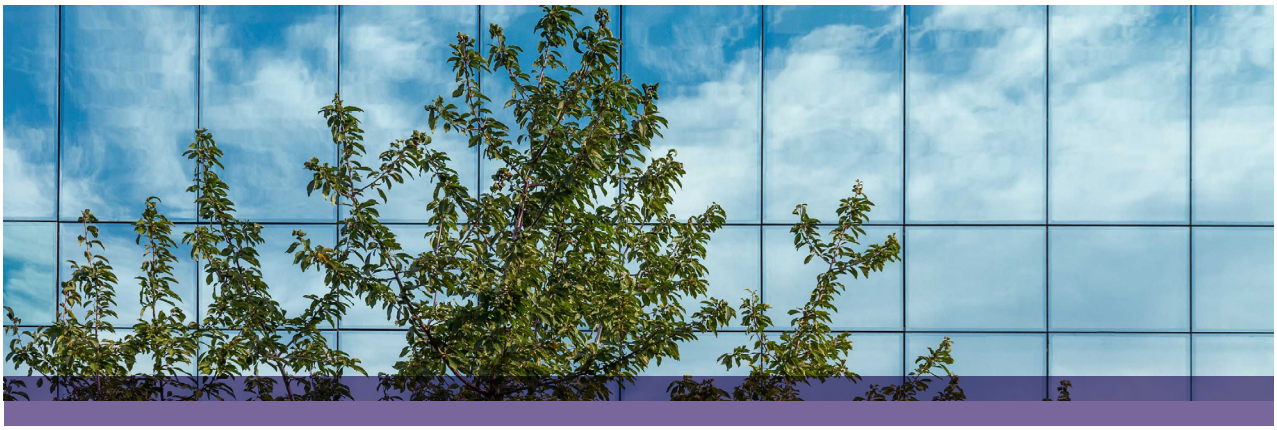
Record-keeping was the most frequently occurring area of concern we identified in PFD reports issued to social care providers in 2024, featuring in 28% (11 cases) of the PFD reports we looked at in this category. This was the fourth year running that record-keeping has been in the 'Top 3' themes for social care.

In one case, for example, the coroner stated in the PFD report that *"Overall documentation at the home was limited and lacked detail"*. In another, there was *"a limited understanding by staff of the level of detail required"* and, in another, *"without access to good records I can see a clear risk to the care of residents"*. Concerns about poor quality and/or incomplete documentation were raised by coroners in relation to numerous aspects of care, including welfare checks, fluid and nutrition charts, pressure sore care and recording instances of falls. Issues also came up in relation to the accuracy of records. In one case, for example, *"It was noted in the evidence, that erroneous record keeping had taken place over a period of time and involved multiple carers. It was caused by carers transposing the records of one resident into the care records of another, leading to inaccuracies"*.

Staff training

Making the 'Top 3' themes for social care providers for the third year running was staff training, which came up as a concern in 26% (10 cases) of PFD reports we looked at.

Concerns about lack of adequate staff training covered various aspects of care delivery. In one case, for example, the coroner highlighted that *"care staff are not properly trained in the use of care plans, record keeping and importance of monitoring skin integrity"*. Coroners also flagged staff training needs in relation to conducting welfare checks and expectations when supervising residents. There were also several examples of concerns being raised about lack of training in how to respond to emergency situations such as residents becoming unresponsive and needing resuscitation - e.g. *"Training on how to deal with emergency situations is not ingrained in care home staff"*.



Care plans

The theme of care plans has consistently been in the 'Top 10' for social care providers over the last four years, but this was the first time it has entered the 'Top 3', featuring in 21% (8 cases) of the PFD reports issued to social care providers in 2024.

Several of these cases involved concerns about care plans being unclear, incorrect or out-of-date - e.g. one PFD report stated, *"The Coroner is concerned that other residents' care plans may contain out of date and conflicting information"*. Another issue that came up was failure to review care plans following an incident. There were also concerns raised about staff not reading care plans and being unaware of their contents - e.g. *"the admitted failure of agency staff, on occasion, to read care plans such that there can be confidence that residents are safe"*.

A newly emerging theme for social care providers related to the provision of first aid by care staff, which was raised by coroners in 18% (7 cases) of PFD reports in this category. Several of these cases involved failure to provide timely, appropriate first aid following choking incidents. In one case, for example, *"The evidence revealed there is still a lack of understanding of providing first aid to those becoming unresponsive"* and, in another, the coroner highlighted *"The lack of confidence expressed by staff in the emergency first aid training provided when responding in a choking case"*.

Other themes we identified from PFD reports relating to social care included: frequency and/or quality of checks/observations (7 cases - e.g. in one case there was *"no clear system or expectation regarding the quality of checks on a resident who exhibited signs of being unwell"* and, in another, *"care staff…do not currently have a checklist in use to accompany them when checking on residents");* delays seeking medical attention (6 cases, including concerns about delays seeking medical review after a fall - e.g. *"after a fall the staff within the home should have a mechanism to ensure medical advice is obtained in a timely fashion"* and about responses to someone becoming unwell - e.g. *"the system for escalation where a patient was unwell was unclear and not understood by staff")*; falls prevention (5 cases, focusing on issues with falls risk assessments and risk mitigation plans - e.g. *"Care Plans and Risk Assessments were not consistent and clear as to what steps were required to mitigate the risks of [the resident] falling"* and on availability of falls prevention equipment - e.g. *"It seems to me the home should have an armoury of measures to pick from to tailor to the needs of the individual resident"*); information sharing (5 cases, including failing to share information relevant to choke risk with the SALT team, failure by domiciliary care staff to report poor living conditions and care staff giving unclear/inadequate information to ambulance services); calling for assistance (4 cases, which focused on insufficient means for residents to call for staff assistance in the event of a medical emergency, including call bells being faulty or not responded to in a timely way); and management oversight (4 cases, mainly involving problems with care provision not having been picked up at management level - e.g. *"The management of the care company did not appear to carry out audits of records and compliance with care plans nor have any other effective means of oversight"*).

How does this compare with previous years?

The overall number of PFD reports we identified as having been issued to social care providers in 2024 (39) was the highest so far (the figures for previous years were 25 in 2023, 23 in 2022 and 35 in 2021).

Across the four years we have looked at, there have been some notable areas of consistency for social care providers. In particular, record-keeping has been in the 'Top 3' themes every year. Meanwhile, falls prevention, staff training and care plans have so far always been in the 'Top 10'.

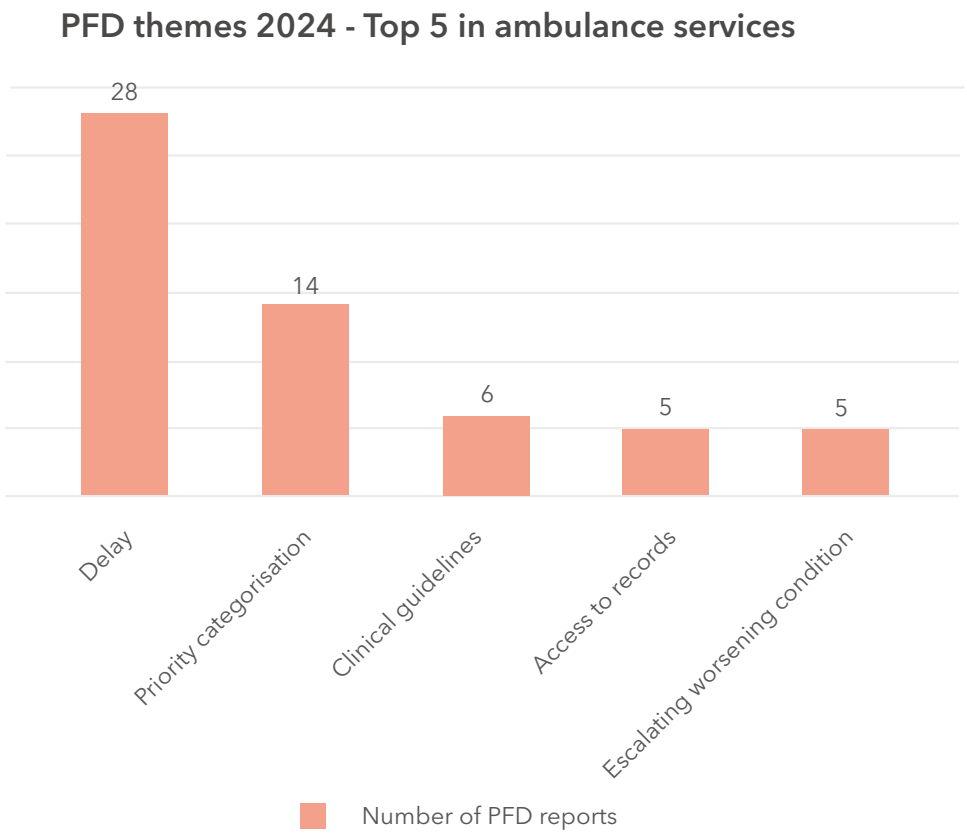
There have, however, also been some changes of emphasis in social care related PFD reports over this period. For example, although we identified a couple of cases in 2024 which raised concerns about incident investigations, for the first time this year, this theme did not make the 'Top 10'. Also, whilst concerns relating to delays seeking medical attention have featured in the 'Top 10' in previous years, 2024 saw a stronger emergence of issues around inadequate responses to medical emergencies, with a particular focus on the ability of care staff to provide first aid in those scenarios.

Ambulance services

We looked at 51 PFD reports issued by coroners over the course of 2024 in relation to ambulance services (the highest number we have identified for this category to date). 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 in which these ambulance-related PFD reports arose, 25% of them (13 cases) involved someone experiencing cardiac issues. Meanwhile, 12% (6 cases) involved overdoses, 10% (5 cases) bleeds and 8% (4 cases) falls (which was notably lower than in the previous two years when around 30% of ambulance-related PFD reports we looked at arose in the context of falls).

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:



Further details of what we found are set out below:

Delay

Over half (55% - 28 cases) of the 2024 PFD reports we looked at in relation to ambulance services raised concerns about delays, specifically in terms of ambulances attending outside target response times.

Often in these cases, ambulances arrived many hours later than they should have done, with coroners finding in some instances that the person would most likely have survived had target response times been met. In one case involving an accidental wrist laceration, for example, the coroner highlighted that *"The time for survival of such injuries was 30-45 minutes, however the time taken to respond was in excess of 9 hours"*.

It is clear from these PFD reports that coroners are very much aware of ambulance delays being a national problem with multiple causes, focused mainly on lack of patient flow through hospitals. Indeed, it was striking that in over two thirds (19 cases) of the PFD reports which raised issues about ambulance delays, coroners expressly attributed those delays to the problem of ambulances being stuck outside A&E/Emergency Departments waiting to hand patients over. This came up again and again - e.g. *"There was a significant delay in offloading patients at hospitals which tied up ambulance resource on that day and meant they were unable to respond to emergency calls", "The resources available in the… Ambulance Service cannot be fully utilised because of the delays in ambulances clearing Accident and Emergency departments caused by the pressure on these departments across the NHS",* and *"The longest wait at the Emergency Department by an ambulance on the evening in question was 11-12 hours, which is the equivalent of a whole 12 hour shift where that ambulance was not responding to calls".*

In several of these PFD reports, coroners went into some detail about the system-level factors felt to be at play here, focusing on blockages in hospitals due to lack of adequate community provision - e.g. *"There is a direct connection between the risk of excessive ambulance delays and inadequate social care provision, community hospital provision and primary healthcare support for discharges…because the inadequacies in these services lead to delayed discharges causing crowding in ED and handover delays. This creates a risk of future systemic failures causing excessive ambulance delays".*

Overall, there was a sense of continuing frustration amongst coroners about the apparently intractable nature of this problem, with one coroner stating that *"…what used to be considered seasonal pressures on ambulance services during the winter months is now becoming an all year round norm"* and another that *"…the problem does not appear to be abating".* Meanwhile, another coroner highlighted that ambulance call handlers and clinical advisors are *"being forced to resort to extreme mitigating measures…in circumstances where ordinarily an emergency ambulance would be provided"* including *"resorting to recommending self-conveyance, arranging taxis and unattended drop offs at ED".*

Priority categorisation

The next most frequently occurring theme in PFD reports relating to ambulances services was about the priority level allocated to calls, which came up in 27% (14 cases) of PFD reports we looked at.

This included coroners raising concerns about the priority categorisation allocated in particular clinical scenarios, including systems not differentiating between low risk and high risk overdoses where treatment may be time-critical (which also came up in previous years). There was also a concern raised about priority categorisation systems not asking about pre-existing conditions (such as, in this case, Addison's Disease) which would have *"dramatically altered the response to the call"*.

There were also issues raised about clinical reviews of system-generated priority categorisations, including concerns about lack of clinical validation of Category 3 and 4 calls given the long response times for those and about a lack of awareness amongst doctors about their ability to challenge the call handler's categorisation and seek a review by an ambulance service clinician.

Other PFD reports raised broader concerns about priority categorisation systems, including one coroner highlighting that the consequence of different ambulance services using different pathways is that *"there is not a consistent approach to call categorisation across the country which can have a significant impact on the dispatch of potentially lifesaving attendance by the ambulance service"* and another questioning whether the existing priority dispatch system is still fit for purpose given that the multifactorial issues affecting resource availability today were not envisaged when the system was introduced.

Clinical guidelines

Issues relating to clinical guidelines came up in 12% (6 cases) of ambulance-related PFD reports we looked at.

These included concerns about lack of guidelines/protocols for ambulance staff in relation to a range of specific clinical scenarios, including conveyance to hospital in obstetric cases where delivery is not progressing and recognising the significance of patients being on steroid medication.

Issues were also raised on the topic of guidelines about which antidote medications should be carried on ambulances so they can be administered 'at-scene', including 2 from different coroners about 'Methylene Blue'.

Other themes arising in ambulance service PFD reports included: failure to escalate cases for a faster response despite the patient's worsening condition (5 cases - e.g. *"The methods of detecting worsening conditions in existing category 2 calls are not sufficiently robust");* and issues relating to access to records (5 cases - e.g. in one case, *"…call handlers are not provided with access to (even an abridged version) of a patient's medical records. I am concerned that this means that call handlers cannot see relevant details of medical history"* and, in another, *"As the Ambulance Service did not have the GP records readily available to them this meant that there was a missed opportunity to treat [the patient] appropriately"*).

How does this compare with previous years?

The overall number of ambulance-related PFD reports in 2024 (51) was the highest number we have identified to date (previous figures were 42 in 2023 and 26 in 2022).

In terms of themes we identified from these PFD reports, the picture was very similar to previous years we have looked at, with issues relating to delay, priority categorisation and clinical guidelines consistently featuring in the 'Top 5' themes for ambulance services. Although the proportion of cases focusing on delay was slightly higher in previous years (64% in 2023 and 65% in 2023, compared with 55% in 2024), this was still very much the main focus of concern.

The themes of training and incident investigations did not feature in the 'Top 5' for ambulance services in 2024 as they have previously, but issues with records access were identified as an emerging area of concern.

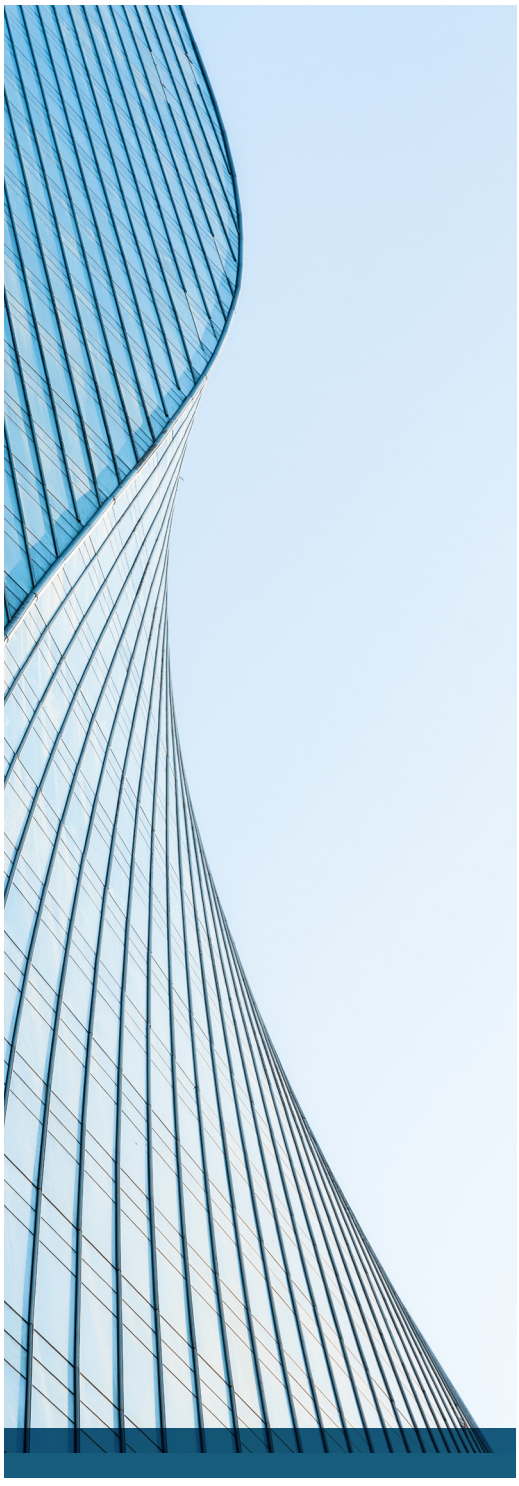
Reflections

After the fourth consecutive year of looking at themes arising from PFD reports relating to the provision of health and social care, what are our key takeaways?

The main headline is that the most frequently arising areas of concern have remained remarkably consistent. This is particularly the case for acute hospital providers, with their 'Top 3' - record-keeping, incident investigation and communication - having remained unchanged across all four years we have looked at. Mental health providers too have seen a lot of consistency, with themes of risk assessment, incident investigation, communication, family involvement and discharge processes having made the 'Top 10' every year. Meanwhile, social care providers have continued to see record-keeping, falls prevention, staff training and care plans amongst their most commonly occurring themes and, for ambulance services, the issue of delays/not meeting target response times has remained the most frequently arising concern throughout.

Within this largely consistent picture, however, we have seen the overall volume of PFD reports issued in relation to health and social care provision going up and some new themes emerging.

In terms of numbers of PFD reports, 2024 saw a marked increase for acute hospital providers compared with previous years we have looked at. Numbers also rose for social care and ambulance services and, whilst the number issued to mental health providers remained static compared with the year before, it was still up compared with the years prior to that. What, if anything, can we read into this upwards trend? Given that the coroner's duty to issue a PFD report is based on the circumstances as they are currently, as opposed to how they were at the time of the death, where appropriate action to address the risk of future



deaths has already been implemented by the time of the inquest, a PFD report should not be required. The fact that numbers of PFD reports are continuing to rise could therefore indicate that health and social care providers could still do more to reassure coroners that enough is already being done to address any areas of concern through existing learning responses. This may in turn suggest that the benefits of PSIRF are yet to be fully felt.

What might the future hold in terms of PFD themes? Whilst it is likely that the overall picture will remain broadly consistent, we may see more of themes we have seen emerging in 2024, including issues with records access/integration of records systems, inadequate first aid responses in social care settings and concerns about lack of mental health inpatient beds. The significant and growing pressure as a result of increased demand and resource constraints is likely to increase the risk of criticism in some of the areas identified by coroners, not only in terms of clinical or operational delivery but also in respect of the corporate or support services (such as those tasked with incident investigation) which are needed to facilitate assurance and improvement.

Meanwhile, PFD reports continue to provide strong leverage for change and sharing the themes derived from them may go some way towards supporting improvements across the wider system.

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 PFD report risks.

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