A thematic review of Prevention of Future Death Reports

Hospital related deaths

Coroners are under a duty to make a Prevention of Future Deaths (PFD) report (also known as a regulation 28 report) when they are concerned that further deaths may occur and action needs to be taken to prevent this. All reports and responses must be sent to the Chief Coroner and in most cases they will be published on the Chief Coroner's website.

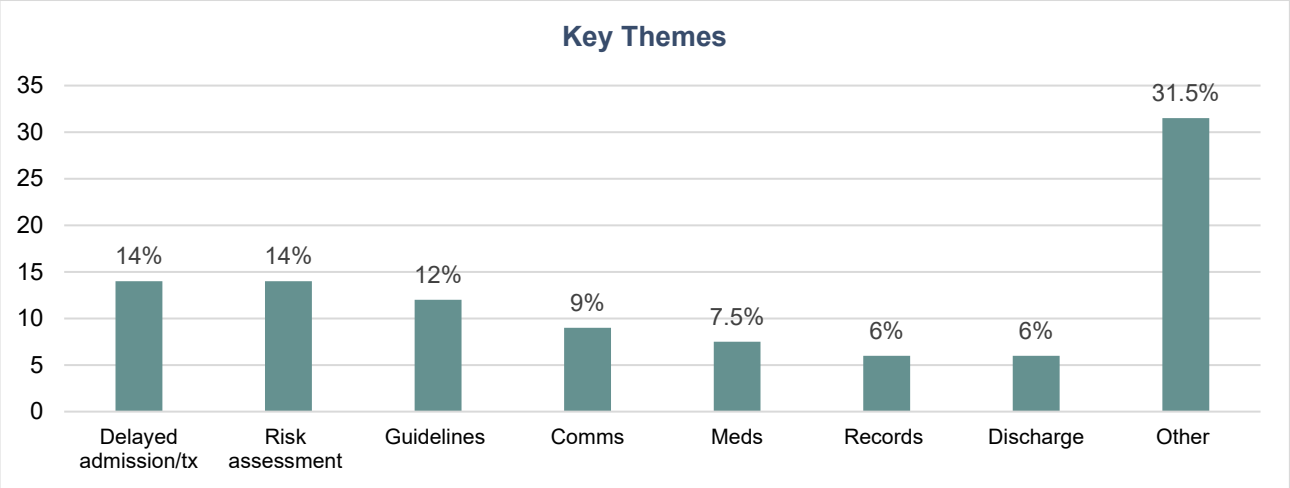
Our review considers key themes from PFD reports issued during the period from1 March 2023 to 31 August 2023, concerning hospital related deaths (clinical procedure and medical management). In a more in-depth analysis, we highlight a selection of issues from the top three categories by frequency to inform patient safety and learning to prevent future harm.

Key themes

65 PFD reports were issued during the six month period, spanning 17 broad themes. Those most frequently identified were:

- delay in admission (to ED/ ward) and/or delay in treatment: **9 reports**
- failures in risk assessment – particularly around falls, pressure sores and deep vein thrombosis (*DVT*)/ venous thromboembolism (*VTE*): **9 reports**
- lack of or defective guidelines/ protocol/ treatment strategy: **8 reports**
- communication issues – within team, between specialities, between sites/Trusts: **6 reports**
- medication issues and prescription errors: **5 reports**
- poor record keeping: **4 reports**
- discharge planning/ social care issues: **4 reports.**

PFD reports often contained multiple themes and references to current staffing issues and/or challenges around discharge to social care, where the concern was also directed to NHS England and/or the Department for Health and Social Care.



Issues of concern highlighted in the top 3 categories

Delayed admission/ treatment

Several cases commenced with a delay in getting an ambulance to the patient with subsequent delays in assessment in the ED and then transfer to a ward. These delays impacted on subsequent treatment delays where staffing issues were also a factor.

PH died in hospital following a fall at home

His hospital *'journey'* comprised care in an ambulance, hospital corridor, rapid assessment room and then a cubicle. The coroner's concerns included lack of space for nurses to attend to his personal care needs and assess pressure areas plus a lack of staff generally. His condition meant that he needed repeated blood tests, but these were never done and clinical staff were not made aware of the fact. There was a lack of written nursing records, including the giving of supplemental oxygen and why this was needed or whether it had been discussed with a clinician.

Conclusion: accidental death.

HT died of sepsis, multi-organ failure and an ischaemic bowel

Despite being an unscheduled return within 72 hours, she was not escalated for consultant review. Witnesses at the inquest reported that the volume of patients was at a level *"the like of which had never been seen"* and *"current resources are unable to deal with that volume"*. As a result HT's blood test results were not reviewed for 6.5 hours. There was a delay in performing a CT scan.

Narrative conclusion: died from an ischaemic bowel which went undiagnosed.

Lack of/ inadequate risk assessment

AN died of sepsis the underlying causes being necrotising fasciitis and a sacral pressure sore

The hospital screening tool scored the deceased as not at risk of a pressure sore. This was incorrect as he was an immobile type II diabetic which meant his risk was increased and further compounded by his age and medical history. No preventative measures were taken to prevent pressure sores.

Narrative conclusion: the pressure sore was preventable with basic nursing care (which was not provided) and his death was contributed to by neglect.

DS died from a head injury after a fall on the ward

A falls risk assessment was not completed until 12 days after admission. When completed it contained an incomplete medical history. There were errors and omissions in subsequent updates (e.g. physiotherapy advice about mobilisation). There was a lack of communication between different professionals and inaccurate record keeping.

Narrative conclusion encompassing all of these as contributory factors.

Failures in guidelines / treatment strategy

DM (who suffered from Addison's disease) died from an acute adrenal crisis following a hip fracture as a result of a fall

Clinicians failed to appreciate that a patient with Addison's required replacement steroid therapy post fracture in order to prevent such a crisis. Hospital guidelines focused on the presentation of an adrenal crisis and peri-operative matters. The coroner's concerns included lack of prompts on ED clerking for clinicians to check if a patient has Addison's. In addition, many clinicians (including consultants) do not have a well- developed understanding of adrenal insufficiency.

Narrative conclusion: died as a result of acute adrenal crisis – insufficient administration of steroids was a contributory factor.

JM died of a prolonged cardiac arrest, caused by lack of oxygen when she could not be re-intubated following a sudden displacement of her tracheostomy

Coroner's concerns included limited evidence of the introduction and use of comprehensive airway strategies and/ or NAP4 algorithms/ checklists (latter should be available on the difficult airway trolley). They should be familiar to ICU staff and the wider anaesthetic team.

Narrative conclusion: died as a result of a cardiac arrest. Lack of individual planning for tracheostomy displacement (despite it being a known risk) and no plan to ensure the correct equipment or senior help was available if the tube became displaced, made more than a minimal contribution to her death.

Learning from this analysis

Although these reports are all from the acute hospital sector they contain important learning for all healthcare organisations.

- Full and accurate records are essential for both the provision of good patient care and managing risk. In the current pressurised climate of care delivery they become even more important to the continuity of care and managing risk around 'pinch points' such as handover or transfer.
- Communication within and between teams / Trusts is vital. All appropriate information should be given and nothing assumed. The need for full and accurate records is also of relevance here.
- Guidelines should be up to date, understood by everyone in the healthcare team and accessible.
- When investigating patient safety incidents any training needs should be highlighted and implemented and ongoing staff competency on the issues, monitored.
- If something is not achievable due to resource issues, the need for the test/scan should still be documented **and** drawn to the attention of a senior doctor. Transfer to another provider may be required, for example for an MRI scan where cauda equina syndrome is suspected.

A thematic review of Prevention of Future Death Reports

Hospital related deaths

- Be aware of recurring themes in your organisation's PFD reports. The Preventable Deaths Tracker database published by Dr Georgia Richards and her team covering reports and responses from 2019 is a helpful resource.

How Capsticks can help

Capsticks is a national leader in representing both NHS and private healthcare providers as well as medical malpractice insurers. Our dedicated team is renowned for advising on the defence and resolution of clinical negligence claims, inquests, management of complaints and serious incident investigations/inquires, and providing an innovative outsourcing service for claims and inquests handling.

Capsticks can help protect your organisation's reputation and give your staff the support they need in the lead-up to, and during, an inquest. We have one of the largest inquest teams in the country, representing all types of service provider in over 1000 inquests a year.

If you have any queries on the topics discussed, or the impact on your organisation, please contact Philip Hatherall, Georgia Ford, Adam Hartrick or Amy Holden.

PHILIP HATHERALL
PARTNER
0780 969 8321
philip.hatherall@capsticks.com

GEORGIA FORD
PARTNER
0759 024 4700
georgia.ford@capsticks.com

ADAM HARTRICK
PARTNER
0758 401 5202
adam.hartrick@capsticks.com

AMY HOLDEN
PARTNER
0788 975 8995
amy.holden@capsticks.com