Shared Insights

Preparing and delivering organisational learning evidence in the Coroner's Court

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Mara Tonks, Director of Midwifery, University Hospitals of Northamptonshire NHS Group

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University Hospitals of Northamptonshire NHS Group

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Introduction

During this session we explored the Coroner's statutory duty to make a Prevention of Future Death Report, including practical tips on preparing organisational learning evidence for the Coroner and ensuring that your organisation is in the best position to provide assurance to the Coroner that learning has been identified and embedded following a death.

The session was chaired by **Nicola Evans**, Partner at Browne Jacobson.

We were delighted to welcome our three experienced speakers:

Simon Tait, Head of Health, Browne Jacobson.

Mara Tonks, Director of Midwifery, University Hospitals of Northamptonshire NHS Group, who shared her reflections on giving organisational learning evidence effectively and compassionately at inquest.

Susan Jevons, Senior Quality Manager, East Midlands Ambulance Service. Sue spoke about the work she does at EMAS to identify relevant Prevention of Future Death Reports nationally and share the learning from those reports within her organisation, to proactively identify best practice and shape ongoing patient safety improvements within EMAS.

How we can help

Our specialist Advisory and Inquest team have an outstanding reputation for representing organisations at inquests across the country. Located across each of our regional offices, our people are known and well respected by Coroners nationally. We are trusted by clients to provide user-friendly, straightforward advice and excellent representation in court and to support witnesses and organisations through the inquest process from start to finish, having particular regard to reputational impact and prevention of future death strategy.

Our pragmatic and friendly team would be very happy to hear from you/your organisation about any difficulty you are facing.

Please do access and share our free inquest resources, which include a series of Guides and mock inquest films which are available on our webpage and Maternity Services Resource Hub. These include our Guide to Preparing and Delivering evidence of Organisational learning to the Coroner.

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Prevention of Future Death reports (PFDs)

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Coroners have an important patient safety role not just to decide how somebody came by their death but also, where appropriate, to issue a report about that death with a view to preventing future deaths (a PFD Report). The Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths sets out the purpose of a PFD report and is a worthwhile read.

In certain cases your organisation may wish to provide the Coroner with evidence to explain the outcome of any internal investigation and provide assurance that organisational learning has been, or is being, implemented. It is important to emphasise that your organisation should not focus on producing this evidence shortly prior to inquest simply to avoid a PFD Report – learning from a death is something that should start immediately through the usual patient safety and governance channels and should involve the professionals and affected family. The organisation should then be in a position to provide the Coroner with evidence that effective steps have been taken to identify and embed learning by the time you get to the inquest hearing.

PFD Reports are not issued after all inquests – they will only be issued if the Coroner's statutory duty is triggered.

1. Reminder of the Statutory Duty

The Coroner's Statutory Duty is set out in Schedule 5 paragraph 7 Coroners and Justice Act 2009 , which states that the Coroner **must** issue a PFD where:

- The Coroner has been **conducting an investigation into a death**.
- Something revealed by the investigation gives rise to a concern that **there are circumstances creating a risk that other deaths will occur in the future**.
- In the Coroner's opinion **action should be taken** to prevent the continuation of such circumstances or to eliminate or reduce the risk of future deaths.

The risk **does not have to have been causative of the death** under investigation. For example, a failure in handover or escalation may not have made any difference in the death which the Coroner is investigating but the Coroner may be concerned that it could cause deaths in the future if action isn't taken to resolve ongoing issues with handover or escalation on the ward in question. That would be enough to trigger the statutory duty even though the risk did not actually contribute to the death under investigation.

Revised Chief Coroner's Guidance No.5 states that when considering whether the statutory duty to make a PFD Report is triggered:

- Coroners should focus on the current position at the date of the inquest and not things as they were at the date of death (paragraph 7).
- The Coroner should consider evidence and information about relevant changes made since the death or plans to implement such changes.
- If appropriate action has already been taken to address the risk of future deaths by the time of the inquest hearing then the statutory duty will not be triggered.
- Action may not have been fully implemented at the time of the inquest but the Coroner will hear evidence of ongoing action and future action plans. The Chief Coroner's Guidance states that whether a PFD Report is required in these cases will be highly fact sensitive and depend on the circumstances of the case. Relevant factors are the nature of the commitment to future action, evidence in support of that action and the Coroner's assessment of the organisation's commitment to addressing the area of concern. In short, if there are outstanding actions, you need to evidence that there is an actual commitment to change.

Prevention of Future Death reports (PFDs)

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2. Evidencing Learning and Change

Where your organisation may be at risk of a PFD, providing evidence of organisational learning at an inquest is important. We recommend that you:

- Identify at an early stage who is going to lead on the learning in the case.
- Consider how will learning evidence be presented to the Coroner.

In complex cases where there have been shortcomings in care an organisation will often disclose written evidence in advance of the inquest to provide the Coroner with assurance that their statutory duty to issue a PFD is not triggered. This may take the form of an internal investigation report or an organisational learning report from someone senior, setting out relevant changes made since the death or plans to implement such changes.

For further information, see our Guide to preparing and delivering organisational learning evidence at inquest.

3. If the Coroner does issue a PFD report, what will this look like?

There is a template for PFD reports in the Chief Coroner's Guidance, which also states that the PFD Report should set out details of the Coroner's concerns in neutral and non-contentious terms and:

- Should **not** contain "forceful" language such as *"I am disgusted"*
- It is not for the Coroner to dictate what action should be taken or prescribe solutions (paragraph 24 CCG). That remains a matter for the person or organisation to whom the PFD is directed.

4. Who will a PFD Report be sent to?

The PFD report will be sent to the person or authority that has the power to take action to reduce the risk of future deaths. It should be sent within 10 days of the inquest,

There are some exceptional cases where a PFD concern is identified before the inquest hearing has even taken place, and if that happens then the PFD Report should be sent within 10 days of the concern being identified by the Coroner.

Coroners also often share PFD reports with regulators such as the CQC, the Department of Health, the Health and Safety Investigation Branch, HM Inspectorate of Prisons etc.

A response must be submitted to the Coroner within 56 days of receipt, although there is no formal sanction if the organisation fails to respond.

The PFD Report and response are public documents which will be published on the Chief Coroner's website.

5. Is there an appeal process?

There is no appeal process to challenge a PFD Report and no system of audit to check the quality of PFD reports issued by Coroners. However if you think that the Coroner has misunderstood the evidence or has got something fundamentally wrong then you can state this in your response.

6. Top Tips

- Don't just submit an action plan. Scrutinise the action plan and test the evidence that action points have been embedded and are effective.

  For example – if your action point is to update CTG fresh eyes review stickers following a maternity death

  - Check that the sticker been implemented (when)
  - Have staff been trained on it – all staff? New staff? Locum staff?

(continued overleaf)

Prevention of Future Death reports (PFDs)

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- Has implementation been audited? Did the audits check
  - That the new stickers are being used consistently in all areas.
  - That the new stickers are being used appropriately i.e. have you audited the quality of the assessment on the stickers?
  - That the change has been effective i.e. you can demonstrate improved outcomes as a result. The Coroner will ask “so what” – making a change is not enough, you need to present evidence that this change has been effective in driving meaningful improvements to patient outcomes. If this change had been in place at the time of the death under investigation, what difference would that actually have made?
- In cases where there are ongoing / incomplete actions which have not yet been implemented – set out a clear timetable and commitment to delivering on the action plan.
- Go through the action plan 2-3 weeks before the inquest and provide an update to evidence that it is a continuing process but the organisation has a genuine commitment to implementation.
- What if something only comes to light at the inquest?
  - Commit to dealing with it as soon as possible. Coroner may be prepared to accept that, but equally may simply do a PFD
  - Consider inviting Coroner to defer decision on the basis that there will be a comprehensive update

Ensure factual witnesses are involved in identifying learning and preparation of organisational learning evidence. The Coroner will not simply accept that change has been embedded because a senior manager says so – the Coroner is likely to ask the factual witnesses to describe their experience of those changes in day to day practice. Part of your pre-inquest preparation should be to test the organisational learning evidence with the factual witnesses to ensure that the changes have been effectively embedded on the frontline.

7. Recurring themes

The Chief Coroner’s Guidance is clear that Coroners will consider local trends and the context of any other PFDs sent to your organisation. Coroners will be looking for themes and will be aware of previous / similar cases.

You can check for previous PFDs on similar issues or involving your organisation by searching here PFD Tracker using keywords to narrow your search. You can search by name of organisation and by individual Coroner.

Common themes we see are record keeping, communication/escalation and the discharge process. Increasingly, PFDs are focussing on the organisation’s investigation process, including how long it has taken to investigate a death. Delay in completing internal investigations can be a PFD issue in and of itself.

8. PFDs are not meant to be punitive

A PFD Report is not a punishment – they are made for the benefit of the public. However, if an organisation has already made or is committed to making changes then it is obviously preferable to provide the Coroner with evidence to demonstrate this and avoid a PFD if possible as these:

- Can bring negative publicity through media coverage.
- May have an impact upon public confidence– essentially the Coroner is saying there is an ongoing public safety risk which still exists many months or even years after the death and creates a risk that more deaths could happen in the future.
- Regulators are notified and this often leads to follow up. We have seen inquests where PFDs have been sent to the CQC, which have in turn been followed by CQC prosecutions.

Reflections on giving compassionate and effective evidence to the Coroner on organisational learning

Mara Tonks, Director of Midwifery, University Hospitals of Northamptonshire NHS Group

Reflections on giving compassionate and effective evidence to the Coroner on organisational learning

Mara shared her experience of giving evidence at inquest. There was a gap of several years between the death and the inquest and a lot of work was done by the Trust in that time because of a strong desire on the part of the whole team to learn from what had happened so no other family had to go through the same thing. The organisation was committed to learning from the death and a lot of time was committed to ensuring that this did happen.

The effectiveness of changes was tested through audits, which demonstrated incremental improvement as a result of learning having been truly embedded within the service. In addition, Mara personally worked a series of night shifts to understand the differences on the ground at night.

This was not about just avoiding a PFD Report. Mara personally was involved in the investigation from the outset and was absolutely committed to ensuring that no other family would go through the same thing. This meant committing time and resources from the outset to learn what had gone wrong and work with the clinical teams to put a plan in place to address this to remove the risk that the same thing would happen again in the future.

From the outset, Mara involved the baby's parents. She wanted them to know that staff were absolutely committed to openness, transparency and making sure that the same issues were not repeated:

- Mara met with the family as soon as appropriate and continued to meet with and communicate with the family throughout the long inquest process.
- Be open about the organisation learning lessons to prevent recurrence of the incident in the future.
- Maintain contact about the process.
- Should be a partnership, working with them.
- Be open about cultural change needing to happen.
- Explain steps taken for learning and change.
- Commit to investing the time to ensure the learning is completely embedded.
- Most families are not used to being involved in a legal process, especially not after a life-changing event. Signpost to advocacy services such as AvMA and the Law Society. Mara's Trust does that in the duty of candour letter and also signposts access to free psychological therapy in case it is required.

Proactive use of PFDs issued to other organisations for learning

Susan Jevons, Senior Quality Manager, East Midlands Ambulance Service

Proactive use of PFDs issued to other organisations for learning

Susan explained that she sees and uses PFDs as a learning tool.

She has signed up to receive every PFD issued in England and Wales. You can sign up here for those email notifications. After reviewing the PFDs and looking in particular at those relevant to ambulance Trusts and those where there may be learning relevant to EMAS Sue then shares the relevant PFD Reports and responses with the Trust's Incident Review Group. This is a group made up of various professionals, including Directors and quality leads which meets twice weekly.

In the Incident Review Group, the highlighted PFD Reports are discussed to see if these identify any issues relevant to EMAS. The Group discuss whether these identify a need to review/change EMAS policies or procedures or if there is any learning to be taken to avoid harm to EMAS patients.

Everything discussed is documented and saved and can be searched by theme.

If relevant learning is identified from national PFDs then this is addressed by EMAS.

One example is another ambulance Trust received a PFD which flagged the use of two triaging systems being used across the country, causing inconsistencies. Ambulance Trusts cover vast areas and sometimes different Trusts operate in the same place. As a result EMAS took the initiative to change their triaging system to match the one the neighbouring Trust was using, and to inform the Coroner that this had been done.

PFDs offer a real opportunity to learn from deaths – all PFDs issued nationally and the responses are published here and you can search by keyword to look at those relevant to your practice area or which have been issued to your organisation or by your local Coroner.

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