# WRITTEN STATEMENT

# BY

# THE WELSH GOVERNMENT

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| **TITLE**  | **Prevention of future deaths reports in Wales** |
| **DATE**  | **19 March 2024** |
| **BY** | **Eluned Morgan MS, Minister for Health and Social Services** |

The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Prevention of Future Deaths (PFD) Report to an individual or organisation where the coroner believes that action should be taken to prevent further deaths. A prevention of future deaths report is distinct from an inquest verdict. The purpose is to prevent the occurrence or continuation of circumstances that create risks that other deaths will occur or to eliminate or reduce the risk of death created by such circumstances thereby seeking to prevent future deaths.

Any loss of life is extremely sad under any circumstances, but when a death is preventable and deemed to have been caused or contributed to by actions of the health service, it is essential that NHS bodies and governments learn from these incidents to improve health and care services and take all necessary action to ensure these circumstances cannot be allowed to be repeated and prevent future deaths.

In 2023, coroners across England and Wales issued around 35% more prevention of future deaths reports than 2022 - the highest number since 2019. The COVID-19 pandemic had a significant impact on the coronial system and coroners in England and Wales have taken steps to deal with any outstanding cases and help the system to recover as quickly as possible.

In Wales, coroners have issued prevention of future deaths reports regarding NHS Wales bodies in relation to 41 deaths since 1st January 2023. In some cases, more than one report was issued in relation to the same death or issued jointly to more than one NHS Wales body and/or other organisations outside NHS Wales.

In that period, 27 prevention of future deaths reports were issued to Betsi Cadwaladr University Health Board; 10 to the Welsh Ambulance Services Trust; six to Aneurin Bevan University Health Board; two to Swansea Bay University Health; one to Cardiff and Vale University Health Board and one to Health Education and Improvement Wales (HEIW).

As Minister for Health and Social Services, I have been issued with six prevention of future deaths reports since January 2023, relating to a range of NHS Wales services and public health concerns.

Of the 27 prevention of future deaths reports issued to Betsi Cadwaladr University Health Board since January 2023, all but three relate to deaths that occurred before the escalation to special measures, including one death which occurred in 2016.

Whilst Betsi Cadwaladr UHB is the largest health board in Wales, with just over 20% of the all-Wales population, the number of prevention of future deaths reports it has received over recent years is of significant concern. I have highlighted my concerns in previous statements to Members of the Senedd, and in quarterly progress [reports](https://www.gov.wales/betsi-cadwaladr-university-health-board-bcuhb-special-measures-2023) on special measures arrangements over the past 12 months.

I meet regularly with the chair and the wider board, where I ask some very challenging questions about how they plan to make the necessary improvements to patient safety, experience, and outcomes to provide the people of north Wales with the reassurance that their health services are safe. The Deputy Minister also chairs a quarterly meeting with the health board to seek assurance about mental health, with a specific focus on patient safety concerns.

I have been clear with the health board that they need to understand the root causes of incidents and address the systemic issues that are apparent in the prevention of future deaths reports issued to the health board. These are:

* The quality of investigations and effectiveness of actions;
* The quality of treatment plans and continuity of care impacted by lack of an integrated electronic health record systems; and
* The impact of delays in the health and social care system on the timeliness of responses by the Welsh ambulance service.

I have received assurances that the health board is fully aware of the issues raised by coroners and is taking this matter extremely seriously. The chief executive and medical director are working closely with both north Wales coroners to ensure that their concerns are addressed, and they are committed to improving their processes for investigating and learning from incidents.

The health board has commenced work to make service improvements including improving the flow of patients through and out of its hospitals, and improvements to the digital infrastructure. It has also established work to improve its investigation process and improve the assurances it can take on existing action plans.

The health board has established a learning from investigations programme, which is led by the medical director, with direct oversight from the chief executive and the wider executive team and reports directly to the Quality, Safety and Experience Committee with a clear escalation process in place. Whilst the health board has made improvements to its inquest process and is making changes to its incident and mortality processes, there are a number of cases yet to be listed by coroners, going back over several years. The health board estimates that there are 350-400 cases awaiting listing for inquest. These cases go back to 2019 although the majority relate to 2022 onwards.

The health board is undertaking a review of all cases that are open to the coroner with the process taking corrective action where necessary, and recommending further changes to the current process for future investigations and mortality reviews.

I have also met with both of the north Wales senior coroners, when they have expressed their frustration about an historic lack of learning within the organisation and poor preparation for inquests. In response to these serious concerns, my officials commissioned an independent review of patient safety concerns. The [report](https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/independent-review-of-concerns-raised-around-bcuhb-patient-safety/) from this review is with the health board for action and the NHS Executive will be working with the board to ensure that the quality and safety governance systems and procedures respond to these issues.

The new duties of quality and candour set out new requirements for NHS Wales bodies to be open and transparent with service users when they experience harm whilst receiving health care, to establish effective quality management systems that focus on learning and early interventions to prevent harm, and to consider how their decisions will improve health care in the future.