6/10/25, 10:45 PM PFD Reports Conference Poster

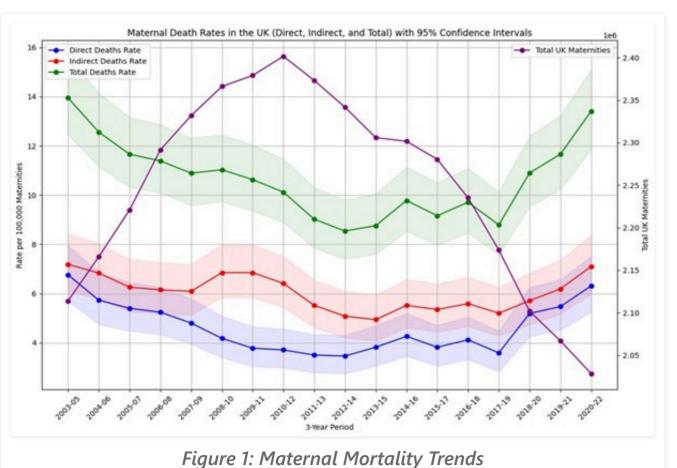
# What do Prevention of Future Death Reports tell us about maternity care in UK hospitals?

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## PREVENTION OF FUTURE DEATH (PFD) REPORTS

**Introduction:** Despite UK government goals to reduce maternal deaths by 50% by 2025, maternal mortality rates increased by 3% between 2010-2012 and 2018-2020 (excluding COVID-19 deaths).



**What are PFD Reports?** Independent judicial assessments issued by coroners following inquests into unexpected deaths, providing cross-organisational perspectives on patient safety issues.

**Research Question:** What do Prevention of Future Death reports reveal about the key safety themes and system-level failures in UK maternity care, and how can automated multi-framework analysis enhance patient safety intelligence?

#### DATA

**51** UK
PFD Reports Judiciary Data

2014-2025 Study Period

**Data Collection Method:** Specialised web scraping tool extracted PFD reports from UK Judiciary website using maternal healthcare search terms including: midwifery, birth, baby, maternal, infant, obstetrics, neonatal, perinatal, pregnancy, postnatal, antenatal, maternity, stillbirth, antepartum, foetal/foetal.

**Data:** Publicly accessible coroners' reports from UK Judiciary website **Ethics:** No ethical approval required for public data analysis

#### FRAMEWORK DEVELOPMENT

## **Three Complementary Frameworks:**

- **1. Safety Intelligence Research framework (SIRch):** Sociotechnical categories based on SEIPS model person factors (staff performance, decision errors), job/task factors (care planning, monitoring), organisation factors (team culture, communication), technologies & tools (equipment issues), environment factors (physical layout, external pressures).
- 2. Black maternal health framework: Equity dimensions from House of Commons Women & Equalities Committee report communication (dismissed concerns), fragmented care (poorly coordinating providers), informed consent/agency (informed decisions), dignity/respect (discrimination faced), care quality issues (microaggressions, racism), socioeconomic factors and deprivation.
- **3. Extended safety framework:** Emerging themes from textual analysis medication safety, diagnostic testing & specimen handling, time-critical interventions, human factors & cognitive aspects, service design & patient flow, emergency preparedness, staff wellbeing & burnout, electronic health record issues.

**Triangulation approach:** Simultaneous analysis across three frameworks enables comprehensive coverage whilst revealing framework-specific blind spots in safety investigation and maintaining analytical rigour.

#### TECHNICAL ARCHITECTURE

## **Enhanced ML Pipeline with Implementation Details**

Automated Web
 Scraping

BeautifulSoup4 + ratelimited batch processing
with PDF extraction &

regex-based metadata

parsing

Advanced Data
Preparation

Multi-file merging, recordlevel deduplication,
temporal extraction,
missing value imputation
& content validation

Interactive dashboards
with data quality
validation, distribution
analysis & cluster
evaluation

Multi-Framework
Concept Annotation
Bio\_ClinicalBERT-based
semantic analysis with
768D contextual
embeddings, generating
thematic annotations
across three frameworks

simultaneously

Theme Identification

Dual-component scoring

system (70% semantic

similarity + 30% keyword

density) with contextual

window analysis &

confidence thresholds

(High ≥0.8, Medium 0.65-

0.8, Low < 0.65)

Advanced Analytics
Dashboard
Interactive Plotly
dashboards analysing PFD
reports by year, coroner
area, framework
distribution, theme cooccurrence networks,
correlation matrices with

multi-format export

## PFD VS HSIB COMPARISON

PFD reports (n=51)		HSIB reports (n=188)	
Medication Safety (*)	78.4%	Communication Factor	84.6%
Staff Performance (+)	78.4%	Teamworking	82.4%
Team Culture (+)	74.5%	Assessment Investigation	79.8%
Informed consent/agency (-)	66.7%	Patient physical characteristics	62.8%
Diagnostic Testing & Specimens (*)	64.7%	Staff-Slip or Lapse	52.7%
Patient Record Attendance (+)	62.7%	Escalation/Referral Factor	51.6%
Physical Layout & Environment (+)	56.9%	National & Local Guidance	48.9%
Staff Decision Error (+)	41.2%	Technologies & Tools-Interpretation	47.9%
Peer Support & Supervision (*)	39.2%	Obstetric Review	47.3%
External Societal Factor (+)	39.2%	Staff Decision Error	47.3%

**House of Commons Women & Equalities Committee themes in PFD reports:** informed consent/agency ranked 4th (66.7%), followed by guidance gaps (37.3%), care quality issues (31.4%), and communication (29.4%).

### **CONCLUSIONS & IMPACT**

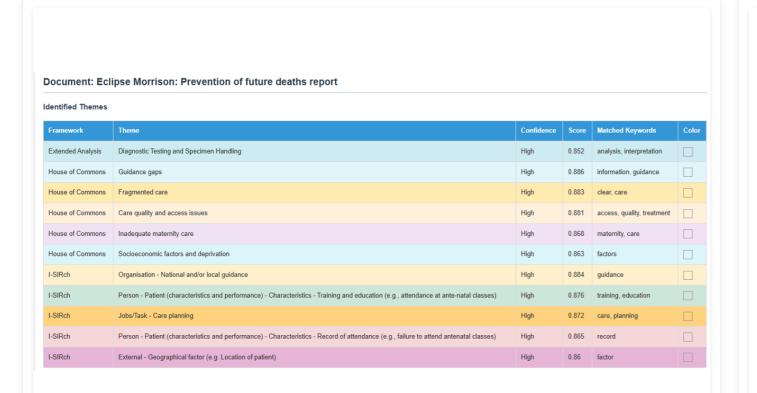
**Clinical implications:** PFD reports identify system-level failures not apparent through individual healthcare provider investigations, providing unique insights that complement existing incident reporting systems.

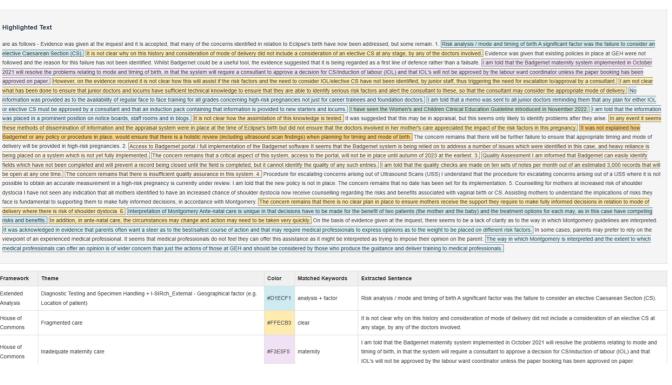
**Research impact:** This first systematic analysis of maternity-related PFD reports establishes a novel data source for patient safety intelligence. The findings reveal priority areas spanning clinical practice, organisational culture, and patient rights, providing evidence for comprehensive safety improvement initiatives across UK maternity care systems.

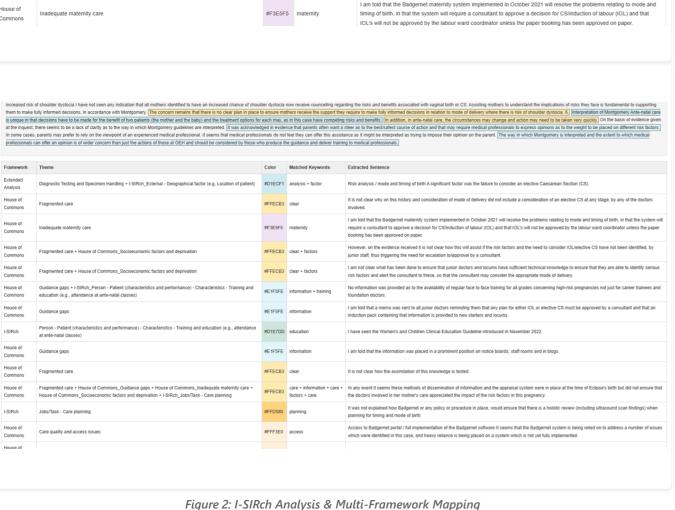
**Future directions:** Development of a unified framework applicable across healthcare specialities including maternity, mental health, and other clinical domains to enable cross-speciality learning and comparative safety analysis.

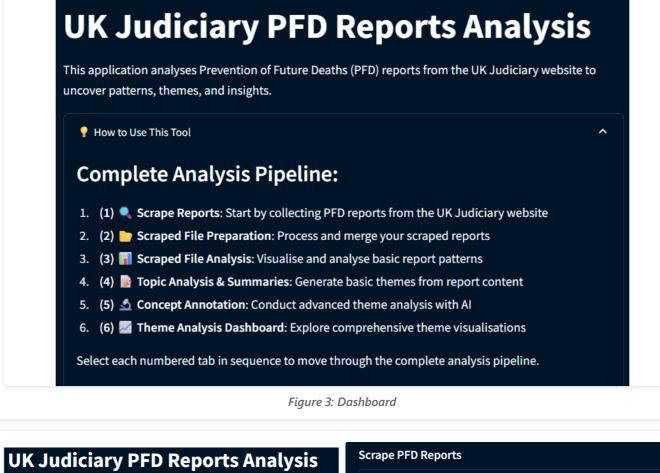
**Study Limitations:** Ethnicity data was not available as PFD reports focus on systemic issues rather than demographic characteristics.

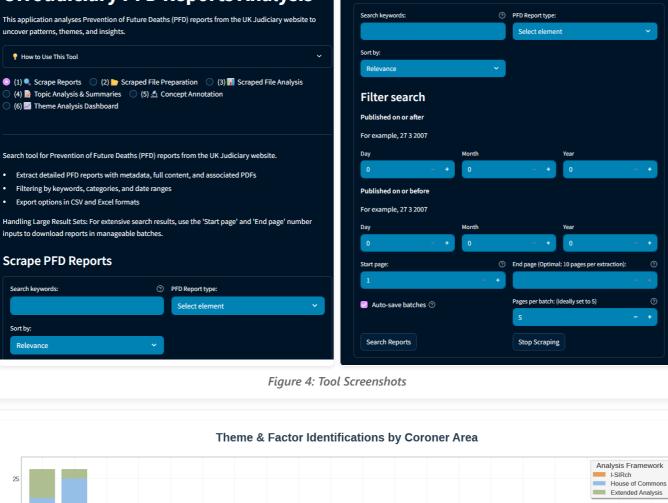
## RESEARCH RESULTS & ANALYSIS

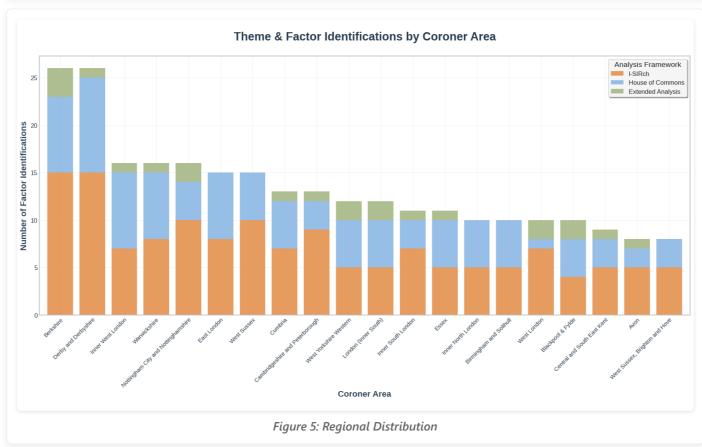


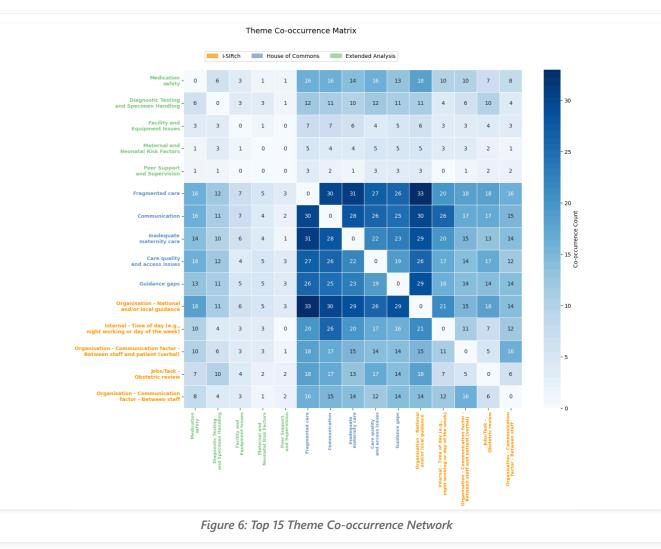


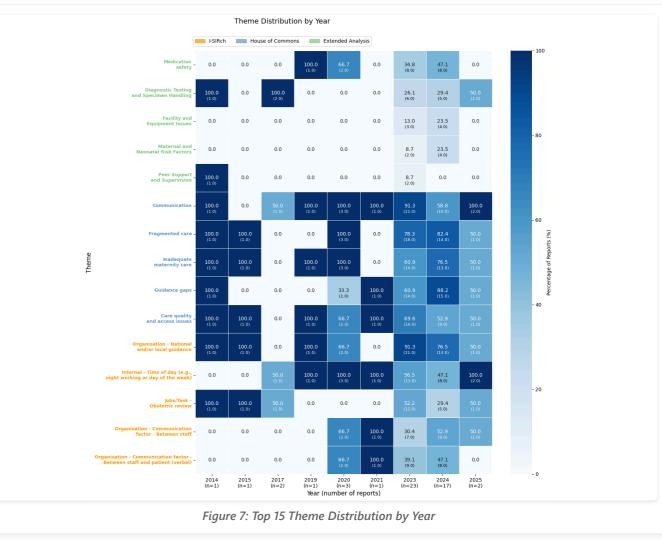












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