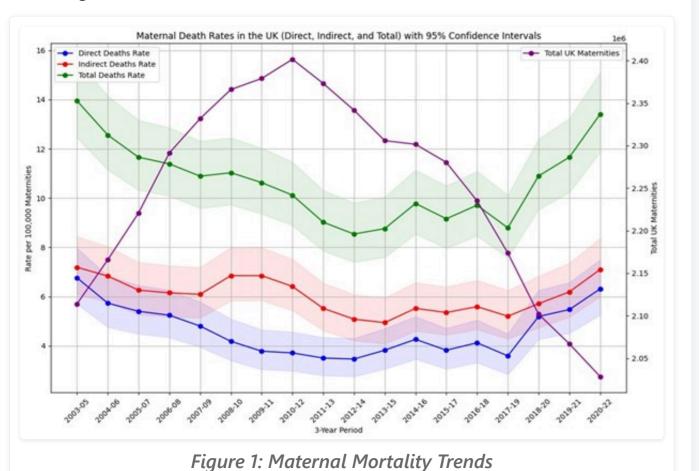
6/10/25, 10:48 PM PFD Reports Conference Poster

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 2014-2025 **PFD Reports Judiciary Data** 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:

PFD VS HSIB COMPARISON

Medication Safety (*)

Staff Performance (+)

Informed consent/agency (-)

Patient Record Attendance (+)

Peer Support & Supervision (*)

External Societal Factor (+)

Staff Decision Error (+)

Diagnostic Testing & Specimens (*)

Physical Layout & Environment (+)

Team Culture (+)

PFD reports (n=51)

- 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.

HSIB reports (n=188)

Communication Factor

Assessment Investigation

Escalation/Referral Factor

National & Local Guidance

Technologies & Tools-Interpretation

Staff-Slip or Lapse

Obstetric Review

39.2% Staff Decision Error

Patient physical characteristics

Teamworking

84.6%

82.4%

79.8%

62.8%

51.6%

48.9%

47.9%

47.3%

TECHNICAL ARCHITECTURE

Enhanced ML Pipeline with Implementation Details

Advanced Data

Automated Web Scraping

BeautifulSoup4 + ratelimited batch processing with PDF extraction & regex-based metadata

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

Multi-Framework

Dual-component scoring system (70% semantic similarity + 30% keyword density) with contextual

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

multi-format export

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

Concept Annotation Bio_ClinicalBERT-based semantic analysis with 768D contextual embeddings, generating thematic annotations across three frameworks simultaneously

window analysis & confidence thresholds (High ≥0.8, Medium 0.65-0.8, Low < 0.65)

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.

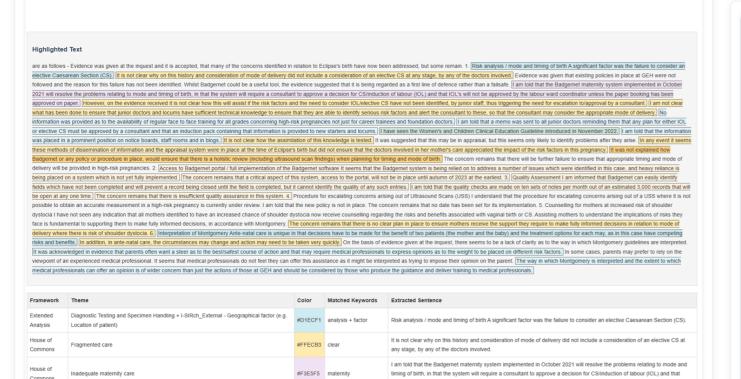
RESEARCH RESULTS & ANALYSIS

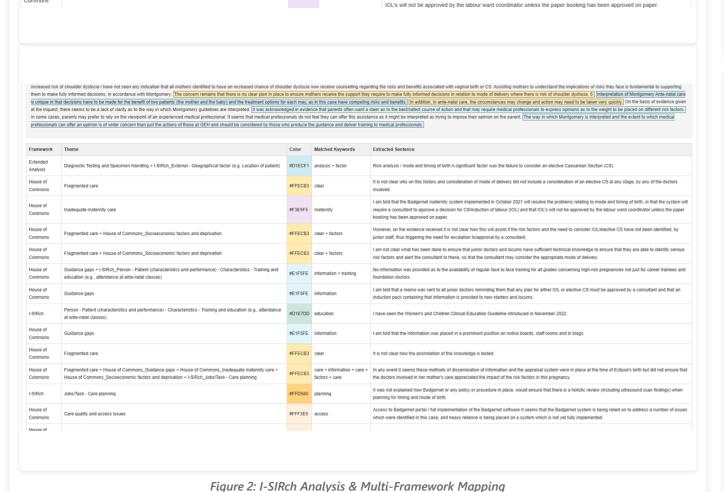
House of Commons Women & Equalities Committee themes in PFD reports:

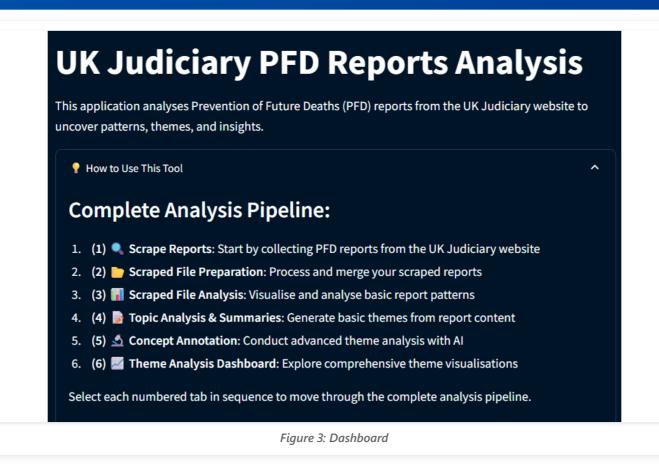
informed consent/agency ranked 4th (66.7%), followed by guidance gaps (37.3%),

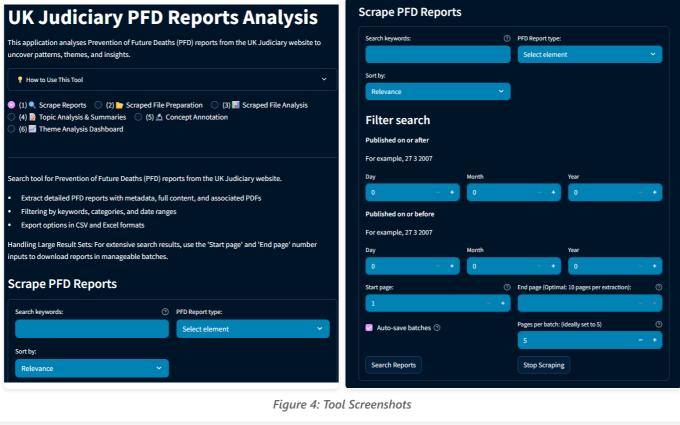
care quality issues (31.4%), and communication (29.4%).

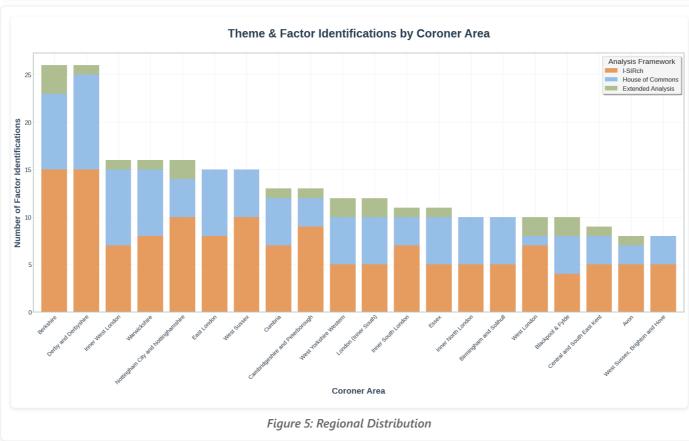


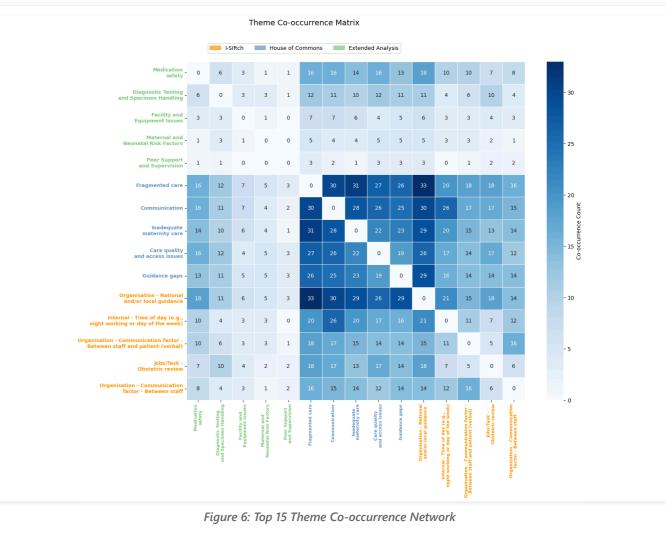


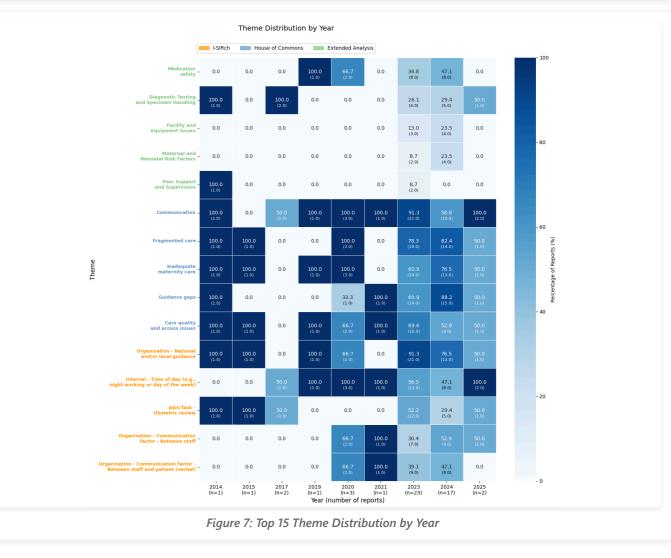












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