Liverpool & Wirral Coroner Area

Annual Report 2020

Contents

LIVERPOOL & WIRRAL CORONER AREA
ANNUAL REPORT 2020

Background Information

On 2nd April 2015 The Liverpool and Wirral Coroner Areas merged to form one jurisdiction. Liverpool City Council is the lead authority working closely with Wirral Council.

The Coroner Area of Liverpool and Wirral is a large geographical area of 26,884 Hectares with a population of around 800,000. The area is a part of the Liverpool City Region which is a world class centre of excellence in commerce, culture, education and industry and as such the area has a significantly larger workforce than resident population. We work closely with two registration districts, Liverpool Register Office and Wirral Register Office.

The Area is a major transport hub with main arterial roads and motorways, Liverpool John Lennon Airport, Main Line Rail links (Lime Street & Birkenhead Train Stations), Mersey Tunnels, Mersey Ferry, Ports and an Ocean Liner terminal.

There are three Universities, two cathedrals, two large local prisons and a diverse multi-ethnic multicultural harmonious population. The area has two Premier League football teams, one Football League football team and a championship golf course.

The area is served by three large district general teaching hospitals namely:

Liverpool University Teaching Hospital
University Hospital Aintree
Wirral University Teaching Hospital

and there are five tertiary centres of healthcare excellence namely:

Liverpool Heart & Chest Hospital
Liverpool Children's Hospital (Alder Hey)
Liverpool Women's Hospital
Clatterbridge Hospital
The Walton Centre for Neurology & Neurosurgery

There are also two adult and two children's hospices. The jurisdiction also contains mental health units with patients detained under the Mental Health Act 1983.

The Role of the Coroner

A Coroner is an independent judicial office holder, appointed by the local authority. They investigate deaths that have been reported to them if it appears that:

- The death was violent or unnatural
- The cause of death is unknown, or
- The person died in prison, police custody or another type of state detention.

The Coroner's service and Court is at:

Gerard Majella Courthouse, Boundary Street, Liverpool, L5 2QD

The Court and Offices are dedicated to the Coroner's Service; however, they are conveniently co-located with the Emergency Planning Team and the Child Death Overview panel. There are lawned areas, a garden, secure staff parking, public parking, a separate jury retiring building, the facility to run up to three courts, a vulnerable witness room, Video-conferencing, five advocate's conference/meeting rooms, a waiting room and an excellent Coroner's Court Support Service.

All coroner's support staff are located in the same building. There is an administrative team of four local authority officers led by the Chief Clerk and twelve Merseyside Police Coroner's Investigative Officers, with their own manager who are from time to time supplemented by serving police officers for investigative duties.

Coroners

In the Liverpool & Wirral Coroner Area there is a Senior Coroner and Area Coroner, both full time, and there are currently nine Assistant Coroners (three of which sit regularly, two are Coroners in the neighbouring Coroner Area – Sefton, St Helens & Knowsley, three are now Senior Coroners in different Coroner Areas and one is a recently retired Senior Coroner).

Our duty

To put families at the heart of the service and provide a professional, sensitive and caring approach to meet the needs of bereaved people who come into contact with the Coroners Service.

Workload

In 2020 there were 3,311 reported deaths. This resulted in 735 inquests being opened in 2020 and a total number of 821 inquests being concluded in 2020.

There is a high inquest rate for the number of deaths reported, however this is the result of a post-mortem examination rate of 34% in 2020 (average of 39% nationally) and an average inquest conclusion time of 11 weeks from the death report (average of 27 weeks nationally). Up to 25% of inquests are concluded based on clinical history and exclusion of unnatural causes as opposed to invasive autopsy. This enables the limited resources to be targeted on those unnatural and state detention deaths which require the most investigation.

Less invasive autopsy is available where appropriate as an adjunct to conventional death investigation in accordance with Chief Coroner's guidance and advice from the Royal College of Pathologists and the Royal College of Radiologists. This enables the limited resources to be targeted on unnatural and state detention deaths, our core statutory duty, which require the most investigation.

In Liverpool and Wirral all directions for investigations opened are timetabled as to when evidence should be filed and dates are set, such as when an investigation will be reviewed, or an inquest opened, or an inquest will be concluded. These directions can only be set by a Coroner Office holder. This method of working ensures that inquests are dealt with in a timely and efficient manner.

Covid 19 Pandemic

The government passed the Coronavirus Act 2020 which introduced temporary easements to death management and affected the way deaths have been reported to Coroners. It should have resulted in a reduction in the number of deaths reported however this has not been the case.

In March 2020 the effects of the start of the pandemic started to be felt within the Coroner's Service. Initially this was an increase in the reported number of deaths alongside dealing with an increased number of enquiries from medical practitioners who were unsure of the change in legislation.

As the months progressed, and to date now, the effects of the pandemic are even greater to the Coroner's Service both in a workload and financial sense. The increase in cases are not Covid related but pandemic related. There has been a noticeable increase in the number of unnatural deaths such as suicides, drug and alcohol related deaths resulting in an increase of post-mortems and other analysis to determine the cause of death.

The communication between people ill in hospital and their families has not been ideal therefore this has resulted in more detailed investigation needed as families need answers as to the care and treatment their loved one received in hospital prior to their death. This has created extra pressure on the team dealing with bereaved families as well as extra financial costs to the service.

Throughout the pandemic, including national lockdowns, the Coroner's Service has remained open and held inquests daily in open court. For the first national lockdown, complex inquest cases with multiple witnesses were temporarily adjourned however from September 2020 the Court had installed screens and upgraded the IT equipment in the courtrooms to enable the building to be Covid-secure and for semi-virtual inquests to be heard in Court enabling a limited number of people in court and for others to attend virtually via MS Teams.

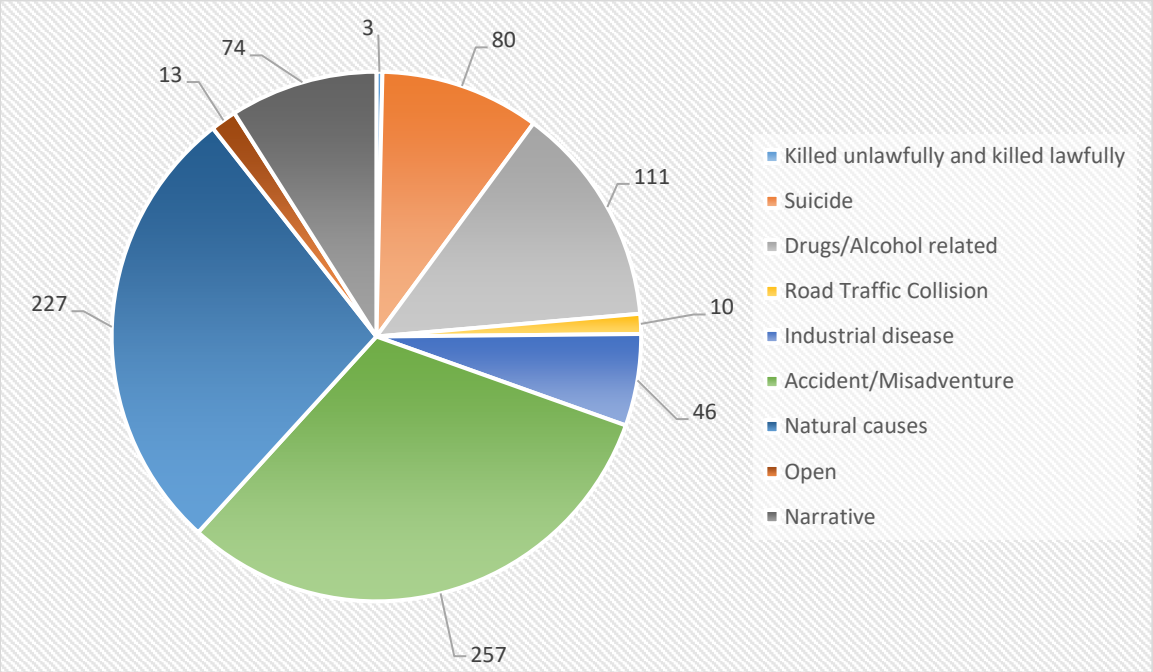
Jury cases however have been more difficult to hold with social distancing measures and so as at September 2021 there is a backlog of 33 jury cases and over 10 complex non-jury cases (lasting more than 3 full days with multiple witnesses giving evidence) which will need to be listed and heard over the following 2 - 3 years. The average jury case is 2 weeks long. From September 2021 the court has listed at least one jury case per month, in some cases 2, every month for the next 18 months, to try and work through the backlog.

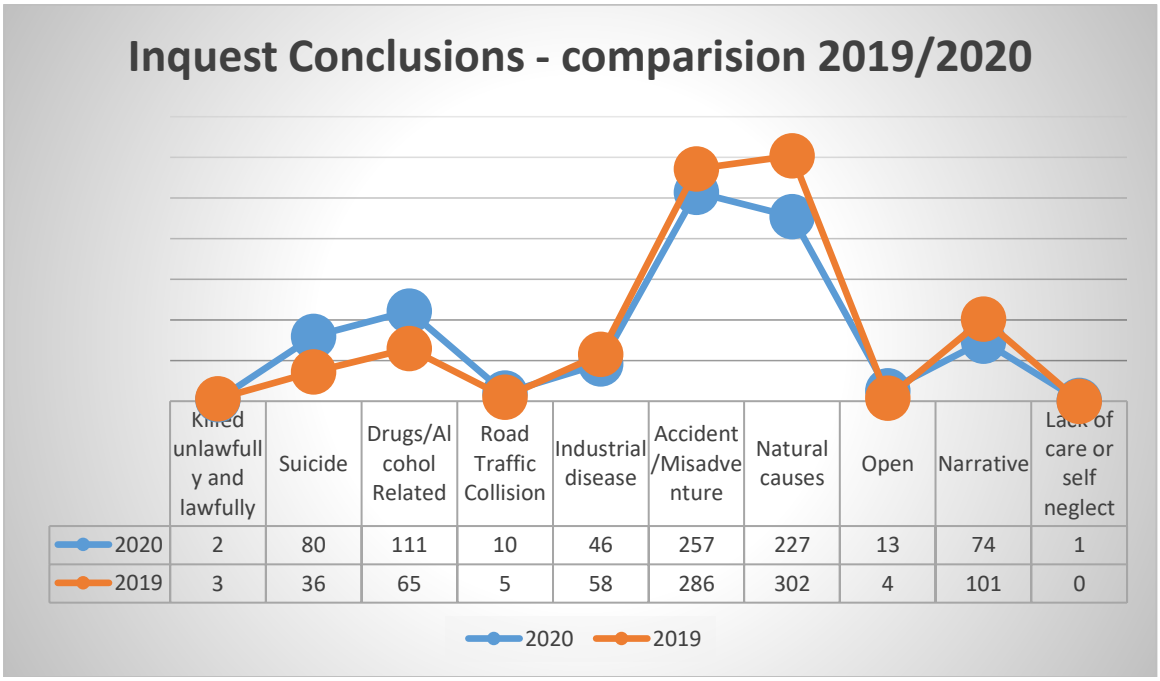
The pandemic has put a heavy burden on the service and will continue to do so for the foreseeable future.

STATISTICS

Key findings from 2020

22% of deaths reported in 2020 resulted in an inquest being held. The breakdown of the 821 inquest conclusions were as follows:





	Killed unlawfully and lawfully	Suicide	Drugs/Alcohol Related	Road Traffic Collision	Industrial disease	Accident/Misadventure	Natural causes	Open	Narrative	Lack of care or self neglect
2020	2	80	111	10	46	257	227	13	74	1
2019	3	36	65	5	58	286	302	4	101	0

Liverpool & Wirral Coroner Area – 2020 Comparison With 2019

REPORTED DEATHS

Reported deaths 1st January 2020 to 31st December 2020	3311
Reported deaths 1st January 2019 to 31st December 2019	3444

INQUESTS

Inquests concluded from 1st January 2020 to 31st December 2020	821
Inquests concluded from 1st January 2019 to 31st December 2019	860
Inquests opened from 1st January 2020 to 31st December 2020	735
Inquests opened from 1st January 2019 to 31st December 2019	829

POST MORTEMS

Number of deaths reported that resulted in a PM in 2020	1124	(34% rate)
Number of deaths reported that resulted in a PM in 2019	1075	(31% rate)

JURY INQUESTS

Number of inquests held with a jury in 2018	4
Number of inquests held with a jury in 2019	5

TIME TAKEN TO CONCLUDE INQUESTS

2020

% of inquests concluded within 1 month in 2020	56%
% of inquests concluded within 3 months in 2020	70%
% of inquests concluded within 6 months in 2020	94%

2019

% of inquests concluded within 1 month in 2019	64%
% of inquests concluded within 3 months in 2019	79%
% of inquests concluded within 6 months in 2019	96%

The statutory guidance is that an inquest should be held within 6 months of the date of death.

Performance

Performance management is critical to maintain an efficient and effective Coroner's Service.

2020 comparison with neighbouring Coroner Areas

Area	Deaths reported	Post-mortems	Post-mortem rate	No. of inquests	Average inquest waiting time
Liverpool & Wirral	3311	1124	34%	735	11 weeks
Sefton, St Helens & Knowsley	2410	772	32%	340	22 weeks
Cheshire	2721	1486	55%	581	21 weeks
Manchester City	2644	1274	48%	659	47 weeks

Coroner Areas which have a prison within their boundary will have to hold jury inquests for unnatural deaths, which inevitably lengthen the time taken to conclude these types of complex inquests.

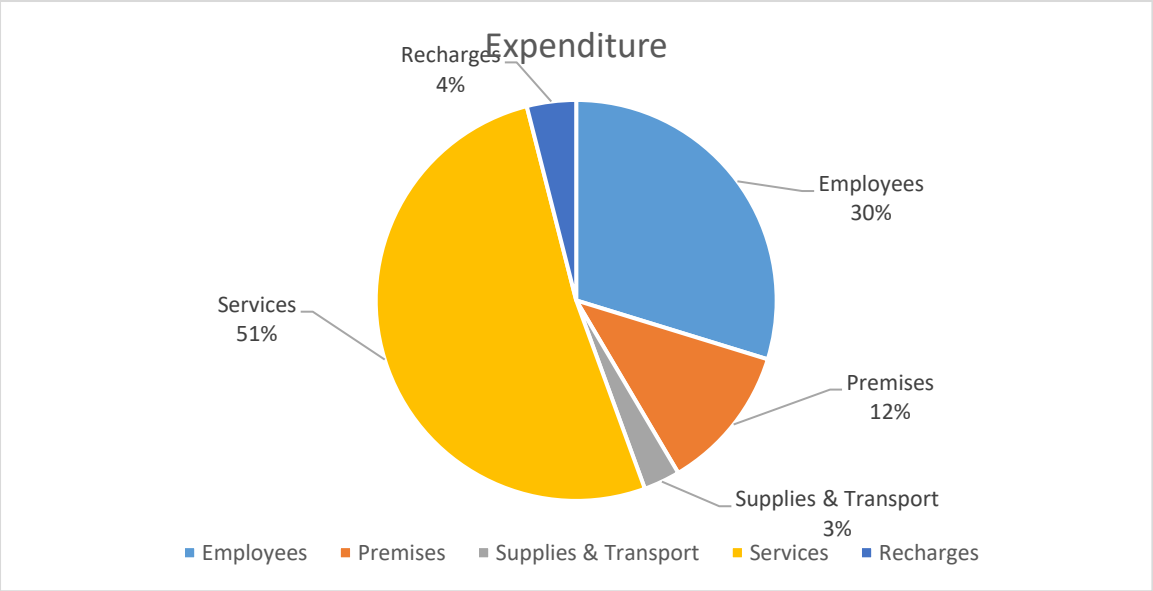
2020 comparison with Coroner Areas of a similar demographic

Area	Deaths reported	No. of Prison deaths	Post-mortem rate	No. of inquests	Average inquest waiting time
Liverpool & Wirral	3311	17	34%	735	11 weeks
West Yorkshire East District	3814	35	33%	683	21 weeks
Birmingham & Solihull	5593	9	29%	794	10 weeks
Manchester City	2644	10	48%	659	47 weeks

Budget

The gross expenditure outturn for 2020/2021 for the Liverpool & Wirral Coroner Services was £1,903,184. The recharge ratio according to population is 63% Liverpool City Council, 37% Wirral Council. Therefore, the cost of the Coroner's Service for 2019/20 was:

Liverpool £1,199,006 Wirral £704,178 The breakdown is as follows:



Over 52% of the budget is spent on services – this includes medical fees (post-mortem fees), outside analysis (toxicology), coroner removals, hospital mortuary fees, juror fees, witness fees and medical reports.

25% of the budget is spent on employees – this includes all the Coroners' salaries and the administration support team for the Court.

23% of the budget is spent on recharges/premises – this is for the running of the Court premises along with central support charges for IT, Legal Services, finance, premise management and resolution centre costs.

Coroner's Court Support Service

The Coroners' Courts Support Service is a registered charity whose volunteers give emotional and practical support to families and other witnesses attending Inquests. The team have been operating in Liverpool and Wirral since 31st October 2011 and currently consists of 17 volunteers 10 of whom started in 2011.

Since 2011 volunteers have supported over 10,000 family members and friends, over 2,400 witnesses and given support to the many professionals (police, fire, ambulance services and advocates, solicitors) who attend court.

Compliments

Each year we receive many compliments from bereaved families which demonstrate our commitment to put them at the heart of the service. Here are some examples:

"*I just want to say a huge thank you. Your support and guidance over the last few weeks has been amazing. It's made the whole process so much easier and I can't thank you enough*."

"My dad passed away in January this year. The officer assigned to dad's case from the start right through to the end was kind, polite, courteous, patient, understanding and made sure everything was explained to us in layman's terms."

"Dealing with a death of someone is a very difficult time as you know and I am so grateful that you were by our side to guide us through the process. The officer dealing with our case is an absolute asset to your team and I wish to say thank you not just to her but to you all for helping us through this extremely traumatic experience."

"I'd just like to say a great big thank you to you all in the Coroner's office for your help and kindness when dealing with me about my Dad's passing. You made an extremely distressing time bearable and were so helpful in dealing with the process."

"I would like to thank the Coroner for his kindness today at the inquest of my grandson. I hope you will pass on to him how much his closing words meant to my son, my husband and myself."

"I feel compelled to email regarding the exceptionally positive experience today from the staff of the Liverpool Coroner's Office during what has been a very sad time for our family. From my initial conversation the whole process was most positive. The Coroner's Officer clearly demonstrated excellent interpersonal skills and was professional yet friendly in her approach. She put my concerns to rest and I felt supported along the whole journey. She replied well within the timescale promised and advanced the paperwork as I was assured she would do. This made what was a very upsetting process bearable and I cannot thank her enough for her gentle yet professional approach. Please do pass on my most grateful thanks to all these staff. Whilst this work is "everyday" to you all it is one of the most upsetting conversations which families will ever have. How it is handled will live with family members for a long time."

"Thank you so much, on behalf of all our family, for the way in which you dealt with our case. It has been a very traumatic time for us as a family and we were very anxious about the inquest but thank for making this as painless as possible. We'd like to express our gratitude to the Coroner for their kind and sympathetic words which were a great comfort and put us all at ease."

"May I say many thanks from myself and my family for the kindness and consideration you have shown during the sad loss of our brother. I appreciate very much your phone calls and concern at this very difficult time for us."

Regulation 28 - Reports to Prevent Future Deaths

The Coroners and Justice Act 2009 provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

In 2020, the Liverpool & Wirral Coroner Area generated 7 Regulation 28 reports. These were addressed to NHS bodies**,** including Mental Health Services, Prison Services and Local Authorities. The reports highlighted a wide variety of issues from healthcare provision within state detention settings to improving communication between local mental health services providers to clearer information documentation protocols in care settings. It also covered highway and health and safety issues.

Multi-Agency Working

The Coroner's Service has an excellent close working relationship with Merseyside Police who ensure sudden and unexpected deaths are investigated appropriately.

We provide regular training sessions to local hospitals for their new doctors and also accommodate numerous visits to Court from nursing students who greatly appreciate this valuable opportunity.

We deal with hundreds of requests each year from insurance companies and solicitors in relation to life insurance policies and pensions along with litigation enquires.

The inquest archives date back to 1939 so we also deal with many requests from family members tracing their family history.

The Coroner's Service works closely with Emergency Planning Teams in Liverpool and Wirral to ensure they have input into the appropriate plans such as the Merseyside Mass Fatality Plan and the Local Resilience Forum Extra Death Plan.

We work closely with the Child Death Overview Panel keeping them notified of child deaths, issues that may relate to Serious Case Reviews and the final outcome of inquests.

The service provides information to a variety of statutory agencies to assist with the prevention of drug related deaths, road traffic accidents, industrial disease and accidents and suicide prevention.

The Year Ahead

With the introduction of the Medical Examiner system, which is voluntary/non-statutory at present, we are working with new medical examiners appointed within Trusts so that all referrals are relevant and appropriate. We anticipate there will continue be an increase in the number of deaths referred to the Coroner that will require an investigation and possible inquest.

This year we introduced electronic referrals via an external portal into our database. This has been working well within the hospitals in our area and we have started to roll this out to all GP practices throughout Liverpool and the Wirral. This will reduce the administration time from inputting duplicate data and will enable us to concentrate more time on supporting bereaved families.

This year we improved the Coroner Service pages on the Council's website to enhance the quality of information available to families, witnesses and jury members. Looking ahead we will be developing methods through the website to encourage engagement to monitor customer satisfaction.