Liverpool & Wirral Coroner Area

Annual Report 2022

Contents

LIVERPOOL & WIRRAL CORONER AREA
ANNUAL REPORT 2022

Background Information

The Liverpool and Wirral Coroner Areas merged to form one jurisdiction in April 2015. 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 approximately 27,000 Hectares with a population of around 820,000. The area is 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 Cruise 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 clubs, one Football League football club and a championship golf course.

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

Liverpool University Teaching Hospital – Royal Liverpool & Broadgreen
Aintree University Hospital
Arrowe Park 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 and funded by the local authority. The Coroner is responsible for investigating 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 purpose of the investigation is to identify who the person was, and where, when, and how they came by their death.

We work under the guidance and direction of the Chief Coroner who works closely with the Ministry of Justice.

The Liverpool & Wirral Coroner's service and Court is based at:

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

In accordance with the provisions of s24 of the Coroner and Justice Act 2009, the relevant lead authorities will provide administration support for the Coroners and the Court. They are also responsible for providing accommodation for the court(s) and for the whole service (Coroners, Coroners Officers and Administration Staff) to be co-located. All running costs for the service; accommodation, information technology (including for coroner's officers), coronial investigations relating to post mortem, toxicology, medical reports and witnesses/jurors fees to be met by the relevant local authority. They will deal with all general enquiries on behalf of the coroner's service from bereaved families to information requests, funeral directors, insurance companies and others.

Merseyside Police provide Coroner's Investigation Officers to investigate deaths and treasure needed by the coroners in each area to carry out their function.

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 advocates 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 thirteen 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 ten Assistant Coroners (five of whom sit regularly, one is an Assistant Coroner in the neighbouring Coroner Area – Sefton, St Helens & Knowsley, three are now Senior Coroners in different Coroner Areas and one is a retired Senior Coroner).

Our duty

To apply the law relating to coronial investigations putting families at the heart of the service and providing a professional, sensitive and caring approach to meet the needs of bereaved people who come into contact with the Coroners Service.

Workload

In 2022 there were 2883 reported deaths. This resulted in 1108 inquests being opened in 2022 and a total number of 1167 inquests being concluded in 2022.

There has been a substantial increase in the post-mortem examination rate, rising from 34% in 2020 to 43% in 2021 and this remained the rate for 2022. The national average for 2022 has also remained at 43%. Our average inquest conclusion time of 11 weeks from the death report has been maintained during 2022, whereas the average is 30 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

Coroners faced an unprecedented challenge at the height of the pandemic in 2020 with complex and jury cases adjourned, although all other inquests took place in court as the service was open throughout. Jury cases resumed in 2021, in some instances with remaining social distancing measures in place. Throughout 2021 and 2022 we have worked through all of the jury inquest cases that were previously adjourned due to the pandemic.

The consequences of the pandemic continue to be felt by the Coroner's Service both in a workload and financial sense. The workload has become more complex due to the increase in the number of unnatural deaths such as suicides, and drug and alcohol related deaths resulting in an increase of post-mortems and other analysis to determine the cause of death which peaked in 2020 and has continued at this higher rate.

The pandemic appears to have undermined the trust of the public in health and social care in such a way that bereaved families are less trusting of doctors and carers. This is evidenced by the previously mentioned increase in post-mortem examination rate.

On 25 March 2022 the Coronavirus legislation surrounding death certification lapsed, so it reverted back to a doctor having to have treated the deceased in their last illness within the

28 days before their death, which has resulted in ongoing challenges for the Coroner's service, which include:

- The pandemic has changed the working practices of doctors and many patients in the community are receiving treatment and consultations by telephone appointments. This has created a significant challenge regarding completing the Medical Certificate for Cause of Death (MCCD), as when a patient dies only a doctor who has seen and treated the deceased in their last illness (face to face or on video) within 28 days can legally issue the MCCD.

- Patients are often treated by other healthcare professionals (not doctors) who cannot legally provide a medical certificate of cause of death (MCCD).

This has resulted in an increase in the number of deaths being reported to the Coroner which are of natural causes, the only reason for the referral is due to a doctor not being qualified to issue the MCCD. It has created extra pressure on the courts' investigative team, demonstrated by the large increase in inquests being held where the conclusion is 'natural causes', as well as extra financial costs to the service. More importantly, it has also created distress to bereaved families who do not understand the need for the Coroner to be involved when their loved one is often on palliative care. The legislation on death certification needs updating to reflect modern medical practice.

The pandemic and its ongoing effects have put a heavy burden on the service and will continue to do so for the foreseeable future.

Medical Examiner System

Since April 2019 there has been the rollout of the non-statutory Medical Examiner (ME) system with the aim that all deaths would be scrutinised either by a ME or Coroner. The legislation to move to a statutory ME scheme was approved by Parliament and included all hospitals from April 2023.

During 2021 and 2022 the coroner's service has worked closely with local hospitals and Medical Examiners and officers to ensure appropriate and prompt referrals to the Coroner from the ME to reduce distress on bereaved families. This has resulted in a decrease in the number of referrals from hospitals that involve a natural cause of death, but the referrals made tend to involve many complexities in medical care and treatment.

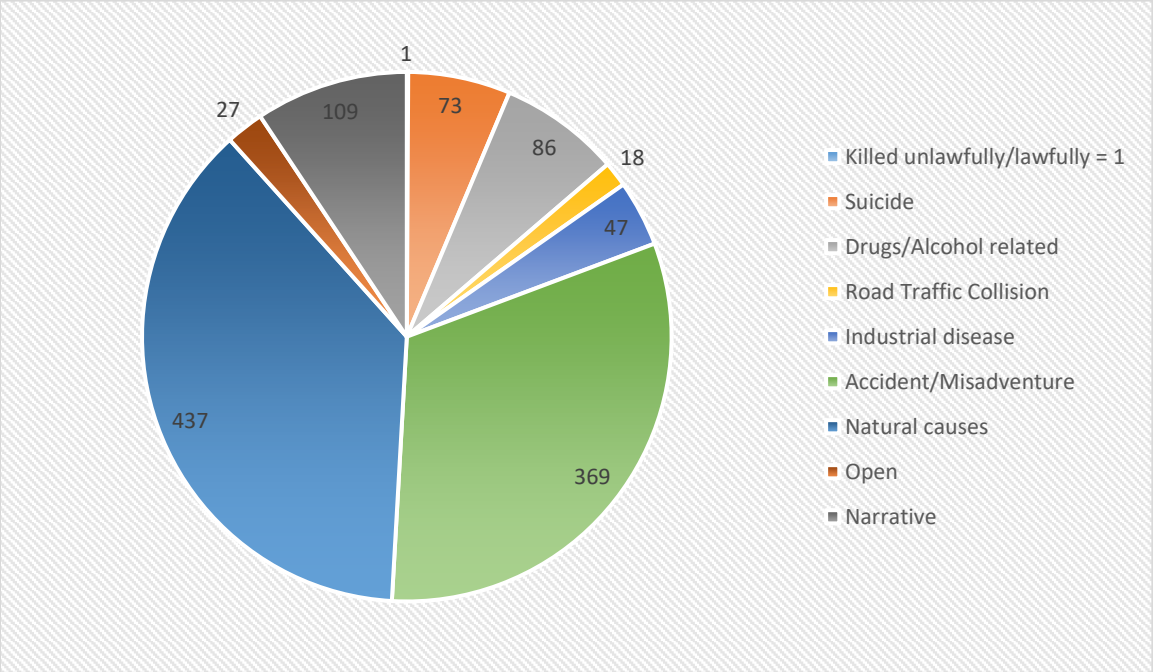
The next step for the Medical Examiner System is for the scheme to roll out across community deaths. This is currently underway in Liverpool and Wirral in a voluntary scheme organised by the ME with all the GP practices (85 in Liverpool and 47 in Wirral) with an anticipated statutory date to go live in April 2024.

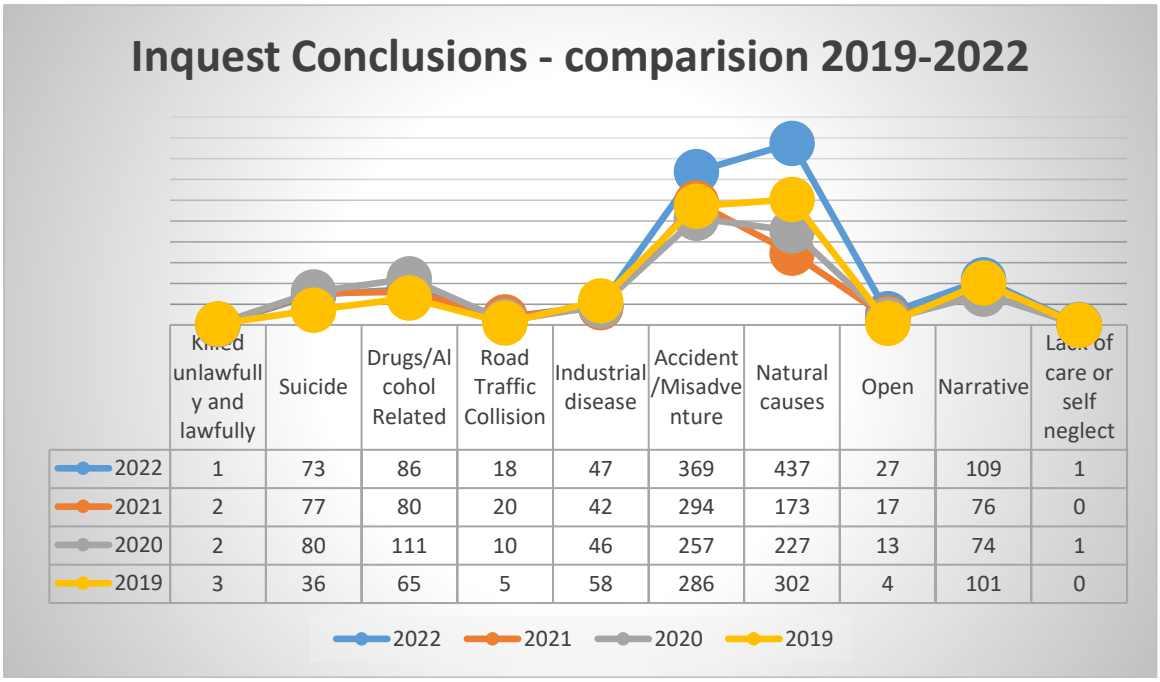
We continue to work closely with the Medical Examiners and their teams and have regular working group meetings to assist with training and sharing best practice.

STATISTICS

Key findings from 2022

38% of deaths reported in 2022 resulted in an inquest being held. The breakdown of the 1167 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
2022	1	73	86	18	47	369	437	27	109	1
2021	2	77	80	20	42	294	173	17	76	0
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 – 2022 Comparison With 2021

REPORTED DEATHS

Reported deaths 1st January 2022 to 31st December 2022	2883
Reported deaths 1st January 2021 to 31st December 2021	3056

6% reduction in referrals

INQUESTS

Inquests concluded from 1st January 2022 to 31st December 2022	1167
Inquests concluded from 1st January 2021 to 31st December 2021	781
Inquests opened from 1st January 2022 to 31st December 2022	1108
Inquests opened from 1st January 2021 to 31st December 2021	733

51% increase in number of inquests opened

POST MORTEMS

Number of deaths reported that resulted in a PM in 2022	1252	(43% rate)
Number of deaths reported that resulted in a PM in 2021	1301	(43% rate)

4% reduction in number of post mortems

JURY INQUESTS

Number of inquests held with a jury in 2022	17
Number of inquests held with a jury in 2021	8

TIME TAKEN TO CONCLUDE INQUESTS

2022

% of inquests concluded within 1 month in 2022	66%
% of inquests concluded within 3 months in 2022	74%
% of inquests concluded within 6 months in 2022	92%

2021

% of inquests concluded within 1 month in 2021	54%
% of inquests concluded within 3 months in 2021	78%
% of inquests concluded within 6 months in 2021	92%

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

National Statistics for 2022

These were published for England and Wales on 11 May 2023 and highlight the pressures felt by the Liverpool & Wirral Coroner Service in relation to the increased post mortem rate, number of inquests opened and complexity of workload. This appears to be replicated across many coroner areas throughout the country.

For example, note the following extracts:

- In 2022, coroners opened the highest number of inquests since reporting began, with an increase in recorded conclusions and post-mortems. Circa 17% of deaths reported to coroners proceeded to an inquest and, of the 36,000 inquest conclusions recorded, natural causes, accident/misadventure and unclassified conclusions were the most prevalent, up 40%, 14% and 7% on 2021 respectively. Further research is required to understand the marked increase in natural causes conclusions.

- In 2022, natural causes conclusions increased by 40% to 5,139. This increase in natural cause conclusions may suggest that there is an increase in natural cause deaths being referred to the coroner.

- Inquest cases represented 17% of all the deaths reported to coroners in 2022, no change from 2021. The number of inquests opened as a proportion of deaths reported in 2022 varied across coroner areas, from 6% in Ceredigion to 38% in Liverpool and the Wirral. However, most coroner areas held inquests for between 10% and 20% of all deaths reported (55 of the 83 coroner areas).

- There were 90,200 post-mortem examinations ordered by coroners in 2022, a 7% rise compared to 2021. The proportion of reported deaths requiring a post-mortem has remained stable over the same period.

- In 2022, 35,600 inquest conclusions were recorded in total, up 10% on 2021. Natural causes, accident/misadventure and unclassified conclusions had the largest increases, up 40%, 14% and 7% on 2021, to 5,100, 8,800 and 8,700 inquest conclusions in 2022 respectively.

- 208,430 deaths were reported to coroners in 2022, the highest level since 2019. This is an increase of 13,250 (7%) from 2021.

Performance

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

Caution should be taken however when making comparisons between coroner areas as differences in local authority support, resource, facilities, and socio -economic make up mean this will not always be comparing like with like.

2022 comparison with neighbouring Coroner Areas

Area	Deaths reported	Post-mortems	Post-mortem rate	No. of inquests opened	Average inquest waiting time
Liverpool & Wirral	2883	1252	43%	1108	11 weeks
Sefton, St Helens & Knowsley	2205	796	36%	421	25 weeks
Cheshire	3107	1626	52%	679	27 weeks
Manchester City	2682	1338	50%	727	48 weeks

Complex 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.

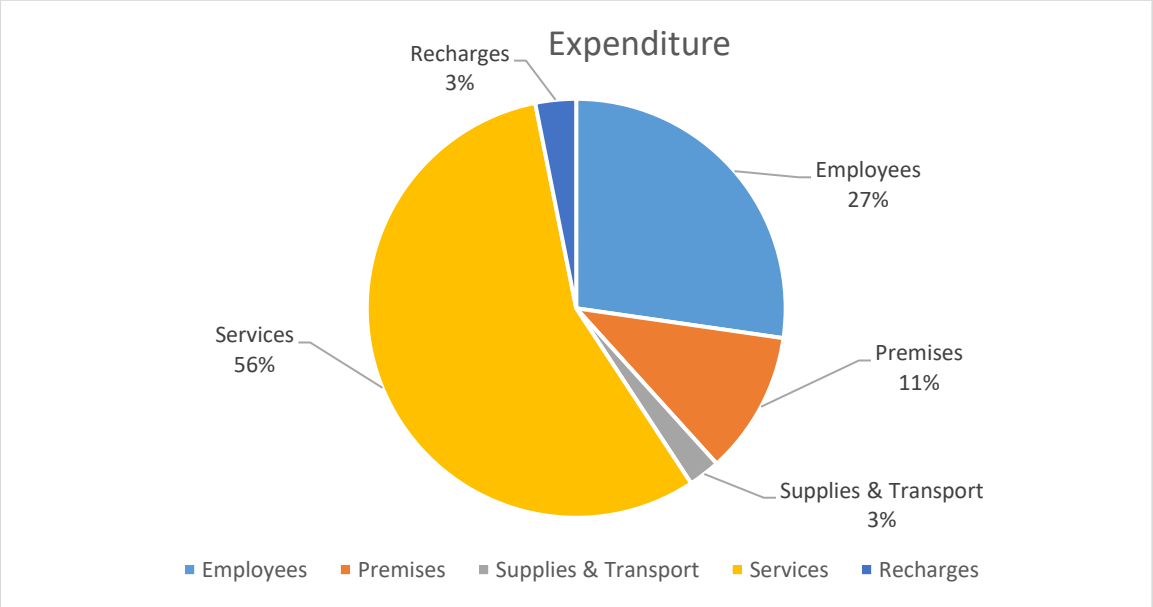
2022 comparison with Coroner Areas of a similar demographic

Area	Deaths reported	No. of deaths in state detention	Post-mortem rate	No. of inquests	Average inquest waiting time
Liverpool & Wirral	2883	15	43%	1108	11 weeks
West Yorkshire (Eastern)	3733	27	36%	893	19 weeks
Birmingham & Solihull	5851	16	32%	823	14 weeks
Manchester City	2682	15	50%	727	48 weeks

Budget

The gross expenditure outturn for 2022/2023 for the Liverpool & Wirral Coroner Services was £2,160,448. The recharge ratio according to population is 63% Liverpool City Council, 37% Wirral Council. Therefore, the cost of the Coroner's Service for 2022/23 was:

Liverpool £1,361,082 Wirral £799,366 The breakdown is as follows:



Around 58% of the budget is spent on services, which include medical fees (post-mortems), outside analysis (toxicology), coroner removals, hospital mortuary storage fees, juror and witness fees and medical reports.

27% of the budget is spent on employees – this includes the Coroners' salaries (including assistant coroner sittings) and the administration support team for the Court.

15% 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.

Coroners' Courts 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.
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.

For more information visit: https://coronerscourtssupportservice.org.uk/

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:

"*Thank you so much for all your understanding. The sudden loss of our son and the added heartache of finding him was made easier with the way you dealt with it all.*"

"Thanks to you and the Coroner for your fabulous communication about the process and conclusion of findings today, all done with such lovely empathy and professionalism. We are very grateful and now have some closure to what has been a very challenging time. You all do such amazing work in very difficult circumstances which cannot be easy for you at times. Wish the public in general knew about your roles and how important you are in matters such as this and so much more harrowing, they then would appreciate and value all that is in the Coroner's Department as much as we do"

"I know that dealing with bereaved parents is really difficult but his parents were really grateful for your time and compassion in explaining things to them. You were so patient and empathetic with them and they have now taken him home feeling much more content. They are really grateful for you taking the time to chase doctors and get everything in order"

"Thank you for all your help. You've made this part of the process much easier than it might have been, thank you."

"On a personal note I would like to thank you for your wonderful service, your kindness, empathy and professionalism. I would also like to pass on my sincere thanks to the Coroner for the sympathetic and expeditious way my father's passing and subsequent inquest was handled. I am sure that the Coroner appreciates what wonderful staff they have working for them."

"I just wanted to say thank you for being so clear and so kind to me. Also having real empathy and listening to me. You must have to make the most difficult calls and all I can say is that even though the information you are relaying is extremely upsetting and what you may hear will be the same you manage to do it in a very careful considered way and I realise it must be very hard for you as well."

"Thank you for your hard work and support. Not all angels have wings but there's at least one with pink hair. I wish you all the best in all your endeavours. I hope that our paths will cross again preferably without the need of someone passing away."

"Thank you for everything you have done for me, for being patient with me and explaining everything so well to me, you have really helped me through the worst thing I have ever had to go through."

“Thank you so much for sending me dad’s report. I know you are all incredibly busy and your prompt and courteous service is well appreciated. I also want to say thank you for looking after dad for me, it’s took a long time to come to terms with his passing and knowing that your service treated him with respect at a vulnerable time means a lot. Your service whilst speaking to me was so kind and thoughtful I’m not sure if you get many “thank you’s” but mine is heartfelt.”

“I just wanted to say ‘thank you’ for all the work you have done in connection with the death of my brother. Like many people, I had never had any contact with a Coroner’s Office. Dealing with the sudden death of someone you love is hard enough to cope with and the need for a post mortem had the potential to cause further distress to me and the rest of my family. However, that was not the case at all. You explained everything so clearly and made the whole process very straight forward from my perspective, such that I knew my brother was in good hands. You were able to answer all the questions I had and always responded quickly to my e-mails and phone calls. You also had to talk me through some difficult matters, especially when the final report was ready but, as always, you were compassionate and understanding whilst still being professional and knowledgeable which is something not everyone is good at.”

“We would like to thank you again for being so thoughtful and kind to us throughout this process. Please thank the Coroner on our behalf for their very kind words, which we thought were very pertinent. We really were not expecting this. We know that we need to accept what happened and celebrate our mum's life, but actually doing this is not so easy. Hearing the Coroner say it helped to reassure us that, not only this is the right thing to do, but it really is the only sensible option.”

“We can’t begin to tell you how much we have appreciated your care and compassion during the most difficult time in our lives. We know that you have gone above and beyond for us and we cannot thank you enough. I wish you had met our beautiful girl, the way you have cared for her it is like you knew her and treated her in such a special way. It takes a very special person to do what you have done for her and us and we will be forever grateful to you. Thank you from the bottom of our hearts.”

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 2022, the Liverpool & Wirral Coroner Area generated 3 Regulation 28 reports. These were addressed to different NHS bodies and highlighted a wide variety of issues from improving communication between local mental health intervention services, missed opportunities due to the need for clearer risk assessment protocols in care settings and adverse medication reactions. The recipient of the report must respond to the coroner within 56 days setting out the proposed action to be taken and a timetable for completing it or explaining why they do not propose to take any action.

Regulation 28 Prevent Future Death reports and responses are publicly available from the Chief Coroner's website: https://www.judiciary.uk/subject/prevention-of-future-deaths/

Multi-Agency Working

The Coroner's Service has a 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 accommodate numerous visits to observe inquests in 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 including the Merseyside Resilience Forum to ensure they have input into plans such as the Merseyside Mass Fatality Plan and the Local Resilience Forum Excess Deaths Plan. We work closely with the Child Death Overview Panel keeping them notified of child deaths, and issues that may relate to Serious Case Reviews and inquest outcomes.

We are aware that part of our role is to prevent future deaths. As a result, we work collaboratively with a number of research projects and provide information to a variety of statutory agencies such as Local Authority public health departments to assist with the prevention of drug related deaths, road traffic accidents, industrial disease and accidents and suicide prevention.

The Year Ahead

We will continue to work closely with the Medical Examiners (ME) and their teams as the rollout of the ME system into community deaths evolves and progresses into a statutory service.

We are working with the British Heart Foundation pilot to identify genetic factors in sudden cardiac death.

In 2022 we worked with Liverpool University Teaching Hospital who have funded SWAN bereavement nurses. We have started to offer bereaved families referrals for this support and look to expand this support over the coming year.