Liverpool & Wirral Coroner Area

Annual Report 2023

Contents

LIVERPOOL & WIRRAL CORONER AREA
ANNUAL REPORT 2023

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 six tertiary centres of healthcare excellence namely:

Liverpool Heart & Chest Hospital
Liverpool Children's Hospital (Alder Hey)
Liverpool Women's Hospital
Clatterbridge Hospital
Clatterbridge Cancer Centre (Liverpool, Wirral & Aintree)
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 Local Authority appoints the Coroner but does not employ them. This is an important distinction to maintain independence. 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

An inquest is an enquiry not a trial. It does not determine matters of civil or criminal liability, nor does it seek to apportion blame for the death. 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 and 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 2023 there were 2727 reported deaths. This resulted in 1066 inquests being opened in 2023 and a total number of 1191 inquests being concluded in 2023.

There has been a substantial increase in the post-mortem examination rate, rising from 34% in 2020 to 43% in 2021 and this increased in 2023 to 45%. The national post mortem rate average in 2023 also increased to 44%. Our average time to conclude an inquest of 11 weeks in 2022 was reduced to 10 weeks, whereas the average increased to 31.5 weeks nationally. The average inquest conclusion time in Liverpool & Wirral has decreased substantially due to the increase in reported deaths of natural causes where the Coroner has to hold a short inquest to enable the death to be registered. 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 to date

The ongoing 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 the increase of post-mortems and other analysis to determine the cause of death which peaked in 2020 and has continued at this higher rate with no sign of abating.

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 and the increase in investigation and inquests.

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 (this changed on 9th September 2024).

- 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. Death Certification Reforms and the introduction of Medical Examiners came into force on 9 September 2024 and should alleviate some of the above pressures.

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.

Over the last couple of years, the Coroner's Service has worked closely with local hospitals and Medical Examiners and their offices 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.

On 9th September 2024 the statutory Medical Examiner System was implemented. The ME system covers all hospital deaths and now includes all deaths in the community. The ME system will cover all the GP practices (85 in Liverpool and 47 in Wirral) to provide scrutiny for all MCCDs (medical certificate for cause of death).

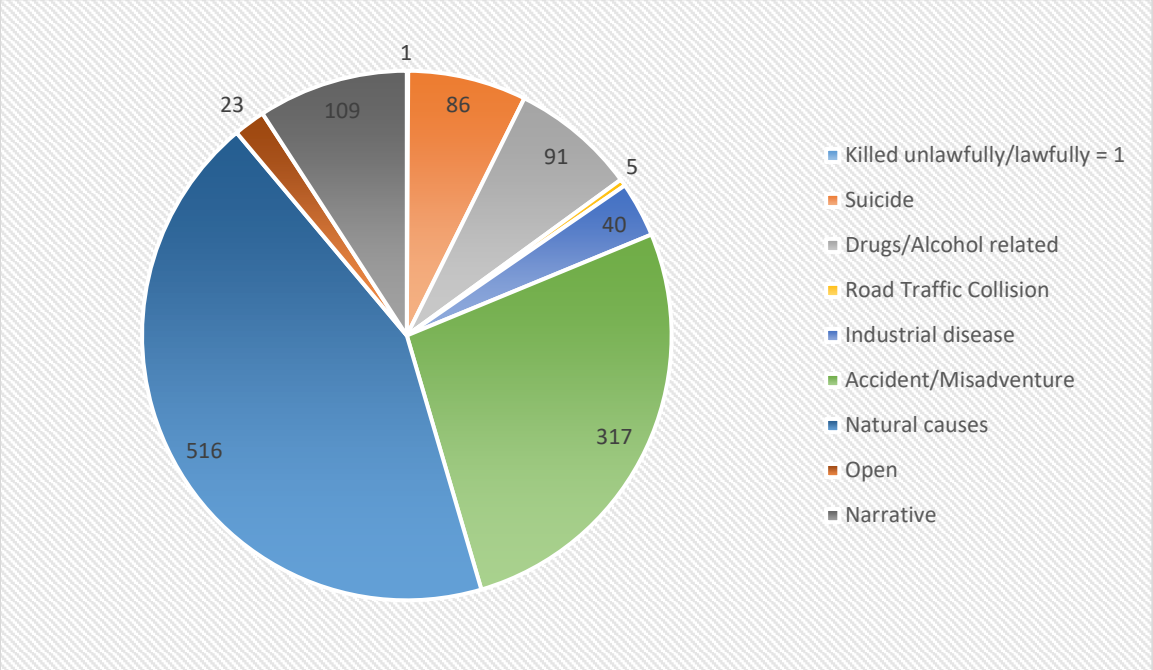
The principle underlying the legislation is so that where a death is natural and did not occur in custody or state detention, scrutiny should be provided by the Medical Examiner, and where S1 Coroners and Justice Act 2009 is engaged, scrutiny should be provided by the coroner. From 9th September 2024, many of the processes within the coronial workflow changed including all the statutory forms issued by the coroner.

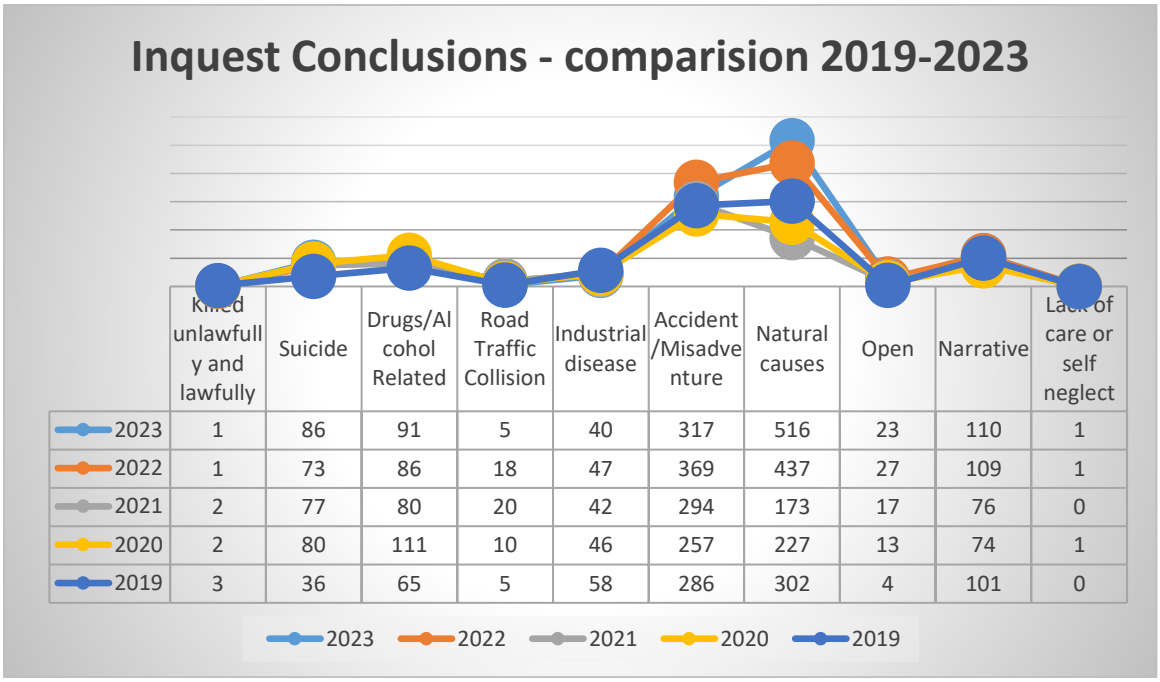
We will continue to work closely with the Medical Examiners and their teams and have regular working group meetings to assist with training and sharing best practice to ensure the bereaved are placed at the centre of everything we do.

STATISTICS

Key findings from 2023

39% of deaths reported in 2023 resulted in an inquest being held. The breakdown of the 1191 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
2023	1	86	91	5	40	317	516	23	110	1
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 – 2023 Comparison With 2022

REPORTED DEATHS

Reported deaths 1st January 2023 to 31st December 2023	2727
Reported deaths 1st January 2022 to 31st December 2022	2883

5.5% reduction in referrals

INQUESTS

Inquests concluded from 1st January 2023 to 31st December 2023	1191
Inquests concluded from 1st January 2022 to 31st December 2022	1167

2% increase in number of inquests concluded

Inquests opened from 1st January 2023 to 31st December 2023	1066
Inquests opened from 1st January 2022 to 31st December 2022	1108

5% decrease in number of inquests opened

POST MORTEMS

Number of deaths reported that resulted in a PM in 2023	1216	(45% rate)
Number of deaths reported that resulted in a PM in 2022	1252	(43% rate)

3% reduction in number of post mortems

JURY INQUESTS

Number of inquests held with a jury in 2023	15
Number of inquests held with a jury in 2022	17

TIME TAKEN TO CONCLUDE INQUESTS

2023

% of inquests concluded within 1 month in 2023	68%
% of inquests concluded within 3 months in 2023	75%
% of inquests concluded within 6 months in 2023	93%

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%

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

National Statistics for 2023

These were published for England and Wales on 9 May 2024 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 the 2023 calendar year, deaths reported to coroners were at their lowest volume in England and Wales since 1995, a decrease of 3 percentage points compared with the previous year.

- In contrast, inquests opened as a proportion of deaths reported to coroners were at their highest in 2023 since the start of the annual time series in 1995, with a corresponding increase of 11% in inquest conclusions recorded since 2022 (2nd highest in the series). The average time taken to complete an inquest rose by 1.3 weeks to 31.5 weeks this year. The main drivers of the increase in the number of inquest conclusions were unclassified conclusions and death by misadventure which together account for half of all inquest conclusions.

- Suicide conclusions were at their highest level since the start of the time series in 1995. An increase on 2022 was higher in females (11% compared with 2022) than males (which increased by 7%). It must be noted that conclusions are recorded after an inquest. This means the conclusions recorded in a certain year may relate to deaths from the same or earlier years.

- Reported deaths which led to inquests represented 19% of all the deaths reported to coroners in 2023, an increase from 17% in 2022. The number of inquests opened as a proportion of deaths reported in 2023 varied across coroner areas, from 4% in Ceredigion to 39% in Liverpool and the Wirral. However, most coroner areas held inquests for between 10% and 20% of all deaths reported (51 of the 80 coroner areas).

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.

2023 comparison with neighbouring Coroner Areas

Area	Deaths reported	Post-mortems	Post-mortem rate	No. of inquests opened	Average inquest waiting time
Liverpool & Wirral	2727	1216	45%	1066	10 weeks
Sefton, St Helens & Knowsley	2025	782	39%	388	20 weeks
Cheshire	2774	1254	45%	544	38 weeks
Manchester City	2258	1207	53%	668	44 weeks

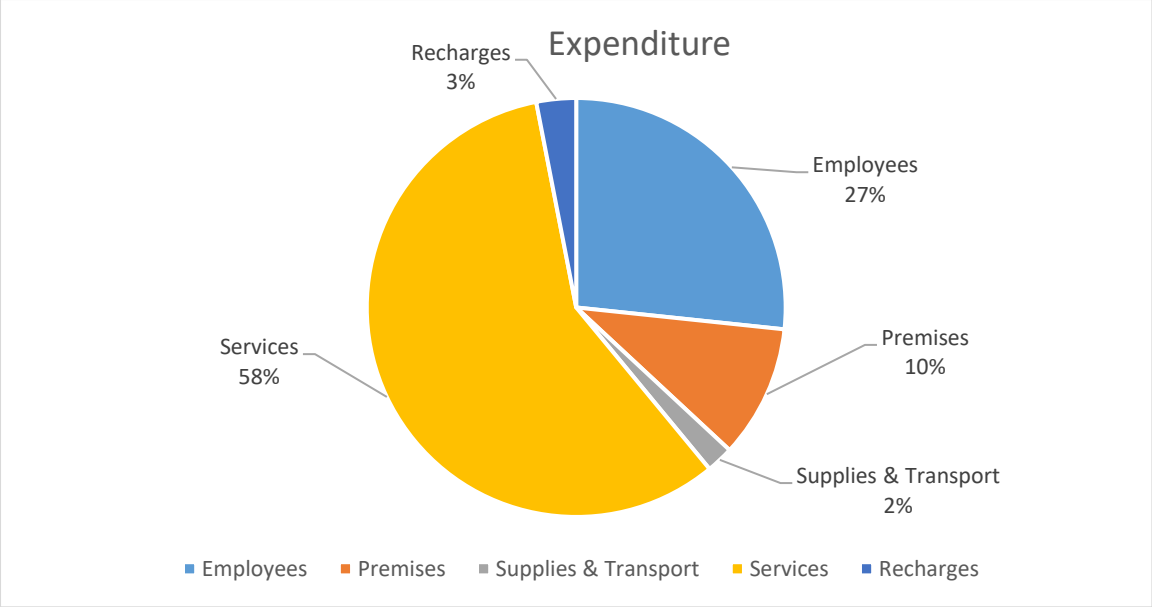
Complex Coroner Areas which have a prison within their boundary will have to hold jury inquests for unnatural deaths, which inevitably lengthen the time taken to conclude these types of complex inquests.

2023 comparison with Coroner Areas of a similar demographic

Area	Deaths reported	No. of deaths in state detention	Post-mortem rate	No. of inquests opened	Average inquest waiting time
Liverpool & Wirral	2727	13	45%	1066	10 weeks
West Yorkshire (Eastern)	3725	25	36%	1086	17 weeks
Birmingham & Solihull	5017	8	36%	873	17 weeks
Manchester City	2258	4	53%	668	44 weeks

Budget

The gross expenditure outturn for 2023/2024 for the Liverpool & Wirral Coroner Services was £2,216,676. The recharge ratio according to population is 63% Liverpool City Council, 37% Wirral Council. Therefore, the cost of the Coroner's Service for 2023/24 was:
Liverpool £1,396,506 Wirral £820,170 The breakdown is as follows:



Around 60% 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.

13% 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. or 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:

“I would like to compliment the Coroners office for the help given to our family at such a sad time for us. The officer kept us updated on every step on the process and has been a great help. The manner in which she talks to you is amazing she has real empathy and is a credit to your office and herself”.

“We’d like to thank you and your team for your professionalism and kindness while mum has been in your care. It wasn’t something we would have wished but the way you explained everything in a gentle and respectful way has helped us move forward. You may not remember me as you are likely to speak to lots of different people but I just wanted to send you an email to say thank you”.

“May I take this opportunity to thank you for all your help and guidance throughout this whole process - you have been kind, supportive and informative”.

“It was a few months ago that we spoke but you were one of the first people who I spoke to after my mum passed away and despite me feeling like my world had ended you really helped to get me through it. You were the first person I spoke to on the phone and discussed her passing and after that first call I put the phone down and cried. I cried because of my mum who has just died so tragically, but I also cried because of how lovely you were on the phone and how at ease you made me feel.

“During our phone calls you showed so much compassion, care, respect and were so professional and helpful to me - such hard things to show on phone calls especially when speaking about the death of a loved one. I’ve since spoken to many other people reporting my mum’s death to them and none of them showed me the levels of care that you showed me during our calls. Not having dealt with death of a parent before or any close relative, I didn’t really know or understand the next steps involved but you really put me at ease and in my eyes got my mum to the chapel of rest as quickly as was possible and I will forever thank you for that.”

“I’d like to hope that you receive emails like this all the time from relatives of people who’ve passed away showing their thanks, however the world doesn’t always work that way so I want you to know that you are a credit to the coroner’s office and if there’s anything that your managers can do to thank you for receiving this feedback then please forward my email on to them”.

“I wanted to acknowledge the professional and personable approach taken by you towards our family at a very difficult and challenging time. We appreciated your guidance, assistance and patience working with us to expedite the matter so my brother could be here with me, mum and family at dad’s funeral. I know you said 'it's my job' but to do it all with kindness takes a skill and meant a lot to us”.

“I just wanted to drop you an email to thank you for your call this afternoon and the professional and caring way you were. I appreciate that working in the coroner’s office means that you have to conduct these calls all the time, but I just wanted to thank you for listening and being so helpful”.

“I am writing to place on record my gratitude and appreciation for the professionalism of one of your officers. She was dealing with my late fathers passing. Throughout my dealings with her she was kind, empathetic and sensitive to mine and my family’s needs at this difficult time. She explained the enquiries she needed to undertake and the subsequent inquest process, she always checked that we understood the information provided and allowed time for any questions and queries. I, and members of my family greatly appreciate the manner with which she conducted her investigation and I wanted to convey our thanks and to make you aware how much her conduct was valued. I would also like to thank you for the condolences offered to my family at the inquest, they were much appreciated”.

“Thank you again for helping to make a very distressing time more bearable - it meant more than I could possibly put into words”.

“I want to thank you so very much for making one of the most difficult days of my life so less unbearable than it could’ve been. You were both so compassionate and understanding, kind and gentle, and that really helped me - thank you very much”.

“Judge, words seem so inadequate. I will never forget your words of wisdom, your explanations and information. Thank you for your time and patience”.

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. A Regulation 28 report can be used before an inquest is held or after the inquest has concluded.

In 2023, the Liverpool & Wirral Coroner Area generated 8 Regulation 28 reports. These were addressed to different NHS bodies, the Prison Service, Department for Health & Social Care and the Departments of Transport and Education. The reports 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, adverse medication reactions and government advice to schools and colleges on the use of seatbelts on school bus transport. 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.

All 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

Since 9th September 2024 the implementation of the statutory medical examiner system, and the rationalisation and reform of the death certification system has taken place. This has radically changed work processes for the Coroners' Service, registrars, and GPs. A lot of multi-agency work has already been undertaken to try and anticipate potential issues and to ensure the transition is as smooth as possible. This collaborative approach will need to continue to work through any issues that bereaved families may face whilst these changes are being embedded into everyday practice.

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

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

Across the country there has been an increase in the number of violent incidents affecting the coronial service. This resulted in the issue of security being raised in the Chief Coroner's Annual Report 2023. There he encouraged Councils who are responsible for providing the service to ensure the courts, accommodation and staff were provided with the necessary security enhancements.

In Liverpool and Wirral following a security assessment of the court building, several risks were identified, and the following have been addressed to reduce the level of risk:

- the panic alarm system has been updated and is linked to City Watch;
- a video intercom has been installed on the front main door;
- Court 2 has been fully refurbished with a coronial bench installed to improve security. The court recording software in Court 2 was end of life, therefore during the refurbishment this was updated and microphones and speakers were integrated into the Courtroom. These enhancements will impact on the budget pressures for 24/25.