Liverpool & Wirral Coroner Area

Annual Report 2021

Contents

LIVERPOOL & WIRRAL CORONER AREA
ANNUAL REPORT 2021

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 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 – 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 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

Coroner and Justice Act 2009

In accordance with the provisions of s24 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 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 (four of which 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 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 2021 there were 3,056 reported deaths. This resulted in 733 inquests being opened in 2021 and a total number of 781 inquests being concluded in 2021.

There has been a huge increase in the post-mortem examination rate, rising from 34% in 2020 to 43% in 2021, which is the national average. This is a reflection of the changing attitude of the public whom we serve. There is an average inquest conclusion time of 11 weeks from the death report (average of 31 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. It is worthy to note the service has now already heard or listed all jury cases that were previously adjourned due to the pandemic.

The situation has continued throughout 2021 as the effects of the pandemic continue to be felt at 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.

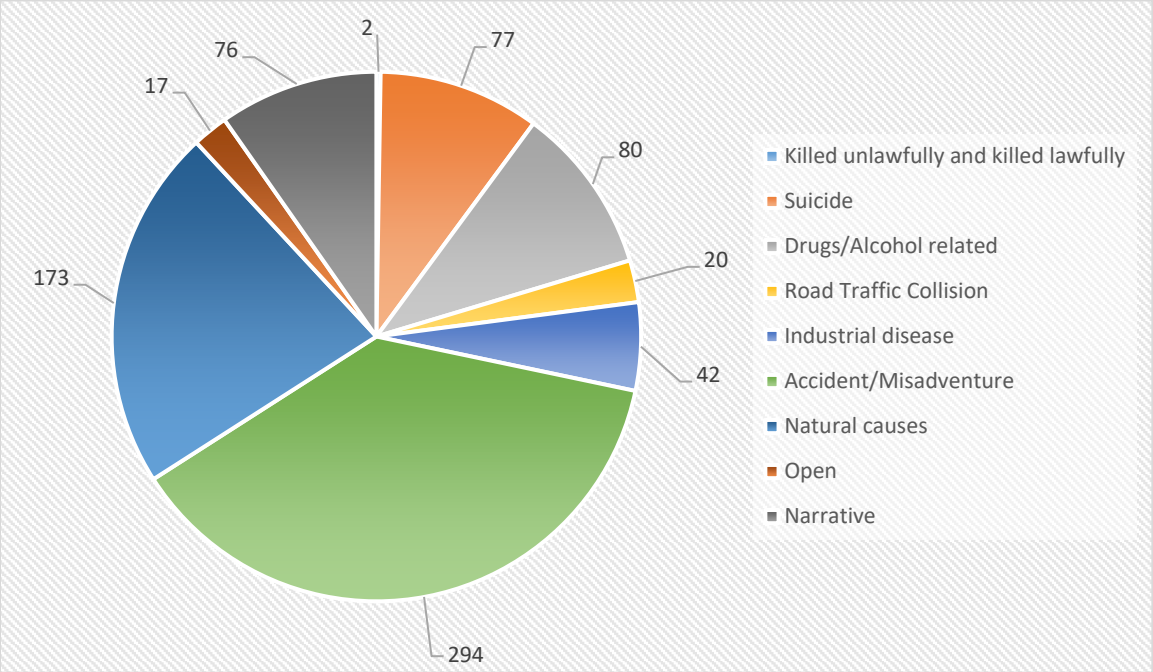
The pandemic appears to have undermined the trust of the public in health and social care in such a way that on the road to recovery of the Coroner's Service bereaved families are less trusting of doctors and carers. This is evidenced by the previously mentioned increase in post-mortem examination rate. The communication between people ill in hospital and their families has as times 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 courts' investigative team dealing with bereaved families as well as extra financial costs to the service.

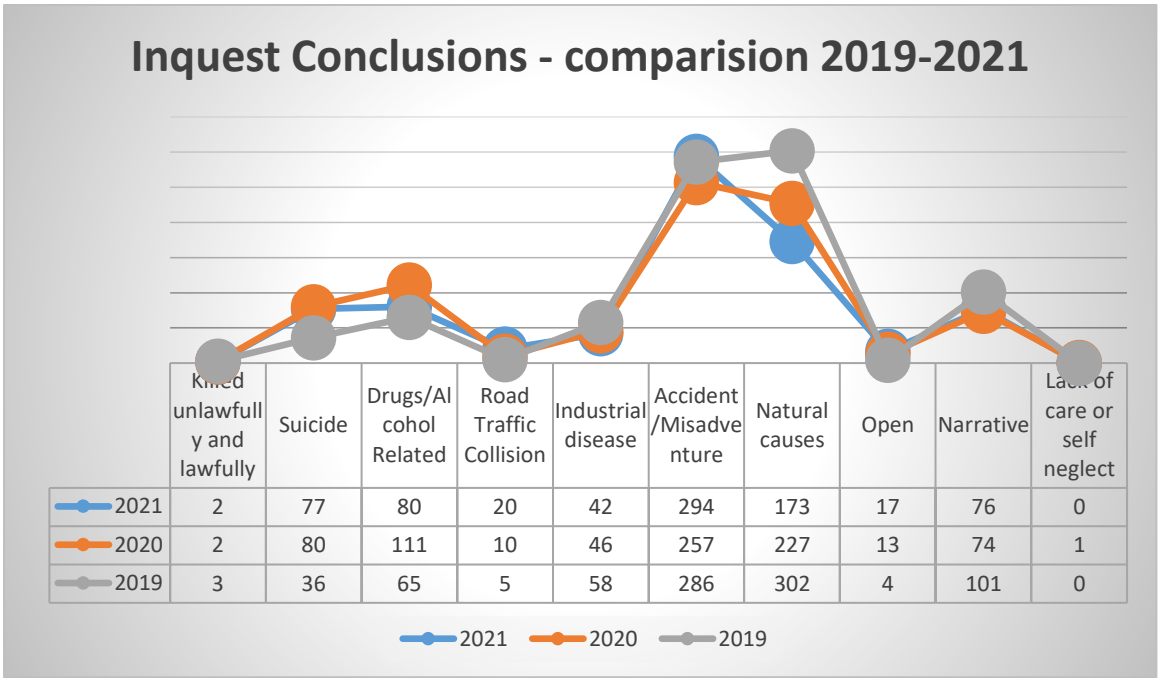
The pandemic has put a heavy burden on the service and will continue to do so for the foreseeable future.

STATISTICS

Key findings from 2021

24% of deaths reported in 2021 resulted in an inquest being held. The breakdown of the 781 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
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 – 2021 Comparison With 2020

REPORTED DEATHS

Reported deaths 1st January 2021 to 31st December 2021	3056
Reported deaths 1st January 2020 to 31st December 2020	3311

INQUESTS

Inquests concluded from 1st January 2021 to 31st December 2021	781
Inquests concluded from 1st January 2020 to 31st December 2020	821
Inquests opened from 1st January 2021 to 31st December 2021	733
Inquests opened from 1st January 2020 to 31st December 2020	735

POST MORTEMS

Number of deaths reported that resulted in a PM in 2021	1301	(43% rate)
Number of deaths reported that resulted in a PM in 2020	1124	(34% rate)

JURY INQUESTS

Number of inquests held with a jury in 2021	8
Number of inquests held with a jury in 2020	4

TIME TAKEN TO CONCLUDE INQUESTS

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%

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%

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.

2021 comparison with neighbouring Coroner Areas

Area	Deaths reported	Post-mortems	Post-mortem rate	No. of inquests	Average inquest waiting time
Liverpool & Wirral	3056	1301	43%	733	11 weeks
Sefton, St Helens & Knowsley	2069	778	38%	379	33 weeks
Cheshire	2670	1564	59%	578	34 weeks
Manchester City	2786	1425	51%	679	51 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.

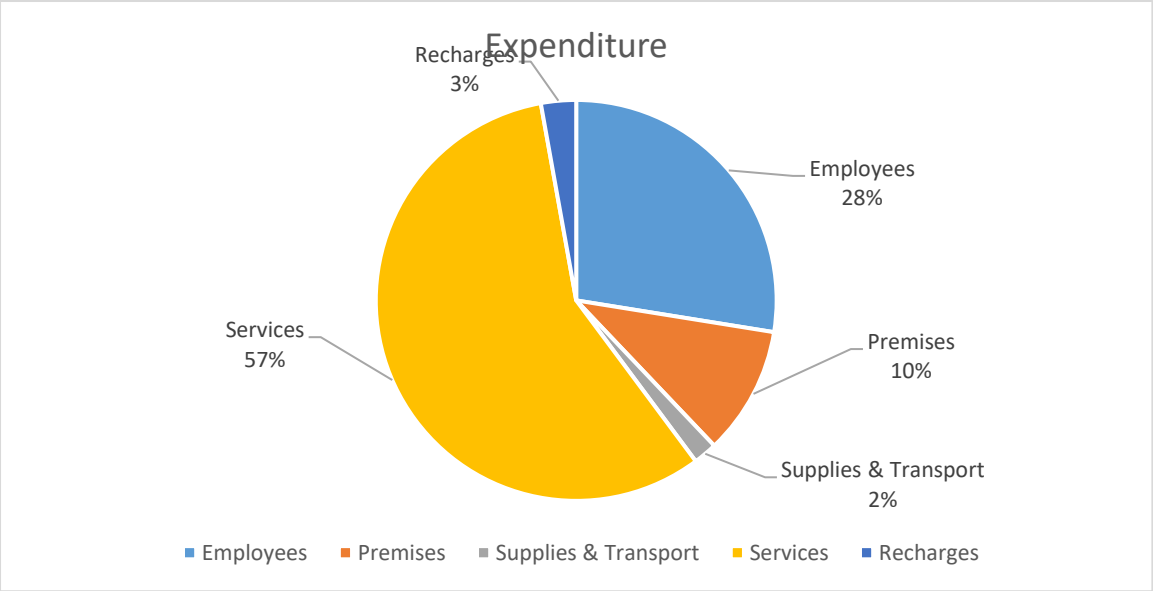
2021 comparison with Coroner Areas of a similar demographic

Area	Deaths reported	No. of Prison deaths	Post-mortem rate	No. of inquests	Average inquest waiting time
Liverpool & Wirral	3056	15	43%	733	11 weeks
West Yorkshire East District	3538	25	35%	729	19 weeks
Birmingham & Solihull	5716	8	32%	760	12 weeks
Manchester City	2786	7	51%	679	51 weeks

Budget

The gross expenditure outturn for 2021/2022 for the Liverpool & Wirral Coroner Services was £1,964,711. The recharge ratio according to population is 63% Liverpool City Council, 37% Wirral Council. Therefore, the cost of the Coroner's Service for 2020/21 was:

Liverpool £1,237,768 Wirral £726,943 The breakdown is as follows:



Over 57% 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.

28% of the budget is spent on employees – this includes all the Coroners' salaries 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.

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.

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 for your care, kindness and respect shown to our family. It meant a lot to us at this difficult time. We appreciate you, you do an amazing job*."

"I would like to take this opportunity to thank you from my heart for your professionalism, understanding, kindness, compassion and empathy. Our family would like to express our gratitude to you for handling the case with sensitivity."

"My wife died tragically earlier this year and I was fortunate enough to have X as our liaison officer. I wish to record my sincere appreciation for X. She advised and kept me informed at every stage. She was not just excellent but outstanding in all our dealings. This may well be the best service of any kind I have received despite my tragic loss"

"I will never be able to thank you enough and show my appreciation for your understanding regarding my sons death. I applaud your professionalism in what must be a difficult occupation at times. However, I'm aware that you must find it very rewarding and your manner is impeccable. On behalf of my family may I once again thank you."

"Many thanks for all your support and guidance throughout the process - it has been much appreciated. I would particularly like to express my sincere thanks to both yourself and the Coroner for making Friday's inquest such a positive experience - it felt inclusive, warm and very much family orientated."

"Thank you so much for taking good care of my son. You made things a little easier by explaining thoroughly everything to us. We'll be forever grateful."

"I wanted to thank you for all of your help and support following the sudden death of my brother. On behalf of my family we are forever grateful to you for keeping us informed every step of the way. Having someone to speak to and ask questions really helped. You have been so lovely and have made an unimaginably difficult time a little easier. Thank you for looking after my brother too. Our gratitude also goes to the Coroner and everyone involved for concluding the inquest sooner allowing us a resemblance of peace."

"Can I just say a big thank-you on behalf of my family. You have shown great empathy and understanding and have progressed mums case, so we can finally lay her to rest. It must be so hard for you with all the delays, but we are so grateful for your professionalism, understanding and support, thanks again."

"I wanted to drop you a quick note to express my thanks for your update call last week following my dad's post mortem. My mum and I really appreciated you taking the time to outline what happened to my dad and explain the next steps. We both found your approach to be professional yet also compassionate and sincere."

“Just a note to say that the family wish to say a big thank you to you for everything that you have done helping with my Mum. We are all very appreciative of the way that you have been sympathetic, professional and gone the extra mile to get the outcome that we wished for in what is a very difficult time.”

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 2021, the Liverpool & Wirral Coroner Area generated 5 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.

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 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 have been working throughout 2021 with new medical examiners appointed within Trusts to try and ensure that all referrals are relevant and appropriate. This involves providing training sessions and monthly meetings to discuss shared learning.

Building good working relationships with Medical Examiners and Bereavement Offices is really important to ensure that bereaved families are kept informed each step of the way. This work will continue to evolve until the service becomes a statutory duty anticipated to be April 2023.

The Medical Examiners have now started to scrutinise community deaths. Although progress has been made building these important relationships, it is likely this will cause an increase in referrals to the Coroner putting pressure on the service and may also affect the bereaved families experience.