BIRMINGHAM & SOLIHULL

CORONER'S ANNUAL REPORT 2021 & 2022

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ROLE OF THE CORONER

The Coroner is an independent judicial office holder appointed and funded by the Local Authority. The Coroner is responsible for investigating all violent and unnatural deaths, deaths where the cause is unknown and deaths that occur in custody or state detention. The purpose of the investigation is to identify who the person was, 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. We are trained by the Judicial College through course directors led by the Chief Coroner.

Our ethos is to put the family at the heart of the process in everything we do and to have an independent, open and transparent service.

The Coroner's service plays a key role in the response to Mass fatalities and excess deaths.

STAFFING

The service is headed by Louise Hunt, Senior Coroner, supported by Emma Brown, Area Coroner and James Bennett, Area Coroner. We have several Assistant Coroners who support the service, one of whom, Ian Dreelan, is working 3 days per week. Our Senior Investigator, Tracy Organ, leads a team of 8 Coroner's Investigators and a number of other Coroner's Officers and Administration staff. In total, we have 23 members of staff. There is also a public mortuary nearby with 6 members of staff.

It is right to say that the last 24 plus months have been challenging for the service. I would like to take this opportunity of thanking the Coroners' team for the incredible work they have done throughout the pandemic and whilst living with COVID. Without them, families would not have been able to arrange funerals and begin to deal with their loss.

WORK DURING & AFTER THE PANDEMIC

We had for many years been preparing for a mass fatality incident. The 2020 COVID19 pandemic brought new and previously unexplored challenges which rocked the whole world.

The Coroners' service was on the front line of the COVID response in dealing with the excess deaths that tragically occurred. We introduced new internal systems, working from home and remote inquests to enable us to continue to provide the service families needed. It is right to say that during the peak of the pandemic and during winter pressure months, processing cases took longer than we would like. Resources remain a challenge for the service. We have had new appointments, but the volume of work continues to grow, and we continue to review what staffing we need.

Whilst we are all "living with COVID" the consequences of the pandemic remain present in the Coroners' service. We continue to receive high numbers of referrals in accordance with the Notification of Death Regulations 2019.

Some of the ongoing challenges include:

- Finding a doctor who can legally provide a medical certificate of cause of death; the different ways doctors now work means less doctors can legally provide this certificate when a patient dies
- Patients are now often treated by other healthcare professional who cannot legally provide a medical certificate of cause of death.
- Doctors' shift patterns, leave and sickness impact upon who can provide a medical certificate of cause of death.
- The legislation on death certification needs an update to reflect modern medical practice.

Throughout 2021 and 2022, we worked through all of the outstanding jury inquests.

The Senior Coroner continues to chair the mortality working group which involves a multi agency response to excess deaths and mass fatalities. Our priority remains to treat all deceased patients with dignity and respect, to ensure families can hold funerals as soon as possible, to plan for any mass fatality and to provide mortuary resilience.

I continue to be immensely proud and humbled by the dedication and hard work of all our staff.

In November 2021 we moved into our new court building which provides three court rooms, including a dedicated jury court and jury suite. We have received very positive feedback from families that our facilities are working well. We need to resolve some issues with the heating system, but our new facilities will future proof the service.

BIRMINGHAM & SOLIHULL CORONIAL FACTS AND FIGURES

Birmingham and Solihull jurisdiction is one of the busiest and most complex Coroner areas covering a population of over 1.3million. Our figures for the last two years are:

2021: 5851 referrals,
722 inquests concluded and
1800 post mortem examinations.

2022: 6000 referrals,
795 inquests concluded and
1850 post mortem examinations.

Birmingham and Solihull have a higher than national average rate of jury cases which are held on a regular basis.

The continued pressure from increased referrals has resulted in some cases taking longer than we would like. Straight forward cases are normally processed within 2-3 days and cases requiring post mortem are processed within 7-10 working days. Those cases requiring an inquest usually conclude within 12 weeks. Very straightforward cases are often concluded within 3-4 days. These time frames compare very favourably to most other areas.

We have processes in place to allow urgency requests to be considered. All requests are considered, and cases are prioritised, within the confines of our Coronial functions. This was more challenging during the COVID 19 waves and winter pressures – however, we were still able to prioritise cases where appropriate.

We have had many families communicate their thanks to the service and we are proud that we can offer a compassionate approach.

REMOTE WORKING

We continue to use some home working which provides resilience to the team. We continue to embrace technology as you will read further in this report.

Most of our court cases are hybrid inquests. As a service, we see the importance of being flexible in our approach whilst always ensuring justice through the process. Witnesses can attend remotely, and this can be used for blue light services who remain under considerable pressure.

With training and support from the Lead Coroners' Investigator, our process are working very well. We continue to review these processes regularly to ensure we improve when necessary.

DEATH REFERRAL PROCESS

The duty to refer a death to the Coroner arises from Section 1 of the Coroners and Justice Act 2009 and the Notification of death regulations 2019. There are many reasons why a death needs to be referred including that the death is unnatural, involved a procedure or medication or where a doctor is unable to provide a cause of death.

Once a referral is received, it is assessed by the Coroner who determines what level of investigation is required. This can include approval of a proposed natural cause of death, further investigation by way of post mortem or gathering of evidence and proceeding to a formal investigation or inquest.

We expect that cases requiring approval of a natural cause of death will be processed within 1-3 days depending on the complexity of the case. Those requiring post mortem can take between 5-10 days depending on the availability of pathologists.

The service considers all requests to prioritise cases in accordance with the AYBS case for religious or other reasons and these cases are then fast-tracked through the Coroner's process.

Due to the fact that every case is different, investigations are tailored to that case. Investigation time frames cannot always be predicted due to the availability of doctors and other agencies, the complexity of the case and the need for onward referral to other investigative agencies.

The Coroners' team are all aware of the importance of releasing patients to their loved ones as soon as possible and do everything they can to achieve this.

The COVID pandemics and the winter of 2022/2023 have resulted in a significant increase in referrals. This has sadly affected some time frames but staff have continued to work tirelessly to process cases as quickly as they can. Further staff have already been appointed with more due to be appointed later in 2023.

Doctors are required to refer a death when one of the factors listed in the Notification of Death Regulations 2019 exists. COVID 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 Medical Certificates of Cause of Death when a patient dies as only a doctor who has treated the deceased in their last illness and seen them (face to face or on video) within 28 days can legally issue the certificate. Modernisation of the death certification rules is needed to allow doctors to issue certificates more readily.

POST MORTEMS & PATHOLOGY

There remains a national lack of pathologists across the country. Currently the service has access to four pathologists. This has resulted in the time to post mortem taking longer that we would like at some times during the year when winter pressures exist. Efforts have been made to find new pathologists but the reality is that due to changes in the histopathology training programme many years ago, there are now very few pathologists opting to undertake the post mortem training module.

The West Midlands has no paediatric or perinatal pathologists. The consequence of this is that children requiring any examination must be taken out of the region. We have raised concerns about this at national level.

We undertook 1800 post mortem examinations during 2021 and 2022. Of that number 875 were CTPMs. CTPM is good for trauma and excluding trauma and for identifying COVID19. It is not able to confirm drugs deaths and complex medical deaths. We continue to undertake CTPM on cases where it is likely to provide a cause of death. Overall, it has a success rate of around 65%.

We provide a 24/7 on call service to authorise forensic examinations in suspicious cases.

Birmingham City Council are scoping the possibility of a new mortuary for the region which would include a dedicated CTPM service; however this will be subject to the necessary funding being made available.

THE MEDICAL EXAMINER SCHEME

The Medical examiner (ME) scheme was introduced several years ago following the governmental Shipman enquiry. There were several pilots across the country and now most Acute Hospitals nationally have an ME scheme in place. It has proven very successful, both in providing information to the Coroner's service and improving the quality of death certificates and supporting Doctors and families.

The legislation for a nationwide ME scheme was approved by Parliament to include all Hospitals as well as the community and the planned "go live" date was the beginning of April 2023. The community scheme for Birmingham and Solihull is being led by a team at University Hospitals Birmingham who have put in considerable work to prepare for the impact of the new legislation. The team at UHB are rolling out a series of training sessions for GPs regarding the new requirements.

Whilst the start date has recently been put back to later in the year, it is important that all parts of the community are ready for this key change.

All community deaths where a medical certificate of cause of death is issued need to be reviewed by a medical examiner. The medical examiner will consider the medical history, the cause of death offered and recent contact with the deceased during their scrutiny. Cases that require a referral to the Coroner in accordance with the Notification of Death regulations 2019 will still be referred to the Coroner however when an MCCD is authorised by the Coroner the medical examiner will still scrutinise that case.

There are 164 GP Surgeries in Birmingham and Solihull and the majority of surgeries have a number of GPs. The inception of the community ME scheme will be very helpful to the Doctors in the community. There is often considerable confusion about who can issue an MCCD and under what circumstances. This was further complicated during the pandemic with the Coronavirus Act 2020 which conferred wide ranging powers and temporary flexibilities to enable the public sector to respond to the Covid-19 pandemic. The Act expired on 24 March 2022 and much of the temporary flexibility ceased apart from a few areas including the previous requirement for the Doctor to have seen within 14 days was amended to 28 days.

The Doctor who treated the deceased prior to death must have seen the deceased in person or by video. For the Doctor to be able to issue an MCCD the Doctor must not only have seen the deceased within 28 days of death or after death but must also have treated the deceased for the condition from which they have died.

The Doctor seeing the deceased after death must be in person in order to comply with the cremation regulations.

The Coroners' team sit on the working group for the roll out of the full ME scheme ensuring a joined up process for all.

MANAGING THE MORE COMPLEX CASES

At any one time the jurisdiction will be investigating a small number of more complex cases (between 12 and 18). These cases are complex because of the events giving rise to the death and will often be heard with a jury (a jury is required in very specific circumstances including deaths at work, unnatural deaths in state detention and any death arising from an act or omission of the police). They include deaths in connection with someone's work, deaths in prison, deaths in mental health units and deaths due to a crime where there is reason to believe that a public agency failed to protect the victim adequately.

These cases usually involve the collection of large volumes of evidence; this may include witness statements, photographic and CCTV footage, social media and phone records, policy and procedural documents, extensive medical and/or work and/or custodial records and documentation from incident investigations carried out by other agencies such as the HSE or Police. When collected it is not unusual for the evidence to comprise of thousands of pages.

As well as an assigned Coroner to manage the investigation and conduct the inquest, the case will be assigned an experienced Coroner's investigator from the outset and the team's para-legal will manage the collation of the evidence and the disclosure. All disclosure is made electronically which requires use of several platforms and techniques to enable participants to access not just PDF documents but also photographs, video and audio recordings.

There will usually be many witnesses. Some witnesses will require reasonable adjustments to enable them to give their best evidence such as steps to alleviate their anxiety or distress, interpreters and measures to overcome a learning or physical impairment.
It is typical that many individuals and organisations will have been involved in the events leading to the death and therefore will be entitled to 'interested person' status at the inquest. This entitles them to legal representation, disclosure of evidence, input in the procedural aspects of the case, questioning witnesses and making submissions on the law.

All these factors mean that a considerable amount of time and resources must be allocated to these cases. As well as the work of the Coroner and their team in analysing the evidence as it is received and preparing the case, the hearings themselves are a complex logistical exercise. Pre inquest review hearings ('PIRHs') will be conducted to plan for the final hearing at which all the interested persons can make submissions on the evidence needed and the procedure to be followed. There will usually be at least two PIRHs for a jury inquest and they can last several hours. As well as the Coroner, other members of the team attend these hearings such as the assigned Investigator, the team's para-legal, the lead Investigator and a court usher. If the case gives rise to a disputed legal decision, it may be necessary for the Coroner to give a written judgement following the hearing setting out the nature of the dispute, an analysis of the law and the reason for the decision made.

It usually takes at least 12 months for one of these complex cases to be ready for final hearing but if other agencies need to complete investigations or prosecutions before the inquest can proceed, it can be years before the Inquest is heard.
The workload peaks at the final hearing. When sitting with a jury, jurors must be summonsed and selected and require an individual member of staff to manage and assist them throughout the inquest. If there are witnesses or interested persons attending remotely, a member of the team will be the online court usher who monitors the link throughout the hearing. In court, the organisation of witnesses, the interested persons and the legal representatives are managed by the case's assigned Investigator. To accommodate all participants, a large court room is needed and a number of consultation rooms for the interested persons to use outside of court; the inevitable emotions of an inquest mean it is preferable and desirable to separate participants from different organisations. Occasionally a witness maybe given anonymity which means that their identity cannot be revealed. They cannot be visible to anyone except the Coroner and legal representatives; this requires their movement in and out of court to be carefully orchestrated and screening to be used during their evidence.

For the duration of the final hearing, the Coroner's time will be fully occupied by the case. Before court, the Coroner will be planning and preparing the questions for witnesses and the documents to be shown in evidence. During the hearing the Coroner will be asking questions of the witnesses, keeping notes and dealing with submissions on the law and procedure from the legal representatives. After court each day, time needs to be spent planning for the next day and collating the summing up of the evidence for the conclusion of the hearing.

Often the case will attract public and media interest. All inquests are public hearings and must be conducted transparently. This requires the media to be able to report the case accurately. Consequently, members of the media may apply for access to certain items of evidence referred to during the hearing. This will require the Coroner's consideration and potentially submissions from the legal representatives. The media sometimes apply for interested person status if the case raises a particular public interest. These applications can be highly contentious and raise the anxiety and distress of others involved in the hearing so they have to be managed very carefully.

When all the evidence has been heard the Coroner will hear submissions from the legal representatives on the appropriate conclusions to be reached. When sitting with a jury, written legal directions will be prepared to assist them through their deliberations. If the Coroner is sitting without a Jury they must give a full reasoned judgement that summarises the relevant evidence, sets out the findings of fact made and the reason for those findings and then distils the findings of fact into the formal conclusion on who the deceased was, how, when and where the death occurred. The Court day usually runs from 10:00am until 4:30pm, but the Coroner with the assistance of their team will spend many hours at the start and end of the day working to ensure the case can proceed efficiently.

The time needed for a jury to deliberate and reach their conclusions will vary according to the amount of evidence and the complexity of the case but they usually require at least 2 days.

Simultaneously, the Coroner will be considering whether the duty arises to make a Regulation 28 report to prevent future deaths, potentially hearing evidence on action taken since the death and drafting the report if one is necessary.

At the end of the inquest the work is not done. The investigator will take time with the family to explain the registration process, there will be requests for the recording of the inquest and copies of the record of inquest to be processed and distribution of any Regulation 28 report to the addressees, the interested persons and the Chief Coroner. Responses to any regulation 28 report will be collated and distributed following receipt.

Finally, the team can reflect on things that went well and anything that should be adjusted in future in the hope that even in these most complex, and often distressing cases, we have still achieved our aim of a full, fair and fearless inquiry.

IT & THE CORONERS' SERVICE

Civica Coroners

The coronial function is complex and sensitive, so it is critical that our IT processes are as streamlined as possible. As such during the Covid pandemic, the Coroners' Service moved to a cloud-based system that enabled the team to access the system at any time from any device and eliminated the use of paper files.

Our system manages the entire coronial process electronically from referral to the closure of the case. The system allows the whole team to move seamlessly through the workflow of the coronial service, including the generation of forms, certificates and letters.

A small team within the Coroners' Service are trained in managing the system, they have the ability to make changes to workflows in line with any legislation changes, changes to documents and creating new processes within the system. They also manage any day to day issues which may arise.
Staff are able to safely store and manage evidence received from external and internal agencies, in the form of emails, PDF documents, photographs, CCTV and body worn footage within the system.

It is through this system that the Coroner is able to create and manage evidence bundles for distribution and use in inquests. The bundles are sent via the secretarial team using secure emails and for larger more complex bundles these are sent via secure cloud link.

The system is able to generate reports which enable the service to monitor and report on deaths, referrals, trends and enable the service to complete the annual Ministry of Justice returns.

We have introduced a portal referral system to the Hospitals within our jurisdiction to enable doctors to refer cases directly to us on-line using our Civica system.

Microsoft Teams

During Covid, the Coroners' Service heavily relied on the use of Microsoft Teams to maintain continuity of inquests remotely.

The use of Microsoft Teams allowed families, witnesses and interested persons to join the inquest hearings using video or audio from a desktop, laptop, tablet or smartphone, or to dial-in to a hearing from a telephone.

This new way of working had its challenges. However, the team managed to work collaboratively, learn new IT skills and successfully open and conclude inquest hearings during the pandemic.

We now continue to use a mixture of remote and in person hearings supported by Microsoft Teams rooms.

Our Systems within Court enable families, witnesses, interested persons, members of the public and press to attend remotely and/or in person. We are able to present documents/ evidence on screens in each of our Court rooms.

REPORTS TO PREVENT FUTURE DEATHS

Alongside our duty to investigate deaths and to answer how the deceased came by their death we also have a statutory function to send a report to prevent future deaths when we are concerned about a possibility of another fatality in similar circumstances. This is a very important part of our role and can bring about important changes which protect the public. It is often the only consolation a family will get after the loss of a loved one.

RPFD reports and responses are made public
via the Courts and Tribunals Judiciary service at:
https://www.judiciary.uk/?s=&pfd_report_type=&post_type=pfd&order=relevance

In 2021 and 2022 seven different Birmingham and Solihull Coroners
issued a total of **18 RPFD reports**, as summarised below:

CATEGORY	NUMBER OF REPORTS	SAFETY ISSUES RAISED & CHANGES BROUGHT ABOUT
Nursing & Care Home	2	• More effective falls risk assessment processes. • More effective internal investigations to learn lessons from deaths. • New skin inspection assessment process.
Hospital (Physical Health)	2	• New clerking system to ensure patients are seen without delay. • Software changes to ensure heart monitor alarms re-set after being silenced. • Changes to NHS lessons learned investigations to ensure they are comprehensive and robust.
Police	3	• More effective system to record risk assessment information prior to a firearms operation. • More effective system to appoint a CPR co-ordinator amongst a team of firearms officers to treat any person shot during the operation. • A new Domestic Abuse policy and new system for recording information coherently. Changes to reduce the work load of associated officers and more effective training to recognise red flags. • Greater understanding amongst custody suite officers/ staff of severe mental illness. Greater understanding of roles and responsibilities between police staff and mental health clinicians in custody suites, and a more robust system for police staff to challenge decisions of mental health clinicians.
Ambulance/ Paramedics	2	• Greater awareness of less common severe mental illness. • Changes to allocation of ambulances to avoid delays in attendance.

CATEGORY	NUMBER OF REPORTS	SAFETY ISSUES RAISED & CHANGES BROUGHT ABOUT
Mental Health Services	5	• Increased number of clinicians. • More effective method for recording critical information coherently. • More effective internal investigations to learn lessons from deaths. • A review of a category of patients identified as being at risk due to changes in support levels. • Review of the effectiveness of a safety fence at a secure mental health unit. • Review of referral process from GP to the crisis team. • Improvements to processes used to share critical information with other agencies.
Prison	2	• Greater officer training on responding to cell emergencies. • More effective systems to record cell fabric history and ligature risks. • Greater resourcing of officers/clinicians to assess cell ligature points. • Greater officer training on recognising signs of self-neglect.
Military	1	• More robust screening system to identify high risk candidates with sickle cell traits pre-training exercise. Greater education on the risks to those with sickle cell traits during strenuous exercise. • More effective system for identifying near miss themes. • More effective system to ensure urgent medical assistance is available during strenuous exercise.
Local Authority	1	• Dangerous kerb at a road junction rectified.

The following are three important examples set out in more detail:

Floyd Carruthers

Floyd was aged 58, had been suffering with Mental Health issues since about 2000 and had a diagnosis of Paranoid Schizophrenia. During 2020 Floyd stopped taking his medication and his behaviour became more irritable and challenging leading to his arrest on 9/4/21. On the 12/4/21 he was remanded to HMP Birmingham. He was sentenced to 66 days imprisonment on 6/5/21. When Floyd arrived at HMP Birmingham, a prison GP noted that he had a pacemaker fitted, and that more information about it was needed, and that Floyd was not taking any medication. Floyd was assessed by the Mental Health Team on 7/5/21 however declined any help from them. Having briefly left his cell on 25/5/21 Floyd didn't then leave his cell again during the following 4 days. During that time, he was spoken to by prison officers, but declined to come out of his cell, and he was also brought his meals. On 29/5/21 when staff unlocked Floyd's cell for the midday meal, they found him slumped in a chair. Medical assistance was requested, staff called for an ambulance and Floyd was taken to City Hospital where he was found to have an infection at the site of his pacemaker. While a number of options were explored in terms of possible treatment, Floyd's condition continued to deteriorate and he died in City Hospital on 14/6/21.

Following a 2-week Inquest in December 2022, the jury concluded that Prison staff and the prison Healthcare staff took insufficient steps to safeguard Floyd throughout the period 10/5/2021 - 29/5/2021. This included insufficient record keeping, handover and escalation of events, such as missed meals and not leaving his cell. The jury also concluded there were failures of Prison staff to make a referral to healthcare in response to Floyd's condition, as reflected in his overall pattern of behaviour and his presentation, between 25/5/2021- 29/5/2021. As a result, the Jury reached a conclusion that death was contributed to by neglect.

A Prevention of Future Deaths Report was sent to the Minister of State for Prisons, Parole and Probation highlighting the concerns over the implementation (to include training) of a national safeguarding policy and that the existing safeguarding escalation process was either inadequate, inappropriately trained or both.

Raneem Oudeh & Khaola Saleem

On 27th August 2018, Raneem Oudeh and her mother were stabbed to death outside Mrs Saleem's home address by an ex-partner of Ms Oudeh. Ms Oudeh had been in a relationship with the perpetrator, however this was an abusive relationship and she had tried to end it. From April 2018 through to August 2018 there were seven incidents of domestic abuse involving Ms Oudeh which resulted in the police attending. On each of these occasions, the police failed to adequately investigate potential offences and failed to obtain evidence in relation to potential serious offences including threats to kill, theft, burglary, harassment, stalking and controlling and coercive behaviour, and they failed to consider the arrest of the perpetrator. On 26/08/18, Ms Oudeh and her mother had attended the Rotana Shisha Lounge to meet a friend. The perpetrator followed them and an altercation occurred inside the lounge which was recorded on CCTV. Ms Oudeh called the police and advised she and her mother had been assaulted. Police response was delayed due to a firearms incident nearby. Ms Oudeh advised police that she was going to her home address as she felt unsafe. Officers attended the original location and did not find the suspect. The call was transferred to Solihull dispatch centre as Ms Oudeh's address was outside Birmingham. The call was then down graded without an adequate risk assessment. Ms Oudeh called police again (3rd call) saying she did not have keys to her flat and asked when officers would attend. She called a 4th time advising she was going to her mother's address as police had not attended. On arrival at her mother's address, the perpetrator was lying in wait and murdered both women. He was convicted and sentenced to life imprisonment with a minimum term of 32 years.

An inquest before a jury held over 4 weeks found that there were numerous failings in how the police had dealt with the 7 incidents including that police had insufficient training and understanding of the issues involved in domestic abuse and failed to identify the risk to Ms Oudeh. Officers failed to investigate potential offences from April to August 2018 and failed to safeguard Ms Oudeh and her mother which materially contributed to the deaths.

Unusually a report to prevent future deaths was sent during the inquest as the court heard evidence that the current domestic abuse department was significantly under resourced and unable to adequately investigate cases. After the inquest a further report to prevent future deaths was sent identifying concerns around training and understanding of domestic abuse, record keeping and resourcing and the use of domestic violence protection notices and orders.

Jack Hurn

At the age of 26, Jack Hurn died at the Queen Elizabeth Hospital Birmingham at 13:06 on the 11th June 2021. He had received a first dose of the Astra Zeneca vaccination for COVID-19 at the Dudley and Netherton primary care network vaccination centre at the Revival Fires Church on the 29th May 2021. At that time, the Joint Committee on Vaccines and Immunisation had advised that it was preferable for adults aged under 40 years without underlying health conditions to be offered an alternative to the Astra Zeneca COVID-19 vaccine unless that would cause substantial delay but people could make an informed choice to receive the Astra Zeneca vaccine to receive earlier protection. Jack was not given all the information to make an informed choice at the time of giving his consent to the vaccine. In particular, the risk of complications for his age group was understated. On the 6th June, Jack developed a headache which persisted and worsened leading to him being admitted to the Alexandra Hospital Redditch on the 8th June 2021. Imaging revealed extensive superior sagittal sinus thrombosis and he was diagnosed with Vaccine-Induced Immune Thrombocytopenia and Thrombosis ('VITT'); a new but extremely serious condition caused by a rare complication of the Astra Zeneca vaccine. Following diagnosis, Jack was admitted to a medical unit, he was not referred to a specialist neurology and haematology team in accordance with guidance on the management of VITT CVST and the regional VITT pathway. Jack deteriorated during the afternoon of the 9th June and at approximately 1800 it was identified that his Glasgow Coma Score had dropped to 11/15 and he had developed dense right hemiplegia. Imaging showed extension of the previous thrombosis along with new areas of thrombosis and haemorrhage prompting contact with specialist services at the Queen Elizabeth Hospital into whose care he was transferred. Despite mechanical thrombectomy and decompressive craniectomy alongside full supportive measures Jack's condition deteriorated and became unsurvivable. Death was due to a rare but recognised complication of the Astra Zeneca COVID19 vaccination: 1a Cerebral venous sinus thrombosis. 1b Vaccine-induced immune thrombocytopenia and thrombosis (VITT) 1c ChAdOx1 nCOV-19 adenoviral vector vaccination.

During the inquest it was identified that whilst much action had been taken to stop the sort of issues that contributed to Jack's death arising again, there had been failings in the investigation carried out by Worcestershire Acute Hospitals ('WAH'). The WAH investigation did not identify that there was national guidance or a regional Pathway for patients in Jack's condition and consequently did not provide any explanation of why they were not followed in Jack's case. Further, during the inquest issues with clinical decisions and monitoring of Jack were identified whilst at the Alexandra Hospital which were not considered in the WAH investigation report. This raised a concern that the investigation was not sufficient and as such had not served its purpose of safeguarding patients which could put lives at risk. Consequently, a regulation 28 report was made to WAH highlighting the issues of concern.

WAH have responded confirming that Jack's case has been revisited and an action plan created which has been discussed with the CQC to ensure that in any future events national guidance and regional pathways are followed. Further the Trust has reviewed the serious incident investigation process to ascertain why the report was deficient and have identified that the investigation process was not fully followed and taken action to strengthen and enforce compliance with the process.

A FOCUS ON ASSISTANT CORONERS

The Birmingham Senior and Area Coroners are supported in delivering Coronial Services to Birmingham & Solihull by a team of 7 Assistant Coroners. These Assistants bring a wide range of backgrounds and experience to the role, being a mix of solicitors and barristers, one of whom is a former military lawyer. Geographically they provide support from Somerset, Wiltshire, Liverpool, Shropshire and Worcestershire. They mainly carry out their duties in person in Birmingham, although since Covid there has been an increased opportunity to provide some support remotely from home, allowing more flexibility in their support to the Senior Coroner.

As Assistant Coroners (the word Assistant simply denoting that they are not full time) they are required to sit for a minimum of 20 days per year, attend Judicial College training and maintain their own currency with developments in Coronial law and procedure. The Assistant Coroners support the service, covering both the back office function (making case management decisions required on cases outside of court) and court days. Court days cover the full range of inquests and can also include specific 'Rule 23' days – where the Assistant Coroner may complete upwards of 10 short inquests where no witnesses are being called to give evidence. As their experience develops, Assistant Coroners will also begin to cover Jury Inquests.

Each Assistant has a nominated full time Coroner to seek advice from. Their full time 'mentor' will also be responsible for carrying out an annual appraisal of the Assistant Coroner's performance in line with the appropriate Chief Coroner's Guidance. The Senior Coroner holds several meetings throughout the year (a mixture of in person and remote) to ensure the Assistant Coroners are kept up to date with developing national issues and Birmingham & Solihull specific issues.

The role of Assistant Coroner is much sought after and is seen as both a very rewarding and very challenging appointment. The Senior and Area Coroners of Birmingham and Solihull all began their Coronial careers as Assistant Coroners.

EDUCATION

For the Coroners' service to be effective, we need good working relationships with other agencies. We conduct regular training sessions and hold quarterly multi agency meetings to ensure efficient working practices. It is through these efforts that we achieve effective processes ensuring families receive a compassionate, timely and efficient service.

We maintained excellent links with all the agencies we regularly work with during the pandemic. This allowed us, and them, to maintain good processes keeping families at the heart of what we do.

The following are a selection of some of the activities in which we are involved, helping to maintain an appropriate level of service for the bereaved:

- Advising Hospital Doctors and GPs on the impact of cessation of the Coronavirus Act 2020 and when they can issue a Medical Certificate of Cause of Death
- Member of the working group for implementation of the community ME scheme
- Giving a talk to MEs at our local Trust
- Chairing the regional Mortality Working Group
- Regular meetings with WMP and CPS regarding suspicious cases
- Member of the LRF Strategic Group
- Member of the Drugs Forum cross agency working group
- Attending DVI, Mass fatality and CBRN meetings
- Close liaison with pathologists undertaking PMs.
- Meetings with acute trust medical directors
- Meeting with Mental Health Trust senior leadership
- Reviews with the Integrated Care Board
- Member of the learning from deaths strategic group
- Member of the suicide prevention working group
- Key member of the SUDIC (Sudden unexpected death in children) process.

We will continue to work with all agencies to ensure we evolve and adapt processes for the benefit of bereaved families.

RESEARCH PROJECTS

We are aware that part of our role is to prevent future deaths. As a result we work collaboratively with a number of different research projects to promote safer practices and avoid future deaths. We are currently involved in the following projects:

- Reducing Child deaths through the SUDIC process and reviews with CDOP
- Provision of a post mortem service for South Staffordshire Coroners' service
- British Heart Foundation pilot to identify genetic factors in sudden cardiac deaths
- Member of the working group to review drugs deaths in the city and plan how to help to reduce them
- Member of the working group to review suicides in the city and to plan how to help to reduce them
- Research study on knife crime to try to improve initial treatment and survival rates
- Pilot project for community medical examiner scheme.

CHALLENGES & THE FUTURE

There are ongoing challenges for the service most notably the lack of pathologists and the death certification laws which have resulted in an increase in referrals. There is no quick and easy solution to the lack of pathologists and a change in legislation is required to improve the death certification process.

But despite these challenges, I remain immensely proud of the special team we have at the Coroners' Office. They are hardworking, dedicated, caring staff who continually go the extra mile to help families. We will keep doing what we do.