Courts and Tribunals Judiciary

BIRMINGHAM & SOLIHULL

CORONER'S ANNUAL REPORT

APRIL 2023 - APRIL 2024

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THE 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 bereaved at the heart of the process in everything we do and to have an independent, open and transparent process.

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

STAFFING

The court 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 team, 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 24 members of staff. There is also a public mortuary nearby with 7 members of staff.

The Coroner's team continue to work tirelessly for bereaved families. I would like to take this opportunity of thanking them for the incredible work they do. Without them, families would not be able to arrange funerals and begin to deal with their loss.

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 year are:
2023: 5152 referrals, 900 inquests concluded and 1782 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, particularly during the winter season. This has been compounded by the national lack of pathologists. Straightforward cases are normally processed within 1-3 days and cases requiring post mortem are normally processed within 5-10 working days. Those cases requiring an inquest usually conclude within 12 weeks; however very straightforward cases are often concluded within 3-4 days. These time frames compare very favourably to most other areas.

During winter pressures, post mortem examinations are taking longer than our normal time frames. The national lack of pathologists has been raised with both the Ministry of Justice and Department of Health and Social care. There is currently no clear identifiable solution to this problem.

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. The lack of pathologists has resulted in urgent cases requiring post mortem taking longer than we would like. We have a system in place to advise families of expected time frames and the situation is reviewed regularly each week.

We have had many families communicate their thanks 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 court, 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 processes 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 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 coroner 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 process.

Since 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.

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 (MCCD) 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 we have 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 particularly 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 1782 post mortem examinations during 2023. Of that number 241 were CTPMs. CTPM is good for identifying 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 75-80%.

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

Birmingham City Council continue to scope the possibility of a new mortuary 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 team 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 is due to start in April 2024.

The community scheme for Birmingham and Solihull is being led by a team at University Hospitals Birmingham who are currently preparing for a date yet to be fixed in April 2024. All GPs are being contacted and advised with the assistance of the ICB. The new statutory requirements are a considerable change to the current practices and includes some changes to the MCCD.

All community deaths where a MCCD is issued and where the death does not need to be referred to the Coroner under the notification of death regulations 2019, need to be scrutinised by a medical examiner. The Doctor needs to have attended the deceased in life (definition awaited) but the requirement to have attended the deceased within a specified time range will be removed. The medical examiner will consider the medical history, the cause of death offered and recent contact with the deceased during their scrutiny. If agreed the MCCD will be sent by the medical examiner's officer to the register office for registration.

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, where the Coroner finds there is a natural cause of death they will issue a form to the GP and the ME to confirm that they are not taking jurisdiction, the medical examiner will then scrutinise that case.

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.

Examples of the complex cases completed this year include:

- Unlawful killing of a visitor to Birmingham fatally stabbed whilst on a night out by a perpetrator with paranoid schizophrenia who was released from prison shortly before the events without any support in place for his mental health and without adequate risk management.

- A death following a detained mental health act patient being able to smuggle heroin into a mental health unit following leave and subsequently smoke it in the unit.

- The accidental death of a contractor working on a HS2 construction site who was struck by the tail end of a 180mm poly-ethylene pipe, as it was being dispensed by a coil trailer where the absence of a means of restraining the tail end of the pipe contributed to the death.

- Death of an elderly care home resident from aspiration and other natural conditions after being mistakenly fed a soft diet.

- A traumatic death of a young man who stepped in front of a train having absconded from a locked mental health unit, failings in his care at the unit amounted to neglect and contributed to the death.

IT & THE CORONERS' TEAM - 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 Coroner's team 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 process, including the generation of forms, certificates and letters.

A small team within the Coroner's team 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 team to monitor and report on deaths, referrals, trends and enable the team 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 Coroner's team 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 it's 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. This includes both local and national safety issues. 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 2023 eight different Birmingham and Solihull Coroners issued a total of **20 RPFD reports** as summarised below. Reports are legally required to be sent to senior people who have the ability to consider the concerns raised and bring about changes. Single reports are often sent to multiple organisations and agencies, and in 2023 this included (a) Chief Executives of NHS trusts/hospitals and private health providers, (b) Chief Executive of Birmingham City Council, (c) Mayor of the West Midlands, (d) Chief Constable of West Midlands Police, (e) regulatory bodies, and (f) a number of government ministers including the Secretaries of State for both health and transport.

CATEGORY	NUMBER OF REPORTS	SAFETY ISSUES RAISED & CHANGES BROUGHT ABOUT
Mental health services (NHS and private providers)	11	• Against a background of chronic lack of resources: increased numbers of inpatient beds, clinicians, safe spaces, pharmacists. • Improved multi-agency collaboration and planning for missing patients. • Improved collaboration amongst internal specialist teams. • Greater consideration of patient family's concerns. • Greater consideration of GP concerns before being overruled. • Consideration of having psychiatrists as part of mental health services in custody. • More effective recording of current patient risk information, and more effective recording of risk information in formal risk assessments. • Greater clinician training to monitor patients on Clozapine. • More effective internal investigations to ensure all lessons are learnt. • More effective steps to prevent illicit drugs entering secure mental health hospitals. • Changes to computer systems to avoid clinicians inadvertently recording medication being taken by detained patients when it hadn't been. • Consideration of the risks caused by different NHS organisations using different computer systems that do not communicate with each other, and cannot be accessed by all clinicians preventing them from having complete patient information at urgent assessments. • Greater clinician training on awareness and prevention of pressure ulcers.

CATEGORY	NUMBER OF REPORTS	SAFETY ISSUES RAISED & CHANGES BROUGHT ABOUT
Police	2	• Improved multi-agency collaboration and planning for missing mentally ill patients. • Greater training on assessing the risks of missing mentally ill patients
Local Authority physical/mental health services	3	• Against a background of chronic lack of resources: recruitment of more approved mental health practitioners to undertake mental health act assessments, and greater provision of mental health inpatient beds. • More effective multi-agency communication around patients in the community requiring 1:1 care/ observations.
Prisons	3	• Greater staff training around spotting mental health risks of prisoners. • Consideration of having psychiatrists as part of mental health services in custody.
NHS (physical health hospitals and community services, including GPs)	10	• Awareness of the risks caused by different NHS departments in hospitals, and different NHS organisations, using different computer systems that do not communicate with each other, and cannot be accessed by all clinicians preventing them from having complete patient information often at urgent assessments. • More effective automated patient record alerts to reduce the risk of key information being missed. • Patient falls risk assessments to consider a greater number of risk factors. • Greater training of staff observing patients at risk of falling. • Consideration of recruiting more consultants to ensure seriously ill patients are assessed by senior doctors. • More effective planning around home births and changes to ensure expectant mothers can make an informed decision before consenting to a home birth. • Raised awareness by clinicians about the rare disease Myasthenia Gravis. • More effective training of clinicians to remove long term catheters. • Awareness of the chronic lack of GP resources.
Transport	1	• More effective security checks to ensure under 18s are unable to access public e-scooters.

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

Steven Sanders

This case involved a regulation 28 report being made before the inquest occurred because a risk to life was identified that illicit drugs were getting into a medium secure mental health unit during a time when there was a particular danger from street drugs being contaminated with nitazenes (potent synthetic opioids). The report went to the Mental Health unit, West Midlands Police and the Care Quality Commission to ensure the risk was identified. Consequently, the organisations were able to cooperate and share intelligence to mitigate, as far as possible, the risk which resulted in very positive steps being taken even before the inquest had taken place.

Mustafa Nadeem

Mustafa fell into the path of a bus whilst riding a public e-scooter enroute to school.
The e-scooter had been unlocked by another school boy via an 'app' on his mobile phone, and was paid for via a children's bank account. The investigation identified that whilst it was illegal for under 18s and those without a driving licence to use public e-scooters, the only verification of age, identify and possession of a driving licence was at the point of registration, but registration could easily be transferred to a child with no further checks. The Regulation 28 report went to (a) Secretary of State for Transport (the Department For Transport was responsible for the e-scooter pilot), (b) Mayor of the West Midlands (the West Midlands Combined Authority was responsible for local implementation of the e-scooter pilot), and (c) Chief Executive of Collaborative Mobility UK (as there was no national regulatory body, this organisation that was involved in working with national and regional authorities on the use of e-scooters, could positively contribute). Consequently, these organisations were able to consider issues around e-scooter providers not having the ability to know if a child's bank account was used and ensure more robust age and identity verification checks at different stages of the registration process to reduce the risk of public e-scooters being used by children.

Dorota Kuklinska

Mrs Kuklinska attended Hospital having woken with a severe headache and vomiting.
She had a CT scan which was misreported as normal, and despite being advised about having a lumbar puncture she went home. Just under a month later she collapsed at home from a ruptured cerebral aneurysm and died a few days later in hospital. The regulation 28 report raised concerns that the guidelines prepared by specialist neurosurgeons for patients with spontaneous severe headache who refused a lumbar puncture were not known to the hospital she attended and that it was important all hospitals understood the guidance for such cases was to refer for specialist neurosurgical assessment.

EDUCATION

For the Coroners' team 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 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 role of the Coroner 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
- 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
- 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
- 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 team most notably the lack of pathologists and the introduction of the statutory medical examiner scheme. There is no quick and easy solution to the lack of pathologists. The statutory medical examiner scheme will need time to bed in once its implemented in or soon after April 2024.

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