Report investigating coroner engagement with local authorities across England, December 2024

PHI Public Health Institute
LIVERPOOL JOHN MOORES UNIVERSITY

Introduction

The Public Health Institute (PHI) based in Liverpool John Moores University (LJMU) are currently commissioned by 26 local authorities within England to facilitate monitoring and surveillance of drug and alcohol related deaths (DARD). Via this commissioned work, LJMU work directly with 11 coroner's offices to 1) gather information related to cause of death for individuals who were in-treatment; and 2) collate information for individuals who were out-of-treatment and died from a drug or alcohol related death. Within these 11 offices, the means and availability of information can differ. This is not dissimilar throughout the country where relationships and levels of communication between coroner's offices and local authorities can vary significantly.

In order to obtain a clearer picture of coroner engagement across the whole of England, the National DARD Intelligence Group which is chaired by staff from PHI agreed to send out a survey to all local authorities across England in order to identify where engagement was good, where it could be improved and where there was little to no engagement at all. Contacts from the Office for Health Improvement and Disparities (OHID) kindly shared the LJMU-created survey with local authorities across England in October 2024 to gather this information.

This report will provide an overview of current engagement of local authorities with coroner's offices on the basis of responses to this survey. It summarises the positive working elements between local authorities and coroner's offices; the areas in need of improvement; and recommendations to foster better relationships and engagement.

Executive summary

- The data presented in this report comes from 130 responses across 121 Upper Tier Local Authorities[1].
- Around two in three (65.4%, n=85) local authorities stated that they receive details of drug related deaths routinely from their local coroner's office.
- For those that indicated they do not receive routine notifications (n=45), 16 noted that they are engaged with their coroner's office, but engagement is non-routine. Another eight local authorities noted that they are currently in the process of building either new or stronger relationships with their respective coroner's offices.
- Among the 85 local authorities that receive information from their coroner's office, the types of information received varies. The two documents received most often are the toxicology reports (78.8%, n=67) and the record of inquest (76.5%, n=65).
- The frequency of receiving this information varies amongst the 85 local authorities, whereby almost three in ten local authorities (28.2%, n=24) receive information on inquest completion and over one in four (27.1%, n=23) receive information monthly.
- Over four in five (84.7%, n=72) local authorities have the opportunity to ask follow-up questions on individual cases.
- In around two in three cases (65.4%, n=53), local authorities were either not given or rarely given early indication of a potential DARD case.
- Over one in five (22.4%, n=19) local authorities were not sure if their coroner's office tested for the new synthetic opioids called nitazenes. Around three in four (74.1%, n=63) local authorities stated that their

[1] Upper tier local authorities provide a range of local services. As of April 2023, there are 153 upper tier local authorities in England made up of 63 unitary authorities, 36 metropolitan districts, 33 London boroughs (including City of London) and 21 counties.

coroner's office did test for nitazenes, but this varied between testing only in specific cases (38.8%, n=33) and routine testing (35.3%, n=30).

- While some local authorities have cited an overall positive relationship with their coroner's office, others have experienced limited engagement. The major challenges or barriers for most local authorities include issues around data sharing, inquest times, organisational issues or changes within coroner's offices/areas, lack of consistency, and lack of clarity in toxicology reports.
- Suggestions for building relationships included establishing clear guidance and a mandate from central government or the chief coroner for sharing information; the creation of a centralised database for all DARDs or a system that shares coroner records automatically with local authorities; the provision of dedicated and consistent information across the country; and establishing regular meetings (e.g. monthly) between local authorities and the coroner's office to address any queries from recent cases.

Survey responses

The data presented in this report comes from 130 responses and represents 121 Upper Tier Local Authorities.

Around two in three (65.4%, n=85) local authorities stated that they receive details of drug related deaths routinely from their local coroner's office (see Figure 1). For those that responded "no" to this question (n=45), 16[2] indicated that they are engaged with their coroner's office, but engagement is non-routine. In these instances, documents are typically only sent on request.

Another eight local authorities that responded "no" to this question noted that they are currently in the process of building either a new or stronger relationship with their coroner's office with the hopes of accessing more real-time data and developing appropriate interventions and early warning systems, and accordingly engagement is pending at this point. Maps of coroner engagement by local authority and by coroner's office are provided in Figures 2-4.

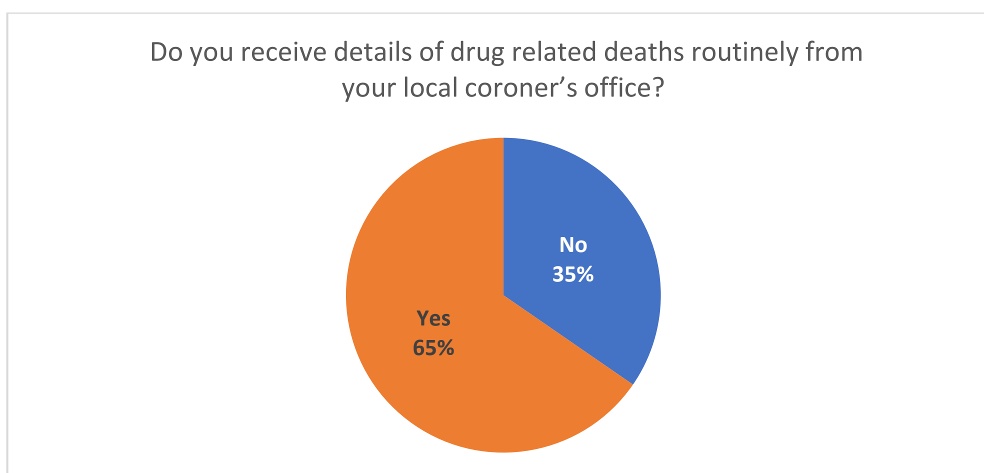

Figure 1

Figure 2 highlights engagement based on local authority. The local authorities mapped as "mixed engagement" (n=4) are those in which more than one response was received for the local authority (e.g. in cases where both a local authority and service provider replied) and had differing experiences.

Local authorities mapped as non-routine engagement (n=24) include those that indicated they do not routinely receive details of drug related deaths but noted documents are sent on request (n=13), as well as some local authorities who responded "yes" to routine engagement as indicted in Figure 1, but when asked about the frequency of receiving these details, indicated that information is only sent on request (n=11, see Figure 6 on page 6).

[2] Please note, one local authority provided four separate responses for its four different coroner areas. Please see methodology section.

Where a local authority did not have the opportunity to respond to the survey, they have been categorised as "not known" on the map (n=32).

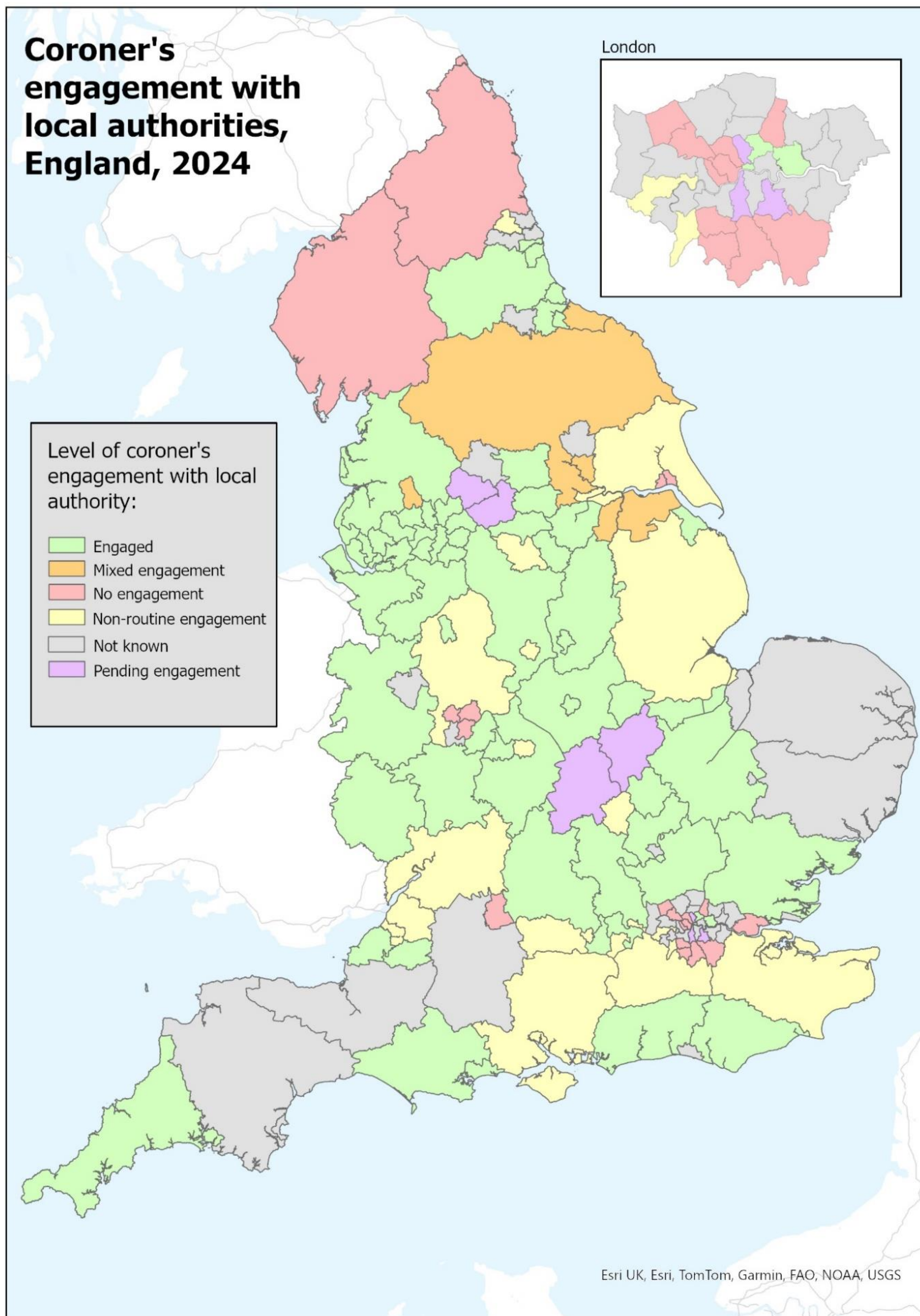

Figure 2

Figure 3 depicts engagement based on coroner's office. For those coroner's offices that work with multiple local authorities, some are marked as "mixed engagement" (n=14) based on differing engagement with the respective local authorities.

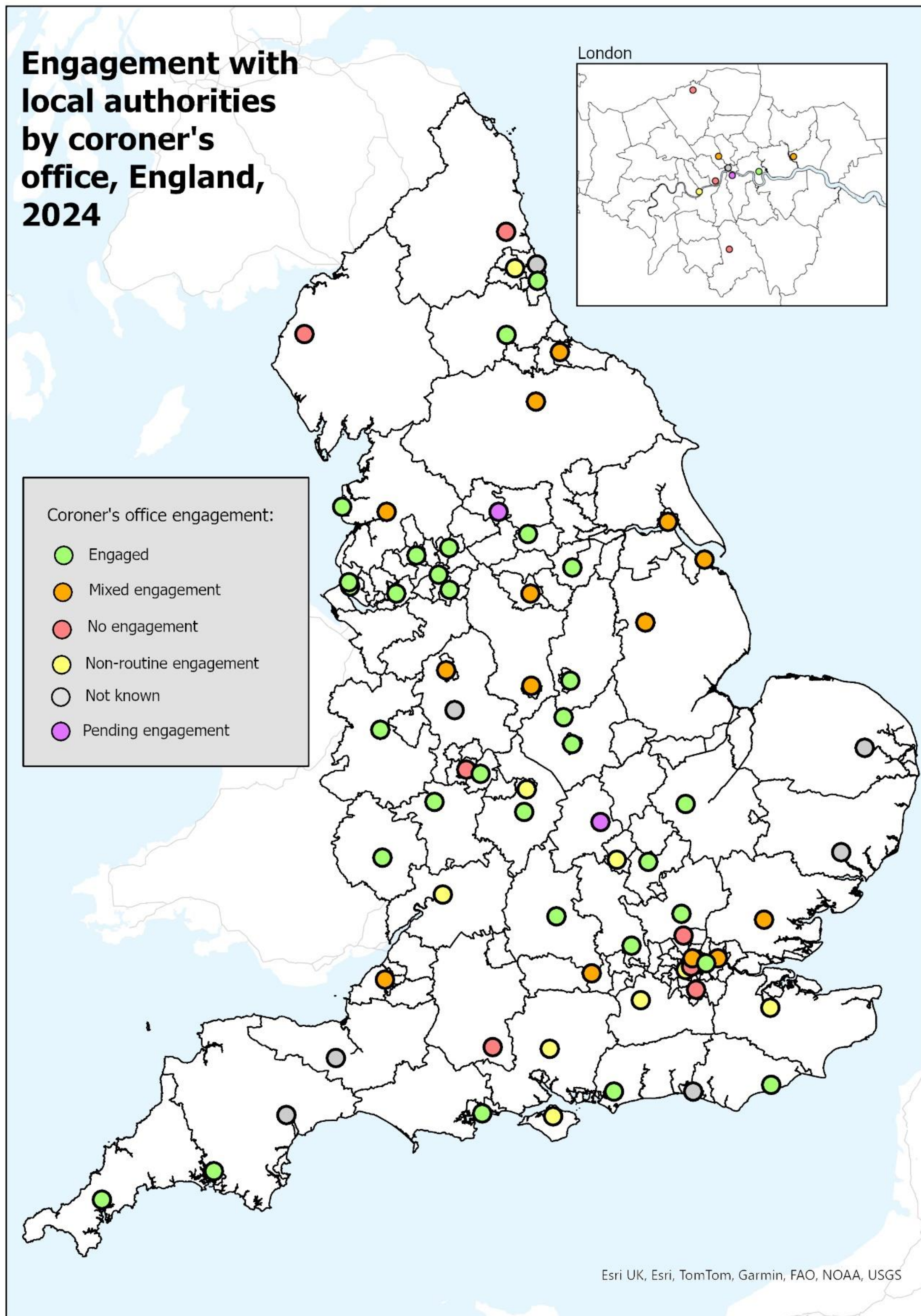

Figure 3

Finally Figure 4 overlays engagement with coroner's offices on top of engagement with local authorities.

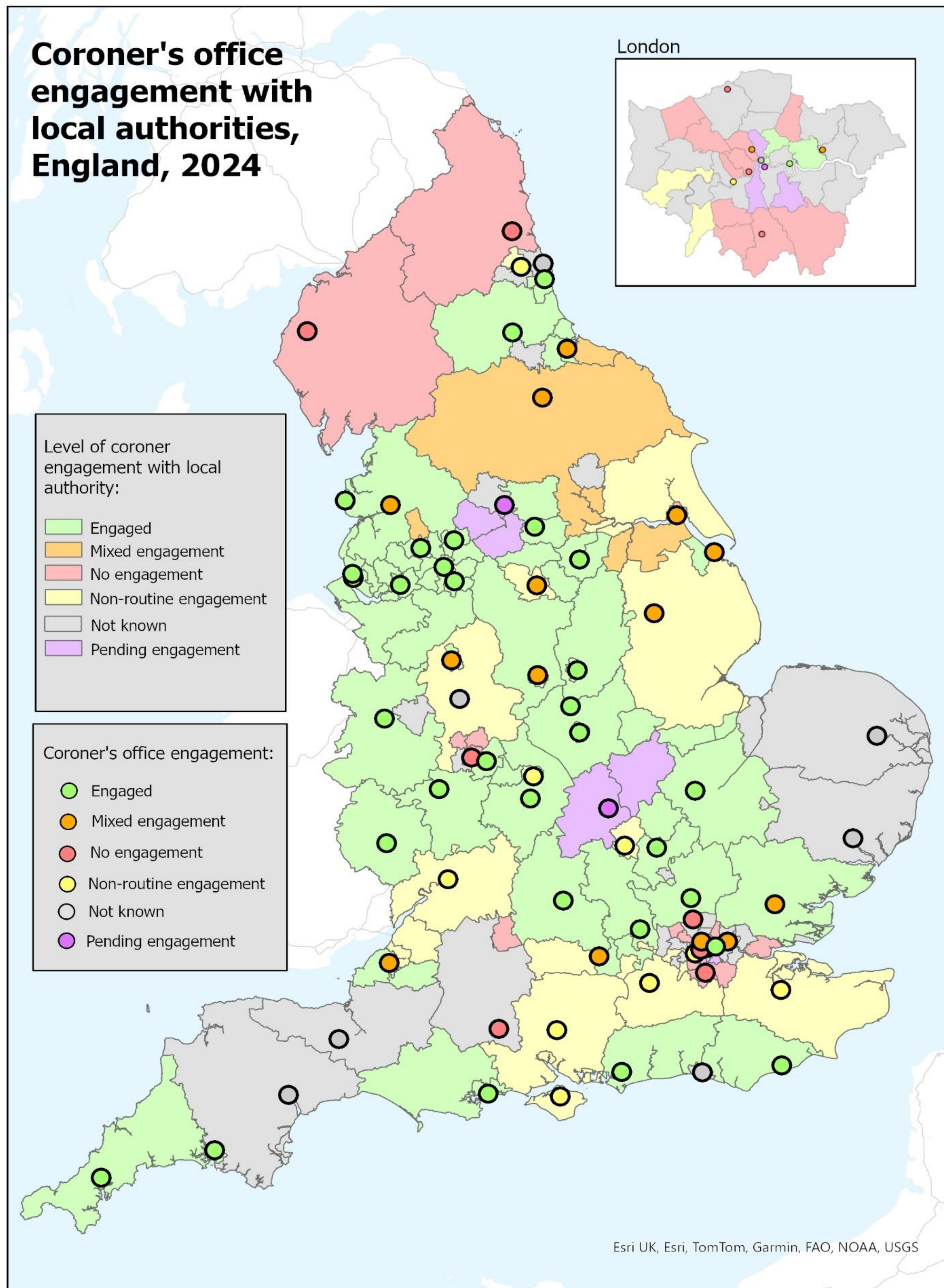

Figure 4

Amongst the 85 local authorities that receive information from their coroner's office, the combination of information sources received vary. The two most common sources received are the toxicology reports (78.8%, n=67) and the record of inquest (76.5%, n=65). Over half (54.1%, n=46) receive a notification form whilst 45.9% (n=39) receive a spreadsheet with basic details (Figure 5).

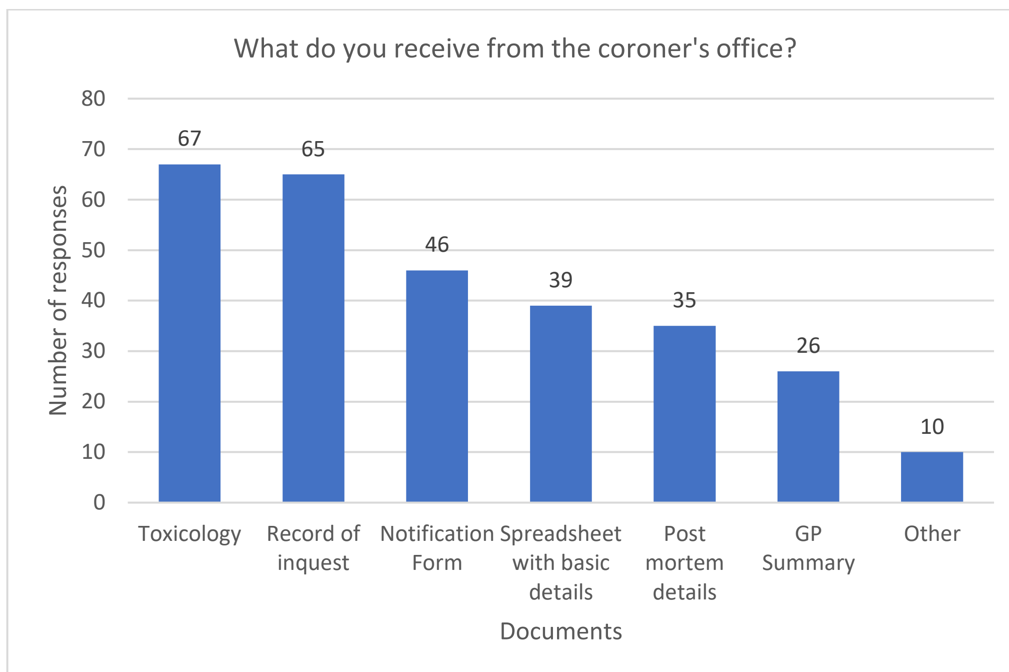

Figure 5

The frequency of receiving this information varies amongst the 85 local authorities, whereby almost three in ten local authorities (28.2%, n=24) receive information on inquest completion and over one in four (27.1%, n=23) receive information monthly.

Three in ten (29.4%, n=25 categorised as "Other" in Figure 6) typically fall into one of the categories below:

- Routinely receive documents once relevant documents become available
- Will receive different documents at different frequencies
- On request

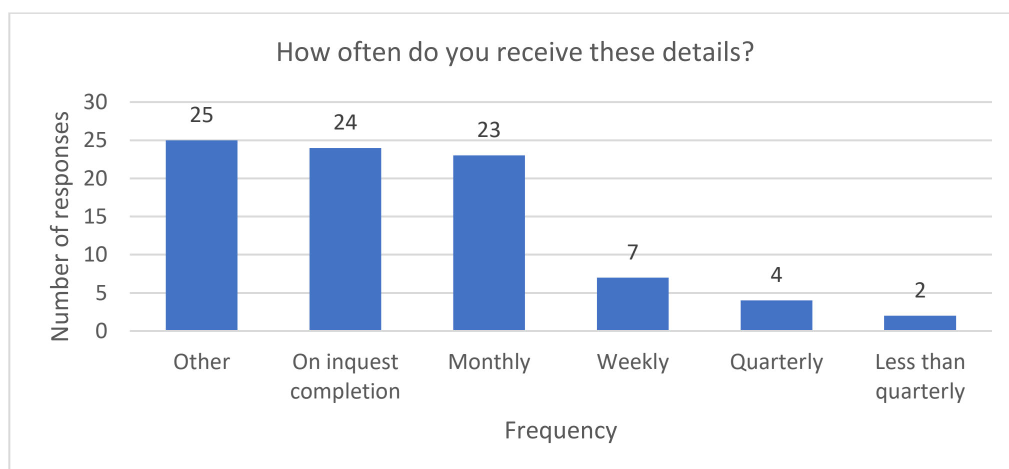

Figure 6

Over four in five (84.7%, n=72) local authorities have the opportunity to ask follow-up questions on individual cases. Of this percentage, 35.3% of local authorities (n=30) are *occasionally* able to do this and 49.4% (n=42) are *usually* able to do this (Figure 7).

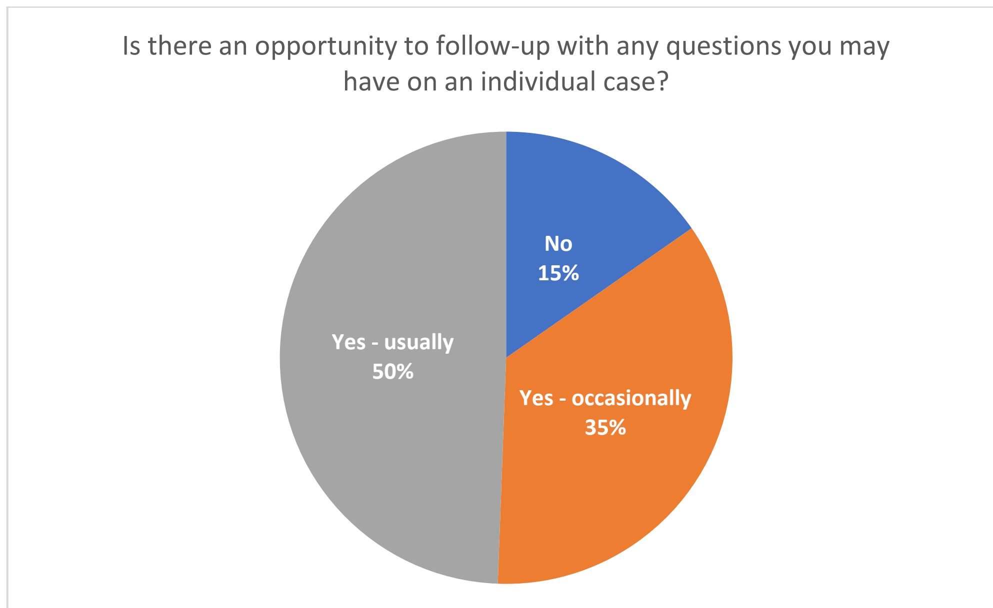

Figure 7

In around two in three cases[3] (65.4%, n=53), local authorities were either not given or rarely given early indication of a potential DARD case (see Figure 8). Four local authorities (4.9%) specified that they were given this information, but only for specific cases such as those involving new psychoactive substances (NPS).

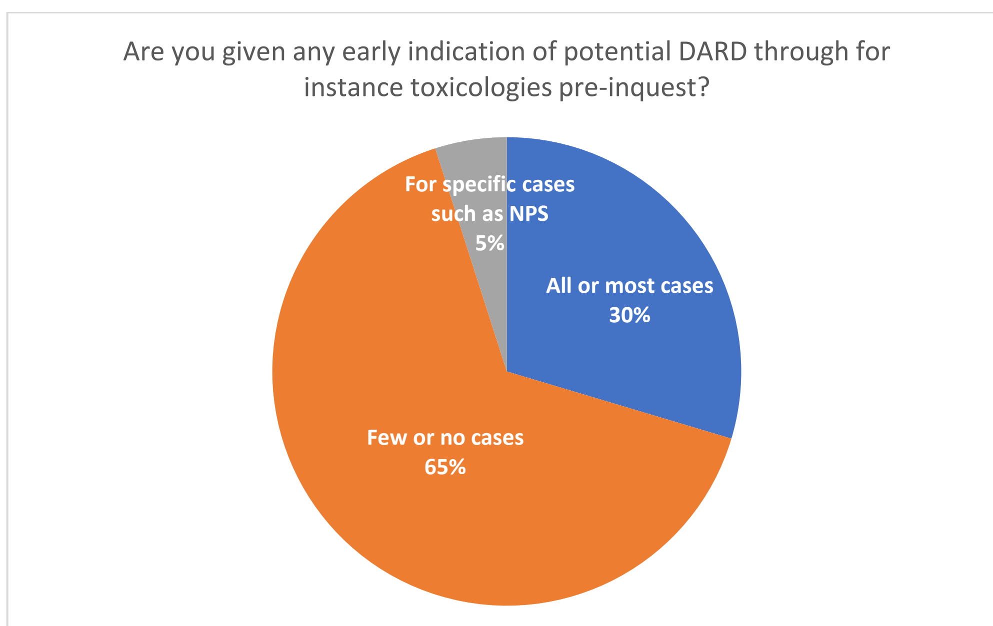

Figure 8

[3] 81 responses to this question in survey

Over one in five (22.4%, n=19) local authorities were not sure if their coroner's office tested for nitazenes (see 'Areas in need of improvement section' specific to *Lack of clarity in toxicology reports* on page 10). Around three in four (74.1%, n=63) local authorities stated that their coroner's office did test for nitazenes, but this varied between testing only in specific cases (38.8%, n=33) and routine testing (35.3%, n=30), as illustrated in Figure 9.

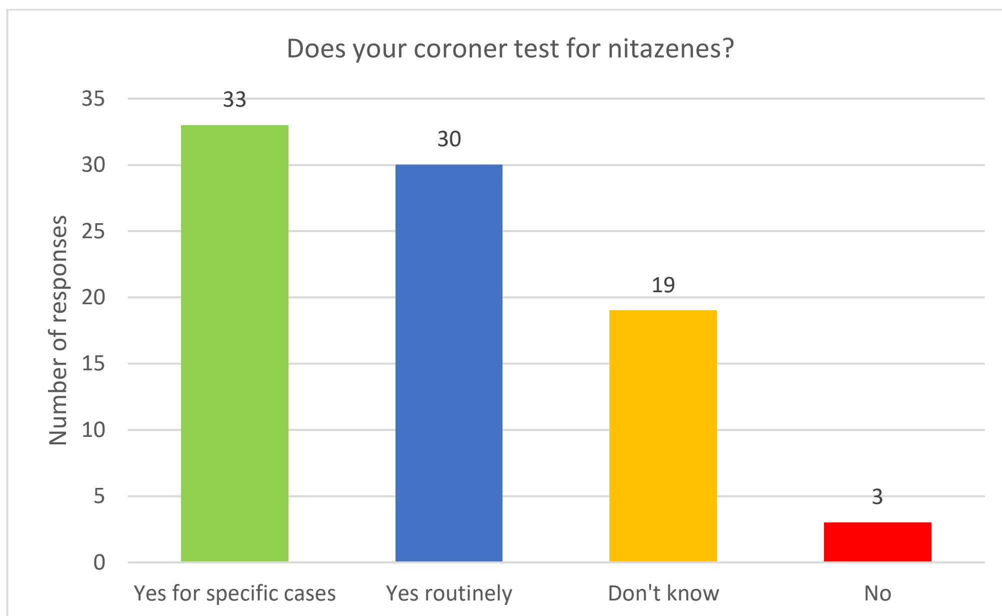

Figure 9

Positive engagement

Many local authorities who have routine engagement with their coroner's office cited a beneficial, supportive relationship. Likewise, several local authorities with non-routine engagement[4] referenced a positive relationship.

One local authority noted: "Although we do not receive regular notifications we have previously had access to files and have been able to complete audits to support our DRD work. We have also engaged in positive conversations with the office to ensure this relationship continues and explore opportunities whilst being mindful of capacity."

Good practice that has been recognised by local authorities include:

- Monthly meetings with the coroner's office and the police. It has particularly been helpful when the coroner's office has shared the same information with local authorities as they have the police (e.g. where a new synthetic opioid has been identified in a DARD within the area) to allow for a real-time response.
- Receiving relevant cases on a regular basis. Some coroner's offices send information on a monthly basis (including all inquests that have completed). This saves on time and resources as staff do not need to send multiple individual cases on different occasions.
- Sending any referrals of suspected DARD for individuals out-of-treatment.
- Setting up a system to share records automatically, including notifications of any inquests that are opened as suspected DARDs.
- The coroner's office taking part in DARD review panels/groups.
- Local authorities being granted access to files or a coroner case management system for audits.
- In cases where electronic sharing is not permitted, being able to visit coroner sites to review files in person.

[4] Typically in cases of non-routine engagement, coroner's offices share documents on request only

Areas in need of improvement

While some local authorities cited an overall positive relationship with their coroner's office, others experienced limited engagement.

One local authority commented: "We have found engagement with the coroner's office extremely difficult. Despite a number of attempts to meet with the coroner's office, across a number of years, we have been unable to do so." Another has commented that their "coroner is not very forthcoming when […] we have asked for information and suspected cause of deaths for drug overdoses, this does not support our CDP death review panel."

Many local authorities noted they would value a closer working relationship with their local coroner, and identified the benefits they felt this would bring to the system. One commented: "Engagement per se could help us confirm drug trends and contributory factors such as existing poor health, poor housing and any preventable death indications…[this] can be fed back into local prevention and treatment plans, supporting our conversations in respect of enhancing local provision and engaging with partners."

Another commented: "We are not receiving any information and I would like to establish the best way to open communication channels. Timely reporting of any increase in deaths related to synthetic opioids will enable us to develop a rapid response plan and collaborate with relevant partners to implement targeted interventions to prevent further fatalities."

The major challenges/barriers for most local authorities include:

1) **Issues around data sharing**: Many coroner's offices do not respond to requests for information or do not send regular notifications. Without having access to electronic databases or the ability to go into the coroner's office, it is difficult to effectively identify learnings from cases.

   One local authority commented that their coroner's office is "apprehensive about sharing information with public health staff. Guidance/mandate from central government / chief coroner regarding information sharing would be useful and will aid preventative initiatives."

   Another commented: "Ongoing data sharing and the establishment of an early warning system would create a more responsive and effective substance misuse programme, ultimately leading to better outcomes for individuals and communities affected by substance use."

   One local authority mentioned needing to obtain a death certificate in order to ascertain cause of death and another referenced having to purchase coroner reports in order to access information, which they did not feel was financially feasible. One coroner's office cited concern over pre-empting the decision of an inquest as the reason for their reluctance to send information in advance of this taking place.

2) **Inquest times:** Inquest times pose a challenge to being able to learn lessons from individual DARD cases and/or inform Local Drug Information System (LDIS) processes.

   One local authority commented: "the huge barrier we have is knowing or being able to access files before the inquest has been completed which currently is around 2 years so too long for any meaningful review or learnings."

   Another commented: "it can be difficult to gather information in a timely manner in relation to our Drug and Alcohol Death review panel, which occur quarterly, due to long waiting lists at the coroner's office."

3) **Organisational issues or changes within coroner's offices/areas:** Organisational issues include problems with capacity, understaffing, and high turnover. These issues contribute to fewer staff being able to respond to queries or provide information in a timely manner and affects continuity of service.

One local authority commented: “Engagement has not been easy due to the demand that is placed upon the coronial services” while another noted: “Our Coroner's office is understaffed and there appears to be a high turnover of officers meaning the continuity of service is very variable.”

The merging of coroner’s offices can also be a challenge as it potentially impacts on resources and affects previous working relationships and processes. One local authority commented: “Our local Coroner's office merged with another Local Coroner's office earlier this year… Since this merger, queries have taken longer to be responded to, or for actions to be taken. For example I waited 8 months for an information sharing agreement to be signed by the Coroner's office for toxicology reports to be routinely sent to local authorities… I'm concerned the merger has impacted on resources.”

Similarly, when one area is covered by different coroner’s offices, there can be lack of consistency if different offices follow different processes. One local authority noted that their local authority “is covered by 2 different coronial offices - and therefore, we have slightly different processes with each office.” Another commented: “I cover multiple areas…the difference in detail and relationships is stark.”

Further, Covid appeared to have impacted on working relationships, whereby it took some time for local authorities to re-establish working practices and relationships.

4) **Lack of consistency:** Some local authorities view the lack of consistency in terms of timings and documentation sent (e.g. toxicology reports) as an area in need of improvement, noting that a routine arrangement would be highly beneficial in contrast to only receiving information on request. Two-way information sharing was identified as being beneficial whereby details of toxicology and inquest verdicts are sent as standard in order to support learning and analysis. The sharing of all DARD cases from the coroner (as opposed to on request) would also mean that deaths outside of treatment would be recognised and facilitate discussions around learning/themes in cases of unmet need.

   One local authority commented: “Currently, all we receive from our coroner’s service is the Record of Inquest form and I am unsure if we get them for every substance related death. I am unable to look at trends i.e. which substances are killing people, as the Record of Inquest will usually say 'multi-drug toxicity' and we do not receive the toxicology…. I don't feel like I can do my job effectively and that we are likely missing out on learning due to not receiving coroners information.”

   Another commented: “The purpose of shared learning/themes is made challenging as we often don't have the cause of death and or coroner involvement. We are also unable to discuss DRD's that occur outside of treatment.”

5) **Lack of clarity in toxicology reports:** Local authorities have noted the lack of clarity of what substances are tested in toxicology reports, specifically whether newer substances like nitazenes and xylazines are tested routinely or just in specific cases. In some cases, it is not clear whether a substance was simply not present or if it was not tested.

   One local authority noted: “There is currently a lack of clarity about which substances are tested for in post mortem toxicology….This creates challenges in terms of if the specific substance is not present on tox reports is this because it was not present or not tested for? Timescales for receiving post mortem tox means the results cannot normally be used to inform LDIS processes.”

Recommendations

Based on the feedback from the survey, there are a number of areas in which local relationships with coroner's offices could be improved:

- Establishing clear guidance around universal definitions (e.g. what criteria needs to be met to classify as a DARD) and a mandate from central government or the chief coroner for sharing information.

- Provision of dedicated and consistent information across the country (e.g. all coroner's offices providing the same and appropriate documents). Standard documents that could be provided include the below:

    - For non-DARD deaths for individuals in-treatment, notification of cause of death.
    - For deaths that go to inquest:
        - Record of inquest
        - Toxicology report (with clarity of what substances have been tested)
        - GP history
        - Notification of Drug Related Deaths (e.g. police report)

- Establishing regular meetings (e.g. monthly) between local authorities and the coroner's office to address any queries from recent cases. These meetings could also benefit from including the police to facilitate timely responses to any immediate concerns. This would save on time and resources as staff within the coroner's office would not need to reply to different queries on multiple occasions.

- In the longer-term, the creation of a centralised database for all DARDs (in-treatment and outside-of-treatment) that coroners can update routinely (e.g. weekly or monthly). This would include, when possible, providing appropriate information before an inquest has completed.[5]

- If a centralised database is unfeasible, another option would be to create a system to share coroner records automatically with local authorities, including notifications of any DARD inquests that are newly opened.

- In the absence of being able to provide appropriate information or notifications of DARDs outside-of-treatment before inquests are closed, local authorities may value from working with police to obtain real-time notifications for sudden deaths.

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[5] One respondent provided some thoughts on how this might work: "Local authorities could then log on and extract their data" directly as opposed to sending individual information requests and in turn requiring coroner's offices to respond to multiple requests.
This could be a more efficient way to use limited resources within coroner's offices and would mean that information is shared proactively. It would also improve access to real-time data which is often hindered by inquest delays and would help local authority practices stay aligned with current public health needs.

Methodology

There were 109 responses to the survey. Seven responses were removed for the reasons below:

- Three responses were removed as there were three instances where the survey was completed by two different individuals within the same local authority council and provided the same information.
- Three responses were removed as in three cases, two individuals from the same local authority responded with differing information; clarification was obtained as to the most accurate response to use.
- One response was removed. Clarification from one local authority that provided slightly differing information was sought but not obtained. In this case, comments that provided greater context were retained.

LJMU added 13 responses to the survey for local authorities who did not respond but work with LJMU to monitor their data. LJMU are therefore able to comment on the relationships with the coroner's offices.

Where a specific local authority provided one response on behalf of several local authority areas, the initial response was replicated, except in cases where one of the local authorities already provided a separate response (n=15 responses added as a replicate).

The data presented in this report therefore comes from 130 responses.

For local authorities that LJMU work with, some responses were amended to match LJMU's known relationship with the coroner's office (n=10).

Five local authorities (North Lincolnshire, North Yorkshire, Leeds, and Redcar and Cleveland, and Blackburn with Darwen) have two included responses to the survey; both responses were retained as one response was completed on behalf of the council while the other comes from a service provider in the area.

In eight instances a service provider or a representative from the police solely provided responses for their local authority (i.e. a response was not obtained from the council). All eight responses are included in the results.

Where a specific local authority provided separate responses for each coroner's office they work with, all separate responses were retained (e.g. Kent provided four responses for different coroner areas; Lancashire provided two responses for two coroner's offices).

The data presented in this report represents 121 Upper Tier Local Authorities.