<u>West London Coroner's Court</u>

West London Annual Coroner Report 2023

1. INTRODUCTION

The previous Chief Coroner, HHJ Mark Lucraft QC, published his Model Coroner Area document, 2nd Edition on 1st July 2020. Paragraph 23 of that document reads:-

"The senior coroner for each coroner Area should present a brief annual report to the Chief Coroner and their relevant local authority in July of each year. The report, which should be published on the local authority website, should include relevant statistics on current and concluded cases (with comparison figures for previous years), an update on coroner work and relevant issues, a summary of the coroner team and staffing arrangements, and any plans for the future."

I am delighted to write and present the 2023 report for this Coronial Area.

2. CORONIAL SERVICE STAFF TEAM & NEW WAYS OF WORKING

Staffing

Acting Senior Coroner supported by 10 Assistant Coroners, 4 Local authority staff, 11 Coroner Officers and 1 manager (Metropolitan Police staff). This year, the Metropolitan Police Team have seconded two serving Police Officers as Coroner's Officers boosting the numbers. One long standing Coroner's Officer will be transferring to another area in October, and we expect a replacement in mid-September who will require training.

It has been another busy and challenging year, but the Coroner's Officers and Local Authority team have responded exceptionally well. Inquests are being heard quicker than ever before and this means that families are better able to gain closure and move on with their lives.

I must also thank the continued support provided by the Court Volunteers from the Coroner's Court Support Service. The volunteers provide an invaluable source of both emotional support and information, advice and guidance to bereaved families and anyone asked to attend the court. The volunteers also offer a telephone service which is helpful for any families taking part in remote inquests.

New Ways of Working

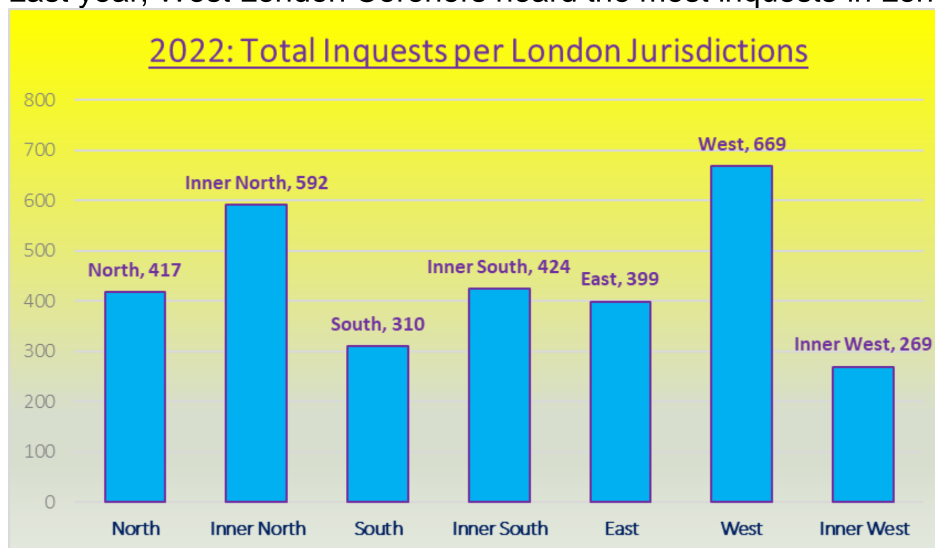
This year, 74% of all cases have been heard by way of either a Rule 23 (documentary Inquest) or Fastrack Inquests (opened and closed same day). These are very brief cases usually taking between 30 and 60 minutes in court. One third of all cases continue to be heard remotely via Teams and this seems to suit most attendees.

Section 9C – Inquests in Writing
We have introduced the workflow for this new type of inquest case which can be heard from anywhere and does not require court space or recording. Although this case type requires a substantial amount of preparation, it will allow the Coroner more flexibility and resilience. Potentially, Coroners can now hear cases simultaneously; two in court and others working in the office or from home.

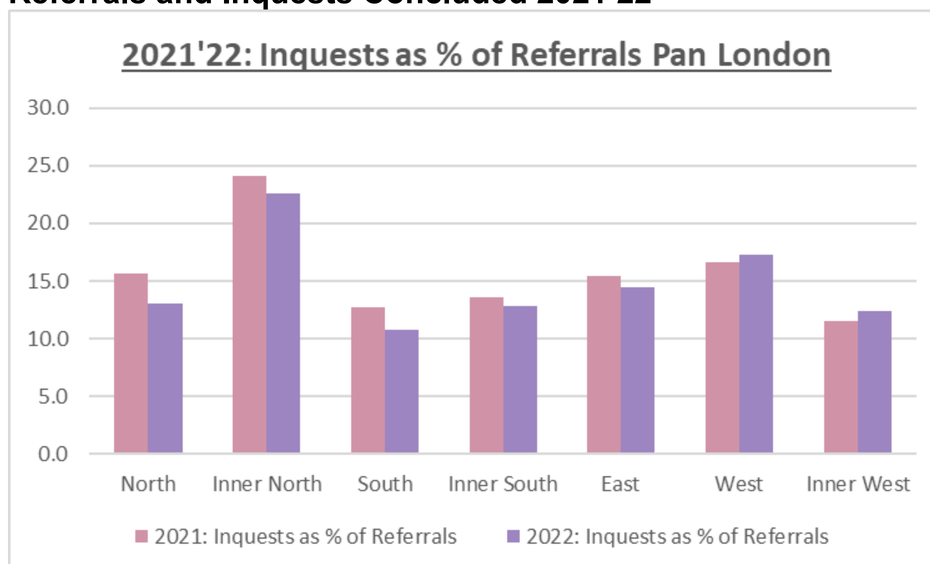
Delays and Adjournments
The NHS is struggling to provide us with the required reports on time and this can lead to last minute adjournments. Strikes by Junior Doctors has added to the pressure on the NHS and further impacted the speed they are able to submit their reports to us.

3. CASE PROGRESSION

Last year, West London Coroners heard the most inquests in London.



Referrals and Inquests Concluded 2021'22



4 of the 7 London jurisdictions heard fewer inquests as a percentage of referrals in 2022 than in 2021. West London however, heard more inquests as a proportion of referrals than in 2021.

	Referrals	Inquests
West	3626	573
Inner West	2231	255
South	2623	297
Inner South	3292	381
East	2620	417
North	2850	459
Inner North	2547	445

The majority of London Coroners received more referrals in 2022 than the previous year. This trend could be linked to the Medical Examiner system which scrutinises all hospital deaths or people not engaging with health care and so dying with Cause Of Death unknown.

West London: Key Data

	Total Referrals	Inquests Concluded	Jury Cases Heard	Over 12mth CLOSED	Over 12mth OPEN
2018	3401	819	7	368	355
2019	3504	556	16	130	96
2020	3560	494	11	69	86
2021	3626	573	9	90	90
2022	3787	622	11	58	62

Referral numbers have been rising steadily since 2018 and the court has generally managed to hear more inquests year on year to keep up with the higher influx of deaths.

Cases Over 12 Months Old:

In 2022, the court concluded 58 cases which were at least 12 months old (oldest case closed from 2016). At the end of 2022, there were 62 cases over 12 months

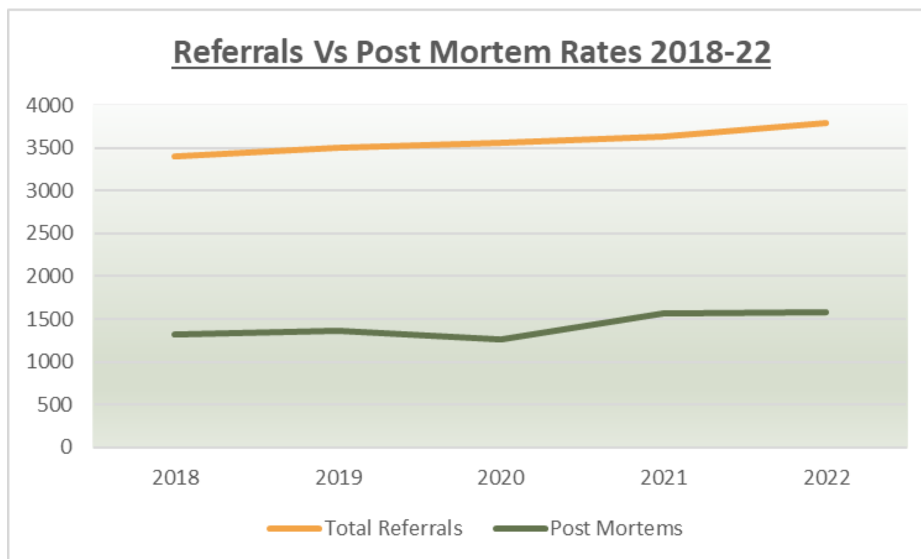
old which remained open, (oldest case open 2018) excluding Suspended cases. The majority of cases over 12 months old are now from 2021.

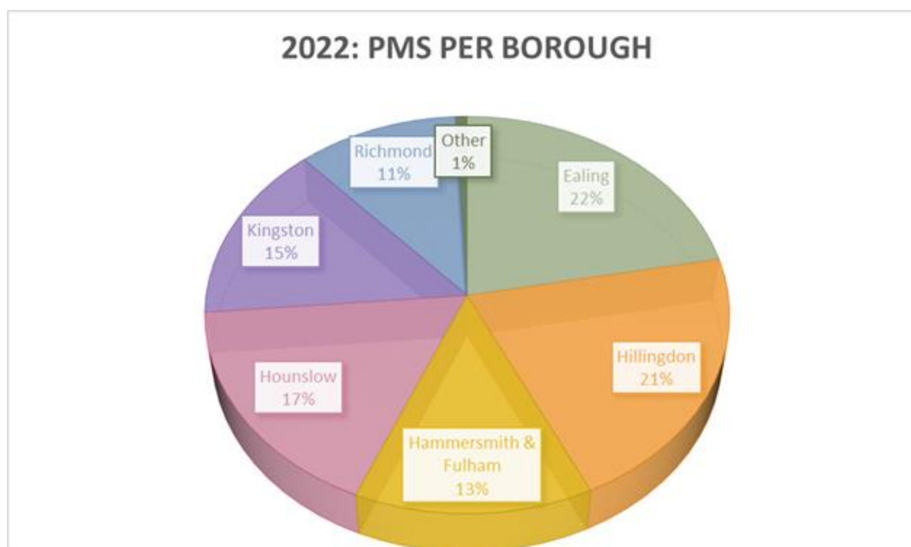
47% of all the over 12 month cases were Suspended (10% higher than in 2021). Suspended cases are pending investigation by the Police and no action can be taken by the court. Jury cases, for example, take approximately 2 years to be ready for hearing due the complexity of the cases and the time required for third parties to produce the necessary reports.

Post Mortem Rates

As referrals have increased the number of post mortems per year has risen.

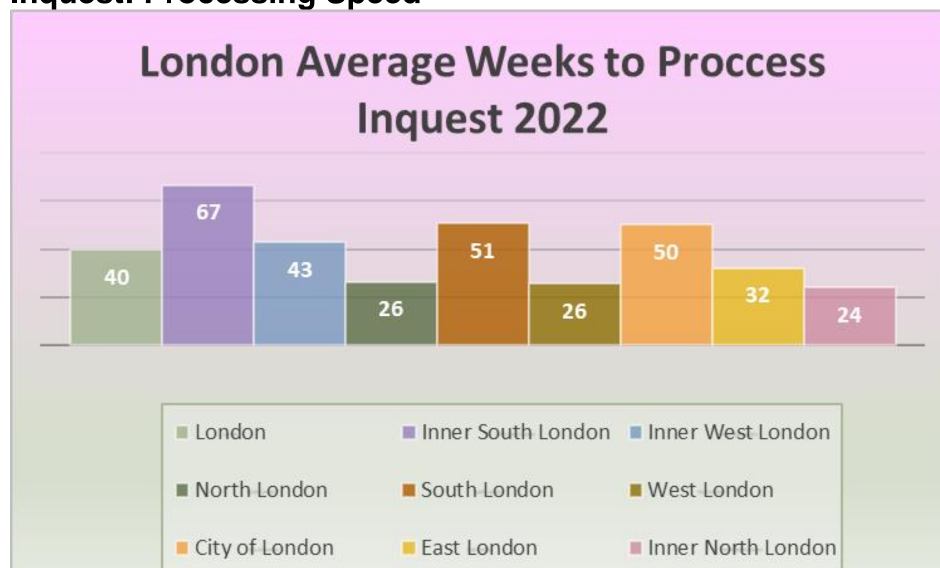
	Total Referrals	Post Mortems	PMs % of Referrals
2018	3401	1314	39%
2019	3504	1367	39%
2020	3560	1267	36%
2021	3626	1558	43%
2022	3787	1585	42%





Ealing and Hillingdon have the highest number of post mortems in West London. This corresponds to the high number of deaths referred by the two boroughs.

Inquest: Processing Speed



West London and North (26 weeks) were joint second fastest to hear cases in 2022 after Inner North London (24 weeks). Therefore the majority comfortably reach the 6 month target to hear inquest cases set by the Chief Coroner. Some complex cases, often with initial criminal investigations take longer to investigate and breach the 6 month target.

4. CORONERS STATISTICS FOR ENGLAND & WALES 2022

Coroners Statistics for England & Wales 2022		**West London Coroners**
Increase in the number of deaths reported to coroners in 2022	208,400 deaths were reported to coroners in 2022, the highest level since 2019 – up 7% (13,300) compared to 2021.	3797 deaths reported in 2022, up 4% since 2021 and 11% more than the 7 year average of 3540.
36% of all registered deaths were reported to coroners in 2022	The proportion of registered deaths in England and Wales reported to coroners is at the highest level since 2019.	Referrals have been increasing since 2015 (see above).
Deaths in state detention, down 8% in the last year	534 deaths in state detention were reported to coroners in 2022 (down from 580 in 2021), the decrease was driven by a 20% fall in deaths in prison custody.	West London reported 7 deaths in custody in both 2022 and 2021; no change year on year. There were 3 in 2020 and 5 in 2019.
Post-mortem examinations were	There were 90,200 post-mortem examinations ordered	2% more Post mortems in 2022 than 2021.

carried out on 43% of all deaths reported in 2022	by coroners in 2022, a 7% rise compared to 2021. The proportion of reported deaths requiring a post-mortem has remained stable over the same period.	As a percentage of overall referrals the figure fell from 43% to 42% between 2021 and 2022 but the general trend shows that the number of post mortems is increasing (2019= 1367 to 1585 in 2022).
11% more inquests opened in 2022	36,300 inquests were opened in 2022, up 11% compared to 2021.	669 inquests in 2022, this is 53% the 7 year average of 436 and 11% more than 2022. This was the highest figure since 2015. In 2015 10% of all referrals went to inquest. In 2022 this rose to 18% of referrals (17% in 2021).
Inquest conclusions up 10%, the largest rise seen in natural causes, accident/misadventure and unclassified conclusions	In 2022, 35,600 inquest conclusions were recorded in total, up 10% on 2021. Natural causes, accident/misadventure and unclassified conclusions had the largest increases, up 40%, 14% and 7% on 2021, to 5,100, 8,800 and 8,700 inquest conclusions in 2022 respectively	Rise in Conclusions since 2021 differ to the national picture: Suicide (22%), Accident/misadventure (18%) and killed lawfully/unlawfully (500% (from 1 case to 5)) had the largest increases in conclusions in 2022. Fall in Conclusions since 2021: Conclusions with Road Traffic Collisions down 50%, Industrial Disease down 22%, Drugs/alcohol Related down 14%, and Open down 10%, compared to 2021.
Average time taken to complete an inquest fell by less than one week	The estimated average time taken to process an inquest decreased from 31 weeks in 2021 to 30 weeks in 2022.	In West London the average time to process an inquest has fallen from 35 weeks in 2019 to 26 weeks in 2022. West London is the second fastest jurisdiction in London. North London is the fastest at 24 weeks. They received 2771 referrals compared to 3787 referrals at West London.
Prevention of Future Deaths reports down by 8%	403 Prevention of Future Deaths reports were issued in 2022, a decrease of 8% compared to 2021.	West London submitted 6 PFDs in 2022 and 5 in 2021.

5. CORONERS ENGAGEMENT WITH STAKEHOLDERS

Meetings have been arranged with many of the stakeholders that HMC works with, and these are continuing to ensure good relationships and best working practise.

During 2022, beneficial meetings have been held with:

- Faith Leaders for the Jewish and Muslim faiths

- Medical Examiners
- Organ Donation Specialist Nurses and Clinical Leads
- Registrars of births and Deaths
- West London Mental Health Trust legal department
- Coronial Lead for Metropolitan Police Service
- Safer Custody Governors of HMP Wormwood Scrubs.
- NHS Trusts
- Funeral directors
- Pathologists
- Kingston Mortuary

In addition, to develop knowledge and maintain staff motivation, talks have been held at the court with a pathologist and The National Programme for Substance Abuse Deaths.

We are one of the few London jurisdictions to engage with NPSAD. Some drug and suicide prevention services from the West London area have commissioned reports from NPSAD to inform their learning.

6. CONCLUSION

I look back with pride at the strength and commitment of the tripartite partnership in West London. Working together to provide a high quality, responsive and compassionate service to the residents of the Consortium has been our top most priority. The investment in the service has made a difference to our ability to undertake our work.

Recruitment of new Senior Coroner is high on the agenda plus training of new Assistant Coroner's which we hope will bolster capacity and reduce the 12 month list. This will help stabilise the area, keep up with the high case load and maintain the high quality of service and performance that we aim to provide to the families of the deceased in West London.

Lydia Brown, 22/08/23