West London Coroner's Court

Senior Coroner's Annual Report

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 second such report for this coroner Area.

2. CORONIAL SERVICE STAFF TEAM & NEW WAYS OF WORKING

Staffing

Acting Senior Coroner supported by 5 Assistant Coroners. Three LA staff and ten Coroner Officers and manager (Metropolitan Staff). During the year we recruited a new Coroner's Executive Support after many unsuccessful recruitment campaigns. Steph has settled well into the new role. The Metropolitan Police Team have had one vacancy Coroner Officer since 2019 and another Coroner's Officer is due to retire in July. Both vacancies will now be filled in the summer.

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

67% of all cases are heard as Rule 23s or Fastrack inquests remotely which last between 30 and 60 minutes. An increasing number of inquests are now opened and heard on the same day which is very well received by many families. One third of all cases are heard remotely via Teams and this seems to suit most attendees.

Covid changed the way the court operates and has had a particular impact on the Local Authority Staff. The LA team now usher all inquests whether they are in court or remote.

Since Covid there has been a slight increase in the number of families and IPs attending court.

Complaints and Compliments
The team regularly receive compliments and last year 10 were recorded on the Council HFinTouch system. 4 complaints were received, of which 2 were not upheld.

3. CASE PROGRESSION

In 2021, we had 3626 referrals. We heard the number highest number of cases across all London jurisdictions.

	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

Of the 3,626 total referrals, 1558 received post mortem examinations (43%). There has been a steady rise in the number of referrals made to the court over the past 3 years

West London Data

	Referrals	Inquests Concluded	Heard with Jury	Cases over 12mths	Post Mortems
2019	3504	556	16	95	1367
2020	3560	494	11	86	1267
2021	3626	573	9	90	1558

At the end of 2021, there were 90 cases over 12 months old, 37% of these cases were suspended pending investigation by the Police and no action could be taken by the court. It can take approx. 2 years for a jury case to be ready for hearing due the complexity of the cases and the time required for third parties to produce the necessary reports.

4. 2021 ANNUAL REPORT TO THE CHIEF CORONER

National Trends in England and Wales

- 5% Decrease in the number of deaths reported to coroners in 2021

	England and Wales: Inquest Conclusions		
	Accident/misadventure	***Suicide***	***Unclassified***
2021	7696 up 2%	4820 up 8%	8126 up 24%

• 4,820 suicide conclusions were returned in 2021, the highest recorded since reporting began. Although the inquests were concluded in 2021, some of the deaths may have occurred prior to 2021 and their respective inquests may have been delayed due to restrictions in the Covid-19 lockdown period.

• Deaths in state detention reported to coroners increased by 3% to 580 in 2021, driven by a rise in number of deaths in prison custody.

• On average in England and Wales, the time taken to process an inquest increased by 4 weeks to 31 weeks. This is very likely to be a result, of the period of recovery from Covid restrictions.

London vs West London Performance

2021	Referrals	Inquests Concluded	Inquests: mean time wks	Suicides
North	2850	459	30	40
Inner North	2547	445	21	52
South	2623	297	42	49
Inner South	3292	381	75	44
East	2620	417	34	86
West	3626	573	27	79
Inner West	2231	255	35	46

- The time taken to process an inquest varies by coroner area - the maximum average time taken in 2021 was 75 weeks in Inner South London, and the minimum average time was 11 weeks in Liverpool and the Wirral. In West London the average time to process an inquest was 27 weeks, second only to Inner North which was 21 weeks.

- In West London, most cases are heard between 1 and 3 months (South London heard most inquests between 6 & 12 months).

- In West London at the end of 2021, 22% of inquest cases were over 12 months (90 cases) of which 37% were suspended. This is equal to the average in England and Wales.

- West London heard the most inquests across London last year with 573 inquests concluded. Inner South with a similar number of annual referrals by comparison heard 381 inquests.

West London Inquest Conclusions
In 2021 the top 5 Conclusion reached at Inquest in West London were:

1. Accident and Misadventure 142 cases
2. Drug and Alcohol Related 97 cases
3. Suicide 79 cases
4. Natural Causes 78 cases
5. Unascertained 72 cases

West London Suicide Data
West London had the highest number of suicides in London, next to East London which has the most deaths from suicide. However, the suicide rate within the jurisdiction has been falling since 2018.

Suicides in West London	
2018	105
2019	96
2020	96
2021	79

Both Hounslow and Hammersmith and Fulham Councils have engaged with the court to analyse the suicide cases with the aim of improving services and prevention.

The National Programme for Substance Abuse Deaths are carrying out research to identify current trends and aim to reduce the number of deaths due to both legal and illegal drugs.

6. 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

Further meetings are planned with the main healthcare providers and the Safer Custody Governors of HMP Wormwood Scrubs.

10. FUTURE PLANS

There has been little time or capacity to consider future plans while dealing with the present pandemic, but the measured consideration of future mortuary capacity and

provision together with the increasing sophistication of CT scanning (which can avoid a full dissection and only require minimally invasive procedures) remains an aspiration for West London. Many families are requesting this preferentially and currently pay a fee for the service, if it can be arranged in a timely manner. To have routine availability at a designated mortuary would be of great benefit for the families of the bereaved and bring the process into the 21st century.