West London Coroner's Court

West London Annual Senior Coroner's Report 2024

1. INTRODUCTION

Her Honour Judge Alexia Durran was appointed as Chief Coroner of England and Wales in succession to His Honour Judge Thomas Teague KC. The appointment started on the 25th May 2024 for a three-year term. The Chief Coroner provides judicial leadership for coroners and the coroner service in England and Wales, as well as issuing national guidance and leading on training for coroners.

I was grateful to be offered a meeting with Her Honour Alexia Durran on the 16th July.

Earlier this year, while carrying out the role of Acting Senior Coroner, I applied for the Senior Coroner post. I was successful at interview and was formally sworn in on the 27th February, after the appointment was approved by the Lord Chancellor and Lady Chief Justice.

I am delighted to write and present the 2024 report, as the new Senior Coroner for West London.

2. CORONIAL SERVICE STAFF TEAM & PERFORMANCE

Staffing & Performance

The Senior Coroner is supported routinely by 6 Assistant Coroners, 4 Local authority staff, 12 Coroners Officers and 1 Coroner's Officers Manager (Metropolitan Police staff). This year, the Metropolitan Police Team have seconded one serving Police Officer and a member of Police Staff as Coroner's Officers boosting the numbers.

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

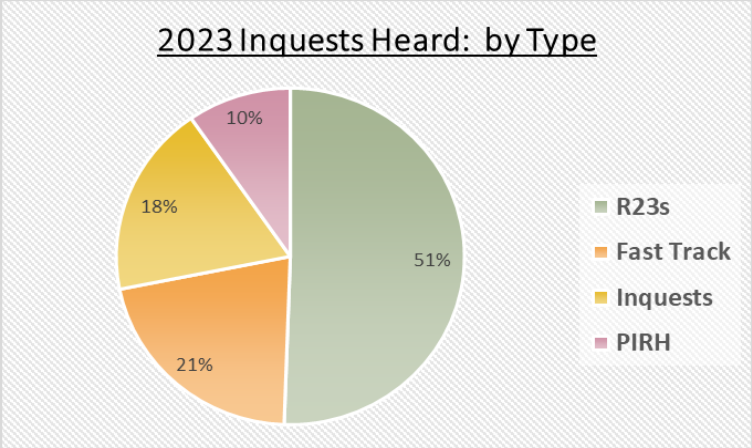
In November 2023, a tragic incident resulted in the loss of a number of family members and their guests in a house fire in Hounslow. It was declared a Disaster Victim Identification (DVI) incident due to the complexity of the scene and challenges in recovering and identifying the bodies. We activated our business continuity plan and the whole team responded well working with the Met Police and other stakeholders. We were able to confirm the identities of the 6 deceased which included 3 children. The inquests will be taking place this year.

I wish to commend 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. Families frequently comment on the enormous benefit they experience from this service, and we remain grateful and thankful for their dedication.

We continued to make improvements to the court facilities and interiors and had the seating in the waiting area and the jury seats re-upholstered.

Efficient Ways of Working
This year, 72% 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 which has reduced court costs and given flexibility and convenience to attendees.

Inquests in Writing. It is intended to start conducting certain cases in writing with no need for a court hearing with the agreement of the interested parties to the inquest. This procedure should free up court space and reduce administration work.



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.

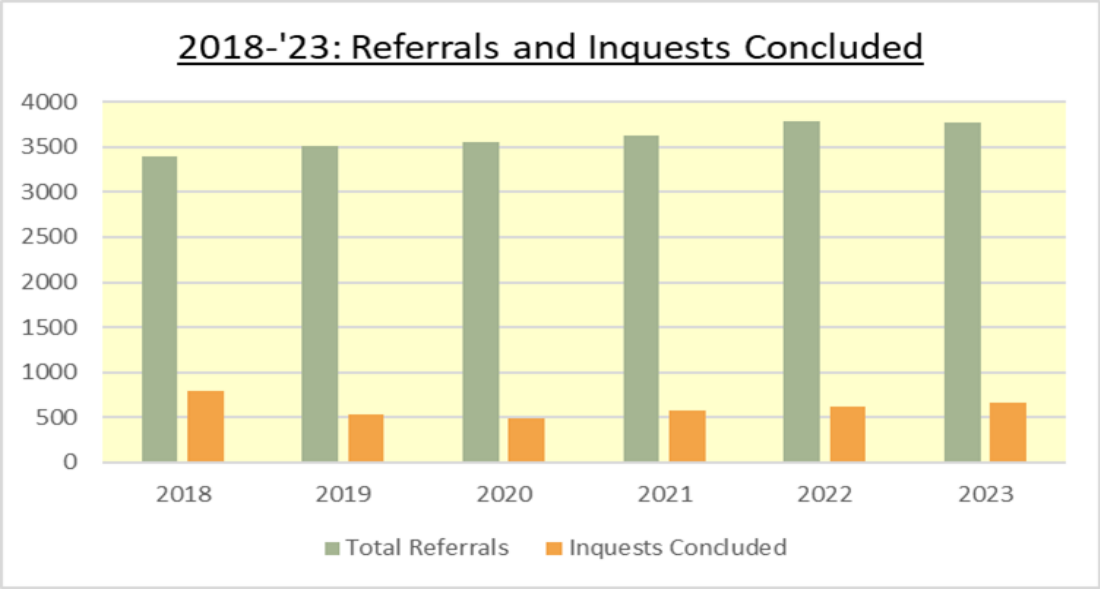
3. CASE PROGRESSION

Last year, yet again, West London Coroners received the most referrals and heard the most inquests in London.

Referrals and Inquests Concluded
West London received over 150 more referrals last year than 2022 and heard 94 more cases. West London is in the top 3 London areas in terms of speed of hearing inquests.

London Jurisdiction	Referrals 2023	Inquests Concluded 2023	Inquests: mean time wks 2023
West	3773	667	30
Inner South	3557	651	66
South	2809	360	56
North	2755	372	37
East	2586	387	30
Inner North	2540	578	29
Inner West	2355	282	50
City	265	59	52

West London: Key Data
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 death referrals.



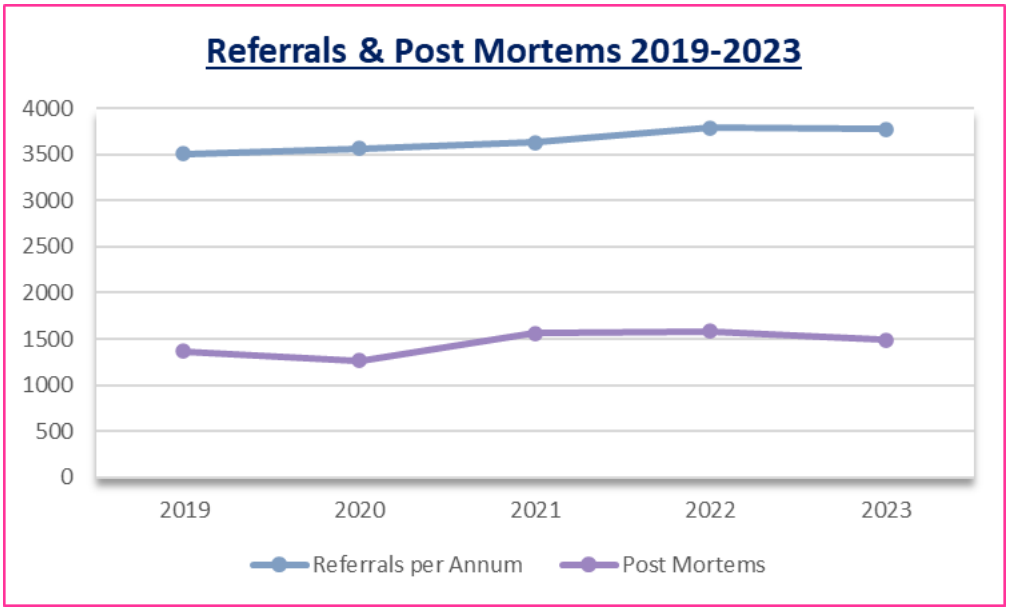
Year	Total Referrals	Inquests Concluded	Jury Cases Heard	Over 12mth Closed	Over 12mth Open inc Adjourned
2018	3401	793	7	366	355
2019	3504	539	16	130	96
2020	3560	494	11	69	86
2021	3626	573	9	90	90
2022	3787	622	11	58	62
2023	3773	667	9	68	97

Last year, the referrals remained at a similar level to 2022. The court heard the most inquests since 2018.

Cases Over 12 Months Old:
In 2023, the court concluded 68 cases which were at least 12 months old (oldest case closed from 2018). At the end of 2023, there were 97 cases over 12 months old which remained open, and this includes Suspended cases. The oldest case noted in our return to the Chief Coroner was a Police case in 2017 and it was heard this year.
Currently, most cases over 12 months old are between 2019 and 2023.

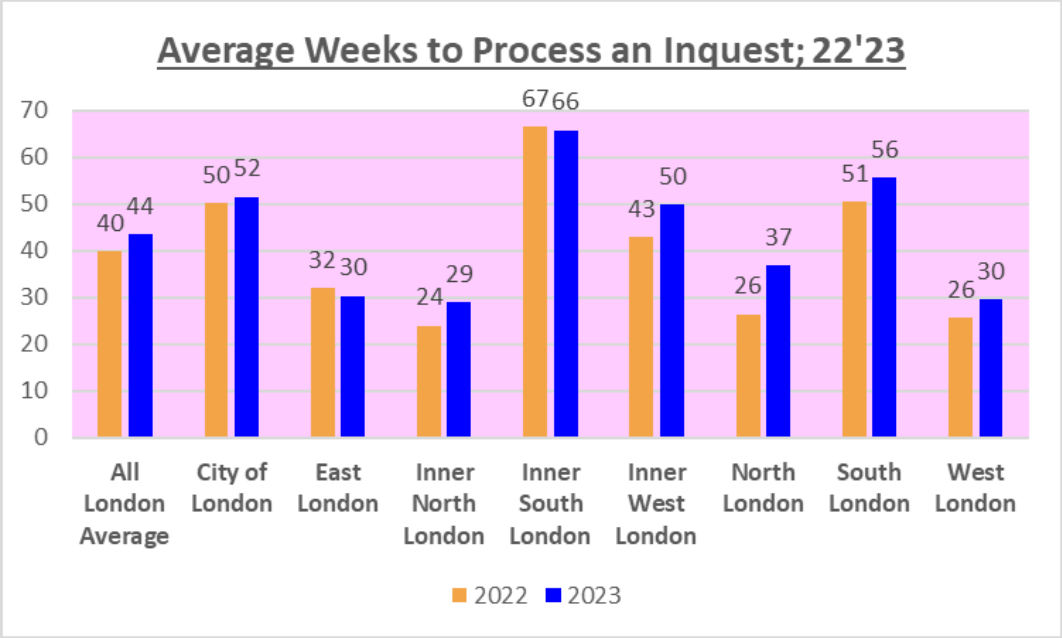
Almost half of the over 12-month cases were Suspended. Suspended cases are pending investigation by the Police and no action can be taken by the court. Jury cases, for example, take approximately 2 years to be ready for hearing due the complexity of the cases and the time required for third parties to produce the necessary reports.

Post Mortem Rates
As referrals have generally increased the number of post mortems per year has risen.



Year of Annual Report	Referrals per Annum	Post Mortems	As % of Referrals
2019	3504	1367	39%
2020	3560	1267	36%
2021	3626	1558	43%
2022	3787	1585	42%
2023	3773	1489	39%

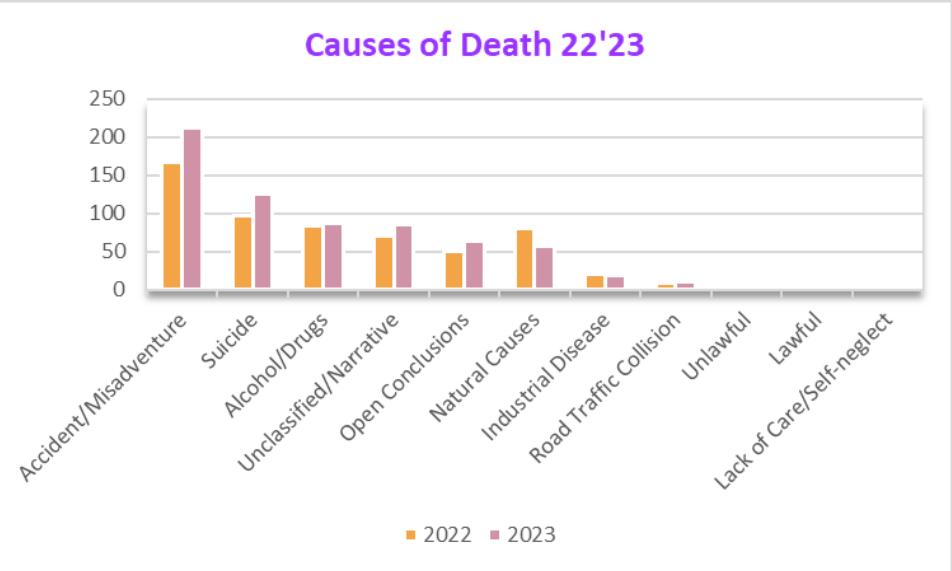
Inquest: Processing Speed



West London and East London (30 weeks) were joint second fastest to hear cases in 2023 after Inner North London (29 weeks).

4. CORONERS STATISTICS FOR ENGLAND & WALES 2024 Vs WEST LONDON

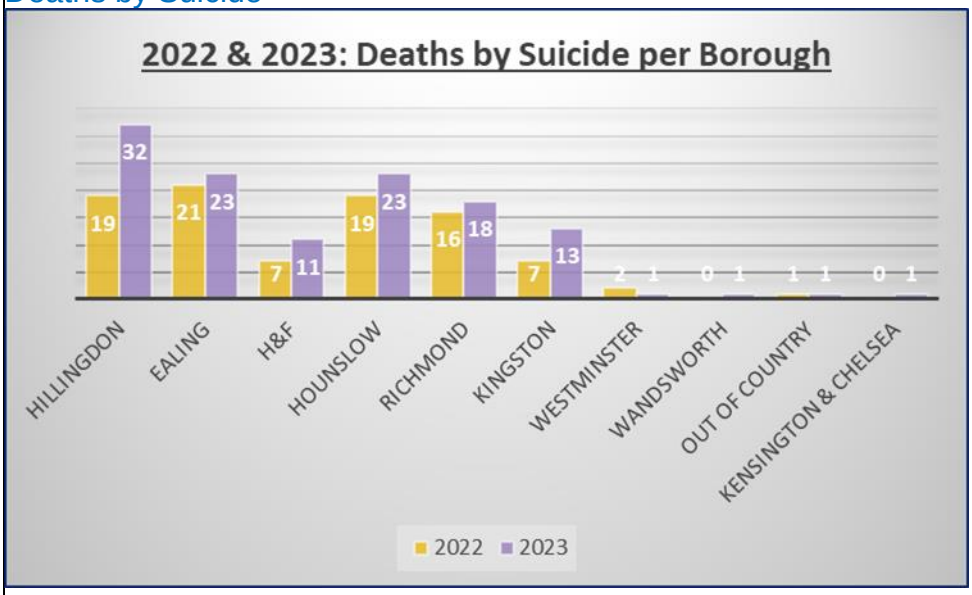
1. Main Points

Decrease in the number of deaths reported to coroners in 2023	**195,000 deaths were reported to coroners in 2023, the lowest level since the start of the annual time series in 1995 – down 6% (13,400) compared to 2022.** West London: 3773 referrals Highest number of referrals in London, down slightly from the six year high of 3787 in 2022, to 3773 in 2023.
34% of all registered deaths were reported to coroners in 2023	**The proportion of registered deaths in England and Wales has decreased by three percentage points compared to 2022.**
Deaths in state detention, down 8% in the last year	**492 deaths in state detention were reported to coroners in 2023 (down from 534 in 2022), the decrease was driven by a 24% fall in deaths of those in Mental Health Act detention.** West London: 13 Deaths in State Detention (7 in 2022)
Post-mortem examinations were carried out on 44% of all deaths reported in 2023	**There were 86,000 post-mortem examinations ordered by coroners in 2023, a 5% fall compared to 2022. The proportion of reported deaths requiring a post-mortem increased by one percentage point over the same period.** West London: 39% of referrals have post mortem which is slightly lower than last year.
2% more inquests opened in 2023	**36,900 inquests were opened in 2023, up 2% (582) compared to 2022.** West London: opened the most inquests in London last year.
Inquest conclusions up 11%, the largest rise seen in drugs/alcohol related, accident/misadventure and unclassified conclusions	**In 2023, 39,500 inquest conclusions were recorded in total, up 11% on 2022. Drugs/alcohol related, accident/misadventure and unclassified conclusions had the largest increases, up 16%, 11% and 15% on 2022, to 4,600, 9,700 and 10,000 inquest conclusions in 2023 respectively.** West London: conclusions up from 622 in 2022 to 667 in 2023. 

Cause of Death	2022	2023	
Accident/Misadventure	168	212	⇧
Suicide	97	125	⇧
Alcohol/Drugs	83	87	⇧
Unclassified/Narrative	71	85	⇧
Open Conclusions	50	64	⇧
Natural Causes	80	57	⇩
Industrial Disease	21	19	⇩
Road Traffic Collision	9	11	⇧
Unlawful	6	4	⇩
Lawful	0	2	⇧
Lack of Care/Self-neglect	4	1	⇩

The top three conclusions for cases heard at West London remained the same as in 2022; Accident/Misadventure, Suicide and Alcohol/Drugs. Conclusions of Accident/Misadventure saw the greatest increase compared to last year. This is similar to the national picture.

Deaths by Suicide



In 2023, most boroughs had a rise in inquest conclusions of suicide.
The most conclusions of suicide were recorded for deaths in Hillingdon and the lowest, in the West London Coronial area, with Hammersmith and Fulham recording the fewest conclusions of suicide.
This data is based on the year the inquest was heard, it does not reflect the year of death.

Average time taken to complete an inquest rose by 1.3 weeks	**The estimated average time taken to process an inquest increased from 30.2 weeks in 2022 to 31.5 weeks in 2023.** West London: average time to process an inquest 30 weeks.
Prevention of Future Deaths reports up by 41%	**569 Prevention of Future Deaths reports were issued in 2023, an increase of 41% compared to 2022.** West London: submitted 7 PFDs in 2023 (6 PFDs in 2022)

5. CORONER'S ENGAGEMENT WITH STAKEHOLDERS

I met with many of our stakeholders in 2023, and these are continuing to ensure good relationships and best working practise.

During 2023, beneficial meetings have been held with:

- Faith Leaders for the Jewish and Muslim faiths, including a visit to Muslim Gardens of Peace in North London.
- Medical Examiners
- Organ Donation Specialist Nurses and Clinical Leads
- Registrars of births and Deaths
- West London Mental Health Trust
- Coronial Lead for Metropolitan Police Service
- Safer Custody Governors of HMP Wormwood Scrubs
- NHS Acute Trusts
- Funeral directors
- Pathologists
- Fulham, Kingston and Uxbridge Mortuaries

The court has also welcomed visitors from numerous professions to observe cases and meet with the team.

6. CONCLUSION

Future Plans:
On 9 September 2024, the new statutory scheme for Medical Examiners commences so that all natural deaths, both in hospital and the community are scrutinised independently. This will be impactful on the work of the Coronial service, but quite what the impact looks like remains to be seen, as pilot schemes have produced very different results! We should experience a reduction in referrals which will allow Coroner's Officers to be deployed more effectively on case work.

An appraisal scheme for Assistant Coroners will be introduced to ensure overview of their work, respecting their role as independent Judicial Officers and supporting career pathways.

West London continues to support the introduction of CT scanning to replace invasive post mortems and is working with stakeholders to continue the dialogue and explore funding options.

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. This remains our highest priority, to keep the families at the heart of the service. The investment in the service has made a difference to our ability to undertake our work.

Senior Coroner Lydia Brown,

July 2024