Chief Coroner

# Report of the Chief Coroner to the Lord Chancellor

## Annual report for 2025

September 2026

Chief Coroner

# Her Honour Judge Alexia Durran, Chief Coroner of England and Wales

# Report of the Chief Coroner to the Lord Chancellor

Annual report for 2025

Presented to Parliament pursuant to section 36(6) of the Coroners and Justice Act 2009

September 2026

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# Contents

# 1. Introduction

**1.1** This annual report is made pursuant to section 36 of the Coroners and Justice Act 2009 ('the 2009 Act'). It covers the calendar year 2025 as the statutory reporting period and must be given to the Lord Chancellor by 1 July 2026. The Lord Chancellor must then publish and lay the report before each House of Parliament.

**1.2** I am the fourth Chief Coroner of England and Wales. The year 2025 represents my first full calendar year in office and I have continued the work identified in my first report. The overall view of the coronial service in England and Wales is one of a service under continuing pressure. Important work has been taken forward during the year in relation to guidance, training and national co-ordination, but this report also reflects longstanding challenges in uneven local resourcing and consistency, delay caused by dependence on other agencies, and the strain those pressures place on coroners and their staff. During this period, significant work has been undertaken to strengthen national consistency, reinforce judicial standards, and ensure that the interests of the bereaved remain central to the coronial process.

**1.3** Section 36 of the 2009 Act outlines the statutory requirements of the Chief Coroner that must be covered in this report, which I will address alongside the more general activities of the office.

**1.4** The Chief Coroner's statutory and primary responsibilities, in addition to providing an annual report, include:

- providing support, leadership and guidance for all salaried and fee paid coroners in England and Wales
- providing training to coroners and coroners' officers delivered by the Judicial College
- representing the interests of coroners to the wider judiciary, government and those with a vested interest in the coroner services

**1.5** The Chief Coroner is supported by a private office, two deputy chief coroners, regional leadership coroners, and strategic wellbeing and diversity and inclusion leads, the latter appointed from 1 January 2025. I remain grateful to all those who have supported the work of the office during the reporting year.

# 2. Coroner statistics

**2.1** The Ministry of Justice is responsible for publishing annual coroner statistics. The 2025 statistics were published on 14 May 2026 in 'Coroners statistics 2025'.[1]

**2.2** These figures cover, among other matters, deaths reported to coroners, postmortem examinations, inquests opened, conclusions recorded, and treasure finds.

**2.3** It is reported that 147,814 deaths were referred to a coroner in 2025. While the overall volume of deaths referred to a coroner has reduced by 15% since 2024, coroners across a number of areas have reported increasing case complexity, particularly in investigations involving specialist medical, forensic or criminal inquiries. The statistics indicate that the average time taken to conclude an inquest has remained stable at around 31 weeks, rather than increasing, despite pressures arising from more complex cases.

**2.4** The statutory medical examiner system, introduced in September 2024, is likely to have continued to influence referral patterns.

1 Ministry of Justice, 'Coroners statistics 2025', May 2026, available at: www.gov.uk/government/statistics/coroners-statistics-2025

# 3. Cases over 12 months

**3.1** As the Chief Coroner, I have a statutory duty to summarise investigations lasting more than a year, usually referred to as cases over 12 months. This period begins on the date on which a coroner was first notified that the body was within their area. Each coroner area provides an annual return explaining the reasons for delay and the measures taken to avoid unreasonable further delay in concluding an inquest.

**3.2** As in previous years, the most common causes of delay remain matters outside the coroner's control and the reliance on the completion of external investigations, including criminal investigations, Health and Safety Executive (HSE) inquiries, investigations by the Prisons and Probation Ombudsman (PPO), Independent Office of Police Complaints (IOPC) inquiries, and work undertaken by specialist accident investigation bodies. The coroners' investigations are rightly suspended pending the outcome of such external inquiries or investigations. This suspension is mandatory by the 2009 Act in occurrences of criminal proceedings and related public inquiries. The external investigations have always been cited as very lengthy, and this year's figures only continue to strengthen my view that coroner services are increasingly affected by an external department or agency's ability to progress their own workload.

**3.3** Local authority resourcing continues to affect timeliness in some jurisdictions. Pressures on coroner officer staffing, mortuary provision and pathology capacity (particularly acute in paediatric and neuropathology) remain challenges, especially in high volume metropolitan areas and large rural jurisdictions.

**3.4** For the 2025 reporting period, coroner areas were asked, for the first time, to provide an estimate of the number of cases they expect to take more than 12 months to conclude. This information will support more targeted engagement with areas where figures are disproportionately influenced by geography, population or specialist facilities.

**3.5** A table showing the number of cases over 12 months as of 31 December 2025 is included in the annex to this report.

# 4. Reports to prevent future deaths

**4.1** Paragraph 7 of Schedule 5 of the 2009 Act imposes on coroners the duty to make a report, where the evidence obtained during an investigation or inquest gives rise to a concern that future deaths will occur, and the investigating coroner is of the opinion that action should be taken to reduce the risk of death.

**4.2** I am responsible as the Chief Coroner for publishing all Prevention of Future Deaths reports and responses on the judiciary.uk website in accordance with the Chief Coroner's publication policy. The number of reports published during 2025 was 647, this is a reduction on the 707 published in 2024, however still an increase on the 550 issued in 2023, showing that overall levels of issued reports remain consistently high, notwithstanding year-on-year fluctuations.

**4.3** By the time of publication of this report I will have published an updated publication policy, focusing on the process for redactions, alongside new Prevention of Future Deaths report and response templates, the aim being to increase consistency nationally and ensure public transparency.

**4.4** Recipients of such reports are under a statutory obligation to respond within 56 days, unless an extension is granted by the coroner. I continue to publish a list of organisations and departments that have not provided a response to a Prevention of Future Deaths report within the statutory time limit. I published two lists in 2025, the first on 30 June 2025 and most recently on 31 December 2025. The list covered responses due between 14 December 2024 and 12 December 2025. It was compiled after confirmation from coroner areas that responses had not been received or that no extension had been granted. Before publication, coroner areas were contacted to ensure the position was accurate.

**4.5** At the point of publication of this report, the list identified 23 reports issued in 2025 for which one or more responses were outstanding. By comparison, the 26 reports identified in 2024 covered a six-month period only, whereas the 23 outstanding reports in 2025 relate to the full year.

**4.6** It is a known feature of the Prevention of Future Deaths framework that coroners, and the Chief Coroner's Office, may from time to time come under public pressure to monitor or oversee the outcome of Prevention of Future Deaths reports. It continues to be my view that this pressure arises from the absence of any statutory system or mechanism to oversee or enforce responses and learning. The legal position is clear: once a Prevention of Future Deaths report has been issued, the coroner is 'functus officio' and has no legal power to take any further steps, other than determining any application by the recipient for an extension of time in which to respond.

**4.7** This is as it should be. Coroners are judges, not regulators. Coroners do not make recommendations and have no power to direct specific action; they may only raise concerns in the light of their investigations. Where responses are sent to me, they are published alongside the relevant Prevention of Future Deaths report on the judiciary website in accordance with my publication policy. I reiterate the importance of accurate reporting and understanding of this legal position.

**4.8** My office continues to work with the Ministry of Justice to ensure that central contact details for government departments receiving reports remain accurate. I have commissioned a piece of work to see whether I can publish on judiciary.uk a list of relevant department's contacts and their area of responsibility, with the aim to increase transparency.

# 5. Deaths of service personnel

**5.1** During the reporting period, I received four notifications of deaths of service personnel within the meaning of section 17 of the 2009 Act.

**5.2** The Service Deaths Cadre was reconstituted during 2025, and a review of the associated guidance was undertaken to ensure that it accurately reflects statutory responsibilities and public expectations. By the time of publication, I will have also published the renewed 'Chief Coroner's Guidance No.7 A Cadre of Coroners for Service Deaths'.[2]

**5.3** I continue to engage with the Ministry of Defence and coroners experienced in military investigations to help create a specialist cadre training day due to take place in Autumn 2026.

2 Courts and Tribunals Judiciary, 'Chief Coroner's Guidance No.7 A Cadre of Coroners for Service Deaths', April 2026, available at: www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-7-a-cadre-of-coroners-for-service-deaths/

# 6. The coroner service in 2025

## Activities of the Chief Coroner

### Consistency of standards between coroner areas

**6.1** Throughout 2025, I have focused on strengthening national standards, improving consistency across coroner areas, and supporting coroners in the delivery of their judicial functions.

**6.2** In January 2025, I published the 'Chief Coroner's Guidance for Coroners on the Bench' to support consistency of judicial approach across coroner areas.[3] Alongside this, I have reviewed the wider body of Chief Coroner guidance and relevant material has been incorporated into the Bench Book, with some guidance withdrawn and other parts updated.

### Regional leadership coroners and lead coroners for wellbeing and diversity and inclusion

**6.3** In the early part of 2025, I appointed regional leadership coroners, lead coroners for wellbeing, and lead coroners for diversity and inclusion to provide structured judicial support to me in the leadership of the coroner system.

**6.4** The regional leadership coroners support my work by acting as a regional point of contact for coroners, representing their regions in regular engagement, supporting the sharing of good practice, and providing informed regional insight to assist me in discharging my statutory and leadership responsibilities. Their role includes supporting me, where appropriate, in aspects of judicial recruitment by acting as my nominee in senior, area and assistant coroner appointment processes, as well as contributing to mentoring, development, welfare and inclusion activity across regions.

**6.5** The lead coroner for wellbeing and the lead coroner for diversity and inclusion provide strategic support to me in areas of particular importance to the judiciary. These roles are focused on shaping and co-ordinating approaches, rather than operational delivery.

3 Courts and Tribunals Judiciary, 'Chief Coroner's Guidance for Coroners on the Bench', January 2025, available at: www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-for-coroners-on-the-bench/

**6.6** The governance arrangements within which coroners operate are substantially different from those that apply to judges in wider courts and tribunals, and this has a direct impact on the way in which wellbeing and diversity and inclusion initiatives can be developed and enacted across the service.

**6.7** Coroners are independent judicial office holders, but are appointed, resourced and administered locally by local authorities, rather than through national judicial appointment and governance structures. As a result, many of the formal levers, frameworks and mechanisms that exist elsewhere in the judiciary do not apply in the coroner jurisdiction. This can create friction, both in expectations and in delivery, particularly where national wellbeing or diversity initiatives assume a degree of central oversight or consistency that cannot readily be replicated for coroners.

**6.8** The strategic roles of the lead coroner for wellbeing and the lead coroner for diversity and inclusion are therefore focused on observing trends, identifying achievable priorities, and advising me on what can realistically be progressed within these constraints, rather than on operational delivery.

**6.9** Clear articulation of these governance differences remains essential to ensuring that expectations are properly managed and that initiatives are aligned with the distinct constitutional and administrative position of coroners.

## Chief Coroner's cadres

**6.10** During 2025, I undertook a comprehensive reconstitution of the Chief Coroner's national cadres, including the Cadre of Coroners for Major Incidents and the Cadre of Coroners for Service Deaths.

**6.11** This work followed a review of the existing arrangements and a decision to refresh membership in full, requiring all interested coroners to apply through updated expressions of interest. The purpose of this exercise was to ensure that cadre membership reflects appropriate experience, availability and capability, and that the cadres continue to provide effective judicial support in complex, sensitive and high-profile cases.

**6.12** The major incidents cadre, which incorporates and replaces the former disaster victim identification cadre, is formed of experienced coroners who can provide advice, expertise and judicial leadership in response to major incidents. Cadre members are available to support the Chief Coroner or other coroners, may be asked to act as the incident coroner where appropriate, and are able to lead the Mass Fatalities Co-ordinating Group in the event of an incident. Members also participate in an on-call rota and undertake regular training to ensure preparedness for incidents that place exceptional demands on the coroner system.

**6.13** During the reporting year, I nominated a coroner from the major incidents cadre to lead the investigations into the fatalities arising from the Air India incident on 12 June 2025. The nomination of a cadre member, to provide expert advice and support, was important in ensuring a consistent, co-ordinated approach for the bereaved who asked for their family members bodies to be repatriated. Such a nomination ensured appropriate judicial leadership and helped to maintain public confidence in the coronial response to an incident of exceptional complexity.

**6.14** The service deaths cadre supports my statutory responsibilities under section 17 of the Coroners and Justice Act 2009 in relation to investigations into the deaths of service personnel. Members of this cadre are available to conduct or support investigations and inquests into service deaths when directed, or to provide advice and assistance to local coroners. Deployment of a cadre member is considered on a case-by-case basis, reflecting the judicial nature of these decisions and the circumstances of each death.

**6.15** Alongside the reconstitution of both cadres, work was initiated during the year to review and update associated guidance, training expectations and operating arrangements. This included early engagement with cadre members following appointment and initial planning for refreshed guidance to support consistent and effective operation.

**6.16** During 2026, this work will continue, with updated guidance and training arrangements intended to be embedded to ensure that the cadres remain robust, responsive and fit for purpose.

## Appointments

**6.17** Schedule 3 of the 2009 Act provides the statutory basis for the Chief Coroner and Lord Chancellor for consent to the appointment of a person as a senior, area or assistant coroner.

**6.18** A significant number of senior, area and assistant coroner appointments were processed during the reporting period.

**6.19** In 2025, I introduced the new annual recruitment process for assistant coroners which aligns how fee-paid coroners are recruited with the wider courts and tribunals judiciary.

**6.20** The overarching aim of an annual recruitment exercise was to provide greater clarity, consistency and transparency for applicants and appointing authorities. This revised approach placed clearer emphasis on defined stages in the recruitment process, including indicative timeframes for advertising, shortlisting and appointment.

**6.21** I wanted to support timely recruitment, manage expectations more effectively, and promote a fair and proportionate process, balancing the judicial nature of the role, while respecting the independence of local authorities as appointing bodies.

**6.22** Towards the end of the year, I undertook a review of the processes, informed by engagement with senior coroners and local authorities and the experience of recruitment exercises conducted during the year. The review found that clarity around recruitment stages and having indicative timeframes were useful however they did place burdens which may not have factored individual local circumstances. As a result, changes were introduced in 2026 to provide clearer expectations around advertising, shortlisting and appointment, and I have ensured greater flexibility for local authorities, particularly at the sift and interview stages.

**6.23** These changes are intended to continue to support the underlying aims of an annual cycle by supporting timely and proportionate recruitment, while maintaining appropriate safeguards.

**6.24** All appointments remain subject to my and the Lord Chancellor's consent, and are supported by mandatory induction training, ensuring that newly appointed assistant coroners are properly prepared for the judicial responsibilities of the role.

## Mergers: reduction in the number of coroner areas

**6.25** Paragraph 2 of Schedule 2 to the 2009 Act allows the Lord Chancellor, by order, to alter coroner areas (including by combining two or more areas).

**6.26** On 5 June 2025, four coroner areas in Kent were merged to create a new coroner area: Kent and Medway.[4] This reduced the total number of coroner areas to 74. The areas were:

4 The Coroners and Justice Act 2009 (Alteration of Coroner Areas) Order 2025, available at: www.legislation.gov.uk/uksi/2025/655/made

(a) Central and South East Kent

(b) Mid Kent and Medway

(c) North East Kent

(d) North West Kent

## Training

**6.27** The judicial training year covers 1 April to 31 March.

**6.28** Coroner continuation training in 2025 to 2026 focused on the scope of an inquest, reflected developments in case law and practice, and used a case study on controlling and coercive behaviour within an abusive domestic relationship, an area of significant and growing national focus.

**6.29** Assistant coroner induction training was delivered in December 2025 in line with the new annual cycle, as outlined in my 2024 annual report to professionalise the jurisdiction.

**6.30** In continuing my endeavour to increase professionalism, I agreed with the Judicial College that coroner officer training would become training delivered on a two-year cycle. The aim is to ensure that all coroners' officers have the ability to attend an event and access the necessary training to fulfil their duty in supporting coroners.

**6.31** Throughout the year I also continued to undertake work with the Judicial College on reasonable adjustments to ensure that training participation remains open to all coroners and their officers.

**6.32** In March 2025, the Chief Coroner's senior and area conference was held and had a thematic focus on mental health.

## Review of the model coroner area

**6.33** My office and I have started a review of the model coroner area which I expect to be a significant undertaking.

**6.34** Feedback from coroners, local authorities and partner agencies was collated and is being used to inform the revision so that it reflects current practice and statutory responsibilities. I have openly expressed the hope to have the guidance published by May 2027.

## Security

**6.35** Concerns regarding the safety of coroners and those attending coroner courts continued during 2025.

**6.36** My office has observed wider judicial security work that is being undertaken and continues to encourage coroners and local authorities to work together to ensure court accommodation is safe and appropriate.

**6.37** Judicial security remained an area of concern during the reporting period, and I continue to emphasise the importance of safe and appropriate court accommodation. To promote an awareness of issues associated with security I worked with the Judicial College on the provision of digital training for coroners.

## Judge-led inquests

**6.38** The Chief Coroner has a power under Schedule 10 of the 2009 Act to request the Lady Chief Justice to nominate a judge to conduct an investigation into a person's death. The Schedule 10 process will be suitable for cases in which national security sensitive material is in scope and the coroner has not been able to discharge their statutory functions because statute prevents disclosure of some security sensitive material to the coroner themselves. The Lady Chief Justice must consult the Lord Chancellor before making a nomination.

**6.39** During the calendar year 2025, one such request was made in relation to the investigation into the death of Alexander Ahmed Kareem, following which Her Honour Judge Anuja Dhir KC was nominated.

**6.40** I will repeat the sentiment expressed in my report for year ending 2024 that there continues to be a concern as to how judge-led inquests are funded. The scale involved means cases can often take years to investigate and conclude. The government has no formal policy in relation to providing centralised funding for such inquests. Due to the funding burden of responsibility falling on the local authority that has jurisdiction, it can have a detrimental effect on their ability to fund the routine work of the area.

## Treasure

**6.41** As well as conducting death investigations, coroners are responsible for conducting inquests into treasure finds. The purpose of a treasure inquest is to establish whether a find constitutes treasure, who found it, and when and where it was found. If an item is deemed to be treasure it becomes the property of the Crown. If it is not deemed to be treasure, it is returned to the landowner where the item was found. In 2025 there were 1,621 finds reported under the Treasure Act 1986, a 18.93% increase in finds reported in 2024. There remain geographical and historical variations across England and Wales.

**6.42** Work continues with the Department for Culture, Media and Sport, the British Museum, and the Coroners' Society of England and Wales as well as support from senior coroners. I will continue to review the practical guide for coroners which provides advice and a set of standard letters and forms for use in treasure cases in England and Wales with updated guidance to be published shortly.

**6.43** It has become clear over the year that it is essential that there is better understanding of the impacts following the implementation of the Treasure (Designation) Order 2002, as amended in 2023. To my knowledge, there have been no cases where a find has fallen within the new class of treasure, but we will need to ensure that the guidance reflects working processes.

## The statutory medical examiner system

**6.44** The year 2025 marked the first full year of operation of the statutory medical examiner system across England and Wales. Early feedback suggests improved consistency in the scrutiny of natural deaths and greater clarity around referrals to coroners.

# External engagement

## David Fuller inquiry

**6.45** Following publication of the David Fuller inquiry report on 15 July 2025, and having considered its findings and recommendations, I wrote to all coroners to draw attention to the inquiry's conclusions, highlighting the serious offences committed by David Fuller. Coroners are already aware of the importance of preserving the security and dignity of deceased persons while they are under the coroner's control, and these duties are integral to the coronial role. I am not currently proposing to issue additional guidance or training. Responsibility for the provision and management of public mortuaries rests with individual local authorities. I will, however, remain alert to the issues raised by the inquiry and will continue to engage with coroners, as appropriate, should further action be required.

## Public Office (Accountability) Bill (Hillsborough Law)

**6.46** The Public Office (Accountability) Bill, commonly referred to as the 'Hillsborough Law', was introduced to the House of Commons on 16 September 2025. The Bill seeks to introduce a statutory duty of candour on public authorities and officials, with the aim of strengthening accountability, transparency and public confidence following major incidents, and of providing greater parity of arms for bereaved families, including through access to legal aid where a public authority is an interested person.

**6.47** On 27 November 2025, I gave oral evidence to the Bill Committee. In my evidence, I outlined the coronial system's established commitment to openness, fairness and the thorough investigation of deaths, and explained how the principles underpinning the proposed duty of candour are already reflected in coroners' statutory responsibilities. I also highlighted several key points, such as:

(a) the independent judicial status of coroners and the importance of protecting judicial independence

(b) the central role of inquests in establishing the facts surrounding a death in a transparent and inquisitorial manner

(c) the expectation that public bodies engage openly and assist coroners during investigations and inquests

(d) the need for any new statutory duty to be clearly framed so that it supports, rather than complicates, the effective and timely delivery of coronial functions

## Inquiry into the death of Dawn Sturgess

**6.48** On 4 December 2025, Lord Hughes of Ombersley published his report following his inquiry into the death of Dawn Sturgess. The publication of that report superseded the inquest proceedings which had originally been commenced as a judge-appointed inquest chaired by Dame Heather Hallett. Although my subsequent decision not to resume the inquest was communicated by letter dated 23 March 2026, and therefore falls outside the 2025 reporting period, I consider it appropriate to note this conclusion here. I decided that there was not sufficient reason to resume the inquest, as Lord Hughes' report provided answers to the statutory questions and wider circumstances of Dawn Sturgess's death.

## Stakeholder engagement

**6.49** I continued to engage widely in 2025 with stakeholders, including the Coroners' Society of England and Wales, national medical organisations, local authorities, faith community representatives and government departments. These discussions addressed issues such as mortuary provision, staffing pressures, out of hours services and deaths in custody.

**6.50** I also attended the Local Authority Registration Coroner Services Association (LARCSA) annual conference, which provided a valuable opportunity to engage directly with local authorities on matters of shared interest and responsibility within the coronial system. I welcomed the opportunity for open and constructive dialogue and hope that participation by the Chief Coroner will continue as an annual commitment, supporting ongoing collaboration and mutual understanding.

# 7. Conclusion

**7.1** I remain grateful to coroners, coroner officers, local authorities and partner organisations for their professionalism and resilience throughout the year.

**Her Honour Judge Alexia Durran**
**Chief Coroner**

# Annex

## Cases over 12 months 2025: reporting period 1 January 2025 to 31 December 2025[5]

| Coroner area | Number of cases over 12 months |
|---|---|
| Avon | 87 |
| Bedfordshire and Luton | 37 |
| Berkshire | 64 |
| Birmingham and Solihull | 51 |
| Black Country | 57 |
| Blackpool and Fylde | 27 |
| Buckinghamshire | 36 |
| Cambridgeshire and Peterborough | 200 |
| Carmarthenshire and Pembrokeshire | 49 |
| Ceredigion | 23 |
| Cheshire | 28 |
| City of London | 3 |
| Cornwall and Isles of Scilly | 42 |
| County Durham and Darlington | 40 |
| County of Devon, Plymouth and Torbay | 507 |
| Coventry | 14 |
| Cumbria | 45 |
| Derby and Derbyshire | 57 |
| Dorset | 42 |
| East London | 94 |
| East Riding and Hull | 50 |
| East Sussex | 62 |

5 These figures are collected by the Chief Coroner's Office directly from each coroner area, via a report produced by Civica or WPC. Section 16 (3) of the Coroners and Justice Act 2009 provides that the Chief Coroner must keep a register of all cases over 12 months.

| Coroner area | Number of cases over 12 months |
|---|---|
| Essex and Thurrock | 122 |
| Gateshead and South Tyneside | 24 |
| Gloucestershire | 54 |
| Greater Lincolnshire | 115 |
| Gwent | 46 |
| Hampshire, Portsmouth and Southampton | 223 |
| Herefordshire | 11 |
| Hertfordshire | 89 |
| Inner North London | 49 |
| Inner South London | 303 |
| Inner West London | 25 |
| Isle of Wight | 173 |
| Kent and Medway | 68 |
| Lancashire with Blackburn and Darwen | 124 |
| Leicester and South Leicestershire | 29 |
| Liverpool and Wirral | 47 |
| Manchester City | 47 |
| Manchester North | 61 |
| Manchester South | 22 |
| Manchester West | 75 |
| Milton Keynes | 17 |
| Newcastle Upon Tyne and North Tyneside | 27 |
| Norfolk | 85 |
| North London | 98 |
| Northumberland | 34 |
| North Wales (East and Central) | 30 |
| North West Wales | 10 |
| North Yorkshire and York | 115 |
| Northamptonshire | 101 |
| Nottinghamshire and Nottingham | 78 |
| Oxfordshire | 29 |
| Rutland and North Leicestershire | 26 |
| Sefton Knowsley and St Helens | 38 |

| Coroner area | Number of cases over 12 months |
|---|---|
| Shropshire Telford and Wrekin | 16 |
| Somerset | 42 |
| South London | 243 |
| South Wales Central | 136 |
| South Yorkshire (East) | 26 |
| South Yorkshire (West) | 34 |
| Staffordshire and Stoke on Trent | 112 |
| Suffolk | 96 |
| Sunderland | 13 |
| Surrey | 82 |
| Swansea and Neath Port Talbot | 68 |
| Teesside and Hartlepool | 145 |
| Warwickshire | 27 |
| West London | 134 |
| West Sussex, Brighton and Hove | 60 |
| West Yorkshire (Eastern) | 74 |
| West Yorkshire (Western) | 101 |
| Wiltshire and Swindon | 80 |
| Worcestershire | 28 |

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