MR TOM OSBORNE
HM SENIOR CORONER FOR MILTON KEYNES

ANNUAL REPORT 2019/20

OFFICE OF MR TOM OSBORNE LL.B
HM SENIOR CORONER MILTON KEYNES

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1. HM Coroners Overview

It is an honour and a privilege to serve as the coroner for Milton Keynes in this fascinating jurisdiction. Some might imagine that given the difficult issues and cases we investigate the court is a sombre place to work. I've always found it to be quite the opposite – the focus on supporting families and preventing deaths gives the workplace a meaningful and positive drive.

Each year we actively investigate over 800 deaths to establish facts as to who, when, where and how has someone died. It has often been said that we speak for the dead to protect the living. This twofold role is a vital component of a civil society.

At the heart of each investigation is a family who have lost a loved one. The court recognises the loss of a loved one is very difficult, especially when the death was sudden and unexpected. We are very conscious of the fact that reporting the death to the coroner is an external intervention into family life at what is a deeply private time of loss. With this understanding we continue to work towards delivering the best service we can to the families of Milton Keynes and to place the family at the centre of the process.

Our own audit confirms that Milton Keynes residents are receiving a competent, thorough death investigation service that meets or exceeds the national standard.

This year the service has focused on enhancing communication and support to ensure those who encounter our service have the information and resources they need to make important decisions and actively participate in the coronial process.

For all families, involvement with the coroner's office is not something they have anticipated. How we make our involvement with them the best it can be is both a challenge and a responsibility. We must always strive to do better.

The court will continue to implement and expand services to make sure the jurisdiction recognises and respects the cultural traditions and needs of the minority groups in Milton Keynes.

The court has sought to improve awareness and understanding of the coroner's jurisdiction amongst a broader community and will continue to do so.

2. Acknowledgements

To all the staff, Sonia Brooks, Faye Toms, Michelle Sapwell and Tara Bonaiti, I thank you for your commitment and professionalism throughout the year. I am enormously proud of what we have achieved under difficult circumstances.

I would like to take this opportunity to acknowledge, upon her retirement, the contribution made by Mel Riley who has served as a Coroner's Officer for 24 years. We will miss her unique approach and the wealth of knowledge that she has acquired during her years of service. The whole team wish her a long and happy retirement.

Once again I must thank Neil Allen for his unwavering support throughout a difficult year and the council who continue to value the work of the coroner service and realise that we fulfil a vital role within the city to protect lives and help to identify and avoid preventable deaths. I hear horror stories from other jurisdictions from coroners who conflict with their local authority whereas Milton Keynes Council have never failed to support me and the service without reservation.

The pandemic has meant that the Coroner's Court support service has not been able to function. But we have missed them, and we look forward to welcoming back the dedicated volunteers when normal service is resumed.

Finally, I must thank my coronial colleagues, Dr Sean Cummings and Adam Smith for their support and acknowledge their enduring passion for the work that we do and the service in Milton Keynes.

Elizabeth Gray has moved on having been appointed area coroner in Cambridgeshire. I thank her for her service as my deputy for 11 years and I have no doubt that she will be successful in her new role. We wish her well.

3. Role of the Coroner

It is the role of the Coroner to investigate and, if necessary, to inquest all unnatural or violent deaths or, deaths that are unexplained. In the case of Jamieson decided by the Court of Appeal over twenty years ago the role was described as:

"It is the duty of the coroner as the public official responsible for the conduct of inquests to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. (And I would add where the state may be involved). He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedures to be followed. His decisions, like those of any other judicial officer, must be respected unless and until they are varied or overruled."

It must always be the case that the purpose of the inquest is not to determine matters of liability or to seek to apportion blame for the death. The purpose is simply to answer four questions

Who is the person that has died;

Where did he/she die;

When did he/she die and

How did she/he die.

"How" in coronial terms means "by what means" and this is extended for an Article 2 inquest, where someone dies in state detention to how and in what circumstances.

The coroner may request a post-mortem examination (PM) where it is necessary to enable the coroner to decide whether the death is one where an investigation is required. I do not order a post-mortem until the views of the family have been ascertained and reported to me. A post-mortem is ordered only as a last resort if the doctors are unable to give a cause of death.

4. COVID 19

Like many other government and local government departments the COVID-19 pandemic was a challenging time for us all. I would like to express my gratitude to all within the service and our partners who worked tirelessly to keep the service operating throughout the pandemic. This was made more difficult for my staff by the fact that I contracted COVID-19 in the middle of December and was absent from court for three months. I have to thank again my assistant Coroners Sean Cummings and Adam Smith who, together with the Coroner officers, kept the service running.

Covid 19 is a natural cause of death and as such is not the subject of investigation by the coroner. There are outstanding issues surrounding the pandemic that will need to be addressed at some time in the future, such as the provision of PPE, the care and protection of the elderly in care homes and the treatment and protection of frontline staff. These are matters not for the Coroner but for the Public Inquiry that was announced by the government on 23 May 2021. I have urged families, who have expressed concerns to me, to ensure that they contact the inquiry team so that their concerns and, in particular, the restrictions placed on visiting love ones are properly addressed. I suspect, however, that the overriding concern will centre around the failure of communication. A great number of people have expressed concerns to my team that they were not able to spend time with their loved ones before they died, and they were not given enough information about the progress or deterioration of their family member. I believe this has had a long-term impact for the surviving family and is something that was not properly addressed during the pandemic.

5. Positive Developments

The Technology available in court has improved beyond recognition. Once again, I must express my thanks to the IT team; without their support the court itself would have ground to a halt. The new technology has enabled us to conduct Inquests remotely via teams so that advocates, witnesses and members of the family can join the court from their office, home or preferred place.

The COVID-19 pandemic has meant that we have completely changed the way we conduct jury inquests. This has resulted in an additonal room being made available to us to provide a new jury room. At considerable expense the build was completed and state of the art technology installed. This already has proved to be a necessary and huge, welcome addition to our resource. The space that we now have available will ensure the coroner service has the resources and infrastructure that it needs for the foreseeable future. Again, I must express my thanks to the council for their support during this difficult time.

The number of deaths at HMP Woodhill continues to fall and this is in part due to the work of all the agencies involved who have made suicide prevention a major priority.

The Medical Examiner system is up and running and the present voluntary system has proved a huge success. We are now hoping to extend the service as a pilot scheme to include deaths in the community. Such an extension will become compulsory by April/May 2022 and we are looking forward to working alongside our medical examiner colleagues.

6. Prevent Future Death reports

I make no apology for again highlighting this important part of the coroner's role which I summarised in earlier reports as follows:

The avoidance of future deaths has long been recognised as a major purpose of an inquest in preventing the repetition of dangerous conduct and encouraging beneficial change. From the Coroners and Justice Act 2009 and the regulations the provisions state

- Where the coroner finds anything revealed by an investigation which gives rise to a concern that circumstances creating a risk of other deaths will continue to exist, or will occur in the future;
- So that in his or her opinion action should be taken to prevent the recurrence or continuation of the circumstances or to eliminate/reduce the risk of death created by those circumstances:
- Then the coroner MUST make a report to the person who may have the power to take action.

The recipient of the report must respond the coroner within 56 days setting out the proposed action to be taken and a timetable for completing it, or, explaining why they do not propose to take action. The Coroner may send a copy of the report to any person who the coroner believes may find it useful or of interest.

In the recent House of Commons Justice Committee report "The Coroner Service" we were singled out for a mention

"the total number of PFD's reported vary widely by coroner area. Manchester South, Inner London North, Milton Keynes, Brighton and Hove, and Manchester north all stand out for reporting an above average number of PFD's. Coroners in these areas deliver the standard of service all bereaved people should expect to receive and highlight the deficiencies in coroner services elsewhere."

The flaw in the PFD system was however highlighted by the Justice Select Committee and it has recommended that the Ministry of Justice should consider setting up an independent office to report on emerging issues raised by coroners and to follow up on actions promised to coroners. We have this covered in Milton Keynes since a copy of every PFD that affects the people of the city is forwarded to the MK Together partnership where the reports and responses are discussed, and actions taken monitored. PFDS 2019/20 have been

Mark Kubiak was critically ill at Milton Keynes University Hospital and was transferred to the John Radcliffe Hospital in Oxford for surgical intervention. He was transferred to a portable ventilator and the oxygen supply was not connected properly and a lack of ventilation was not recognised. He suffered a cardiac arrest and died. I sent a report to the Thames Valley Transfer Network requesting they review their procedures and that the check list used at transfer must be reconsidered and if necessary amended. They responded assuring me that the guidance was amended to ensure that adequate ventilation was confirmed prior to transfer and that the change in the guidelines will be communicated to all units. The consultant at Milton Keynes University Hospital has also been invited to present the case at the network clinical forum.

Margaret Shaw and Susan Henderson

Both women were driving on the A5 when one of the cars aquaplaned on standing water across the road into the path of the oncoming vehicle and both drivers died at the scene as a result of their injuries. During the inquest I heard evidence as to the examination and monitoring of the A roads and that the inspection had failed to identify the problem of blocked gullies along the A5. Highways England responded to the report outlining the improvements in the inspection process that have been introduced and confirming that a memorandum has been sent out to all areas highlighting the importance of understanding the location of gullies and improving maintenance.

William Vickers aged 37 suffered a cardiac arrest whilst detained in HMP Woodhill, despite resuscitation he suffered hypoxic brain damage and subsequently died at Milton Keynes University Hospital. My concern was the delay in the ambulance crew attending to Mr Vickers. It took 11 minutes for the crew to be escorted from the main gate to the scene of the incident. I considered a more robust system should be put in place to ensure that emergency crews are admitted to the prison without delay. All the stakeholders involved in the process have worked together to ensure that a better system was immediately put in place.

SG was 16 years old when he took his own life.
Concern was expressed as to the availability of mental health services for children in Milton Keynes and the sharing of information across the services. As a result of the report many of these issues have now been addressed.

Iain Macinnes died as a result of suicide. My concern at the inquest was the information concerning the deterioration in his mental health was not communicated to his family. I asked the mental health trust to review their procedures for ensuring that families were involved in the care and treatment of their family member and the response from Central and Northwest London will ensure this aspect of sharing care will improve. They have launched the initiative "Think Family" that is proving successful.

John Shrosbree age 72 was admitted to Milton Keynes University Hospital and there was a failure to recognise the serious nature of his illness. During the inquest I was informed that there were staff shortages in the emergency department which were putting lives at risk. I requested the trust address this problem as a matter of urgency. I was assured by the Chief Executive of the Hospital that in their most recent inspection by the regulator, the Care Quality Commission, they did not flag any concerns regarding staffing numbers in the emergency department.

Thomas Smythe was 86 years old and suffered a fall resulting in a head injury and he was admitted to Milton Kings University Hospital. A CT scan revealed a subdural haematoma and the neurosurgeons advised that his anticoagulation medication should be stopped. Unfortunately, it was recommenced a day later. The error was primarily due to staff failing to refer to the appropriate page in the electronic medical record. The problem is going to be addressed in training and "this specific case will be used for learning in plenary sessions during the year to reach a wide medical and multidisciplinary audience. "

Darren Williams was 39 years old and died from suicide at HMP Wood Hill. In my report I expressed concerns regarding the suicide prevention procedures and documentation and the director-general for prisons at the Ministry of Justice responded to indicate that a new local operating procedure was to be put in place to improve the system.

Alana Cutland was a student working in Madagascar when she suffered a psychotic event and fell from a light aircraft. I sent a report to the medicines regulatory agency as the concern was about the drug doxycycline which is used as an antimalarial medication. The drug is going to be kept under review.

7. Faith communities

Due to the Covid 19 pandemic I have not been able to meet with the faith groups this year, but I hope to arrange such meetings as soon as it is deemed safe to do so.

8. Stake Holders and Partners

The work of the court is highly collaborative and strong relationships with our partners and stakeholders are essential.

We have continued to work collaboratively with all our partners across the region including Thames Valley Police and the South Central Ambulance Service. During the pandemic we worked closely with all the councils and coroners in Berkshire, Buckinghamshire and Oxfordshire to provide enough mortuary and body storage facilities at all times. The Milton Keynes Council were particularly proactive and had a temporary place of rest up and available within a short space of time. A more permanent solution may have to be found in readiness for the next pandemic that will surely follow, and I will be discussing this with other coroners to ensure we are ready.

9. Numbers

I set out below details of the deaths dealt with in 2019 and 2020

CONCLUSIONS OF INQUESTS	2018	2019	2020
Alcohol and Drug related	14	26	17
Narrative	14	13	15
Accident	40	43	45
Industrial Disease	6	17	10
Natural Causes	28	19	18
Open Conclusion	5	4	5
Stillbirth	0	0	0
Suicide	15	29	24
Road Traffic Collision	13	6	4
Neglect	1	0	0
TOTAL	**136**	**157**	**138**
Total number of deaths reported	**802**	**839**	**811**
Number of Post mortems	**239**	**261**	**212**

I also set out a table comparing our figures with the average for the whole of England and Wales.

	Deaths reported	Inquests opened	Post mortems	% MK Inquests	% E&W Inquests	% MK Post Mortems	% E&W Post Mortems
2009	781	130	513	17	13	66	46
2010	791	126	441	16	13	56	44
2011	718	121	340	17	14	47	42
2012	775	132	327	17	14	42	42
2013	772	105	308	14	13	40	41
2014	821	114	253	14	12	31	40
2015	870	179	221	21	14	25	38
2016	904	205	247	23	16	27	36
2017	819	170	237	21	14	29	37
2018	804	146	239	18	13	30	39
2019	839	154	261	18	14	31	39
2020	811	145	212	18	16	26	39

10. And finally

There is no doubt the past 12 months have been a challenge to us all, not least to the coroner service. The lesson learned is that in future we must be ready to deal with the next pandemic when it comes rather than prepare for if it comes.

The other lesson is the need for better communication on behalf of all who have the responsibility of caring for loved ones and dealing with their family in difficult circumstances. We must not seek to avoid communicating by hiding behind the Data Protection Act and confidentiality.

From a family after an inquest

"the trouble you took to listen carefully to all the witnesses and to ascertain the facts is an important sign to all, that people matter and that even as we record their deaths we are able to take steps to ensure that life is preserved and that justice is done .

May I take this opportunity to say *"Thank you" to you and your staff, for the exemplary way you conducted this difficult inquest. Your skill, wisdom, fairmindedness to all concerned shone through. It was a wonderful example of thorough professionalism and true humanity combined."*

Tom Osborne

Her Majesty's Senior Coroner for Milton Keynes **1st March 2020**