Inquests - Key Information for families

Who is the Coroner and what is their role?

The Senior Coroner for Milton Keynes is Mr Tom Osborne and we also have two Assistant Coroners, Dr Séan Cummings and Mr Adam Smith.

Each Coroner is an independent judicial officer who has a duty to investigate any death in Milton Keynes which is due to an unknown or unnatural cause.

Coroner's Officers

The Coroner is supported by Coroner's Officers who work to gather the required information to enable to the Coroner to complete their judicial role. This will include gathering evidence for inquest hearings and liaising with families to ensure they are fully informed and prepared for the inquest hearing. The Coroner's Officer will be the point of contact for the family and other properly interested persons. One officer will be allocated to each inquest case to try to ensure continuity although there may be occasions where you will deal with more than one member of the team, such as during periods of annual leave.

In Milton Keynes the Coroner's are supported by:

Sonia Brooks – Coroner's Officer Manager

Jennifer Cook– Coroner's Officer

Luke Grove - Coroner's Officer

Faye Toms – Coroner's Officer

Heather Batchelor – Assistant Coroner's Officer

What is an Inquest?

An inquest is a legal inquiry which enables the Coroner to find the answers to a limited but important set of questions;

Who the deceased was
When and where they died
The medical cause of their death
How they came by their death

It is usually the 'how' question that is the main focus of the inquest. The Coroner cannot, in law, deal with any other matters.

An inquest is opened very soon after the death – this is a legal process which allows for the body to be released for funeral and interim death certificates to be signed so that the family can start to deal with the practical things they need to do whilst the investigation is ongoing. A time and date for a full inquest hearing will be set and the family will be informed of this with plenty of notice.

Inquest hearings are court hearings held in all cases where someone dies and it is not due to a natural cause - this can include cases where the person died and, although they may be very unwell with an illness, there is some indication that the care or treatment they have received has impacted on their death. These are held at our Coroner's Court in Central Milton Keynes.

The inquest hearing will look at matters directly related to the cause of death and this is set out in law. Sometimes families have questions or concerns which fall outside what the Coroner is legally able to address, if you do have concerns or questions it is helpful if these are shared with the Coroner's Officer so that we can advise you which matters can be addressed at the inquest and point you in the direction of where to address any other concerns.

An inquest is not there to apportion blame but should examine the facts of how a person has died in order for the Coroner to make findings and reach a conclusion such as the death being due to an accident, misadventure, suicide natural cause etc.

Whilst not apportioning blame, the Coroner is able to identify issues that have contributed to a death or recognise where there have been complications. The inquest is a fact-finding process. It does not deal with issues of blame or responsibility for the death, or with issues of criminal or civil liability. These can be addressed in other courts if necessary.

It is very much in the public interest to have an effective inquest system. It safeguards the legal rights of the deceased's family and other interested persons, highlights lessons to be learned and advances medical knowledge. Many families also find it helps to have the chance to ask questions and, at the end of the process, know that they have the full and accurate facts about the death.

Inquest Evidence

Between the inquest being opened and the full inquest hearing date, the Coroner will direct what information they require (such as hospital notes and records, statements from particular people etc). These will be gathered by the Coroner's Officer and shared with both the Coroner and the properly interested persons ahead of the hearing.

If there are any particular areas of concerns or questions that you have, please make the Coroner's Officer aware of these at the earliest opportunity. They may well ask for you to put these in writing so that they can be shared with the Coroner ahead of the inquest hearing so that he can confirm which issues will be addressed as part of the inquest process and we can offer direction for any concerns or questions which fall outside of this. Where appropriate, we will also ask if these can be shared with the other properly interested persons and those writing reports for the hearing so that they can be addressed.

As the people who knew the person best, families often have important information for the inquest hearing but providing an account of this can be very difficult and you may be unclear what information is needed for the hearing and how much you want to or feel able

to share. Please contact the Coroner's Officer if you wish to provide an account and they can give you some guidance with this and assist you.

Disclosure

When reports are received by the Coroner's Court, these will be shared with the properly interested persons ahead of the hearing and the Coroner's Officer should discuss with you how this disclosure is made.

The Coroner will then decide what evidence is necessary for them to answer the 4 statutory questions and reach a conclusion as to the death. If the Coroner feels a particular report is not contentious and they have no further questions for the witness, then they can propose this is read under Rule 23 of the Coroner's and Justice Act 2013. This means that the report will be accepted as evidence without the author having to attend the hearing in person. Through the Coroner's Officer, the properly interested persons will have the opportunity to object to the evidence being read if they feel there is a need for the author of the report to attend, although the final decision is with the Coroner.

At the inquest hearing

When you attend the court building on the first day of the hearing you will be greeted by either the Coroner's Officer or one of the Coroner's Court Support Volunteers who will show you to the court or waiting room and let you know where the facilities are. You should be informed who else is attending the hearing.

There is no formal dress code for the Coroner's Court.

Inquest Hearings are held in open court and therefore anyone can attend and observe including members of the press. The Coroner's Officer will let you know who is attending on the day.

All inquest hearings are audio recorded and a copy of this can be made available to the properly interested persons following the conclusion of the hearing by application to the court. No one else is permitted to make any form of recording in the hearing.

Facilities at the Court

We have a small family room which can be used if you wish for a private area to wait before the hearing or during breaks etc.

There are no food/drink facilities at the court other than drinking water.

Food and drink can be purchased at the shopping centre directly opposite the court building. During long inquests, breaks will allow time for the facilities to be accessed.

A hearing loop is available.

Key people in the court room

The Coroner – a legal professional who is responsible for investigating deaths in particular situations.

Properly Interested Persons – The Coroner will identify people or agencies with the right to actively participate in the inquest proceedings. This always includes the family of the deceased but can also include agencies such as hospital trusts, mental health trusts, the prison service etc. They will sometimes be legally represented. It is open to the family to be legally represented at the inquest and if you are intending to seek legal advice you should do so as early as possible.

The Coroner's Officer – someone who works within the Coroner's Office who will work to ensure the smooth running of the inquest process, they will be the key point of contact for you if there are any questions either in the lead up to the inquest and on the day.

Coroner's Court Support Volunteers – we are lucky in Milton Keynes to be supported by the Coroner's Court Support Service whose volunteers attend our inquest hearings to offer support to attending family and witnesses – more information on the service can be found here About CCSS - Coroners Courts Support Service

How will evidence be heard at the hearing

When a witness is called to give evidence at the inquest hearing, the Coroner will begin by taking them through their statement and asking them questions. This will be followed by the properly interested persons being given the opportunity to ask questions. The Coroner will ensure that these are relevant to the scope of the inquest and will intervene if the questions are deemed inappropriate.

Pen Portrait

The Coroner will usually ask the family at the end of the hearing, if there is anything they wish to say before he concludes. This does not just have to be about the circumstances of their death and you may wish to share something about them as a person. This is entirely a matter for you but you may want to think about it before the day or prepare something which you can read aloud or something you wish for the Coroner to read aloud as part of the hearing.

Findings and conclusion

Once the evidence has been heard the Coroner will consider this and then deliver any key findings of fact along with the conclusion as to the death. All conclusions in a Coroner's

Court are decided on the 'balance of probabilities' test, i.e. if something is more likely than not. The type of conclusions the Coroner can read come in two types:

1) Short Form conclusion – Chief Coroner's Guidance is that Coroner's should return a short form conclusion wherever possible. These are brief one or two word statements to explain the nature of the death. The Coroner will explain which short form conclusions are available for them to reach and may seek the opinions of the properly interested persons as to what is most appropriate. Again, the final decision is with the Coroner.
2) Narrative conclusion – If a short form conclusion alone is not felt to be appropriate, a narrative conclusion can be reached. This can be as an addendum to a short form conclusion or can stand alone. A narrative conclusion should be a brief factual paragraph outlining the details of the death.

The Coroner is prohibited in law from framing a conclusion in such a way as to apportion civil or criminal liability or blame and they may not name individuals.

At the end of the inquest the Coroner is able to take legal applications with regard to the conclusion(s) available. This can be difficult to navigate unless you have legal training but the Coroner will explain the process to you.

Prevent future death reports (Regulation 28 Reports)

During an investigation or inquest, if the Coroner has cause for concern that that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future then they will consider issuing a Report to Prevent Future Deaths. And if in the coroner's opinion, action should be taken to prevent those circumstances happening again or to reduce the risk of death created by them, then the coroner has a duty to report the matter to a person or organisation who the coroner believes may have power to take such action.

To do this, they will issue a PFD (prevent future deaths report) also known as a Regulation 28 Report. The recipient has 56 days in which to respond either stating what action they will be taking or, if they are not taking any action the reasons for this. Copies of the report and responses received will be sent to the properly interested persons as well as the Chief Coroner and other bodies the Coroner deems may be interested to receive it. All PFD's are published by the Chief Coroner Reports to Prevent Future Deaths - Courts and Tribunals Judiciary

Following the inquest hearing

Once the Coroner has concluded the inquest it will be their responsibility to register the death and this will be done within a couple of days. The Coroner's Officer will inform you when this has been done and how to obtain copies of the full death certificate. There is a charge, set by the General Registry Office, for each certificate.

The Coroner will also produce a 'Record of Inquest' which is the formal public document recording the conclusion of the inquest hearing. A copy of this will be sent to you. Any person may apply for a copy of the Record of Inquest.

If you have any questions please contact us.

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