MR TOM OSBORNE
HM SENIOR CORONER FOR MILTON KEYNES

ANNUAL REPORT 2017

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

Annual Report 2017

1. HM Coroners overview

This year has seen a major change with me as the Senior Coroner moving from part time to a full time role. This is in part due to the commitment of the Milton Keynes Council (MKC) to recognise the value of the coroner service. We want to contribute to the success of Milton Keynes as a city by trying to ensure that we are improving the lives of the people who live, work and travel through the city. Our task is to save lives and where deaths occur it is essential that the circumstances are properly investigated so that a conclusion if arrived at, lessons are learned and justice is delivered to the bereaved.

The challenges of reviewing and completing cases in a timely manner when our resources do not match our workload are ever present. Throughout the year the coroner service has endeavoured to provide the public of Milton Keynes with a professional and independent service within the resources available to the service.

2. Acknowledgements

I wish to thank my two Assistant Coroners Dr Sean Cummings and Elizabeth Gray for their support this year; their knowledge, support and their ability to analyse with skill and compassion is a great asset to this jurisdiction. I rely on their opinion and counsel continuously and I am indebted to both for their unwavering support.

I wish to make special mention of the work of my staff, namely Sonia Brooks the coroner's service manager; the coroner's officers Mel Riley, Andrew Winnett and Fred Howe. Also special thanks to Faye Toms who, in March 2017, returned from maternity leave and admirably fulfils the role of trainee coroner's officer and as my personal assistant. They all work tirelessly and without complaint to provide the service every day of the year.

There is a strong culture within the office of placing a high priority on assisting families to understand the coronial process. My staff work seamlessly behind the scenes to ensure that the deceased person is returned to their family for a funeral, in a timely manner. Whilst some families find the coronial process intrusive and at times confronting, most families accept there are necessary procedures to follow.

It is my view that the staff at the coroner's court always act with compassion to families who are experiencing trauma and grief and they go above and beyond to enable families to continue with funeral preparations as quickly as possible whilst simultaneously having the procedures of the court explained to them.

I would like to thank all the pathologists for their expertise, knowledge and their willingness to support the coronial team. My thanks extend not just to my regular team of pathologists but to the team of forensic and specialist pathologists without whom my investigations and inquests would be delayed and protracted.

I wish to thank the volunteers with the Coroners Court Support Service who provide support to families and indeed witnesses who often attend an inquest in difficult circumstances. They willingly give up their time and their contribution to the service is such that the courts would be unable to function without them.

I would like to extend my thanks particularly to Neil Allen, MKC Head of Regulatory Services, and Duncan Sharkey, MKC Corporate Director – Place, again for their unwavering support and friendship. Their support enables us to continue working when, at times, the situation is difficult.

3. Role of the Coroner

A coroner must conduct an investigation into a person's death if the coroner has reason to suspect that the deceased died

(a) A violent or unnatural death; or

(b) The cause of death is unknown, or

(c) The deceased died in custody or otherwise in state detention.

It must always be the case that the purpose of an 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 he/she 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 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 cannot give a cause of death.

4. Positive developments

The most positive development throughout the year has been the fall in the number of suicides at HMP Woodhill, Milton Keynes. By the end of 2015 to mid-2016 HMP Woodhill had the highest suicide rate of any prison in the UK with 12 suicides during that period

We wanted to arrest this state of affairs to try and implement real change. I submitted a number of PFD's (Prevent Future Death Reports) and the prison responded. This coincided with the appointment of Nicola Marfleet as the acting governor and her leadership and tenacity brought about real change in the culture.

I was anxious to visit the prison and spend a day with the prison team. I arrived early in the morning and attended the senior management meeting. I then had a tour of the prison including the health care centre and first night reception. I met with the listeners who are prisoners trained by the Samaritans to support prisoners who are struggling. I met the entire staff and assured them they had the support of the Coroner's team to bring about real change; that the inquest process should be seen, not as a process to apportion blame, but as an opportunity to discover what had happened and how can we implement change. I also met with representatives of the Prison Officers Association to understand their concerns.

When news of my proposed visit became known, I received an objection from a firm of lawyers suggesting such a visit may interfere with my position as an independent judicial office holder. However, this view was not shared by me or, I am pleased to say, by HH Judge Mark Lucraft, the Chief Coroner who viewed such a visit as part of the role of the Coroner particularly to learn and engage with those involved at the prison to prevent future deaths.

I was delighted to return to the prison on 12th December 2017 to congratulate the staff there for a major achievement in going a full year without a reported suicide at Woodhill. I wish again to publicly acknowledge the work of the governor and her team and I repeat what I said following the death of Daniel Dunkley at the conclusion of the inquest in April 2017.

"I can say to Daniel's family that Danny's death and this inquest are I believe a turning point; indeed we have not had a self-inflicted death at the prison since December 2016. Long may that continue. My hope is that we may go a whole year without a suicide. If that is achieved it will be in no small part due to lessons learned from Danny's death……It seems to me from what we have heard over the past two weeks demonstrates an organisation that was at breaking point.

I am absolutely convinced that when every prison officer attends the prison to start work in the morning, they do so with the intention of working to keep prisoners safe and to treat them with humanity. They are often overtaken by events, such as happened with Daniel, when it became impossible for them to carry out their duties and the safety of prisoners was compromised. This is a situation that cannot be allowed to continue. I am hoping under the leadership of Governor Marfleet things will change but it is essential she is supported by the prison service and by the next government; otherwise Daniel will have died in vain."

5. Prevent Future death Reports

The avoidance of future deaths has long been recognised as a major purpose of an inquest in avoiding the repetition of dangerous conduct and in encouraging beneficial change. In the most recent legislation and regulations the provision can be summarised as:

- Where a 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 a person who may have the power to take necessary action.

The recipient of the report must reply to the coroner within 56 days setting out the proposed action to be taken and a timetable for completing it, or, explaining as to why they do not propose to take action.

The reports written this year have been

1. Simon Turvey aged 27 was a death which occurred at Woodhill prison and my concern was the family of a prisoner should be able to contact the prison with regard to any concerns that they may have for the wellbeing of their family member. The confidential telephone number is now displayed prominently in the visitor centre and all routes into the prison. There will be continuing further work to improve awareness of the confidential line.
2. Colin Smith aged 80. A consultant from the hospital critical care unit gave evidence to me that there are only 7 intensive care beds and 3 high dependency beds at Milton Keynes Hospital. The number of such beds has been the same since 2000. The hospital did not accept the lack of ITU beds posed a problem. But I will continue to keep it under review.

3. Ida Toole aged 82. I wrote a report to Excel Care who is responsible for running Water Hall Care Home. Ida fell at the home when she did not have a movement sensor mat by her bed despite being recognised as a high risk of falling. The company have reviewed their policy and improved their procedures.

4. Daniel Dunkley aged 35 died from suicide at Woodhill Prison, despite having been referred for three mental health assessments. Central and North West London NHS Trust, who provide healthcare at the prison have strengthened their referral and mental health assessment procedures.

5. William Wilkes aged 80. I wrote a report to the Chief Officer of Milton Keynes Clinical Commissioning Group (CCG) with my concern that the procedures for discharging elderly patients from hospital are cumbersome and time consuming. A better system needs to be in place for effective discharge. A new local protocol between the CCG and the hospital will achieve this.

6. Kevin Morgan, aged 53, who was a poorly controlled diabetic was not registered with a GP and had not been in contact with his family for several weeks. It was known he was in rent arrears, his phone had been disconnected and he was without gas and electricity. In addition Mr Morgan was not claiming his benefits and was known to suffer mental health problems. I wrote a report to the Chief Executive of Milton Keynes Council outlining my concerns: (i) Social services and the housing team were aware of the problems experienced by Mr Morgan and yet there was no effective follow up and no plan put in place to support him, (ii) The case was reviewed by senior managers on at least two occasions and no action taken, (iii) Following Mr Morgan's death there was no Serious Incident Review conducted by social services and it was not referred for a Safe Guarding Review so that lessons can be learned. The response from the Chief Executive has been to refer the case for a Safeguarding Adults Review.

7. Pamela Pritchard aged 88. I wrote to South Central Ambulance Service when the Service failed to respond to a request from a GP for an ambulance to attend within 4 hours, as a result there has been a review of the protocols, but I will continue to monitor in future the response of the ambulance emergency response.

8. Patricia Parker aged 89 suffered a cardiac arrest whilst undergoing a laparoscopic procedure under sedation. My concern was that there appeared to be numerous guidelines for the use of sedation. I received a response from Sir Bruce Keogh, the medical director for NHS England who put forward a plan for reviewing current guidance, to work with others to promote best practice and to alert all clinical staff to the importance of pre-anaesthetic assessment for ERCP.

9. Peter Cotter aged 84. Again I wrote a report to South Central Ambulance service as I was concerned the computer system used by call operators did not seem to register the fact that a patient may have suffered a head injury. I was reassured by the Clinical Director that the system was designed to identify head injuries and those patients receiving anti-coagulant treatment.

10. M1 Fatal Accident. During the bank holiday weekend in August a tragic incident on the M1 motorway resulted in the deaths of 8 people travelling in a mini bus. The emergency services tried to access the motorway at the service station via Newport Pagnell but could not do so because the code to the access barrier had been changed and the emergency services had not been notified of the new code. I felt this was a matter of considerable concern so wrote a report even before the inquest was held to the CEO of the company operating the services asking that the access for emergency services should be reviewed. I was informed the procedure was in their view robust but in view of my report all site managers will receive a written reminder that whenever the codes are changed the emergency services and Highways England must be informed.

11. 11. Anthony Porter, aged 33, was a vulnerable homeless man who died of hypothermia on 22nd February 2016 outside the Church of Christ the Cornerstone. My narrative conclusion recognised *"there was a failure to carry out a needs assessment to identify his care needs and a failure to provide him with the support, care and protection that had been identified when he was diagnosed with autism."* Rather than submitting a PFD report I have requested the matter be referred to the local Safeguarding Board for a multi-agency review.

    I stated at the inquest that I have worked in Milton Keynes for over 40 years and this was the first time that I had ever been ashamed of our city which allowed a death to occur in these tragic circumstances. I hope the review will ensure a similar death will not occur in the future.

12. Jason Basalat, aged 52, died in HMP Woodhill in 2016. I have concerns as to the lack of communication between the Northamptonshire Police and Magistrates Courts with the prison to inform the prison of concerns for the welfare of prisoners about to be remanded. I have asked both to review their procedures.

13. Ayse Yalcinkaya aged 35 died when she was queuing on the M1 motorway to leave at junction 14, when a HGV lorry collided with the back of her car. I have brought my concerns to the attention of Highways England as many of the up to date motorway junctions have run off lanes which junction 14 does not have. I have yet to receive their response.

6. Faith communities

I have met regularly with members of the faith communities and in November attended Friday prayers at the Wolverton Mosque to address those attending. I explained that I try and avoid, whatever their faith, unnecessary post mortems. We are also able to offer a non- invasive post mortem procedure whereby the body is taken to Oxford and a CT scan is carried out to try and determine the cause of death. At present, this additional cost has to be met by the family or the community.

I am also encouraging the lawyers amongst the Muslim community to take an interest in the work of the coroner so when we have to advertise to appoint a new Assistant Coroner for Milton Keynes there are applicants from the ethnic minority communities.

7. International cases

We still have concerns surrounding the delays in completing the investigations and inquests in relation to the deaths that occur abroad. The responsibility to investigate rests with the country where the death occurred, and often it is very difficult to get any meaningful information from the foreign authorities. At present we are still waiting for information following investigations in France, USA, and Canada. These inquiries have been outstanding for over 12 months and I have very little at my disposal to try and complete the inquest in a timely manner. I have made representations to the Foreign and Commonwealth Office and to members of Parliament but despite all such attempts the delays persist. One particular death in France is causing concern as the death occurred in May 2015 and we are still awaiting the outcome of investigations in France.

8. Stake Holders and Partners

We have continued to hold informal meetings with the emergency services to try and work seamlessly together and will continue the meetings on an informal basis.

I, together with my senior officer, hold a regular meeting with the hospital team, not to discuss individual cases but to ensure the reporting, preparation and inquest process works as smoothly as possible and delays to the family are kept to a minimum.

I have also participated in training exercises at the hospital including a full mock inquest that was well attended and well received.

I have continued to work with our neighbouring jurisdictions, conducting a 10 day jury inquest for Bedfordshire, and a lengthy inquest relating to the death of a haemophiliac patient who was infected with HIV and hepatitis C from imported blood products in the early 1980's.

We have also been working with our neighbouring jurisdictions within the Thames Valley Area, namely Buckinghamshire, Oxfordshire and Berkshire to implement a new Coroner computer management system we hope will go live early in 2018. The new integrated system will save costs to the service and the ability to operate across the four jurisdictions will enable us to support one another in the event of a mass fatality incident, a matter that we have to consider at all times. It will also improve our business continuity resilience in the event of being unable to operate locally for any reason.

9. Mass fatalities

I have attended a number of meetings to plan for when a mass fatalities incident happens in the city. In view of recent events in other cities, namely London and Manchester, the question should be regarded as not ***if*** it happens but ***when***, so we are able to confidently assure the people of Milton Keynes we are ready to react and deal with any incident that may occur in the future.

10. Chief Coroner

I have attended the training for Coroners organised by the Chief Coroner and the Judicial College and I have encouraged my assistant coroners to attend likewise. It is an essential part of the role to stay up to date and fully aware of recent changes in the law.

I have also continued to act as the Chief Coroner's nominee for interviews to appoint senior and area coroners in other jurisdictions. I was also asked to present at a workshop organised by the Chief Coroner for assistant coroners considering applying for a full time post at some time in the future, emphasising to them the need for detailed preparation for the interview.

I have presented lectures to doctors, trainee health visitors and newly qualified pathologists and will continue to talk to anyone prepared to listen to explain the role and work of the coroner.

11. Numbers

I set out below details of the deaths dealt with by way of inquest over the past two years. The spike in the number of deaths from natural causes in 2016 is due to the requirement to hold an inquest in every case where a Deprivation of Liberty Safeguard (DoLS) was in place. The law has now been amended and there is no longer a need to hold an automatic inquest where there is a DoLS.

CONCLUSIONS OF INQUESTS	2016	2017
Alcohol and drug related	16	14
Narrative	16	18
Accident	25	50
Industrial Disease	13	14
Natural causes	93	67
Open Conclusion	4	4
Stillbirth	Nil	2
Suicide	12	21
Road Traffic Collision	3	7
TOTAL		
Total Number of Deaths reported :	**903**	**817**
Number of post Mortems	**247**	**237**

12. Issues of concern

Post Mortem Rate – I believe the post mortem (PM) rate is still too high, and we will continue to work with both the pathology team and Doctors to give them the training and confidence to give a cause of death without a PM. Most families when approached about the question of the PM express the view that they believe their loved one "had suffered enough". My view is a post mortem should be a last resort to finding the cause of death.

Suicides – I am concerned about the rise in the number of suicides generally and will, over the next six months, be concentrating the team's efforts to trying to identify what the problems are in the city and seeking to work and engage with others to see that suicides are reduced.

People in crisis – In many cases there is a pattern emerging of vulnerable people not being supported when in a state of crisis. There is a need, for all those involved in the care of the elderly, the mentally ill, and the vulnerable in our city, to improve their methods of working and collaborating together to ensure patients are not discharged with inadequate support, and the sick and vulnerable have someone to turn to in times of crisis.

13. The year ahead

We are planning to move from the crematorium site to our newly provided offices and court at the Civic Offices and we hope this will enable us to work more efficiently and provide a service that is regarded as the gold standard in the UK. The new court will be fitted out with state of the art technology that will enable the proceedings to be recorded, for witnesses to give their evidence by video link to avoid costly travelling and accommodation costs and for vulnerable witnesses to give evidence from a conference room. The whole coronial team are committed to making the move and working with other stakeholders.

I hope to reduce the number of PM's to below 20% by engaging further with all medical practitioners currently working in the city.

We will also be working with other stake holders to prepare for the introduction of a Medical Examiner that is planned for April 2019. The impact of such a change is anticipated to be an increase in the number of deaths referred to the coroner that will require an inquest. We will be ready to cope with any increase in our workload that may result.

Our performance targets for next year will be:

1. To try and reduce the number of post mortems to less than 20% of deaths reported.
2. To complete 95% of all inquests within 12 months of the death being reported.
3. To issue 95 % of all Part A forms within 3 working days of the death being reported to us.

14. And finally

I want to finish by quoting an email received by one of my coroner's officers in December this year:

"I want to extend my thanks and gratitude to yourself and anyone else within your team that helped raise awareness of the issues within the mental health team which contributed to my father's death.

I hear the inquest went very well and that the coroner was an extremely kind and understanding man who went the extra mile to make sure something was done about this, so again I wanted to extend thanks to him also.

Thank you for your patience and understanding throughout."

I would also urge all organisations, particularly in the public sector, to be less defensive towards the coroner's service. Participating fully in the inquest procedure improves and benefits the organisation and the lives of the people who use the service whether it is a hospital, a care home, a GP practice social services or a prison.

My aim is that together we should be a force for improvement.

Tom Osborne

Her Majesty's Senior Coroner for Milton Keynes **1st February 2018**