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Written evidence for the Justice Committee follow-up inquiry
on the Coroner Service

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1. The submission

The evidence in this submission derives from an ESRC-funded study, *Voicing Loss* (ESRC project reference ES/V002732/1), on the role of bereaved people in the coronial process. The study, conducted by the authors with colleagues Professor Penny Cooper (Birkbeck), Dr Camillia Kong (Queen Mary University of London) and Dr Hannah Rumble (University of Bath), started in May 2021 and runs until April 2024.

The submission draws on the *Voicing Loss* empirical research findings in addressing the first question posed by the Justice Committee: ‘What progress has been made towards the goal of placing bereaved people at the heart of the Coroner Service?’ The findings reported here have not yet been published.

2. Summary

This submission reports on the findings of research interviews conducted for the ESRC-funded project *Voicing Loss*, which is examining the role played by bereaved people in the coronial process. Interviews were conducted with 89 individuals who had personal experience of coronial investigations ('bereaved respondents'), and 82 coronial professionals including coroners, coroners' officers, lawyers and others ('professional respondents').

Among the bereaved and professional respondents alike, there was general support for the principle that bereaved people should be 'at the heart' of the coronial process. From both lay and professional perspectives, an important part of the rationale for this principle was that the bereaved are often in a position to provide information and insights that aid the coroner's fact-finding task. There was also a perceived *moral imperative* to including bereaved people in the coronial process – as individuals who can represent and give a voice to the otherwise silenced deceased, and whose grief should be acknowledged.

Most of the professional respondents appeared confident that, in practice, bereaved people are centrally and properly included in the coronial process. It was sometimes emphasised that recent years have seen growing efforts by the coroner service to support bereaved people's inclusion and participation. Some of the experiences reported by the bereaved respondents accorded with professionals' accounts of an inclusive process, and point to the benefits this can offer the bereaved. Engagement with the process was described, for example, as 'healing' and 'cathartic'; another comment was that this gave 'some feeling of control' in circumstances that otherwise – in the wake of a traumatic bereavement – felt out of control.

However, the bereaved respondents spoke more frequently about exclusion from, than about inclusion in, the coronial process. They recounted experiences of marginalisation and disempowerment as investigations unfolded and during inquest hearings. They told us of feeling like they (or the person who had died) 'didn't exist' or 'didn't have a voice'; of being no more than a 'bystander or 'sideline' in the coroner's court; of becoming 'shadows'.

Respondents described various causes and manifestations of this sense of exclusion. They spoke of a paucity of information and poor communication from coronial teams, which left them struggling to understand the coronial process and feeling 'in the dark' about how the investigation was proceeding. Many felt deeply disadvantaged within a process that seemed to be all about the lawyers, other professionals and their legal 'games', or focused on 'box-ticking' rather than the robust investigation of individual deaths. Some respondents described encountering a marked lack of compassion and of sensitivity in their interactions with professionals, including in terms of how the deceased was referred to or represented. There was also an evident mismatch between what many respondents *expected* of the coronial process – particularly, meaningful answers about the death, learning that would lead to action to prevent future deaths, and justice and accountability – and the outcomes that were, in fact, delivered. Frustration, distress and additional grief were among the consequences of these reported experiences.

We conclude from these findings that aspects of practice fall short of the policy aspiration to place bereaved people 'at the heart' of the coronial process. We also conclude that some relatively straightforward changes can be made to the coroner service – without involving structural reform or significant investment of additional resources – that would significantly enhance bereaved people's inclusion in and engagement with the process. Broadly, such changes can be described as 'better treatment' and encompass, for example: improved provision of both generic and case-specific information for bereaved people; more compassionate, courteous and respectful conduct and

communications on the part of all professionals; and greater acknowledgement and reflection of the personhood of the deceased.

Better treatment alone, however, cannot overcome all the barriers to bereaved people's inclusion and participation in the coronial process that our research has identified. Addressing the problem of 'inequality of arms' and the tendency towards adversarialism, especially in inquests involving large numbers of lawyers instructed by public bodies, would require a substantial overhaul of the way proceedings are conducted. Furthermore, narrowing the gap between bereaved people's expectations of the process and what, in practice, it often delivers would demand wider reforms. These might include, for example, the introduction of mechanisms for follow-up and oversight of responses to Prevention of Future Deaths reports, and a rethinking and elaboration of the concept of 'accountability' as it applies in the context of the coroner service.

We end this submission by suggesting that the unhelpfully vague terminology of 'at the heart' should be reviewed. Ethically, the case is strong and compelling that bereaved people should be treated with the utmost compassion, respect and consideration throughout the coronial process, on the grounds that they are the ones who have suffered the loss, and often in sudden and tragic ways. Our research demonstrates that exclusion and poor treatment frequently lead to hurt and emotional harm, while the positive impact of inclusion and good treatment is also far-reaching. It is clear, moreover, that the evidence, wider knowledge and commitment that bereaved people bring to the process can be key to a thorough, robust investigation and a fair, accurate conclusion; but that systemic inequities and imbalances can impede and undermine these contributions. Perhaps, therefore, what is needed is a coronial process that better facilitates the *effective participation* of bereaved people and has *humanity* at its heart.

3. Introduction

The *Voicing Loss* study examines the role played by bereaved people in coroners' investigations and inquests. It focuses, in particular, on whether and in what ways bereaved people feel included and can actively participate in the coronial process. An important part of the policy context of *Voicing Loss* is the stated commitment by government and successive Chief Coroners to place bereaved people 'at the heart of the Coroner Service'; a commitment which the Coroners and Justice Act 2009 was intended to advance. The study thus focused on experiences of the coronial process since implementation of relevant provisions of the Coroners and Justice Act in 2013.

The empirical research undertaken for *Voicing Loss* primarily took the form of in-depth one-to-one and small group interviews with a total of 89 bereaved people who had experienced the coronial process (henceforth 'bereaved respondents') and 82 coronial professionals (henceforth 'professional respondents').¹

The 89 bereaved respondents:

- Were recruited through support services and networks, publicising the study at coroners' courts, and snowballing.
- They were parents (almost 60% of the sample), siblings, spouses/partners, adult children, and a cousin, aunt, mother-in-law and close friend of the person who had died.
- They spoke to the research team about 79 final inquest hearings,² held over the years 2013-2023; all but one respondent opted to attend the hearing, in person or remotely.

¹ An additional, smaller component of the study involved interviews with 19 individuals who had been witnesses at inquests in a professional capacity. Data from these interviews are not included in this submission.

- The approximate length of time between the death and the final inquest hearing ranged from 2 months to 6.5 years; the length of the final hearings ranged from about 1 hour to more than 3 months.
- 23 of the inquests engaged Article 2, and 13 were jury inquests.
- The ages of the deceased ranged from 6 to 82 years.
- Around one-third of the deaths were recorded by the coroner as suicide.

The 82 professional respondents:

- Were recruited through the study team's professional networks, direct approaches to coroners and coroners' courts, and snowballing.
- They included area and senior coroners (14), assistant coroners (3), coroners' officers and staff (21), inquest lawyers who variously had experience of representing families and state bodies (20), staff and volunteers from the Coroners Courts Support Service (CCSS) (12) and individuals in various other support and/or campaigning roles (12).

In the research interviews, we invited the bereaved respondents to tell us about their expectations and experiences of the coronial process, including whether and how they had felt included and had actively participated – to the extent they wished to do so – in the process. Professional respondents were asked about the ways in which their role brings them into contact with bereaved people, and their perceptions of what the coronial process does, and does not, offer the bereaved.

The resultant research dataset is large and diverse, and makes clear that bereaved people's experiences cannot be easily summed up or neatly categorised; this reflects the widely differing types and circumstances of death which coroners investigate, as well as the variety of personal attributes and expectations that bereaved people bring to the process. We must also acknowledge that our research, being qualitative in nature, does not offer an exhaustive or representative portrayal of the coronial process. In particular, the self-selected nature of the sample of bereaved respondents means it was likely to be skewed towards those bereaved in contentious circumstances or who had particular dissatisfactions with the coroner service that they wished to make known.

Nevertheless, our respondents' detailed, nuanced and reflective accounts offer many insights into the nature of the coronial process, its impacts on those involved in it, and some of its more problematic aspects. Most importantly for the purposes of this submission, our data suggest that, for significant numbers of bereaved people, the policy aspiration to place them 'at the heart' of the coronial process is inconsistent with the reality they experience.

In presenting the interview findings in this submission, we have not included any names of respondents, and have changed some details of their circumstances to preserve their confidentiality.

4. Key findings

Below, we report key findings from the *Voicing Loss* interviews in relation to three themes:

- Respondents' views on whether bereaved people *should* be 'at the heart' of coroners' investigations and inquests;

² Some of the respondents were interviewed in pairs (for example, as both parents of the deceased) about the same inquest; four had experience of more than one inquest; and in three cases the coronial investigation had not resulted in an inquest by the time of the interview.

- The extent to which, according to respondents, bereaved people are, in practice, centrally included in the coronial process;
- Aspects of the process which can cause or underline a sense of exclusion from the process.

4.1 Should bereaved people be 'at the heart' of the coronial process?

Among the bereaved and professional *Voicing Loss* respondents alike, there was general support for the principle of placing bereaved people 'at the heart' of the coronial process – and various ideas of what this broad principle or aspiration entails:

Lots of people may be used to court. The coroners can be used to courts; advocates can be used to courts; and you may have witnesses that have come a few times, and they're used to that. The families aren't... [We should] keep them as strong as possible ... let them know that, yes, there might be people in this court that actually have been here before. But I'm not the most important person as a coroner; these advocates aren't the most important. You're the most important people. You're the ones that we really want to hear from. [coroner]

Every single inquest should start in that same way. Acknowledge the family, acknowledge what they've lost, and that this is what the process is, and let them have their five minutes just to explain who that person was that's died. [NGO representative]

Absolutely [the bereaved family should be 'at the heart']. Because we really were the only ones – you know, no one in that room – the coroner, his officer – nobody knew our loved-one like we did. [sister]

From both lay and professional perspectives, an important part of the rationale for the inclusion of bereaved people was that the bereaved are often in a position to provide insights into the life and death of the deceased person that aid the coroner's fact-finding task. A coroner's officer commented that 'without [families], obviously we'd struggle as coroner's officers, because they provide a lot of the integral information to us, from our investigation point of view'. In the words of a coroner, 'despite all the clever people in court, sometimes the families have a habit of finding the question which cuts to the very heart of the issue you have to decide'. Families were said to have not only the requisite information but also the *motivation* to advance the investigation:

They are making sure that every possible reasonable line of inquiry is exhausted, because it's only really the family that can do that. They're the only ones who've really got the interest in doing so... So, involving them brings that perspective or a counter voice, I suppose, to the narrative of the [health] trust or the prison or whoever else. [family lawyer]

The same point was made by a bereaved mother:

My impression of the inquest was everybody had a view ... about why that death happened. But none of them lived with [my son], none of them had that contact, and knew that young man inside out, as we did... Now, if the inquest had taken place without us being there, without us having the ability to challenge or question or input into the process, then that in-depth knowledge and understanding and that personal relationship isn't acknowledged.

Some professional respondents believed there to be an additional instrumental benefit – beyond that of assisting the investigation and coroner's decision-making – to the inclusion of bereaved

people. They argued that family members who actively participate in the coronial process are more likely to regard the process as fair and to accept the outcomes as legitimate:

I think it's important, and it gives greater legitimacy ... to the coroner at the end of it if he knows that the family has had a lawyer, asked the questions they want asked, been able to say something about the deceased, go away feeling that the exercise is worthwhile – then then that's your job done well, isn't it? Whereas if, in fact, you just think, 'Right, can I get this over with as quickly as possible? Yes, well I've got that one boxed off' – and all you get is either a complete lack of interest or concern and hostility and possible lawyer's letters – then you've failed as an investigator. [family lawyer]

[Whether I allow family members to raise questions outside the scope of an inquest] depends how upset they are. Sometimes I feel it's better if you just allow them to say it and then I discount it when I'm summing up. I say, 'I'm not taking this into account because –.' By the end of the evidence, they'll have heard everything and they'll actually understand better where I'm going with my findings and conclusion. [coroner]

There was, further, presumed to be a (non-instrumental) *moral imperative* to including bereaved people in the coronial process. We saw, above, that the relationship of the bereaved to the deceased was understood to endow the former with privileged information which can assist the investigation into the death. This relationship also grants the bereaved a special moral status – in addition to their legal status as 'interested persons' – within the coronial process, as individuals who can represent and give a voice to the otherwise silenced deceased, and whose suffering as a result of their loss should be acknowledged and even, where possible, assuaged.

To me, it feels wrong that you wouldn't be at the heart of the inquest process. You are that bereaved person's spokesman. When they're dead they don't have a voice. You're their only voice. [daughter]

To actually be there for the deceased who hasn't got a voice, and to make sure everything is done right by them, but equally, so the families know that we're doing right by their loved one, but also by them as well... So, we are very much in touch with the families. And I'm also very proud when we see thank you cards, which we do actually get a lot of. You think, 'These people are so, so sad, and yet we've touched their heart and we've touched their lives to such an extent, that at their rawest and their lowest, they still want to say, 'Thank you' and to write in.' [coroner]

When they contact us, they're at their lowest. They need support; they want answers; they want people who will listen to them and allow them to vent and not judge them. [coroner]

Although the bereaved and professional respondents generally expressed their agreement with the policy goal of making bereaved people central to the coronial process, some added caveats. In so doing, they tended to draw a distinction between coroners' formal legal responsibilities and their wider obligations in relation to the putative needs of the bereaved – suggesting there was a tension between the two. A coroner, for example, spoke of the importance of being 'mindful of the rights of *all* interested persons', including family members and others. In the situation where a coroner's decision is judicially reviewed, he went on to explain, the higher court will 'look at the hard and fast bits of your judicial decision-making. They're not going to look at whether you were family-focused'. Another coroner said:

Ultimately, the coroner's function is to perform their statutory duties, and it may well be there are tensions between that function and the families' wishes. So, although the family is at the heart of the process, it's not to the exclusion of everything else. So, I would say, 'Yes, of course, they are at the heart of the process. But this is a process perhaps with two beating hearts, not just one.'

A coroner service manager referred to the same tension:

So yes, we will listen to families. We will listen to their concerns and we will take them on board and put them in front of the coroner, but ultimately, the coroner has a job to do and that job is to find out what's happened, to make sure justice is done and to get those conclusions in whatever way that case concludes. So, they are the heart of the process – they are, and they should be, but we've still got a function to do.

There were echoes of this qualification in some of what the bereaved respondents told us, including a bereaved husband who said he was 'struggling a bit with this idea of the bereaved family at the heart of the process', because he was 'not quite sure what that means'. While it was important, he said, that the family 'should be treated with respect and empathy ... I wouldn't want anything to damage the process in any way which shields the facts'. An aunt spoke of the need for 'a balance ... because it is and isn't about the family. It is also a legal process, which the coroner needs to hold'. Ultimately, she went on, 'we need the law to be the law, and the standards to be the standards'. And a sister referred to 'a slight danger that the coroner might in some circumstances take the family so seriously that they don't adequately focus on the inquest'. But the outright rejection of the very idea of bereaved people being at the heart of the process, as voiced by a bereaved daughter and cousin (with experience of two inquests), was unusual:

Of course they're not [at the heart of the process], and actually they can't be. I don't even think of it as a proper aim... It's a proceeding to determine who died, when they died, where they died and how they died. That's its core purpose. Not putting bereaved people in a chair with a cup of tea and being kind to them. If you want to look after bereaved people, then have a competent coroner service... Sorry, I just think it's nonsense.

4.2 In practice, are bereaved people centrally included in the coronial process?

Most of the professional respondents appeared confident that bereaved people are centrally and properly included in the coronial process. A coroner explained that, in practice, this means:

We just keep them fully engaged; we communicate with them. We, hopefully, answer the questions within the scope of the inquest that we can, that they've got. And help them have a greater understanding of how their bereaved relative came by their death.

According to a coroner's officer, bereaved families are included by virtue of being listened to, treated with empathy and kept informed throughout the investigation; moreover, they experience the process as 'empowering' because:

We do a lot of disclosure in advance so that the families have everything that I have, and it gives them the opportunity to write notes, ask questions. Families have an opportunity to give evidence if they want to... They can ask questions throughout.

A few of the professionals emphasised that recent years have seen growing efforts by the coroner service to support bereaved people's inclusion and participation:

There's been an increase in awareness of grief and loss and the fact that bereaved people need some form of participation and some form of information to be able properly to deal with it... So, I suppose there's been a change in the idea of the family is no longer a spectator at an inquest, but essentially a participant and indeed, the most important participant.'
[family lawyer]

Some of the experiences reported by the bereaved respondents accorded with the professionals' accounts of a family-oriented process, and point to the benefits that participation can offer the bereaved. A mother said, 'It was really healing to have the opportunity to attend the inquest... It felt important to go and hear the evidence and be part of that.' Another mother described the inquest process as 'cathartic' in the way it enabled her 'to vocalise my issues and my concerns'.

Very often, key to these experiences of inclusion was a coroner who engaged with the bereaved in a direct, compassionate and sensitive manner – like the coroner described by another mother as 'really, really good' because she was 'very compassionate. Looked at me all the time, gave eye contact, listened to me, listened to everyone else, and you just came out feeling you'd really been supported.' A sister described having felt 'at the heart' of the process because the coroner had been 'very sensitive' to the needs and concerns of the family – for example, by taking care to exclude, when reading out the deceased's suicide note in court, the most personal and painful parts of the letter.

A bereaved partner spoke about her mixed experience of the coronial process. She initially struggled to access information and consequently felt 'extremely strongly that I was not at the heart of the process; I wasn't anywhere in the process. I was completely excluded'. But the inquest itself she found to be 'dignified, sensitive, inclusive... Utterly inclusive.' She received support on the day from a coroner's officer and a CCSS volunteer, and most of all valued the approach of the coroner who:

was very clear. She was very courteous. She was very unofficious. She made sure I was able to ask my question. She asked me if I had any other questions. It was just dignified. It wasn't frightening... She just made it a very professional, safe environment, where it felt like she was trying to do the best, to really get the right verdict.

Another respondent recounted a similar experience in relation to her husband's inquest: that is, of struggling to access information in the long lead-up to the inquest, but then feeling 'totally' at the heart of the hearing itself, because 'my coroner was just lovely' and 'made sure it was all about me first. It was all about me first'. This, she said, gave her back 'some feeling of control', in the context of a traumatic bereavement which had left her feeling 'so out of control'.

Relatedly, several respondents spoke of receiving valuable compassion and support from CCSS volunteers:

[The volunteers] did help. They were quite supportive. They were lovely actually. I've got to be honest. The volunteers were lovely. [wife]

[The volunteer] was so lovely. She was like, 'If you need anything, I am here.' It felt like having a grandmother, actually. [sister]

The volunteers were absolutely lovely. They explained the process, but they also gave us cups of tea... [asked] did we want to talk, did we not want to talk, what did we need, did we want to go for a walk. You know, just held us through the whole process. [aunt]

Experiences of representing and reflecting upon the personhood of the deceased also gave some of our bereaved respondents a meaningful sense of inclusion in the coronial process. This tended to arise when families made a statement about the deceased person (or 'pen portrait') at the inquest, or were permitted to display photographs. A bereaved sister said that the coroner 'made me feel like I owned that courtroom' when her brother's picture was shown on two large screens and she started to read out her pen portrait. A mother described choosing to read out her statement from the witness stand, at the inquest into the death of her son in prison, so that she could face the jury:

I wanted to be there, feel that I was there and that I was a person. I didn't want to stay to the side; it was important to me to actually face the people who were making these decisions. And I'm glad I did. I wanted to read it, for [my son]. It was probably the last thing I could do for him, and that was my way of being there... We wanted them to see him as a person. You know, he was a son, he was a brother, he was a cousin and he was a friend to a lot of people. And that's what we wanted to get through: that he was more than just a prisoner.

Another mother said that a large, framed photograph of her daughter was prominently displayed throughout the lengthy inquest:

For the whole of four weeks, she was up front and centre, almost next to the coroner, just in front of him... It was wonderful. I can't overestimate the positive impact that that had for us, as a family, to really feel that she was part of the proceedings... It's heart-breaking, but it was wonderful... To have a picture of her to be part of it as well, just to remind everybody ... that this name on the documents that they're talking about was a person, and a young person, who had funny-coloured hair.

Notwithstanding the positive comments about a sense of inclusion, the majority of our bereaved respondents made it clear that they had felt excluded from the coronial process – rather than at its 'heart' – in the often lengthy period before the inquest hearing or at the hearing itself. We will examine their explanations for this in the next section of this submission; here, it suffices to just a few general comments about exclusion:

[We felt] like we didn't exist, like we didn't matter. [wife]

Looking back on it now, it's almost like I was a bystander. [mother]

I didn't have a voice. They didn't want to hear what I had to say. [mother]

I hardly had any voice at all. Hardly any voice at all. They just didn't ask. [mother]

During the whole process, as a family we became shadows – I just felt we were shadows. [mother]

4.3 Exclusionary aspects of the coronial process

Bereaved respondents spoke of various causes and manifestations of a sense of exclusion from the coronial process. Particular concerns included a paucity of information and poor communication from coronial teams; perceptions that the process favoured professionals over lay people; encountering a lack of compassion and of sensitivity in interactions with professionals, including with

regard to representation of the deceased; and a mismatch between what they expected of the process and what it delivered.

4.3.1 Information

Many respondents described the experience of finding themselves, in the immediate aftermath of an often sudden bereavement, being 'catapulted into' a legal system of which they had previously known nothing, and in relation to which they struggled to access information.

I remember getting a call, the very next day – I was still absolutely in shock – from the coroner's officer... And I'd never even really taken any notice of inquests, I didn't even know what a coroner's officer was... So, nothing was explained to me... All they said was there will be an inquest and, 'We'll keep being in touch with you.' And that was it really... So, I just didn't have a clue really, what would happen.' [sister]

There was nobody to tell us much, anything at all, especially right at the beginning. We didn't know who to contact; we didn't know who to speak to; we didn't know where to go. [mother]

We never knew what an inquest was. It wasn't really explained to us. We didn't even know what a coroner was, to be honest. [mother]

While some respondents could not recall being provided with any written guidance, those who did remember receiving information, such as the Ministry of Justice *Guide to coroner services*, tended to find it difficult to engage with.

I can vividly remember an envelope coming through the door with a booklet, and I can remember where I put it: it was on my radiator in my bedroom. But I didn't really look at it... I couldn't think for myself – you live in this fog of just nothing really. Numb is a really good word, but unless someone said to me, 'You haven't eaten for like eight hours,' it wouldn't cross my mind... And I suppose maybe if I'd read the booklet, I would have been more prepared, but ... I literally couldn't take anything in. [mother]

I got a booklet and I can't remember who I got the booklet from... It was a booklet that said 'inquest' on, which at the time you don't want to read: you don't want to read anything; you just want to survive. [mother]

As the investigation proceeded, it did not necessarily become any easier to understand what the process entailed:

We didn't really understand the inquest process at all, so trying to deal with different lawyers, dealing with the police... [My son's] body had to be moved from one hospital to another because they realised that he was right on the wrong boundary and it went to Kent first and it should've gone to Essex. Gradually, we started to realise it was a bit more complex. [father]

I was being asked a lot of questions by a police officer, but I found it very distressing to be asked... There was nobody explaining to me what the process was, whether I had to answer those questions, why that information was needed. [sister]

Respondents spoke also of not knowing how to prepare for the inquest hearing. A bereaved mother, for example, said she emailed the coroner's officer to ask for a meeting to talk through what would happen, and did not receive a response. A daughter commented:

We knew there would be an inquest, obviously... We didn't know anything about what you do, where you sit. We just roughly knew where it was... It was, kind of, 'There will be an inquest. We'll come back to you in January.'... We all just were told when it was: 'Turn up at the Town Hall at this time,' and that was it.

Consequently, many respondents said they did their own research on the process – usually online. A bereaved mother said, 'I did google it ... to have some little ideas about what to do or what to wear or what to expect, whatever; and a father talked of watching YouTube videos in an effort to 'educate myself'. A daughter described struggling with the statement she was writing for the inquest:

In my desperation, I turned to Twitter and was just like..., 'Anyone got any experience of inquests? I am totally lost. I know what I need to say; I don't know what I'm doing though. Ultimately, I know what needs to be said, but I just don't know how I'm going to do this.'

Many respondents mentioned approaching voluntary organisations and networks in their search for information, and tended to speak especially highly of help obtained from the charity INQUEST – in the form of emotional support and assistance with accessing legal advice and representation, as well as information and guidance. Respondents variously described INQUEST as 'really brilliant ... I don't know where I would be without them'; 'a small organisation doing big, big things'; and 'incredible, in terms of being supportive and giving you the information'. A bereaved sister said that when she spoke to INQUEST, it felt like it was the first organisation that 'was on our side' and that, without them, 'we'd have gone into that inquest blindly, with no legal support'.

Some respondents took the initiative to attend other inquests in order to get an idea of what happens (in one case, making a special trip from abroad to do so), and of seeking help from others who had been in a similar situation:

The only way we prepared was finding out things ourselves. Also, I spoke to other people that have lost children ... about their experiences of coroners and also what was coming. We didn't have an information pack, nobody briefed us: it was just like we were flapping around. [mother]

We heard about the difficulty that respondents often encountered when they sought updates on their case from coroners' officers. A bereaved wife spoke of the stress caused by the fact that she was 'just waiting in the dark' until very shortly before the inquest date; while a sister was among a number of respondents who said they constantly (and sometimes over many months) checked coroners' courts online listings to try and find out the inquest date: 'That was gruelling, and it also meant that I could never be free mentally.' Several respondents had felt that the onus was on them to maintain communication about case progression: 'I had to initiate contact right the way through from my first contact ... to the very bitter end', said a bereaved partner. A sister recounted how her family:

rang [the] coroner's court, as we were guided to do so, formally identified ourselves, and got told to wait until they formally contact us. The first correspondence we received was 12 weeks after [my brother's] death ... That was a very simple black and white letter that said, 'We are hereby informing you we are carrying out an inquest'.

If many had felt, at the outset of the coronial process, that they lacked the information needed to navigate the new world in which they suddenly found themselves, some also felt uninformed and cast adrift when the process abruptly ended. A bereaved mother said that she had not been properly informed, after the hearing, about how to apply for the death certificate or the record of inquest (although the latter should be provided routinely to all interested persons), and since then had found it 'too hard' to make contact again with the coroner's office to enquire. She added: 'Even now, it's like, "Gosh, can I still get a copy of that record? How do I do that?"' Another mother said:

At the end there's nothing: everybody just goes home... [No one says,] 'Are you all right? Did you understand what's just happened?' ... Everybody was getting up, packing up and going home, and then the court officer comes up to me and gives me this multiple photocopied piece of paper and said, 'This is how you can apply for the death certificate.' That felt like a huge blow. I thought, 'Oh God, no.' I wasn't ready for that.

4.3.2 'Playing a game you didn't fully understand, by their rules'

While bereaved people designated by the coroner as 'interested persons' have certain participatory rights, participating as a lay person within a legal process poses multiple challenges.

Some of our respondents felt marginalised by proceedings which seemed to be oriented around the legal practitioners and other professionals rather than their own rights, needs and expectations. A bereaved father said that, at the inquest, 'there was a sense of playing a game you didn't fully understand, by their rules'; and a sister commented that any bereaved person drawn into a coroner's investigation should 'just prepare for the absolute frustration of not getting the answers you want, and playing these legal word games. The frustration is unbearable'. A 'circus' rather than 'game' was the preferred analogy of a daughter who said: 'It did feel a bit like we [the family] were a sideline. They've got to be here to check a box. But the main circus is all the professionals.' A similar sense of exclusion or alienation was expressed by a mother who spoke of suddenly feeling 'that everyone knows where they are, and where they fit into the process, and how it's all going to work, and you're the one who has no idea'.

For some respondents, what they perceived to be the excessive formality of inquest hearings underlined their feeling of being peripheral, rather than central, to what was going on:

It looked very much like a courtroom... There used to be a lunchtime programme about 50 years ago about a courtroom drama, and it was just like that... It's full of oak panelling. It's galleries. It's very, very formal. [mother]

I was surprised about having to do the whole legal swearing [in]. I was really surprised that we had to do that... Obviously, there is a lot of legal speak that you are disenfranchised from. And it is set up in a way to make you feel outside of the process. [sister]

Very, very arrogant was the attitude I got from the coroner. He's above everybody else in the room. All this nonsense: 'My learned friends,' and the way they address people. It's so antiquated, pompous and full of ceremony. It should be absolutely ripped apart and started again this inquest process. I shouldn't have to stand up when that man walks in a room when he won't even look me in the eye to discuss my daughter. [mother]

In the context of a formal, usually unfamiliar and often complex legal process, it is inevitable that whether or not respondents were legally represented had a bearing on their capacity to participate. (Around half of the respondents had legal representation for at least part of the process.) Some who

were unrepresented struggled to participate actively in the hearing – such as a mother who said of the approximately two-hour inquest into her son’s death: ‘I didn’t get to ask any questions. Any. None.’ Another (unrepresented) mother spoke of her realisation that the health staff due to appear as witnesses, whom she planned to question, would be legally represented – at which point ‘the reality hit us that we were in a different world, in a world that we couldn’t compete with’. A third mother who was also unrepresented spoke at length about how she had been impacted by failings in disclosure:

So, then the coroner suddenly realised that we haven’t got the evidence. So, they just handed us a great big bunch of papers in the middle of the hearing. Told us to go away. I think it was 20 minutes, half an hour adjournment. How can you look at things like that? You’ve never seen the report. You’re all psyched up to do this this inquest and you’re actually given papers showing your daughter’s distress... You know, I’d never seen them before. I mean, how dare they. How could they think that was appropriate?

I didn’t read most of it. One, it was too upsetting, and also, it was made even worse by the fact my ex-husband is Spanish and his English isn’t that good. So, I was having to translate things I was seeing for the first time – things that are really, really upsetting, and I was having to try to translate into Spanish for him and trying not to cry and trying not- for him to cry. It’s awful. Awful.

Some of the bereaved respondents who were themselves legally represented nevertheless felt disadvantaged by the sheer numbers of lawyers who attended inquests as representatives of state and other bodies:

On one side is all the army people and all their barristers, and there are loads of them, there is a whole bench of them. And then, on the other side, there was just me and [my lawyer]. [mother].

By the time the fourth [pre-inquest review hearing] came, we sat there watching the people come in and we were like, ‘Who are these people?’ It was barrister after barrister, and solicitor after solicitor. Suddenly we’d gone from having six people in the room to twenty. [mother]

It’s quite intimidating actually. Because you get told initially that inquests aren’t adversarial. And then you turn up to a PIRH [pre-inquest review hearing] and all of the public bodies – the police, the NHS trust, the schools, the pharmacies – they’ve all got barristers and solicitors. It’s not just them and one other person: they’ve got teams of people. [father]

In the last of the above quotations, the respondent refers to the fact that inquests are not meant to be adversarial. He was by no means alone in saying that the heavy presence or conduct of lawyers had the effect of turning what was nominally an inquisitorial into an adversarial process. ‘Lawyers may say, “It’s inquisitorial,”’ commented a bereaved mother, ‘but they can’t help being adversarial. That’s who they are.’ Some respondents had felt as if they were themselves been ‘on trial’, on account of aggressive questioning they had faced as witnesses; such as a bereaved husband who said, ‘I respect the fact that it’s not a trial, but [the coroner] turned it into a trial’. He described having been ‘quizzed’ for about two hours as a witness: ‘You just have to take the battering, and maybe get it over with quickly.’ He had attended the hearing remotely, by video-link, and reflected that this might have made the experience more difficult – since if he had been physically present, the coroner ‘would have seen my perplexity, my distress. It’s easy to look away from a screen’. Others commented:

The whole thing is like something is visited on us, isn't it, and we get transported to this sort of planet that we don't want to be on. Then, we get this punishing treatment from adversarial people – like the health trust and the council. [mother]

We didn't know what it would be like in there, and it was very much very formal and very much like we were on trial in a court, which is not in keeping with that phrase ['at the heart'], really, is it, at all? [daughter]

4.3.3 Quality of interactions

We saw, in Section 4.2 of this submission, that compassionate and sensitive treatment by individual coroners had the effect of making some of our bereaved respondents feel that they were centrally included in the inquest proceedings. The converse also applied and was more common in the experience of our respondents: treatment by coroners and other professionals that was deemed insensitive, uncaring or discourteous provoked feelings of exclusion and marginalisation:

But for me, I don't feel like we're at the heart of things. I don't feel like they are compassionate enough. I don't feel like they – like they just see it as another dead person, rather than that's someone's son, someone's brother, someone's nephew, someone's cousin, someone's uncle, whatever. [sister]

[The coroner] spent the entire time mumbling, either through his hand ... or leaning with his head in his hands, both hands. Very disinterested and vague. And obviously, because he kept covering his mouth, it was really difficult to hear him. [wife].

[The coroner] kept on saying, 'Sorry for your loss,' and she had the biggest grin. The biggest grin. I just kept on thinking, 'Why do you keep saying that and your face isn't saying it?' You just realise they're just doing their job. It's just personal to you, but they're just totally detached from the whole thing. You feel like a number or a something. [mother]

The husband who spoke of having been 'quizzed' for about two hours, as quoted above, went on to say that the inquest process 'was such a disaster' because of the complete absence of 'respect and sympathy and empathy and understanding, for everybody'. We heard from others who emphasised that the simplest expressions of sympathy would have made a large difference to their experience:

Other coroners actually start off the inquest by saying, 'I'm really sorry that you're here under these circumstances. I'm sorry that you've lost your sister'... Even that would go a long way... That's all it would take, to make me and other families feel better ... to accept the whole process and go through it much more easily. [sister]

Nobody says sorry. Nobody says just a really simple thing: 'I'm sorry that happened, how can we make it better?' That's all you need, to turn things around. [wife]

Very few respondents mentioned receiving an expression of condolence or informal apology from other interested persons or witnesses at the inquest. We heard, more often, of respondents being 'ignored' or 'blanked' by witnesses during hearings, or of witnesses 'laughing and joking' as they gathered outside the courtroom 'as if it's just another day in the office'; 'chatting as though they were at a nightclub'; or 'grinning' their way through the process of giving evidence.

Many respondents talked of a process that focused on bureaucratic requirements at the expense of being person-centred, individualised and thorough. 'It's a system, and the system is cold', one

mother said. A bereaved wife described a coroner who 'kept sighing' when she was 'upset and visibly crying' during the inquest hearing; it seemed to her that 'he was trying to tell me, "Look, can you be quiet because I need to get on, and get this done."' A sister described getting a letter from a coroner asking her to refrain from sending more information to the coroner's office as it was taking up too much of the officers' time and preventing them from helping other families. This 'really hurt me; I mean, I cried... I was just doing what they'd asked – I was trying to help them get to the bottom of it.'

Phrases like 'rubber-stamping' and 'tick-box' were frequently used:

And to me ... it was a case of lip service and trying just to tick a box. To me, there was no support for us; there was no ability for us to sit down with anybody and try and understand what was happening. Don't get me wrong, we're both intelligent people, with good jobs. But we were very much excluded from everything. To the extent whereby the day of the inquest was determined by everybody else's availability. [mother]

I imagined that a coroner was somebody who was very intelligent, had all the services he could pull on, and really wanted to get to the bottom of exactly what had happened to your loved one. It's anything but. It's a rubber stamping: 'Let's get this over as fast as possible, please don't ask any questions; we actually really don't want you to come.' [mother]

For a couple whose son had died in a road traffic accident abroad, the inquest held in the UK produced no new insights into the death and felt like 'just another hoop that we had to jump through, and another set of people that we had to parade our loss in front of'. They perceived the inquest as having been little more than an elaborate pretence:

If it's a box-ticking exercise, then make it *more* of a box-ticking exercise. Don't do the pretend-y bit... Don't even have us there. Just say, 'Oh, yes, that's it. That's what has happened in France. We'll send a form out.' Don't go through the rigmarole of the inquest in the UK if all it is a box-ticking exercise. [mother]

An especially stark example of a narrow focus on 'process' rather than 'person' was provided by a mother who described her interaction with a coroner's officer when she rang up to ask when the post-mortem examination of her son's body would be completed:

I didn't want to ... make them think I was pushy but we had got this funeral booked. I remember standing in the kitchen. There're certain points that stand out to you. He said, 'Oh, let me check the list and see where he is.' He went, 'One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, oh, he's number sixteen ... All those fifteen numbers before. Number six is somebody's relative – somebody's son, somebody's granny.

We heard about other ways in which the personhood of the deceased individual seemed to be denied: for example, where terms like 'the deceased' or 'subject' were used rather than the name. A sister was deeply upset at the lack of respect shown towards her deceased brother:

So we witness [my brother] being stripped of everything before us, again, in death. That was quite something, I'll never be able to describe that. He suffered; he had a life of difference to us because of [his poor health]. How is it possible that he could just be invisible-ised?

We noted above (section 4.2) that some of our bereaved respondents found the experience of displaying photographs or presenting a 'pen portrait' highly valuable, and that this supported a sense of inclusion within the coronial process. Others, in contrast, reported not being given the opportunity to make a statement about their family member – 'We never got to explain about the boy, my son, whatsoever', a mother told us – or being told to take down pictures. For another mother, this underlined her exclusion from proceedings:

I certainly wasn't at the heart of anything, and neither was [my daughter], not a chance... They wouldn't let me put a picture of [her] up. They made me take a photo of her down because it was too upsetting for the clinicians giving evidence. I thought, 'Fuck your clinicians, what about us?' There was no way that [she] or any of us were at the heart of anything to do with this.

A third mother told us about a coroner's objection to her appearing (online) at pre-inquest review hearings in front of a mural depicting her young daughter:

My solicitor received a letter from the coroner saying to remove the background, and I'm like: 'It's painted on the wall.' He said, 'Because it's distracting.'... I was like: 'A man of your standing – and this is why we're here, by the way: this is the person, this is why we're here – you find that distracting?... If that's distracting you, how the hell do you think we feel, sat here at our own child's inquest?'

A specific aspect of the coronial process that many bereaved respondents found especially challenging was that it entailed being exposed to distressing evidence and information – particularly from the post-mortem examination. Very often, they expressed anguish not just at the *fact* of this exposure, but also at the *manner* in which the evidence had been presented or made available. Some described receiving post-mortem reports and other evidence by email, with little or no warning – such as the bereaved partner who told us:

I was going down to Cornwall. I received those [reports] on the train ... and rather stupidly, I started reading them... It was utterly shocking. I don't know quite what I expected but, obviously, there was a post-mortem. He had to be identified through... teeth or something; I mean, he was so badly burnt. The descriptions were just mind-blowing. I was staying with a friend, so I stopped reading them on the train when I realised they were gruesome beyond anything I'd imagined, and waited until I was with my friend. We went through them together, and I tried to protect her. I said, 'There are some you don't want to read.'

Hearing evidence presented in court was also distressing. A bereaved wife said that she had been advised not to read the post-mortem report, yet at the inquest hearing they went through it:

The coroner ... told [the pathologist] exactly which page to look at and which part to read out. She told him to read out all these fine details of what had happened to [my husband], ... and I had to get up and walk out because I couldn't bear it.

Similarly, a mother said that at the inquest, 'They read out the literal post-mortem results. They read out, "brain weight". And as soon as I heard that my fingers went in my ears.'

4.3.4 Mismatch of expectations and outcomes

Although the large majority of our bereaved respondents had had little or no knowledge of the coronial process prior to their bereavement and being told that the death was to be investigated by

the coroner, they tended to formulate various hopes and expectations of what the process would deliver as the investigation unfolded. Some of these expectations were fulfilled, but more frequently they were disappointed – heightening respondents’ feelings that their own needs and wishes were not at the ‘heart’ of the process.

A common expectation was that the coronial process would produce ‘answers’ about the death – in accordance with its core statutory function of determining who died and how, when and where the death occurred. For some of our bereaved respondents, certain answers they had sought were indeed forthcoming; this, moreover, had assisted them as they continued to grieve their loss. A bereaved aunt, for example, said the inquest ‘answered a lot of unanswered questions – not entirely about “why”, but certainly about “how”... So, I think, definitely, that was helpful.’

More often, however, respondents felt that their questions went unanswered. This was sometimes couched in terms of a perceived failure on the part of the coronial process to seek ‘the truth’: ‘Just to get the truth would have been great, but no, nowhere near it’ [mother]; ‘I didn’t want much, I just wanted the truth. And ... they wouldn’t tell me’ [daughter]; ‘I just wanted to have the truth. I just wanted to know, and for them to accept, how it happened’ [father]. Others blamed a lack of answers on apparent defensiveness of state bodies implicated in the death, or coroners’ lack of commitment to tackling this defensiveness: ‘To have to go through this... Trying to find answers and the very people who’ve got the answers continually and repeatedly shutting that door on you’ [father]. A mother, whose child had died at a very young age following what she believed to be profound healthcare failings, expressed her anguish about ‘lies and deceit’ that she felt had gone unchallenged by the coroner’s investigation. Adding to her anger and distress:

At the end of the inquest, [the coroner] even said to us ... ‘I hope the family have got all the answers they wanted.’ I’m like, ‘Can you not see us? Did you not hear us? How could you possibly think -?’

More than ‘answers’, what many respondents most wanted was that the coroner’s investigation would give rise to learning and action to prevent future deaths in similar circumstances to those in which they had been bereaved. But very few respondents reported feeling that progress had been made towards prevention, and a frequent refrain was that ‘nothing has changed’ as a result of the inquest. Some were frustrated with investigations that were too narrowly focused and thus did not address all the factors that, in their view, could have caused or contributed to the death. A bereaved sister commented, for example, ‘If coroners are refusing to actually listen fairly to all the evidence, and admit that something is wrong, then these deaths are going to keep happening’; ‘As a result of the coroners not looking at causation ... other people will career down this path, will lose their lives, and still nothing will be done about it’ [father].

Where the coroner had produced a Prevention of Future Deaths reports (PFD), this was often a focus of particular disappointment – both in terms of content, which was often considered weak, and their apparently limited impact. Recommendations made in a PFD ‘weren’t specific’, according to a bereaved mother: they were ‘wishy-washy ... not a robust plan. A father said that the report was ‘like slapping them with a wet lettuce leaf ... a child could’ve written [it]’. In some cases, family members were pleased and greatly relieved when they learnt that a PFD was to be produced, but then bitterly disappointed when they found out that was no oversight or enforcement of any subsequent actions. Echoing others who rhetorically asked ‘what’s the point’ of an inquest that does not lead to change, a mother said:

Even though they make recommendations for prevention of future deaths, ... it’s not binding; we’re all still here... So why say it? We go through the whole process for something,

which absolutely means nothing. I'm sure my son is not the first person to die in prison from lack of medical [attention]... So it makes you wonder: what was the point of the whole thing that you're going through?

Some bereaved respondents regarded the (potential) coronial outcomes of answers, learning, and preventive action as secondary to a larger goal of achieving justice for the deceased and holding to account those responsible for the death. One mother told us: 'I needed more than answers. I knew what the answers were, in some senses. But I needed accountability'; another said that the coroner 'wasn't interested in justice for [our son]. I think that's why ... both of us feel let down: because we didn't get justice'.

While a few bereaved respondents felt that – to some extent – justice or accountability had been delivered by the coronial process, many more regarded these outcomes as unachieved or even unachievable. This was often attributed to imbalances of power in a system which seemed to systematically protect the interests of state bodies, such as health trusts, and dismissed their own concerns about how those bodies had failed the deceased. These comments resonate with others, noted above, about a process that seemed oriented around professionals, leaving the lay people outside it or on the margins:

It takes a while for you to realise it's not about justice. You get the feeling that this is mostly for the lawyers and the coroners... You never really do get the outcome you expect because of legal jargon, where they spend their whole time ... trying to find ways to find a legal way to get out of it ... It's not for the family. It's just for the system or whoever. [mother]

There's a lot more powerful people and cleverer people than me have managed to bat me away like a little fly and all I want is some transparency and some answers. [father]

Through the whole thing, I just felt like, 'Why are these people, who've done what they've done, getting more support and more protection and more everything than us?' [sister]

Some comments focused on the difficulty of achieving justice when the coronial process explicitly rules out the determination of liability – such as the following:

I know now that an inquest is not in order to apportion blame or to find reason, but just to find the cause of death. I probably knew that in advance, but I still expected more of a sense of justice, I think, from the inquest. [mother]

You're not going to get justice and the learning process – that is one of the very clear messages. You're told it's about the 'what' and the 'where' and the 'how' someone has died. That is the case. But families always think there is justice to be gained in there, somewhere. [mother]

Where respondents felt that the coronial system did not deliver the justice or accountability they had hoped for, one of the potential repercussions was a loss of trust in the justice system more widely: 'Well, what faith do we have in the judicial system, after this?' asked one mother, who described herself as 'absolutely devastated' that the coroner had not identified failings in the care provided to her adult son in a residential home. A step-father described his reaction to the inquest which, he believed, had failed to examine the key factor underlying his step-son's suicide:

It's not that I'm angry about it all. I'm incredibly disappointed, as a citizen of this country, that at the time when people need the most care, that a system like this is allowed to

continue. So, for me, I am utterly, utterly despondent and disappointed in the whole system. I've got no interest in supporting it going forward the way it is.

5. Conclusion

The *Voicing Loss* study participants – both those with professional and those with personal experience of the coronial process – were generally supportive of the principle of putting bereaved people ‘at the heart’ of the coronial process. Some of our bereaved respondents recounted positive experiences of inclusion in the process, and spoke of how they had benefited from this. More of these respondents, however, described experiencing significant aspects of the coronial process as exclusionary – which was often a cause of frustration, distress and additional grief.

Respondents vividly conveyed what it was like to be plunged into a system – at a time when they were in a profound state of shock – about which they had previously known little or nothing. Limited access to or engagement with generic information about coroners’ investigations, and poor communication about case progression, left many continuing to feel that they were ‘in the dark’ even as the final inquest hearing approached.

The formality and legalistic character of proceedings were also alienating; as was – in some cases – the experience of being heavily outnumbered by lawyers who were representing public bodies. Respondents reported feeling that they had no voice; that they were a ‘bystander’, ‘sideline’, ‘shadows’, or even a ‘little fly’ that could be batted away – within a process that seemed to be all about the professionals and their legal ‘games’, or focused on ‘box-ticking’ rather than the robust investigation of individual deaths. Respondents also spoke of conduct by coroners, coroners’ officers and other professionals which did not feel compassionate or sensitive, and apparently failed to acknowledge or respect the personhood of the deceased.

Thus, if being genuinely ‘at the heart’ of the coronial process means that bereaved people experience the process as inclusive and respectful, and actively contribute by exercising their rights to participate, then evidence from the interviews suggests that aspects of practice often fall short of this policy aspiration. The shortfall is even more pronounced if being ‘at the heart’ also means that the *outcomes* of the process are at least partially aligned with bereaved people’s expectations – since many respondents reported their disappointment at the seeming failure of the coroner to deliver that they had hoped for: meaningful answers about the death, learning which could lead to preventive action, and justice and accountability.

We can also conclude from the evidence presented in this submission that some relatively straightforward changes can be made to practice that would significantly enhance bereaved people’s inclusion in and engagement with the coronial process. Broadly, such changes come under the heading of ‘better treatment’ and encompass such matters as:

- provision of clear, concise and practical information and guidance about the coronial process (including the Ministry of Justice *Guide to coroner services*) in a range of formats and on a repeat basis, to help bereaved people access the information as and when they are best able to engage with it;
- clear, timely, proactive and person-centred communication about case progression and outcomes, and about what to do after the inquest;
- avoidance of excessive formality and use of legal jargon during hearings and in all communications;
- sensitivity and restraint in the questioning of bereaved people as witnesses;

- ensuring that all interactions between bereaved people and professionals (not only coronial professionals but also, as far as possible, witnesses and others) are conducted in a compassionate and courteous manner and include, as appropriate, acknowledgement of the loss suffered by the bereaved;
- maintenance of decorum and respect in witnesses' and others' behaviour within and outside inquest hearings;
- referring to the deceased person in a respectful way, and acknowledging their humanity and individuality – including, where the family so wishes and as practicable, by allowing for pen portraits to be presented and/or photographs shown;
- careful attention to the ways in which distressing evidence is presented to bereaved people in writing, and presented orally at hearings.

To assert that these kinds of changes are 'relatively straightforward' is by no means to suggest that they are easy to deliver, especially within what is an over-stretched, under-funded and under-staffed service. However, the suggested improvements could largely be achieved without structural reform or significant investment of additional resources, although they may require some additional training, a greater willingness on the part of professionals to reflect on and review their own and their peers' practice, and an awareness of the risks of compassion fatigue.

Existing resources can assist this process, such as the competency framework and accompanying guidance for lawyers practising in the coroners' courts, issued in December 2021,³ and the guidance documents provided by the Chief Coroner, one of the most recent of which has addressed the issue of pen portraits.⁴ Insights provided by procedural justice theorists, who have long studied the ways in which members of the public are treated within justice institutions (particularly, the police), may also be valuable. A growing body of research on procedural justice in differing kinds of court settings points towards the importance of fair and respectful treatment of lay court users, which is associated with acceptance of court decision-making and trust in the justice system more widely.⁵

Not all the shortcomings identified in this submission, however, can be readily addressed through changes to practice focusing on 'better treatment'. The problem of the perceived imbalance between state bodies, which typically have publicly funded legal representation at inquests, and bereaved people, who often do not, is a continuing subject of public debate. Although, since January 2022, non-means tested legal aid has been available for bereaved interested persons at inquests which engage Article 2, concerns remain about 'inequality of arms' and a tendency towards adversarialism when public bodies instruct multiple lawyers.⁶ Reinforcing the inquisitorial character of the coroner's inquest – within a wider system of justice that is predominantly adversarial – may require a substantial overhaul of the way in which proceedings are conducted.

There is also no obvious answer to the question of how to address the apparent mismatch between bereaved people's expectations of the coronial process and the outcomes that are often delivered. Many of the professional respondents interviewed for *Voicing Loss* suggested that any such problem

³ *Resources for those practising in the Coroners' Courts*, <https://www.barstandardsboard.org.uk/for-barristers/resources-for-the-bar/resources-for-practising-in-the-coroners-courts.html>

⁴ *Chief Coroner Guidance No. 14: Use of 'pen portrait' material*, July 2021, <https://www.judiciary.uk/wp-content/uploads/2021/07/Chief-Coroners-Guidance-No-41-Use-of-Pen-Portrait-material.pdf>.

⁵ For a short review of this evidence base, see A. Kirby and J. Jacobson (2022), *Procedural Justice in the Courts*, Clarks Evidence Library, <https://www.clarks.org/publication/procedural-justice-courts>.

⁶ Government has recently rejected the idea of a cap on the number of lawyers who can represent public bodies at inquests, but pledged to keep the issue under review. Home Office (2023) *A Hillsborough legacy: the government's response to Bishop James Jones' report*, <https://www.gov.uk/government/publications/hillsborough-disaster-report-government-response>.

of mismatch largely has its roots in ‘unrealistic’ expectations on the part of bereaved people, and that better ‘management’ of these expectations is therefore important. From this perspective, the provision of more information and guidance for bereaved people – as proposed above – would assist, by ensuring that expectations are better informed. However, wider reforms may be required to achieve a more comprehensive resolution of the problem of dissatisfaction with outcomes. These might include, for example, the introduction of mechanisms for follow-up and oversight of PFD responses,⁷ and a rethinking and elaboration of the concept of ‘accountability’ as it applies in the context of the coroner service.

Finally, we suggest that the terminology of ‘at the heart’ should be reviewed. The phrase is unhelpfully vague; further, one might question how exactly it fits with the core, statutory function of the coroner, which is to determine who died and how, when and where they died (and, in some cases, the circumstances of the death) – but *not* to meet the needs of those bereaved by the death. Ethically, the case is strong and compelling that bereaved people should be treated with the utmost compassion, respect and consideration throughout the coronial process, on the grounds that they are the ones who have suffered the loss, and often in the most traumatic and tragic of ways. Our research demonstrates that exclusion and poor treatment cause hurt and emotional harm, while the positive impact of inclusion and good treatment is also far-reaching. It is clear, moreover, that the evidence, wider knowledge and commitment that bereaved people bring to the process can be key to a thorough, robust investigation and a fair, accurate conclusion; but that systemic inequities and imbalances can impede and undermine these contributions. Perhaps, therefore, what is needed is a coronial process that better facilitates the *effective participation* of bereaved people and has *humanity* at its heart.

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⁷ Like the issue of legal representation at inquests, this is a subject of wide debate. The charity INQUEST launched its campaign for a National Oversight Mechanism for PFDs, *No More Deaths*, in July 2023, <https://www.inquest.org.uk/no-more-deaths-campaign>.