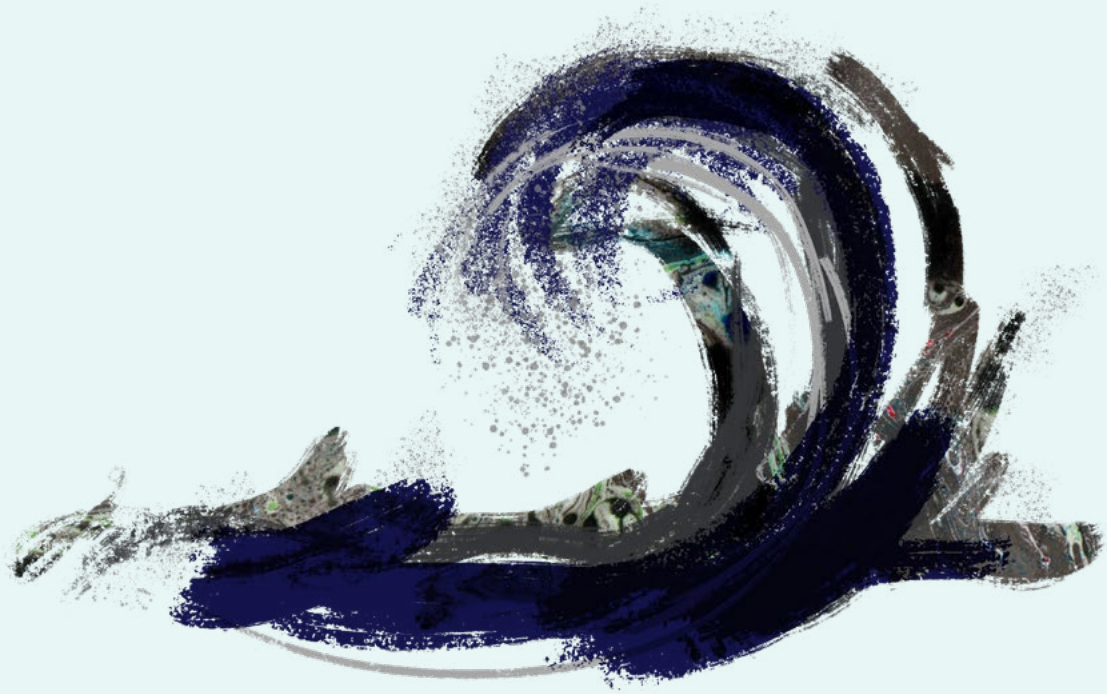
Voicing Loss

Research Findings Summary

‘I feel like I’ve been swept along on a tsunami’:

Bereaved people’s experiences of coroners’ investigations and inquests



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The Voicing Loss project explored the role of bereaved people in coroners' investigations and inquests, and the scope for policy and practice reforms to support their inclusion in the coronial process. The project involved interviews with 89 people who had experience of the coroner service following the death of someone they were close to, as well as interviews with coronial professionals and witnesses.

Key messages

- Some of the bereaved respondents who took part in the Voicing Loss research reported that their experience of the coronial process had helped them and offered some sense of 'catharsis', 'peace' or 'relief'.
- More of the bereaved respondents, however, spoke of being negatively impacted by the process. They described anxiety and uncertainty over the often lengthy period of investigation, severe distress during inquest hearings, and the subsequent long-lasting emotional and psychological toll it took on them.
- Factors which shaped respondents' positive or negative evaluations of the coroner's investigation and inquest variously related to the nature of the process itself; to their experiences of participation; and to the outcomes of the process.
- **Process:** Respondents described the difficulty of navigating a complicated legal process of which they had little or no prior knowledge, while in the early stages of grief. Problems were exacerbated by a lack of information from, and poor communication with, the local coroner service. Experiences of being treated with, and without, compassion, sensitivity and respect were vividly recalled; as were instances of respectful, and disrespectful, conduct in relation to the deceased person.
- **Participation:** Many respondents made strenuous efforts to ensure their voices were heard and their concerns about the death were addressed. Yet they frequently encountered barriers to participation and found many aspects of the process alienating and disempowering. Opportunities to present 'pen portraits' about the life and character of the deceased person were welcomed.
- **Outcomes:** Some respondents found it helpful that the inquest gave them answers about the death. Others learned nothing new from the inquest. Many were deeply frustrated and disappointed by the limited capacity of the coroner to help prevent future deaths.
- Based on the Voicing Loss findings, we have identified a range of policy and practice measures that would ameliorate the harms caused by poor experiences of the coroner service and bolster the chances of positive experiences.

1. Introduction

Coroners are independent judicial officers. They have responsibility for investigating deaths suspected to have been violent or unnatural, where the cause of death is unknown, or where the person died while in prison or another form of state detention. The investigation must seek to determine who died and how, when and where they died. Where necessary, a coroner's investigation culminates in an inquest: an inquisitorial, fact-finding hearing, usually held in public.

The Voicing Loss project examined the role of bereaved people in the coronial process, and explored ways in which their inclusion and participation could be better supported. The main component of the project was a qualitative, empirical investigation, in the form of interviews with 89 bereaved people who had experienced the coronial process, as well as interviews with coroners, coroners' officers, inquest lawyers and others involved in the coroner service in a professional capacity. Voicing Loss is the largest ever empirical study of lay and professional experiences of the coronial process in England and Wales.

This paper summarises key themes that have emerged from the research, focusing primarily on the interviews with bereaved people. These and other themes are discussed in detail in a series of Research Findings papers available, along with other project outputs, on the Voicing Loss project website.

2. Impacts of the coronial process on bereaved people

> "Not making assumptions that you have any understanding of somebody else's grief, and their response to it, is the important thing... I think it is impossible to generalise and anybody who does is doing bereaved people a disservice." **- Assistant coroner/inquest lawyer**

Coroners investigate a vast array of types and circumstances of death. In 2023, almost 200,000 deaths – 34% of all registered deaths in England and Wales – were reported to the coroner, and almost 40,000 inquests were concluded.[1] Many inquests are entirely uncontentious and may be very short, lasting well under an hour. At the other end of the spectrum, inquests can last many months, entail scrutiny of large quantities of different kinds of evidence, and involve multiple legal teams representing various individuals and organisations. Bereaved people's experiences of the coroner service are thus enormously diverse – reflecting not only the nature and length of the investigation, but also their own capacity and disposition to engage with it, and whether or not they have questions or concerns about the death.

[1] Ministry of Justice Coroner Statistics 2023: England and Wales, updated 10 May 2024.

The bereaved people who were interviewed for Voicing Loss had all come into contact with the coroner service following the death of someone they were close to; more than half of the respondents were a parent of the deceased person. In all but three of the cases, the coroner's investigation had included a final inquest hearing. All the bereaved respondents had a personal interest or stake in the process (they would otherwise have been unlikely to volunteer to take part in this research). But the ways in which they had been impacted by the coroner's investigation and inquest varied widely.

Some of the respondents reported that they had been helped by the coronial process, which had been in some way 'cathartic' or had offered some sense of 'peace' or 'relief'.

> "The whole experience of being bereaved and losing a child is devastating. I think it would have been even worse had we not had some sort of acknowledgment and examination of what took place. Had that not taken place, I think we would have been even more devastated and lost… If we hadn't had an inquest, I don't think we'd have ever been at peace… It has helped us. As the years go by, we reflect on it. Without that kind of closure – which is not closure – but – she has been given her space." **- Mother**

> "I found peace in that inquest, strangely… For me, I found peace, because I could see everything, or pretty much everything was uncovered." **- Mother**

More of the respondents, however, spoke of being negatively impacted by the process. They described all-consuming anxiety and uncertainty as investigations proceeded over weeks, months and even years, and (often unexplained) delays to hearings made the pressures even more intense. The experience of attending inquest hearings was frequently described as highly distressing – to the extent that the distress was sometimes said to be comparable to that caused by the death itself.

> "We felt [as if we were] in the moment of my brother's death again. It felt like I was experiencing it twice: we haven't come out of it; gosh, we're never going to come out of it; we never will." **- Sister**

> "I don't really understand the whole process, to be honest. To have the most traumatic thing happen – to find your son dead in the hallway – but actually the inquest was probably not far off as traumatic for me." **- Mother**

The consequent emotional and psychological toll was one that some of the bereaved respondents continued to pay long after the inquest concluded.

> "I would say it's probably deeply damaging to my own personal journey with the grief because disappointment is not something you want on top of trauma… So my sense is that it's probably made my grief worse, that experience." **- Mother**

3. Understanding the impacts of the coronial process

Many factors shaped the bereaved respondents' positive or negative evaluations of the coroner's investigation and inquest. Some of these factors related to the nature of the coronial process itself; some to respondents' experiences of participating (or trying to participate) in the process; and some to the outcomes of the investigation and inquest.

3.1 Process

Respondents spoke of the difficulty of navigating a complicated legal process of which they usually had no prior knowledge or experience, while in the early stages of grief after what was often a sudden and traumatic death. In such circumstances, clear explanations of the process and updates on case progression were of great value. However, respondents more typically reported that they received limited information and that communication with the local coroner service was poor.

> "We didn't know who to contact; we didn't know who to speak to; we didn't know where to go." **- Mother**

Not just the content but also the style of communication with coronial professionals, throughout the investigation and inquest process, had highly significant repercussions. Experiences of being treated with – and without – compassion, sensitivity and respect were vividly recalled.

> "The coroner was really kind and encouraging, recognising our grief, our distress and that this was a hard process, but actually, we had a voice in this and we were an active part… I think the actual process was really healing for us as a family." **- Mother**

> "[The coroner] acknowledged the family and she spoke to us and whatnot. She was very warm… And she was like, 'You know, I'm conscious of the way we're talking about this and because – you know, it's a person who is involved; it's your loved one.'" **- Sister**

> "I get it. [Coroners] have got to stay professional. They've got to stay – not cold, not emotionless, but very stern. But obviously, I was upset, and I was visibly crying. And he kept sighing… It was obvious he was trying to tell me, 'Look, can you be quiet because I need to get on, and get this done.' He was sighing at me all the time because obviously, I was crying. I was trying to control it, and the more I'm trying to push it down, the more it was." **- Wife**

Some respondents spoke about the particular distress that was caused when the deceased was referred to in a disrespectful manner, or in a way that denied their personhood. They also spoke of distress arising from insensitivity in discussions about the post-mortem examination or in the presentation of graphic evidence during inquest hearings.

> "Then, one morning, [the coroner's officer] phoned me up to give me the 'good news'. That was

exactly what he said… He phoned and said, 'I'm just phoning to give you the good news that the autopsy has been completed. I just want to ask you what you want to do with the soft tissue samples.' I said, 'I beg your pardon. What do you mean?' … At that point, I hadn't actually comprehended the intrusive nature of the autopsy… That was very, very, very distressing, distressing to the point of nightmare stressing." **- Mother**

"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." **- Mother**

3.2 Participation

Bereaved people's participation in the coronial process takes various forms. Those designated as 'interested persons' have certain formal rights to participate – including the right to receive documents and evidence that may be considered at the inquest, and to question witnesses.[2] Bereaved people may themselves appear as witnesses at the inquest. It is increasingly common for the bereaved to provide a 'pen portrait' about the life and character of the deceased – sometimes accompanied by a photograph – which they may themselves read out at the hearing. More broadly, government and successive Chief Coroners have frequently reiterated that the bereaved should be 'at the heart' of the coroner service.

Many of the Voicing Loss respondents had made strenuous efforts to ensure that their voices were heard over the course of the investigation, including at the inquest hearing, in order to raise issues that they thought might otherwise be overlooked or given inadequate attention.

"I had no medical training or knowledge at all, and I was so worried that I was going to miss something. And I spent hours going over these reports… So, I was really keyed up because I was going to ask [witnesses] these questions. 'Oh, God, what if I miss something? Oh, God, what if I can't keep it together enough to ask my questions? And I just break down and cry?' And my uncle who came to the inquest as well, did break down and cry." **- Daughter**

Yet, the respondents encountered multiple barriers to participation and often felt they were far from 'the heart' of the process. The process was experienced as daunting and alienating. They felt marginalised and powerless; particularly during longer inquest hearings at which multiple professionals, all with legal representatives, were present.

"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**

"I feel like I've been swept along on a tsunami: just swept out, and you've just got no control whatsoever." **- Mother**

For some respondents, providing or presenting a 'pen portrait', or displaying a photograph, was a

[2] Interested persons usually include close family members or other representatives of the deceased, and may also include other individuals who were associated with the death in some way.

highly meaningful form of participation in the inquest hearing, and had the effect of humanising what was otherwise experienced as a cold, impersonal process.

"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." **- Mother**

"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." **- Mother**

3.3 Outcomes

At the end of an inquest, the coroner (or, in a small minority of cases, the jury[3]) records their conclusion on the cause of death. If the coroner believes there to be a risk of other deaths and that action should be taken to reduce that risk, they are also obliged to write a Prevention of Future Deaths (PFD) report for relevant bodies.

Coronial professionals interviewed for Voicing Loss emphasised that, in many cases, the inquest conclusion is helpful for the bereaved, and supports the grieving process, because it offers them much-needed answers about the death. Some of the bereaved Voicing Loss respondents had experiences which accorded with this perspective.

"I have a very strong feeling and view that if [the inquest] is properly managed for them and they're included in a proper level, families can go away feeling that their questions have been answered, and that it has been a helpful process in just processing everything that's happened and understanding how it all came about." **- Coroner**

"It answered a lot of unanswered questions – not entirely about 'why', but certainly about 'how'. At least we knew how it had all happened." **- Aunt**

"The things we didn't have answered, the coroner explored thoroughly. Because she asked every single person: 'Would you do it differently? What would you do differently?' And she pushed and pushed and pushed; she wasn't taking, 'It's fine,' for an answer, from anyone. So that, we did find helpful." **- Mother-in-law**

But, for many of the bereaved respondents, the inquest conclusion did not provide the answers they were looking for, or it told them no more than they already knew. Some blamed the lack of answers on the defensiveness of state bodies implicated in the death, and on the coroner's lack of commitment to tackling this defensiveness.

"So what did that achieve? So what did it achieve? All it did was for a coroner to turn around and say exactly what we knew: that [my son] took his own life without intent." **- Mother**

[3] The inquest must be held with a jury if it is investigating a violent, unnatural or unexplained death in custody; a death resulting from an act or omission of a police officer; or a death caused by a notifiable accident, poisoning or disease.

"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**

A source of profound frustration and disappointment to many bereaved respondents was that the coroner had seemingly done little to help prevent future deaths. Failings in prevention were variously attributed to the narrowness of the investigation; to the weak content of PFD reports; and to the lack of oversight of institutional responses to reports. This engendered mistrust of the coroner system and the authorities more widely.

"We don't learn from the past… And it is heart-breaking when you go through the process of getting [a PFD] done and thinking that you've brought suicide to an end, or something close to that, to then turn the TV on and watch another set of parents going on TV to say, 'I'm doing this thing because I want it to avoid future deaths'. So, I say to my dad, bless him, beyond the grave: 'Dad, you were wrong about the coroner; they're not powerful.'" - **Father**

4. Policy and practice implications

Some of the bereaved people interviewed for Voicing Loss had – in the wake of the personal tragedy they had suffered – experiences of the coroner service that were positive, at least in some respects. They reported kindness and sensitivity on the part of coronial professionals; opportunities to reflect upon and pay respect to the life of the deceased; responsiveness to concerns and questions they raised in relation to the cause of death; and robust scrutiny of evidence. But reports of the converse were more common. Many respondents described insensitive and disrespectful treatment – towards themselves and towards those who had died – and feeling marginalised and intimidated. They spoke of encountering dismissive or defensive attitudes towards institutional failings which they believed had contributed to the death and would, in the absence of preventive action, contribute to more deaths in the future.

The Voicing Loss findings make clear the extent and severity of harms, over both the short and much longer term, that can be caused by poor experiences – in relation to process, participation and outcomes – of the coroner service. Ameliorating these harms, and bolstering the chances of positive experiences, requires multifaceted policy and practice change.

In a series of policy and practice briefings based on the research, we have set out a number of proposals for change. In so doing, we recognise the challenging wider context in which any change must take place. Like most public services today, the coroner service is under-resourced and over-stretched. Its workload is increasing in size and complexity, and societal expectations of what it can achieve – particularly in terms of addressing the causes of preventable deaths – are growing. There are continuing calls for far-reaching structural reform, with many arguing, for example, for the creation of a unified national service to replace the current local authority-based system.

We believe that this challenging context makes our proposals all the more vital. They are focused on three main areas.

First, we point to multiple tensions and ambiguities within the coroner's role and remit. These, we argue, result in a mismatch between bereaved people's expectations of the coronial process and what, in practice, it tends to deliver. We therefore propose measures for bringing greater clarity and transparency to the purpose, structure and operation of the coroner service. (See Policy Brief No. 1: Clarifying the role and remit of the coroner.)

Second, we argue that the policy aspiration to locate bereaved people 'at the heart' of the coronial process is vague, overly broad and, in some respects, unrealistic. We propose that it should be replaced by commitments to:

- ensuring that *humanity* is central to, or at the heart of, the coronial process
- supporting bereaved people as participants in the process
- developing improved provision for the bereaved beyond the coroner service, potentially including forums for restorative dialogue between the bereaved and professionals who had some involvement in the death.

(See Policy Brief No. 2: Locating bereaved people in the coronial process.)

Third, we identify principles for good practice which support the overarching aim of putting humanity at the heart of the coronial process. These principles are set out in three Principles for Practice (PfP) papers. PfP No. 1 addresses information and communication throughout the investigation process; PfP No. 2, the quality of interactions at inquest hearings; and PfP No. 3, respecting and reflecting the personhood of the deceased.

The bereaved people and others we interviewed for Voicing Loss took time to reflect deeply upon, and share with us, many aspects of their experiences. It is our sincere hope that the insights produced by these interviews, and the reports and briefings to which they have given rise, will help bring about tangible improvements to the delivery of the coroner service and particularly to the treatment of the bereaved.

Voicing Loss

- The Voicing Loss project was conducted by the Institute for Crime and Justice Policy Research (ICPR) at Birkbeck, University of London, and the Centre for Death and Society (CDAS) at the University of Bath. It ran from May 2021 to May 2024.
- The study involved interviews with 89 bereaved people with experience of the coronial process; 82 coronial professionals (including coroners, coroners' officers, lawyers and others); and 19 individuals who had given evidence to an inquest in a professional capacity and/or supported colleagues who were witnesses. This constitutes the largest ever empirical investigation of lay and professional experiences of the coronial process in England and Wales.
- The project examined the role of bereaved people in the coronial process, as defined in law and policy and as experienced in practice; and explored ways in which the inclusion and participation of bereaved people in the process can be better supported.
- As a qualitative study, Voicing Loss does not seek to provide an exhaustive or representative portrayal of the coronial process. The self-selected sample of bereaved people is likely to be skewed towards those who had been bereaved in contentious circumstances. However, this does not detract from the value of their detailed, reflective accounts of direct experiences.

Further information on the study, including research, practice, policy and other outputs, is available on the project website

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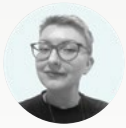

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