Voicing Loss

Research Findings No.1

‘I needed more than answers‘:

Bereaved people’s expectations of the coronial process

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This report is one of a series of Research Findings papers produced by the Voicing Loss project, which examined the role of bereaved people in coroners' investigations and inquests. Voicing Loss was conducted by the Institute for Crime and Justice Policy Research at Birkbeck, University of London, in partnership with the Centre for Death and Society at the University of Bath. The project was funded by the Economic and Social Research Council (grant reference ES/V002732/1), and ran from May 2021 to May 2024.

All outputs of Voicing Loss, including other Research Findings papers, are available on the project website.

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This Research Findings paper examines bereaved people's expectations of coroners' investigations and inquests, and the extent to which these expectations are fulfilled. It is based on findings of the Voicing Loss project on the role of bereaved people in the coronial process. The research 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.

The large majority of the bereaved Voicing Loss 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. As the investigation proceeded, they formulated various hopes and expectations of what the process would or could achieve, which can be broadly categorised as:

- hopes that the process would provide answers, and potentially the wider 'truth', about the death;
- hopes that lessons would be learnt about failings which had caused or contributed to the death, leading to action to prevent future deaths;
- hopes that the identification of failings would, more broadly, be part of a process of achieving justice for the deceased and accountability for the death.

With regard to each of the above, some bereaved respondents gave positive accounts of what the coronial process had delivered, and spoke of how this had helped them as they continued to grieve for the person who had died. Many more of the respondents, however, described a process which had not provided what they had sought from it, and which they consequently perceived to have failed them and the deceased person.

For example, respondents said that the questions they wanted answering were not properly addressed by the coroner; or described coming to the realisation that the coroner's investigation was never going to extend beyond what they already knew. Many respondents emphasised that their overriding hope for the process was that it would give rise to learning and preventive action, but only rarely did they feel that progress had been made towards prevention. More often, they voiced their profound distress that 'nothing has changed' as a result of the death and inquest. Much of this disappointment and disillusionment focused on Prevention of Future Deaths reports, which were deemed to be weak in terms of their content and – most critically – to have no effect in the absence of a system of

oversight and enforcement. Hopes that the coroner might deliver 'justice' and 'accountability' went unfulfilled for respondents who felt marginalised or powerless within a process that appeared to them to be weighted in favour of public bodies or uninterested in looking beyond the immediate facts of the death.

The professionals interviewed for the study acknowledged that there is a problem of mismatch between some bereaved people's expectations of the coronial process and what, in practice, they experience. The problem was partly attributed to practical obstacles – particularly, relating to resourcing and staffing – that impede effective delivery of the service. Many of the professional respondents (particularly coroners, coroners' officers and inquest lawyers who represent state bodies) also argued that the problem of mismatch is rooted in 'unrealistic expectations' on the part of some of the bereaved, and that its resolution therefore depends on better expectation management. In contrast, other professional respondents (including family lawyers and representatives of some support services) spoke of systemic imbalances within the coroner service as the primary impediments to the realisation of bereaved people's hopes and expectations.

Our research findings suggest that the task of narrowing the gap between expectations and realities of the coronial process is complex and challenging. Meeting the challenge is likely to depend, in part, on structural reforms to the process to enhance its effectiveness, robustness and consistency. The provision of more extensive and accessible public information about the coroner service, to help ensure that bereaved people's expectations are better informed, is also of critical importance. Beyond this, there is a need to address a number of tensions and ambiguities inherent in the coronial process and its essential functions. These tensions and ambiguities relate to the coroner's statutory obligation to determine 'how' but not 'why' the death occurred; the status of the coroner's preventive function; and understandings of the concepts of 'justice' and 'accountability' in the context of the coroner service.

1. Introduction

This Research Findings paper, produced as part of the Voicing Loss project on the role of the bereaved in coroners' investigations and inquests, examines **bereaved people's expectations of the coronial process, and the extent to which these expectations are fulfilled**.

In England and Wales, coroners are independent judicial officers with 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 purpose of the investigation is to determine who died and how, when and where they died. Where necessary, the investigation culminates in an inquest: an inquisitorial, fact-finding hearing, generally held in public, and sometimes with a jury. Around 35% of all registered deaths are referred to coroners each year; of these, around 15-20% result in an inquest. The coroner service is localised, although the Chief Coroner provides leadership, guidance and support for coroners at a national level.

1.1 Background

By law, bereaved people have certain formal rights to participation in the coronial process, if they have been granted 'interested person' status by virtue of being closely related to, or a personal representative of, the deceased person. More broadly, government policy and successive Chief Coroners have emphasised that bereaved people should be 'at the heart' of the process. The part played by bereaved people in coroners' investigations and inquests was the focus of the project Voicing Loss. Specifically, we explored what *is* – according to law and policy, and as experienced in practice – and what *could and should be* the role of bereaved people in the coronial process.[1]

We explored these issues by interviewing 89 bereaved people with experience of a coroner's investigation (henceforth 'bereaved respondents'). We asked them about whether and how they had participated in the process; how it had impacted them; and their understanding, hopes and expectations of the process.[2] We also interviewed coronial professionals ('professional respondents')

[1] Information on the project aims and background, including the existing research evidence base, is provided in our paper, Voicing Loss: Research context and methodology.

[2] Over half of the bereaved respondents were parents of the person who had died. All but three of the coronial investigations experienced by the bereaved respondents had included a final inquest hearing by the time of the research interview. For more details on this and the other samples, see the Voicing Loss Context and Methodology paper.

– including coroners, coroners' officers, lawyers and others – about their perspectives and experiences relating to the role of bereaved people in the coronial process.[3] We addressed this theme further through a small number of interviews with individuals who had given evidence to coroners' investigations in a professional capacity ('witness respondents').[4]

The Voicing Loss empirical research was qualitative; hence we did not seek to recruit respondents who would be representative of all individuals with experience of coroners' investigations. The self-selected nature of the sample of bereaved people meant that it was skewed towards those who had been bereaved in contentious circumstances. This does not, however, detract from the value of respondents' detailed, reflective and nuanced accounts of their direct experiences, nor from the critical importance of addressing the more troubling aspects of these experiences – especially since it is precisely in contentious cases that the robustness and sensitivity of the coronial investigation are most essential. Further, the range of professional perspectives incorporated in the research significantly widens the scope of our findings.

1.2 Statutory functions and evolution of the coronial process

Under Section 1 of the Coroners and Justice Act 2009, coroners have a duty to investigate deaths reported to them where they have:

> reason to suspect that—
> a) the deceased died a violent or unnatural death,
> b) the cause of death is unknown, or
> c) the deceased died while in custody or otherwise in state detention.

Section 5 of the Act defines the 'purpose' of a coroner's investigation as being to address the four core questions of who died and how, when and where. It also specifies that the investigation should ascertain 'in what circumstances the deceased came by his or her death', if there would otherwise be a breach of the European Convention on Human Rights. This latter provision relates specifically to the state's Article 2 (right to life) obligation to conduct an effective investigation into any death in which it is implicated. Accordingly, inquests with the wider remit of ascertaining the 'circumstances' – on the basis that the state or a state body is implicated in the death – are generally known as 'Article 2 inquests'.[5] Coroners, further, have a preventive role, under Schedule 5(7) of the Act,[6] whereby they must issue a report if an investigation raises 'concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future', and they consider that 'action should be taken' to prevent or reduce that risk. The report – generally known as a Prevention of Future Deaths (PFD) report – should be addressed to those who the coroner believes have power to take such action, which might include individuals, organisations, local authorities or government departments or agencies.

[3] The professional respondents numbered 82 in total, including 17 coroners, 21 coroners' officers and other coronial staff, 20 lawyers, 12 staff and volunteers from the Coroners Court Support Service, and 12 individuals in a range of support, campaigning and other roles.
[4] 19 respondents had given evidence to coroners' investigations in a professional capacity and/or had supported colleagues who were witnesses.
[5] Also known as 'Middleton inquests', with reference to the case of *Middleton* [2004] 2 AC 182.
[6] With additional provisions in Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The legislation (Section. 10) makes it explicit that the coroner's role may not include attribution of criminal or civil liability for the death. However, Chief Coroner guidance (2021a) states that a conclusion in an Article 2 case may be 'judgmental' – although 'words which suggest civil liability such as "negligence", "breach of duty", "breach of Article 2" and "careless" are not permitted'.

The office of the coroner dates back to at least the 12th century, and its remit has changed in multiple ways over the hundreds of years since. Today this remit is, in some sense, narrow: with its primary focus on the statutory questions of 'who', 'when', 'where' and 'how', and the explicit ruling out of questions of liability. At the same time, the remit is broad: encompassing as it does a preventive function, potential consideration of 'circumstances' in which the death occurred, and a duty to put bereaved people 'at the heart' of the service. The breadth reflects various socio-political-legal developments since the later decades of the twentieth century. These developments include the evolution of human rights jurisprudence; growing public expectations of 'learning' from avoidable deaths; a more general expansion of the realm of the law and regulation; and political concern with the perceived harms suffered by some vulnerable groups, including bereaved people and crime victims, within the formal justice system.

1.3 This paper

Against the backdrop of the simultaneously narrow and broad functions of the coroner's remit, the interviews with bereaved respondents that we conducted for Voicing Loss included questions about what the respondents had expected from the coronial process, and to what extent these expectations had been fulfilled.

The interviews revealed that the bereaved respondents had various expectations of the coroner's investigation and inquest, which tended to centre around the themes of 'answers' about the death; 'learning and prevention of future deaths'; and, more broadly, 'justice and accountability'. Common to many of these accounts – in whatever way the expectations were articulated – was a sense of profound mismatch between what was expected and what, in practice, was experienced. In other words, most respondents felt they had been let down by a process that failed to deliver what, in their eyes, it should. When we interviewed coronial professionals, they largely acknowledged that the coronial process risks disappointing bereaved people involved in it. However, their views were mixed as to the extent to which this risk arises from uninformed and unrealistic expectations on the part of the bereaved, or from systemic imbalances within the process.

2. Expectations and experiences of the coronial process

Coroners investigate an enormously wide array of types and circumstances of death. In 2023, a total of 194,999 deaths – 34% of all registered deaths in England and Wales – were reported to the coroner. 36,855 inquests were opened over the course of the year, representing 19% of deaths reported to the coroner (Ministry of Justice, 2024). Many inquests are entirely uncontentious and may be very short – lasting well under an hour. Hearings can take the form of 'documentary inquests' which take place in the absence of any live witnesses,[7] and with or without any bereaved family or others present. At the other end of the spectrum, inquests may last many months; entail scrutiny of vast quantities of oral, written and other evidence; and involve multiple legal teams representing various individuals and organisations. Inquests may also be held with a jury – as was the case for around 1% of inquests held in 2023.[8]

Given the diversity of coronial investigations and inquests, it may seem problematic even to refer to 'bereaved people's expectations', if this might imply that such expectations are in any way homogeneous. The fact that a death results in a coronial investigation does not necessarily mean that there are individuals associated with the deceased who want or expect anything at all of the process. Any family or friends of the deceased may be estranged or otherwise unknown or uncontactable; or they may be so mistrusting of or detached from state institutions that they are not interested in any findings that a formal investigation could produce. In less extreme circumstances, family or friends of the deceased may simply not have any questions or concerns about the causes of death, and consequently regard the coronial process as an administrative matter of little consequence to them.

In volunteering to take part in the Voicing Loss project, our bereaved respondents made clear their interest, or stake, in the coronial process. But they differed in how they articulated this interest. The large majority of the 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. As the investigation proceeded, they formulated various hopes and expectations of what the process would or could achieve – among which, some clear patterns emerge. The hopes and expectations can be broadly

[7] Under Rule 23 of the Coroners (Inquests) Rules 2013. Since June 2022 it has, further, been possible for inquests to be held entirely in writing – under new Section 9C of the Coroners and Justice Act 2009, inserted by the Judicial Review and Courts Act 2022.
[8] Under Section 7 of the Coroners and Justice Act 2009, a jury is required where the inquest 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. A jury inquest can also be held if the coroner deems there to be 'sufficient reason for doing so'.

categorised as follows:

- that the process would provide answers about the death – perhaps extending beyond answers to the four statutory questions so as to capture the 'truth' of what happened;
- that lessons would be learnt about failings which had caused or contributed to the death, leading to action to prevent future deaths;
- that the identification of failings would, more broadly, be part of a process of achieving justice for the deceased and accountability for the death.

With regard to each broad type of expectation, more respondents spoke of being disappointed than of being satisfied with what transpired – as we detail below.

2.1 Answers

We noted above that the core statutory purpose of a coroner's investigation is to answer a specific set of questions about the death. For some of our bereaved respondents, the 'answers' they expected from the process were forthcoming; moreover, they felt that this had assisted them as they continued to grieve their loss. These respondents included a bereaved aunt who said that the inquest 'answered a lot of unanswered questions, just about, not entirely about "why", but certainly about "how" … So, I think, definitely, that was helpful.' Similarly, a bereaved partner commented, 'How do you call it? Relief. That was great. I'm still dealing with some things, but the inquest part is closed and some questions are answered.' Another respondent, a bereaved mother-in-law, emphasised that she had valued the coroner's rigorous pursuit of explanations, even if all the answers did not emerge:

> "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**

A mother similarly spoke of finding the process 'really healing' because, even though no answer was forthcoming to the question of what had caused the fatal road accident in which her daughter died, it was important that 'this was taken seriously. This was something as a society, as a community, we were looking into'.

However, many more of the bereaved respondents said that the questions they wanted answering were not satisfactorily – or at all – addressed. 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 the lack of answers on apparent defensiveness of state bodies implicated in the death, and the coroner's lack of commitment to tackling this: '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 -?'***" **- Mother**

For some respondents, any supposed 'answers' provided by the coronial process were never going to extend beyond what they already knew:

> "The purpose of my brother's inquest was to check that he wasn't murdered – of course he wasn't murdered. Why did my brother have an inquest? We needed to know that he died and that he killed himself, I suppose, [but] I mean we all knew that." **- Sister**

> "Somebody had said to me that the inquest might give us some answers. I was a little sceptical all the way along because I'm not entirely sure that there ever are going to be any answers, other than that the man [whose driving caused the fatal accident] really needed a pizza. I don't think that the inquest was illuminating in any way, shape, or form." **- Mother**

And for others, the questions that were most troubling simply did not have answers – as for the father whose son had died by suicide: 'You are thinking, why? That's the question all the time – why, why, why? We wanted to know why'. Similarly, a mother whose son died in a drug-related death commented: '[The coroner] cannot provide answers as to why the death happened, which is the question which haunts me daily. So having an inquest serves no purpose'.

On the other hand – illustrating the hazards of generalising about individuals' responses to traumatic bereavement – one respondent spoke forcefully about how she had benefited from a coroner's conclusion that left the main question unanswered. Her long-term partner had died in a fire in his car, in which he had been sleeping for a few days. It was initially assumed that he had deliberately set fire to the car with the intention of taking his own life. At the end of the inquest, however – which was conducted in a 'dignified, sensitive, inclusive' way and was 'beautifully managed' – the coroner recorded an open conclusion because it had become apparent that the fire could have started accidentally. The respondent explained:

> "We all know there's no closure, so I would never say it was closure. For me, it was transformational … The most transformational bit, certainly, was the verdict because, for eight months, I was being told by the police, by the coroner's [officer], 'He killed himself. Cut and dried.' … So I think, for me, the fact that it was an open verdict was transformational. Not in my grief, but in the fact it wasn't definitely suicide. It just made the whole thing different. He'd still died in a horrendous way, but to think that somebody had definitely lit a match and set himself alight was different from he was sitting in the van at two in the morning and he had a candle. He, obviously, loved candles. I knew he would get candles. That it was accidental, maybe. Who knows?"[9] **- Partner**

[9] This inquest was held after the standard of proof applied by coroners to determinations of suicide was changed from the criminal standard of 'beyond reasonable doubt' to the civil standard of 'on the balance of probabilities'. This change resulted from the High Court case of *Maughan* [2018] EWHC 1955 (Admin), and was thereafter confirmed by the Supreme Court.

2.2 Learning and prevention of future deaths

We have noted above that the coroner's preventive role is set out in statute, and that the main mechanism by which this role is performed is the Prevention of Future Deaths (PFD) report. Typically, around 1-1.5% of inquests lead to the issuing of a PFD report, with 569 having been produced in 2023.[10] Chief Coroner guidance (2020) makes clear that a PFD report 'raises issues and is a recommendation that action should be taken, but not what that action should be'. Recipients of a report are required to respond in writing within 56 days, although there is no sanction for non-response, nor oversight of any actions that may (or may not) follow.[11] PFD reports are public documents, and there is a presumption that they, and responses to them, are published by the Chief Coroner.[12]

The large majority of bereaved people interviewed for Voicing Loss believed that failings by state or other bodies – most often, providers of health and social care services – had caused or contributed to the death. In this context, many emphasised that their overriding hope for the coroner's investigation was that it would give rise to learning and preventive action. 'That's what all the families want: they want lessons to be learnt,' said one bereaved sister. Otherwise, she added, 'What's the point of inquests? Because they're not going to prevent other deaths'. Another sister, speaking about the death of her brother during a psychotic episode when he was a hospital inpatient, commented:

> "If you're going to engage with an inquest, the aim of it is that you want to make sure that the problems that led to the person who you loved died, doesn't happen to someone else. … Every single family, every family that I have talked to, who have gone through something similar, that is what they want. Then you feel like it's not in vain. Why [otherwise] put yourself through this gruelling process?" **- Sister**

Only rarely did respondents report on progress made towards prevention. One such respondent was a mother whose son had died by suicide after his employer had abruptly suspended him. In a written contribution to our project, she explained that the 'very sympathetic' coroner had recognised that her son's employer had not adequately supported him when they suspended him from the job that was 'his whole life'. Although no PFD report was issued, the mother – with permission – fed back the coroner's findings to the employer, who changed their practices in relation to suspension as a result. This was of real significance to the grieving parents:

> "I wanted some acknowledgement that the manner in which my son's employer acted directly led to my son's death. The coroner's inquest helped with that and in some part helped our family come to terms with losing our precious son. We have been able to make a small difference with HR and employment practices. That has been a comfort, if only a small one." **- Mother**

[10] Ministry of Justice (2024). The Preventable Deaths Tracker, accessed on 19.5.24, noted that over 4,900 PFD reports had been published on the judiciary.uk website since July 2013, equating to an average of 463 per year, https://preventabledeathstracker.net/trends-over-time/. The Preventable Deaths Tracker provides a wide range of other information on PFD reports, including a breakdown of reports by category.
[11] The lack of oversight of PFD reports is a subject of wide debate; it is addressed, for example, by a campaign for a National Oversight Mechanism launched by the charity INQUEST in July 2023, https://www.inquest.org.uk/no-more-deaths-campaign.
[12] See Chief Coroner (2021b).

We heard about another suicide which followed suspension from work – in this case, the young man who died was a police officer. Here, too, there were inquest findings which were, in the father's words, 'damning' of the police force and the absence of proper welfare provisions. The PFD report issued by the coroner was direct and highly critical: 'We couldn't have asked for anything better'. In terms of achieving change, the PFD report had 'done a bit [but]… nowhere near enough, in my view'.

But many more respondents were dissatisfied than were satisfied with the coroner's efforts to draw lessons from the death. 'Nothing has changed' was a frequent refrain, as voiced by four mothers:

> "We hoped that something would change, but nothing did … because they got away with it, didn't they - they got away with it." **- Mother**

> "The people are still there and doing exactly the same thing, two and a half years later." **- Mother**

> "They've done nothing, they have learnt nothing from [my son's] death, because lots more young people have died." **- Mother**

> "As far as I'm concerned, absolutely nothing has been done as a result of him dying." **- Mother**

Failings with regard to prevention were attributed by some to the narrowness of coronial investigations: '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' [sister]; '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]. But a particular focus of disappointment was the PFD report. For some respondents, a PFD report was something to fight for and offered much promise, but the reality then fell short when the content seemed weak: 'wishy-washy … not a robust plan', according to one mother; or, as a father said, 'like slapping them with a wet lettuce leaf … a child could've written [it]'.

If the content of PFD reports was disappointing for some respondents, there was greater disillusionment when the lack of oversight and enforcement of subsequent action became apparent. Echoing others who rhetorically asked 'what's the point' of an inquest that does not lead to change, a mother said, during a group interview on deaths in prison or police custody:[13]

> "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]; I'm sure your loved ones are not the first to die in police custody… So it makes you wonder: what was the point of the whole thing that you're going through?" **- Mother**

The sense of disillusionment in relation to PFD reports was expressed with particular vividness by two parents whose experiences are set out in Box 2.1.

[13] This discussion was part of a Family Listening Day facilitated on behalf of Voicing Loss by the charity INQUEST.

Box 2.1: Disillusionment regarding PFDs

Adam's[14] 19-year-old son, Ivan, was at university and struggling with his mental health when he died from suicide:

Prior to the inquest, Adam and his wife:

> "... heard that there was something called a Prevention of Future Deaths notice, and it was something that we felt might be a good outcome from the process, so we made it known quite early on that that's what we wanted to do."

The coroner wrote a PFD report which was sent to various bodies concerned with higher education. Adam described his feelings at the time:

> "we came out of the court, punching the air, like it was some kind of victory, at a time when you've just lost a son. But you'll hang onto anything that ameliorates the pain. And so it did for a period of time until you realise: well actually, nothing is changing."

Today, his feeling about the PFD is:

> "What a shame that everyone succeeded in achieving the aims of the inquest and nothing got done because the arrogant ministers who received the letter pushed it down to some pen-pushing civil servant, who then farmed it out to a policy guidance organisation who then wrote some stuff that never got done. ... Shame on us.
>
> 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 families or parents going on TV to say, 'I'm doing this thing because I want it to avoid future deaths'."

Yet, Adam's personal quest for change continues, several years after the inquest into his son's death, because 'you seek for a meaning from the loss, and the meaning is gained by involving yourself in something that you think might make a difference'.

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Vivienne's 20-year-old daughter, Kara, died from suicide at the age of 20, while she was in a mental health crisis. At the end of a lengthy Article 2 inquest, at which Vivienne was legally represented, the coroner issued three PFD reports aimed at health trusts and other bodies. She told us:

> "I wasn't expecting any [PFD reports]. I was chuffed that we managed, that we got three, because we weren't expecting any. I felt that [the coroner] nailed the issue in legalese, sort

[14] All names are pseudonyms.

of thing. He might not have phrased it how I would have phrased it, but I was coming from an emotional perspective and he was coming from a legal perspective, so I was happy with them. I thought they were good.

I had a moment where I thought that actually something might happen as a result of them and that they would have some impact … but, of course, it hasn't, and they haven't."

Vivienne requested, and received, feedback on responses to the PFD reports – and found that little had changed.

"I know that, almost a year after Kara died, a young girl died under almost identical circumstances."

She then came to a bitter realisation:

"Then I realised that if I'm standing in the trust's crisis centre, talking to the chief person when Kara was alive – begging for their help to save her life – if they didn't listen to me then, they're not going to listen to me now she's dead, unless it impacts their funding or their job. They responded enough to secure that, but no more.

It was at that point, when I read the responses to the reports, I thought: 'Enough. Enough.' And I just let it go because I ran out of fight."

2.3 Justice and accountability

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.

"I needed more than answers. I knew what the answers were, in some senses. But I needed accountability." **- Mother**

"[The coroner] gave a lot to saving future lives [but] 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." **- Mother**

Respondents did not define the broad concepts of 'justice' and 'accountability', and expressed mixed views about whether or how the coronial process could deliver them. Among a small number who spoke of positive experiences in this regard was the mother quoted above who 'needed more than answers'. Her son had had a developmental disorder and died at the age of 13, and the coroner identified a range of serious shortcomings in the education and health provision that had been made available to him. The mother was hopeful that this exposure of failings that were 'causing children to die' would have 'far-reaching consequences', and said it allowed her to feel that she was in the process of 'getting justice'. She told us that, moreover, 'I found peace in that inquest, strangely … because I

could see everything, or pretty much everything, was uncovered'.

Another mother was relieved that the inquest had 'made accountable' a health trust and local authority for their failures to respond properly to her daughter's 'spiralling' problems of mental illness, addiction and homelessness, which eventually led to her suicide at the age of 26. The state bodies had adopted a highly defensive stance during the inquest, but were effectively challenged by the coroner, with the result that the mother 'felt I was honouring [my daughter]' and that 'all the issues I had raised were vindicated'.

But while a few of the bereaved respondents felt that – at least to some extent – justice or accountability had been delivered, many more regarded these outcomes as unachieved or even unachievable within the coronial process. Respondents often attributed this to imbalances of power in a system which systematically (whether deliberately or not) protected the interests of state bodies and dismissed their own concerns about how those bodies had failed the deceased.

> "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**

> "I'm going down a very dark path that gets narrower and narrower now … 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**

> "It was just total bias towards the services, making sure they got the right outcome, and closing it down and sending us away." **- Mother**

> "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?' It felt like people always keep forgetting that we are the victims in this." **- Sister**

For some respondents who found a sense of justice – for themselves or for the deceased – to be out of reach, the problem was not so much their powerlessness vis-à-vis state bodies, but a powerlessness inherent in their situation as grieving individuals. This was powerfully conveyed by a mother who was still reeling from the shock over her son's suicide at the time of the inquest, five months later.

> "I think I was probably in shock … I was really shaking, I was feeling very sick, I wasn't good at all. … I just kind of went along with whatever I was told, so I didn't fight … I didn't really know what was expected of us, and it wasn't until the day that I thought: actually, I don't think we did him justice, and that's a horrible thing to come away [with] … I was so weak that day. I wasn't myself at all. I literally can remember barely being able to speak; I was so quiet. No, like I said, I don't think I did [my son] justice that day at all." **- Mother**

Some comments focused on the difficulty of achieving justice when the coronial process explicitly rules out the apportioning of blame:

"I didn't feel I got to a 'judgment'. That won't come across in the tape: I'm doing inverted commas in the air... 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**

"No one is the winner. 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**

A young woman whose father had died in hospital following a serious incident of self-harm spoke of wanting to feel that she was 'doing my dad justice'. She had found it 'validating' when the coroner pointed to the poor care provided by the hospital and said the death was preventable. She fully understood that assigning blame was outside the coroner's remit, but acknowledged finding this difficult: 'The bit of you that's still relatively raw and grieving wants there to be more of an element of punishment.' And she was angry with a family friend who had misunderstood the purpose of an inquest and had thereby, in her view, jeopardised her chances of influencing the outcome:

"My uncle, he brought along a family friend who had a bit of a legal background in something, and she was just like, 'Okay. So, we're going to court next week to establish that there's been wrongdoing and guilt.' I was like: That's not what an inquest is ... That's really unhelpful. Stop embarrassing me in court – I'm trying to look like a serious person... If we look like we don't have our shit together, excuse my French, then we're not going to be taken seriously... They're going to write us off as kind of grieving cranks, and I don't want to be a grieving crank. I want to be a grieving, serious, relatively intelligent person, who is asking proper questions that should be answered." **- Daughter**

A mother-in-law recounted an anecdote which neatly exposed divergent expectations – in this case, among the professionals – on the accountability function of the coronial process:

"There was one hilarious point, when the barrister for the mental health trust, who seemed to be about 12 and was useless – right at the end, after the narrative verdict. Just as the coroner was about to take a deep breath and say she was going to write a prevention of future deaths report, this barrister stood up and said, 'Please don't judge us'. And the coroner looked literally down her nose at this young woman and said, 'It's my job.'" **- Mother-in-law**

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 whose adult son, who had learning and other disabilities, had died in a care home following an epileptic seizure. She was 'absolutely devastated' that the coroner, in finding that the death was from natural causes, had not identified failings in the care provided to her son. Box 2.2 sets out the experiences of two other respondents who spoke out passionately about losing the faith they once had in the institutions of the state.

Box 2.2: Loss of trust

Luke's stepson had died from suicide after struggling with a gambling problem for many years. Luke described providing as much information as he could to the coroner, in the belief that this was his 'civic duty' and that the inquest would scrutinise the factors underlying the suicide.

In the event, the inquest hearing was short and cursory, and only the briefest mention was made of gambling. Luke told us:

> "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...
>
> "My God, I'm just an ordinary guy, who's been a normal citizen for years. But I see this sort of thing where we just don't get anywhere, and stuck in it, whether it is Grenfell, or all the way that the Manchester bombings were handled... And I am getting very, very disappointed in, not society, but the way that society is governed and so on, and the way that things happens."

****

Eva's husband, Louis, was a long-standing member of the armed forces when he died from suicide at a time when he was facing significant pressures relating to his military role. To Eva's surprise and anger, the coroner attributed the suicide to mental health issues and problems stemming from Louis' childhood, and not to the work pressures. The coroner based this conclusion on the findings of a Ministry of Defence (MOD) internal investigation, shattering Eva's trust in the law:

> "I had total faith in objectivity and the law, the law being ... based on fact. This coroner took an internal document, a self-serving, internal examination of so-called facts, with no objectivity – he took this whole document. And what should have been an equal opportunity for me as well, to evaluate and propose my side of it, was completely lost... It was the beginning of realising that institutions aren't always as equal as they should be... You know, this stuff happened to me, and I was fighting for the truth... It's hardly fair, is it?"

Reflecting on what should have happened at the inquest, Eva said:

> "It's only a question of looking at facts... You know, it's not a big deal. You don't have to be Recorder of London – you don't have to be the top barrister in the land to actually just look at facts and see if they are facts or not... Just do your job properly, that's all.
>
> I looked at the British system, systems and institutions, and I certainly believed that the MOD – I believed in the MOD, otherwise I wouldn't have given it my service and my life, 20 years of life. And now I don't. No. And if I had anything to do with the law or the coroners [again], no, I don't trust them. Absolutely not."

3. Professional perspectives

The most striking aspect of the bereaved respondents' accounts of what they had expected from the coronial process is how often those expectations were unfulfilled – and the distress, frustration and mistrust that resulted. Our interviews with coronial professionals offered various perspectives on this apparent mismatch between expectations and practical realities.

A number of the professional respondents alluded to practical obstacles which impede effective delivery of the coronial service – with knock-on effects on bereaved people's experiences and (dis)satisfaction. Resource constraints, and particularly shortages of coroners' officers and administrative staff, were widely regarded as foremost among these obstacles, with repercussions said to include exceptionally high officers' caseloads, frequent and lengthy delays to all stages of the investigative process, and poor communication with bereaved people about case progression and evidence. Respondents also commented on high turn-over of coronial staff; the complexity of staff management arrangements (with coroners, as judicial appointees, not having line management responsibility for local authority- and sometimes police-employed coronial staff); and, in many areas, limited facilities for hearings. Wider contextual factors were said to include a chronic shortage of pathologists and the general pressures on local authority finances.

Beyond the concerns with practical obstacles to delivery, two main strands of opinion emerged from professionals' comments about the capacity of the coroner service to fulfil bereaved people's expectations. First, it was argued while the service is successful in meeting the needs of most bereaved people, some expectations are not fulfilled, primarily because they are uninformed or unrealistic. Thus, tackling any problem of 'mismatch' largely depends on expectation management. The second strand of opinion focused on systemic imbalances within the coronial process itself. From this perspective, the process's inherent inequities and inconsistencies are what primarily prevent the fulfilment of bereaved people's hopes and expectations of it.

It is simplistic to suggest that our professional respondents were necessarily aligned with one or other of these two strands of opinion: many individuals expressed views combining elements of both. However, in broad terms, a distinction can be drawn between respondents who emphasised unrealistic expectations, and those more concerned with systemic imbalances within the process. The former were predominantly coroners, coronial staff, lawyers representing state bodies, and Coroners Courts Support Service (CCSS) staff and volunteers; the latter made up a smaller sub-set of the professional sample, largely comprising family lawyers and individuals attached to support or campaigning NGOs (excluding the CCSS).

3.1 'Unrealistic expectations'?

An assistant coroner, who also represents state parties at inquests, described the varying expectations of the coronial process: some 'just want it to be over'; some 'want to use the process as a means of establishing that it won't happen to anyone else'; some 'want to come face to face with the people they hold responsible and to make them feel uncomfortable'. Expectations are disappointed, he said, if bereaved people have questions 'that can't be answered within the limited scope of an inquest' – for example, where there are concerns about hospital care that are not pertinent to the cause of death, in which case, 'We have to disappoint them and say, "I understand your concerns, but we can't go there"'.

A number of professional respondents emphasised that bereaved people may not receive the answers for which they are searching because the required evidence does not exist: 'I think, families seem to think that we can somehow persuade, and … unlock a magic store of information, which simply isn't there in a lot of cases' [lawyer for state bodies]. Or because, more fundamentally, there are no answers. Some of our bereaved respondents spoke of how their most anguished questions were never going to be answered; such as the father bereaved through suicide whom we quote above as saying: 'That's the question all the time – why, why, why?'. But some professional respondents spoke of bereaved families who struggle to accept that the coroner cannot provide the answers they want most of all:

> "I think you can … understand why [after a suicide] there are senses of guilt and senses of, 'Why has this happened?'… Ultimately, the coroner … can't often really ever answer those questions for the bereaved person, and relieve them of that sense that they are feeling, that severe grief reaction… I think those families will always tend to feel that the coronial process has not been good enough for them." **- Lawyer for state bodies**

> "If people don't want to hear something they are not going to hear it. It really doesn't matter how many times you tell them. You can say it's the who, where, when and how and not the why, but they'll always still be there asking us, particularly in cases of suicide, 'Why? Why? Why?"
> **- CCSS volunteer**

According to many professional respondents, the greatest source of disappointment and frustration for some bereaved people is the fact that coroners are unable to apportion blame for a death – an aspect of the coronial process that is often poorly understood:

> "For some of them - … you know, blame, blame, blame. A lot of misunderstanding, a lot of anger. And anger at us for even asking what their name is, when they go in, because they are so het up about coming to this strange place." **- CCSS volunteer**

> "It's not about the blame game or the accountability arguments, all the time… Some inquests can become quite tense because either the coroner or the coroner's officer haven't got the message across at a pre-inquest review, that it's inquisitorial, it's fact finding: 'This is what we're going to do. These are the boundaries; this is the scope. These are the witnesses. We can do this, but we can't do that.'" **- Coroner**

Professional respondents sometimes linked expectations around blame to wider societal factors:

'We live in a blame culture, don't we. Whatever happens, there is almost no such thing as an accident now' [CCSS volunteer]; 'It's just a society thing: it's expectation, blame, not accepting what people say, challenging everything, challenging every decision' [coroner's officer].

Respondents also linked what they deemed to be 'unrealistic' expectations on the part of some bereaved people to the overwhelming nature of the grief they may be experiencing – or what one respondent described as 'bereavement pathology':

"Part of [some bereaved people's] bereavement pathology – not their healthy bereavement… – is to feel somebody else must be responsible and therefore I need them to come and answer for it. Sometimes it's not bereavement pathology: it's true, there are significant questions to be asked of a public body and it's very proper that it should be explored. As a coroner, I manage lots of different bereaved. Some who have realistic expectations; some who have wholly unrealistic expectations; some who have a realistic complaint but it's not something that coronial process can help with." **- Assistant coroner/lawyer**

"[Some bereaved people have] what one might say are much more extreme or unreasonable responses, whereby there's something else playing out: whether it is grief, which is completely understandable as well, or just a sense of wanting someone to be made to be responsible in a way that isn't always appropriate… You do see, if I'm putting it bluntly, that sometimes [grief] is what is driving the process as opposed to an understanding or wanting to take part in what the legal basis for the inquest is." **- Coroner**

Professional respondents made frequent reference to the importance of 'managing expectations', as illustrated by the quotations in Box 2.3.

Box 2.3: The need to 'manage expectations'

"The lawyer has a responsibility to manage the expectations of their families. If the families think it's about naming, shaming, blaming, having somebody disciplined – using it as a prelude to litigation – then they can forget that: it's an inquest. It's a fact-finding inquiry." **- Coroner**

"So, we do manage their expectations because the scope of an inquest can be very limited, as to what they might expect." **- Coroner**

"I think it's trying to manage their expectations, that this is just to find out what's happened, not blame anyone." **- Lawyer for state bodies**

"Although I've said that the family's interests should be… the aim, there still does need to be that kind of managing of expectations. The inquest isn't necessarily going to provide them with every answer that they want." **- Lawyer for state bodies**

"So sometimes it's about finding a balance of letting them get off their chest what they need to, and then managing their expectations." - **Coroner's officer**

"And it is managing expectations in those circumstances [where family are angry] which is perhaps the most difficult for the coroner, and the coroners' officers" - **Coroner's officer**

"So for us it is really important that we are able to support people right from an early stage, that we can manage those expectations … and explain what the remit is and what it isn't " - **CCSS staff**

Some respondents commented on features of the coronial process – particularly, that inquests are judicial proceedings played out in a 'court' – that may encourage the erroneous perception that this is an adversarial process which involves some attribution of blame. A lawyer who represents state bodies said that families 'think that they're going to get their day in the Coroner's Court to get all of their questions answered'. A coroner's officer said, 'the word, inquest, I always find, puts a bit of a strain on families, because a lot of them think something's been done or someone is to blame'. Some coroners noted the ambiguity of the term 'justice' and the consequent scope for misunderstanding:

"In perhaps a large minority of cases there are expectations that justice will be done. That's a funny phrase, isn't it?... It's very subjective as to what justice would be." - **Coroner**

"I've heard a lot of bereaved people say they want justice for their deceased relative. I have to say, I was a little bit wary about that, because sometimes what they mean by that is, they want to blame somebody else for the death... I do try and say in the inquest, if they say that to me, 'Look, justice isn't on behalf of the person, it's a concept that everybody is entitled to.' Yes, so I worry about them using justice as a sort of, 'We want it to go our way'... To me, [justice] means fairness to all parties." - **Assistant coroner**

Another coroner was explicit in stating that the delivery of 'justice', in the terms that the bereaved often understand the concept, is not the primary purpose of an inquest:

"You'll sometimes hear the word 'justice' used – you know: 'We want justice for our loved one, the way they were treated was awful.' Well, they're not going to get 'justice' in an inquest; they're going to get facts." - **Coroner**

In this last quotation, we see the clear articulation of a theme running through much of what our professional respondents said: that is, that the coronial process can provide certain objective 'facts' about the death, but these will not always align with bereaved people's subjective interpretations of what caused the death or what should be the consequences. A coroner's officer commented: 'You don't want people to come to an inquest with an idea that they're going to get anything more than what the facts of the case are'; while a coroner emphasised that bereaved people benefit from learning about the 'facts' at the inquest even if they do not accept them:

"[The family] are getting those actual facts… that open and honest information… They're not necessarily going to like it; they may not agree with it; and of course, as much as we say it's 'open and honest information', if they don't agree with it, they might say: 'That's not honest information.' But they are getting those actual facts." - **Coroner**

3.2 Systemic imbalances

Among the professional respondents who spoke about systemic imbalances within the coronial process, a particular consideration was what they perceived to be the marginalised or unequal status of bereaved people vis-à-vis interested persons and witnesses from state organisations. Reflecting wider policy debate, an aspect of this was said to be families' limited access to legal representation for inquests, which means there 'isn't a level playing field' with state bodies which 'go into defence mode [and] lawyer up' [family lawyer].[15] On the theme, again, of understandings of 'justice', a coroner commented that 'it must be very hard for a family, who won't feel justice is being done if a load of silks [King's Counsel lawyers] sit on the other side, and they are on their own'.

There was also discussion of more general marginalisation of bereaved people, beyond the issue of legal representation. The coronial process was criticised for routinely shutting out families' questions and concerns:

"Coroners are still very powerful. Although there's a lot of European legislation, human rights legislation, human rights case law; although there's lots of human rights case law that says that families ought to be at the centre; it's as if we've had to drag coroners kicking and screaming to recognise the rights of families on just very simple things, such as disclosure." - **Family lawyer**

"All the bereaved families say to me, 'No one is listening to us. No one is accepting what we're saying'… What the bereaved family get is, 'Look, you may say that, but that's not the purpose. The purpose of the inquest proceeding is to establish how somebody died, when they died and all the rest of it.' Already the family say, 'This is not our process. This is not seeking to get where we think we want to be.'" - **Family lawyer**

A journalist and campaigner described as 'performative scrutiny' the way in which 'we perform an investigation or a question or a hearing or some sort of scrutiny so that people feel that we have got answers', rather than 'wanting to really get to the bottom of everything'. For many families with whom she is in contact, she said, the coroner's investigation seems to be

"one of many processes that are designed to exhaust a family and give them the sense that they have done enough now. 'There, there. You have asked your questions and we have done our best to get you the answers.' Coroners often say, 'We tried to get the answers you need.' And I think: 'Oof. Is it enough to *try*? Are we saying the process of *trying* is enough?'" - **Journalist/campaigner**

[15] Government advice, as set out in the Ministry of Justice *Guide to Coroner Services* (2020), is that 'You do not need a lawyer to attend or participate in the inquest'; accordingly, it has long been difficult for bereaved families to access public funding for legal representation. However, non-means tested legal aid has been made available for Article 2 inquests since January 2022, following a campaign by the charity INQUEST and the 2021 House of Commons Justice Committee inquiry on the Coroner Service.

The result, she said, is the problem of mismatch: 'The massive, massive distance and gap between rhetoric and reality. Between what we say the inquest is for and what we then enact in our daily representations'. Similarly, a representative of a campaigning and support NGO said that there is a vast gap between families' hopes for a process that will be 'truthful, candid, transparent, accountable', and the 'sad reality [involving] … the closing down of access to information, the lack of disclosure, the adversarial processes, the lack of candour, and everything that becomes obstructive'.

Inconsistencies in coronial practice – often regarded as an inevitable feature of a system which grants coroners, as judicial officers, wide discretion in all decision-making – was a focus of criticism. The phrase 'postcode lottery' frequently recurred, with respondents drawing attention to disparities in determinations of scope of inquests and whether to engage Article 2. A related concern was a lack of accountability of the coronial system itself. Comments from family lawyers included:

> "… it's a postcode lottery. So, I'm possibly giving different advice to one family in [area 1], against another family in [area 2]… even though the circumstances are exactly the same. Or I can have a case in [area 1] where they've ruled Article 2 isn't engaged, and a case in [area 2], where they've engaged it, on exactly the same circumstances." **- Family lawyer**

> "We're still in a scenario where it depends who the coroner is to what you're going to get by way of disclosure, by way of any arguments around Article 2." **- Family lawyer**

> "Coroners have a really wide remit to basically do what they like. They're effectively unappealable in all but the most extreme cases, and just the variety of coroners in post is alarming, frankly." **- Family lawyer**

While the lawyers for state bodies were generally much less critical of the coronial system than the family lawyers, some of the former shared concerns about inconsistency – based on similar experiences of working across many parts of the country. One such respondent commented that practice 'varies dramatically from court to court, and even from coroner to coroner within the same jurisdiction' – such that there can be marked disparities in how 'the same set of facts' are addressed in different areas. A representative of an NGO which supports bereaved people told us:

> "Somebody will die in one jurisdiction and we'll think, 'Thank God it's there, because at least we know the coroner will take it all seriously,' although a death will happen in another jurisdiction and we know we've got a battle on our hands from day one." **- NGO representative**

Some of the coroner respondents were of the view that measures such as the creation of the post of Chief Coroner in 2012 were having the desired effect of improving the consistency of coronial practice: 'We are more reined in than we used to be. There are less mavericks'. But other respondents were sceptical about this, such as an NGO representative who said that while there is now Chief Coroner guidance, this will not produce consistency if it, 'like everything else, is being interpreted in a million different ways by coroners'.

While many of our family lawyer respondents, and those in campaigning/support roles, were

outspoken in describing shortcomings of the coronial process, most of them believed that the process at least has the potential to meet bereaved people's needs and expectations. Far from describing these expectations as unrealistic or unreasonable, one family lawyer said:

> "Yes, people often say, 'Look, we know they let her down. We know something went wrong, but we love the NHS. We know no-one did it deliberately. We just want them to basically say they're sorry, and we just wanted to know what went on.' I think families are often surprisingly generous in that sense, and they actually don't have an axe to grind. They really do just want, yes, some reassurances, and … to feel they're being listened to and respected, and that their loved one is being respected posthumously."

On occasion, this lawyer explained, the coronial process does deliver what the family wants:

> "I think sometimes, in the right case, with the right coroner, with the right family who have … expectations that are aligned with what the process can do – then it can work. But that's a lot of ifs… Yes, and it can be a really meaningful, rewarding process, even with all the limitations that still apply, but just with the right person dealing with it." **- Family lawyer**

We heard, similarly, from another family lawyer who talked of bereaved people seeking 'accountability' from the inquest process, meaning 'they just want someone to hold their hands up, and say, "I'm really, really sorry this happened. We don't want this to happen again"'. This does not happen often, the lawyer said – but 'sometimes' it does. And what happens more often is that progress is slowly, incrementally, made towards preventive action:

> "One of the things I always say is, 'It's all about chipping away. And your case might just be a chip, but then the next case comes along, and adds another chip, and then another chip.' And then, eventually – I have seen it … that eventually there is some change… because of chipping away at inquests." **- Family lawyer**

According to an NGO representative, the very process whereby witnesses are questioned at an inquest, regardless of outcome, comes close to 'justice':

> "It can still sometimes look almost like justice – when you see a police officer answering really difficult questions from a family barrister. Even if there is not going to be an accountability, any misconduct or disciplinary process, CPS referral; even if there is going to be none of that, the family will at least be able to sit there and listen to those questions being asked."
> **- NGO representative**

4. Tensions and ambiguities

Deaths investigated by coroners, and the scope and nature of the investigation and inquest process, are highly diverse – as are bereaved people's expectations of what the process might deliver. In some cases, these expectations are few or none. An assistant coroner and inquest lawyer told us that generalising about what people want of an inquest is to do them a disservice; that 'not making assumptions that you have any understanding of somebody else's grief and their response to it is the important thing'. She elaborated:

> "You know, the question is, 'What does Mr Jones' wife want from this inquest and what does Mr Jones' daughter want from this inquest and what does Mr Jones' brother want from it?' Even that might be three different things." **- Assistant coroner/lawyer**

Nevertheless, there were recurring themes in what our bereaved respondents – all of whom were personally invested in the coronial process – said about their expectations. They had variously hoped that the process would deliver answers about the death; learning that would help prevent future deaths; and justice and accountability. The other recurring theme was the perceived failure of the process, in many instances, to deliver these outcomes, repercussions of which included anger, mistrust in the authorities, additional grief, and a sense that the deceased person had been let down. The overall picture that thus emerges from our interviews is of mismatch between most of the bereaved respondents' expectations and their experiences of the coronial process.

Understanding and addressing the problem of mismatch is a substantial and complex challenge. Meaningful progress towards meeting the challenge is likely to depend, in part, on structural reforms to the coroner service – and accompanying improved resourcing – aimed at enhancing the robustness, consistency and accountability of investigations, decision-making and the production of PFD reports. In public commentary and debate about the service, calls are frequently made for the further extension of publicly funded legal representation for bereaved people; establishment of a system of appeals against coroners' decisions; the introduction of a mechanism for oversight of responses to PFD reports and follow-up actions; and the creation of a national coroner service.[16]

The Voicing Loss research, with its relatively narrow focus on the role of bereaved people, has not

[16] See, for example, the report of the 2021 House of Commons Justice Committee inquiry on the Coroner Service, and evidence submitted to the Justice Committee's follow-up inquiry in 2024.

closely examined the case for, or barriers to, structural reforms to the coroner service. But our findings suggest that, regardless of whether or to what extent such reforms are implemented, there are aspects of the problem of mismatch that will continue to need attention.

Our interviews with coronial professionals, as reported above, revealed concerns about bereaved people having expectations that are unrealistic and therefore in need of tighter 'management'. There is no doubt that most bereaved people come into the coronial system with little or no understanding of it, and hence expectations – particularly at the outset – may be uninformed. As we discuss elsewhere,[17] there is a need for more extensive and accessible public information about the coroner service. Yet, our research findings also strongly suggest that more information about coroners' investigations, on its own, will *narrow* but not *close* the gap between expectations and practical realities. This is because there are inherent tensions and ambiguities in the formal functions of the coronial process that information alone cannot address.

One area of ambiguity is the distinction between the questions of 'how' and 'why' a death occurred. The four statutory questions that must be addressed by the coroner include the former but not the latter. The question of 'how', or causation of death, is generally understood in terms of conduct or circumstances which 'more than minimally, negligibly or trivially contributed to the death'.[18] However, it becomes apparent that no line can easily be drawn between 'how' and 'why' when it is considered that examination of the 'circumstances' of a death falls within the remit of the coroner – as a matter of legal requirement in Article 2 cases, and potentially in any other.

An illustration of the blurred nature of the boundary between 'how' and 'why' is provided by the recent case of Dove. Here, the Court of Appeal held that a fresh (non-Article 2) inquest should be held into the self-inflicted death of Jodey Whiting which followed the withdrawal of her disability benefits. The Court ruled that 'it is open to a coroner to record the facts which contributed to the circumstances which may or may not in turn have led to death', citing cases which demonstrate 'the wide discretion conferred on coroners to establish the background facts, and then determine whether those facts were or were not causative of death'.[19] Consideration of facts which contributed to circumstances which may (or may not) have led to the death can be said, at the very least, to stray into the territory of 'why' the death occurred.

If the how-why distinction gives rise to tension and ambiguity, so too do the concepts of 'justice' and 'accountability' in the context of the coronial process. It is clear in law, policy and guidance – and our bereaved respondents were generally well aware – that the coroner does not assign blame or liability for a death. However, this does not rule out holding individuals or organisations to account, if accountability is understood as a matter of acceptance of responsibility more broadly. As one of our coroner respondents put it: 'There's nothing wrong with families asking robust, difficult questions of witnesses who should be properly accountable.' But as with the distinction between 'how' and 'why', it is not self-evident where the line should be drawn between 'holding to account' and 'assigning blame'. This is particularly evident in the context of Article 2 inquests, where (as noted in Section 1.2, above)

[17] Principles for Practice No. 1: Information and communication.
[18] As set out in case law which is reflected in *Chief Coroner Guidance No. 17* (Chief Coroner, 2021a).
[19] *Dove* [2021] EWHC 2511 (Admin) [70].

the conclusion can be 'judgmental', but must avoid any words that suggest liability.

Also pertinent to concepts of justice, accountability and liability is the statutory obligation on coroners to produce a PFD report when they have 'a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future', and believe that action should be taken to reduce that risk. Clearly, 'concerns' of this kind do not exist in a vacuum, but are necessarily linked to systems, behaviours or circumstances that have been deemed problematic and hence may be, at least to some extent, blameworthy. There is, furthermore, a tension in relation to the level of importance accorded to the coroner's preventive role. It is widely recognised that what many bereaved people want above all is that lessons are learnt through the death investigation and that future deaths are prevented. The Coroners and Justice Act 2009 enhanced the preventive aspect of the coronial function, by making PFD reports mandatory where a relevant concern arises. On the other hand, Chief Coroner guidance on PFD reports (2020) stipulates, citing case law, that 'PFDs are important, but they are "ancillary to the inquest procedure and not its mainspring"'. The lack of follow-up and oversight of responses to PFD reports, and their relative infrequency (with an average of just 459 issued per year) underlines their 'ancillary' character.

The Voicing Loss Policy Brief No. 1: Clarifying the role and remit of the coroner, further considers the tensions and ambiguities noted above, and proposes some ways in which they could be addressed. Specifically, we propose that a joint statement of the purpose of the coroner service should be issued; that stepwise guidance on certain elements of coronial decision-making should be introduced; and that there should be wider adoption of informal approaches and use of space in coroners' courts, to underline the inquisitorial and fact-finding character of inquest proceedings. It is our firm contention that greater clarity and transparency with regard to the purpose, structure and operation of the coroner service would help to address the problem of mismatch which this research paper has identified. It would also enhance understanding of the coronial process among the general public.

In the Policy Brief we argue, further, that the endeavour to clarify the coroner's role and remit should be an intrinsic part of wider policy discussion and debate about the future of the coroner service. As the Chief Coroner (2024) has recently observed:

> "... it would be beneficial for the role of the coroner service to be better understood and, where necessary, more clearly defined, so that policymakers can give informed consideration to how it should be structured and resourced to make its purpose achievable."

References

- Chief Coroner (2020) Revised Chief Coroner's Guidance No.5: Reports to Prevent Future Deaths, November 20, 2020
- Chief Coroner (2021a) Chief Coroner Guidance No. 17: Conclusions – Short-Form and Narrative, September 7, 2021
- Chief Coroner (2021b) Prevention of Future Deaths Reports: Publication policy, September 9, 2021
- Chief Coroner (2024) Extraordinary report of the Chief Coroner: The coroner service 10 years post-reform, Courts and Tribunals Judiciary
- House of Commons Justice Committee (2021) The Coroner Service: First Report of Session 2021-22
- Ministry of Justice (2020) A Guide to Coroner Services for Bereaved People
- Ministry of Justice (2024) Coroners statistics 2023: England and Wales, updated 10 May 2024

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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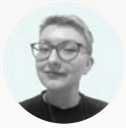

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