Voicing Loss

Research Context and Methodology

The Voicing Loss project on the role of bereaved people in the coronial process

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This paper sets out the context and methodology of 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.

The Voicing Loss research team gratefully acknowledge the help and support of many individuals and organisations.

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1. Introduction

The Voicing Loss project examined the role of bereaved people in the coronial process in England and Wales. The project was conducted by the Institute for Crime and Justice Policy Research at Birkbeck, University of London, and the Centre for Death and Society at the University of Bath, with funding from the Economic and Social Research Council.

The origins of Voicing Loss lay in the researchers' long-standing interest in what it is like for members of the public to participate in court hearings and other judicial proceedings.[1] We were aware that participation by bereaved people in coroners' investigations and inquests was a subject that had hitherto received limited attention from academic researchers in England and Wales. An in-depth empirical inquiry thus seemed overdue. This was all the more important in light of reforms to the coroner service (contained in the Coroners and Justice Act 2009 and implemented in 2013) that had sought to improve the treatment of bereaved people and to locate them 'at the heart' of the service.

The purpose of this paper is to outline the policy context and aims of Voicing Loss, to provide a brief overview of some of the existing research pertinent to the project, and to describe the study methodology and samples of respondents.

Many findings of the research, and their implications for policy and practice, are presented in a series of project outputs, as listed in Section 5 of this paper. These outputs and further information relating to Voicing Loss are available at www.voicing-loss.icpr.org.uk.

[1] For example, Jacobson et al. (2015); Jacobson and Cooper (2020).

2. Context and aims of Voicing Loss

Coroners are independent judicial officers. They are appointed by the local authority and supported by coroners' officers and other members of the local coroner service. Their primary statutory duty, under Section 1 of the Coroners and Justice Act 2009 (CJA), is to investigate 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.

2.1 Functions of coroners' investigations

As set out in Section 5 of the 2009 CJA, the coroner's investigation must seek to determine who died and how, when and where they died. The final stage of the investigation, where needed,[2] is an inquest: an inquisitorial, fact-finding hearing, generally held in public, and sometimes with a jury. Around 200,000 deaths are reported to the coroner each year, and well over 30,000 inquests are held.[3]

If the state or a public body is implicated in the death, the coroner has a duty to undertake an enhanced investigation which must consider not only 'how' the person died but also 'in what circumstances' the death occurred (s.5(2)). This reflects the state's duty to conduct an effective investigation into deaths which may have resulted from failures to protect the right to life under Article 2 of the European Convention on Human Rights (ECHR). However, the central purpose of what are commonly referred to as 'Article 2 inquests' remains fact-finding: the coroner (or jury) cannot assign blame or liability for the death.

The coroner's statutory role has a preventive dimension, under Schedule 5(7) of the 2009 CJA. The coroner must provide a report – generally known as a Prevention of Future Deaths (PFD) report – where an investigation raises concerns about issues that may, in the future, lead to further deaths and the coroner believes action should be taken to reduce the risks.[4] PFD reports are public documents, sent to individuals or organisations in a position to take action to reduce the identified risks. Recipients are required to send a formal response to a PFD report within 56 days.

[2] An investigation can be discontinued before the inquest if a natural cause of death has become clear and the coroner deems it unnecessary to continue the investigation. However, an inquest must be held if the if the cause of death remains unknown, the death may have been violent or unnatural, or if the person died in prison or other form of state detention.
[3] Since June 2022, it has been possible for inquests to be held entirely in writing (section 9C of the Coroners and Justice Act 2009, inserted by the Judicial Review and Courts Act 2022).
[4] The procedures applying to PFD reports and responses are set out in Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. PFD reports are also sometimes known as 'Regulation 28 reports'.

By addressing the core questions of 'who', 'how', 'when' and 'where' in relation to certain kinds of death, coroners' investigations thus serve multiple purposes. These include the essentially administrative function of ensuring that there is an accurate record of deaths. This, in turn, supports effective public health surveillance and interventions.[5] Coroners' investigations are expected to bring to light institutional failings which caused or contributed to past deaths, and – through the mechanism of the PFD report – help to mitigate risks of future deaths. The coroner also has a critical part to play in strengthening the state's compliance with its Article 2 (right to life) obligations.

A further perceived purpose of the coronial process, which has become increasingly prominent in policy and practice discourse over the past two decades, is that of addressing the concerns and needs of the bereaved. In his *Extraordinary Report* (2024: 4), the Chief Coroner, HHJ Teague, included the following within a short list of 'important functions' fulfilled by the coroner service:

> "providing bereaved families with answers as to how their loved ones died with the assurance that an independent judicial process has investigated any relevant concerns."

The Chief Coroner's perception of the coroner service as providing – among its other functions – a service that helps the bereaved appears to be widely shared by coroners. The 2020 Coroner Attitude Survey, in which around 90% of all 403 coroners in England and Wales took part, found that:

- 91% of respondents identified providing answers to the families and the public as to how the deceased died as one of the most important functions of the coroner;
- 70% identified facilitating closure for families as one of the most important functions;
- 94% agreed that the inquest can be a cathartic process for families and others involved a death;
- 88% believed it is appropriate for a family member to provide a pen portrait of the deceased when giving evidence

(reported by McGuinness, 2023).

2.2 Policy shift and an emerging research agenda

The 2000s saw growing awareness of systemic failings in processes of death investigation, including in terms of treatment of bereaved people. The growing concerns about poor treatment of the bereaved echoed developments in criminal justice policy which, since the early 1990s, had seen the introduction of measures intended to enhance the role and rights of victims within the prosecution process.

Failings in death investigations were highlighted by several government reviews and inquiries,[6] and ultimately led to the reforms contained in the Coroners and Justice Act 2009. The policy shift towards a focus on the bereaved is evident in the formulation of these reforms. For example, in 2004 a Home Office 'position paper' noted, 'Central to the changes we are proposing is the need to make the system sensitive to the needs of the bereaved' (2004: 2012). Two years later, the Foreword to a draft Coroners

[5] The new national medical examiner system, currently being rolled out across England and Wales, further supports public health analysis.
[6] Official reviews include those of Brodrick (1971), Davis et al. (2002), Luce (2003), Smith (2003), the House of Commons Constitutional Affairs Committee (2006).

Bill (which was superseded by the Coroners and Justice Bill) referred to the 'vital task' that coroners have in 'giving certainty and re-assurance to bereaved people' (Department for Constitutional Affairs, 2006: 3).

In due course, the 2009 CJA included measures to clarify and enhance the participation rights of family members at inquests, and those of other 'interested persons'. These include the rights to be told the dates and details of inquest hearings; to receive documents and evidence that may be considered at the inquest; and to question witnesses at the inquest. More broadly, government stated that one of the main aims of the Act's coronial reforms was to put the bereaved 'at the heart' of the coroner service.[7] This policy aspiration to locate the bereaved 'at the heart' of the service has since been reiterated by government as well as by successive Chief Coroners.[8]

The bereaved family's centrality might even be seen as a defining characteristic of the contemporary inquest, according to legal academic Kirton-Darling. He observes that:

> "Where the historical inquest saw the community gathered metaphorically, if not actually, around the body of the deceased, the contemporary inquest can be understood as gathering around the family, their involvement represented as critical in achieving a process and outcome which contains the possibility of going beyond the mere technical identification of cause of death. The provisions requiring their involvement establish **participation as a key feature** of the contemporary jurisdiction" [emphasis added] (2022: 70).

The Voicing Loss project was conceived as an investigation of what this 'participation' by bereaved people in the inquest process entails. More specifically, we sought to find out:

- How is the status and role of the bereaved in the coronial process defined in law and policy, and what are bereaved people's own expectations and experiences of the process?
- To what extent, in what ways and for what purposes should bereaved people be 'at the heart' of the coronial process and have an active role in proceedings?
- What policy and practice changes would support inclusion and involvement of bereaved people in the coronial process in ways that are viable, appropriate and attuned to their expectations?

We addressed these questions primarily through a qualitative, empirical investigation, which involved interviews with individuals who had personal or professional experience of the coroner service – focusing on the period since implementation of the Coroner and Justice Act reforms in 2013.

We carried out this work in a policy context which continued to evolve. The formal start of our project in May 2021 coincided with publication of the House of Commons Justice Committee's report on its inquiry into the effectiveness of the coroner service. The Committee identified a pressing need for further reform to many aspects of the service – for example, calling for the creation of a unified national coroner service (an issue that persistently arises in discussions of coronial policy), and the

[7] For example, Ministry of Justice (2013, 2015).
[8] Thornton (2014); Lucraft (2018); Teague (2023).

introduction of a system for review of responses to PFD reports. Also recommended were a number of measures that would support 'putting bereaved people at the heart of the Coroner Service', including the extension of public funding for legal representation of bereaved people and extension of inquests and the introduction of a coronial appeals system. Most of the Justice Committee recommendations remain live issues in policy debate and, at the time of writing (May 2024), the Committee is engaged in a follow-up inquiry to examine changes made since 2021.

Also pertinent to the experiences and role of bereaved people in the coronial process are even broader policy questions about the future of the coroner service. As noted by the Chief Coroner HHJ Teague in his *Extraordinary Report* (2024), this is a service which is chronically under-resourced, but faces a workload of increasing size and complexity, and ever greater expectations of what it can achieve.

3. The existing knowledge base

The research conducted for Voicing Loss has been informed by relevant existing scholarship, including prior empirical investigations of bereaved people's experiences of the coroner service and work addressing wider questions of law and policy. Some of the key studies and themes they have addressed are briefly outlined below. Voicing Loss makes a significant contribution to the existing knowledge base, as empirical research which has examined experiences of the coroner service in relation to death investigations in many different circumstances, since the implementation of the 2009 CJA reforms in 2013. The value of the study also lies in its bringing together of lay and wide-ranging professional perspectives.

3.1 Bereavement and the coronial process in England and Wales

Although it is a relatively under-researched topic, a number of empirical studies have explored the implications of the coronial process for those who have suffered certain kinds of bereavement. Concerns raised by the official reviews of death investigation processes which preceded the 2009 CJA were echoed in (predominantly qualitative) studies such as those of Wertheimer (2001), Harwood et al. (2002), Biddle (2003), and Chapple et al. (2012) on suicide bereavement, Howarth (1997) on road deaths, and Snell and Tombs (2012) on workplace deaths. Themes that arose from these studies include experiences of uncertainty, delay and poor communication with coroners' teams; anxiety about media coverage and invasions of privacy; and the importance attached by the bereaved to the thoroughness and accuracy of coroners' 'verdicts' (as they then were[9]) and, consequently, the frustrations resulting from verdicts considered inadequate.

Biddle's interviewees, for example, spoke of having been distressed by 'a number of aspects of the inquest ranging from its setting and procedures, through its content—giving and hearing evidence—to its eventual outcomes and explanatory potential.' A particular cause of upset to her interviewees was the fact that 'no attempt had been made to disguise the reality that their enormous personal tragedy was no more than routine administration' (2003: 1038). Snell and Tombs found that bereaved people were 'left bewildered as to the nature and purpose of the inquest', and that the process 'exacerbated [their] suffering …, deflating expectations, and exposing them to a combination of a lack of rigour and an absence of compassion' (2012: 215, 216).

[9] The word 'verdict' for the coroner's (or jury's) determination of how the person died was replaced by 'conclusion' under the 2009 CJA and associated rules and regulations.

Similar issues continue to emerge in later qualitative research on bereavement and exposure to legal proceedings around death in England and Wales.[10] A study of bereavement through substance misuse, for example, reports on bereaved people's concerns about post-mortem examinations, inquests and inquiries with regard to 'how long such processes took, uncertainty about the remit of an inquest …, understanding jargon and paperwork, communication and the approach of the officials involved' (Templeton et al., 2016: 345). Research by Pearson, on the impact of inquests on people bereaved by road death, identifies a number of ways in which the coronial process causes the bereaved to become 'secondary victims'. She notes that notwithstanding the political and moral commitment to placing the bereaved 'at the heart of the system', this is a system that continues to serve the state rather than those affected by the death. The resultant 'expectation gap' has the effect of leaving families 'feeling let down, isolated and unheard' (2019: 236). Bereaved people's experiences of inquests into deaths of military service personnel were explored by Lester. While some of her research participants reported positively of hearings which helped provide 'clarity, explanation and information in addition to … an opportunity for the validation and acknowledgement of their loss', others struggled to access information and found that proceedings heightened their distress (2019: 30).

3.2 Meaning-making and therapeutic jurisprudence in the coronial process

The potential contribution of the coronial process to bereaved people's 'meaning-making' following a sudden or traumatic death, or ways in which the process can generate more broadly defined 'therapeutic' outcomes for the bereaved, are core considerations in some of the research cited above and in other empirical and theoretical work.

Death studies scholar Walter describes the 'search for a story about the deceased's life and death that makes sense to them' as something that mourners frequently do. He further observes that a key part of this process of meaning making can be 'the public declaration of the definitive story of [the deceased's] life and/or death – whether in inquest, funeral or obituary' (2005: 408). Relatedly, Scott Bray and Martin have noted that coronial death investigations 'are not reducible to a simple fact-finding endeavour… They perform a much broader meaning-making task around death' (2016: 121). Biddle describes the expectation, on the part of some of her suicide-bereaved interviewees, that the inquest would help them with the task of 'arriving at an account of the death that makes sense of what has happened and which [they] can live with' (2003: 1038). In practice, however, they more frequently found that the inquest process hindered rather than helped this aspect of 'grief work'. Lester similarly found that, for some of the bereaved people she interviewed, the experience of the coronial process 'compromised their ability to derive a sense of meaning from their loss and to progress in their grief after the inquest' (2019: 30).

A significant portion of existing scholarship on the coronial process is informed by therapeutic jurisprudence – an approach to the law and legal scholarship that considers the ways in which the law itself can act as a therapeutic or antitherapeutic agent. This research largely emanates from Australia, where the coronial system has similarities with – as well as some important differences from – that of

[10] Also in Spillane *et al.*'s study of suicide-bereaved family members' experiences of inquests in Ireland (2019).

England and Wales. On the basis that the inquest is a forum in which legal decision-making necessarily involves encounters with 'raw and pressing emotions' (Tait et al., 2016: 572), these studies make the case for wider adoption of an 'ethic of care' towards all involved but especially the bereaved, with a view to supporting therapeutic and reducing antitherapeutic outcomes (King, 2008; Freckelton, 2016; Tait et al., 2016; Carpenter et al., 2022). The application of therapeutic jurisprudence to the coronial jurisdiction is understood to have many dimensions, including:

> "enhanced communication with family members and other parties, clarification of the scope of inquests at an early juncture, sensitivity to grounds of opposition to exhumations and autopsies, better explanation of decisions not to hold or re-open inquests and an increasing focus upon both the human rights of interested parties to inquests and the prophylactic potential for the death investigation process" (Freckelton, 2019: 170). [11]

3.3 Death investigations and the state

There is a substantial body of research and scholarship on investigations of deaths in which state actors are implicated, such as the police and prisons. Investigations of state-related deaths make up a 'complex net' within which 'the coroner's inquest is just one cog' (Padfield, 2023: 117), and can play out over periods of many years. Empirical and other research has documented how these investigative processes serve the interests of the state and state institutions; as Scott Bray reminds us, 'The political labour that goes into the "search for the truth" following contested death is incalculable' (2020: 99). Scraton, among others, describes the ways in which this compounds the grief of those bereaved by state-related deaths. For example, in his influential work on the ongoing struggles for justice following the 1989 Hillsborough disaster, he observes that '[t]he suffering of bereavement and survival has been exacerbated by the continual torment of injustice embedded in the failures of formal inquiry and criminal justice' (2013: 25). The experiences of the Hillsborough families – including in relation to the two sets of inquests, in 1990-91, and 2014-16 – have also been closely examined by the government-commissioned review of the disaster led by Bishop Jones. This describes the 'patronising disposition' of authorities which display 'an instinctive prioritisation of the reputation of an organisation over the citizen's right to expect people to be held to account for their actions' (2017: 6).

Writing of deaths in police custody, Loader argues that 'the deep structure of the [investigative] process is … one in which the state is defensive and defends itself, while victims' families are denied effective redress and accountability' (2020: 13). Others contend that bereaved families are not only denied justice by flawed accountability mechanisms surrounding state-related deaths, but that unevidenced assumptions about their expectations and experiences serve to shore up those very mechanisms. With reference to prisoner death investigations, Tomczak and Cook note that death investigators regularly invoke bereaved families 'to legitimise investigations in their current form and limited impact' (2023: 18-19).[12] Writing about NHS investigative processes and drawing on her own

[11] For further Australian work which addresses these themes, see also Freckelton (2007), Tait and Carpenter (2013), Matthews *et al.* (2016), Roper and Holmes (2016), Trabsky and Baron (2016), Dartnall *et al.* (2019); see also the work of Moore (2015) which primarily focuses on the coroner service in New Zealand.

[12] For more on the role of families in prisoner death investigations, see also Tomczak (2022), Shalev and Tomczak (2023), Easton (2020). Also relevant, particularly from a policy perspective, are the Harris review (2015) on self-inflicted deaths in custody and the Angiolini review (2017) on deaths and serious incidents in police custody.

experience as a bereaved parent, Ryan similarly critiques assumptions about the 'cathartic' value of investigations to the bereaved which 'may reduce the [investigative] process to little more than a nod to harmed families and the wider public, leaving unrealised the effective change that is so important to families' (2019: 225).

In their discussion of prisoner death investigations, Tomczak and Cook (2023) consider the implications of evolving human rights law for the role of bereaved people in inquests into state-related deaths, following the incorporation of the ECHR into UK law under the Human Rights Act 1998. Others have also looked at the emphasis on 'participation' by bereaved family in case law which has sought to elaborate the state's procedural obligation to investigate deaths under Article 2. Kirton-Darling argues that this emphasis leads to two 'competing perspectives' on the inquest. One perspective is that the roles of the coroner, family and inquest itself are 'limited, serving a neutral expert accounting for death'; the other is an 'emergent framing in which the participation of those connected to the deceased is conceived as essential to meaningful accounting' (2022: 176). McIntosh also has an interest in the state's Article 2 procedural obligation and the role played by families, and the communities of which they are a part, in the search for justice following deaths at the hands of the state. He contends that family and community involvement can be essential to the success of inquests in 'producing meaningful narratives, that test and challenge dominant state narratives, including by broaching systemic concerns or deeper social pathologies' (2016: 157).[13]

[13] See also McIntosh (2012), Scott Bray and Martin (2016), Easton (2020).

4. Methodology

The main component of Voicing Loss was qualitative, interview-based research, which was supported by a policy and literature review.

4.1 Recruitment and interviews

Ethical approval for the empirical study was granted by the Research Ethics Committees of Birkbeck and the University of Bath. Interviews were conducted over the period February 2022 to May 2023. A total of 190 respondents – as shown in Table 4.1 – were recruited through a combination of purposive, convenience and snowball sampling.

Table 4.1: Project sub-samples

89 'bereaved respondents'	Those with experience of the coroner service following the death of someone they were close to
82 'professional respondents'	Individuals performing a variety of professional or practitioner roles in relation to the coroner service
19 'witness respondents'	Those with experience of giving evidence to a coroner's investigation and/or supporting colleagues who were witnesses

Recruitment was supported by a large number of organisations and individuals, who publicised the study or directly invited potential respondents to take part. Organisations included the Chief Coroner's Office, several coroners' courts, law firms, the Coroners Courts Support Service (CCSS), the charity INQUEST, and a range of other charities which support bereaved people or are otherwise involved in work or campaigning in relation to death investigations. The research team also drew on their existing professional networks. We continually reviewed the samples to ensure they encompassed sufficient diversity in terms of respondents' backgrounds and experiences, and adjusted our recruitment accordingly. For example, several months into the fieldwork we sought to engage more bereaved people with experience of relatively short – rather than lengthy and complex – inquests; our measures included publicising the study at a number of coroners' courts and asking CCSS volunteers to pass on details of the study to individuals attending inquests.

The large majority of interviews across all three samples were conducted online, usually via Microsoft Teams.[14] Most interviews were one-to-one, but there were some paired and group discussions (see below for more details). Interviews were audio-recorded and professionally transcribed, other than in two cases where the respondents had a preference for written notes only. Bereaved respondents were offered a £20 voucher as a 'thank you' for their participation.

The interviews were loosely structured around key themes set out in topic guides; the themes are listed in Box 4.1, below. All respondents were encouraged to speak freely, in the way they found most comfortable. Most interviews with professionals and witnesses were around 40 to 80 minutes in length; interviews with the bereaved respondents tended to be longer, typically lasting between 90 and 120 minutes.

Box 4.1: Key interview themes

Bereaved respondents

- Initial knowledge and expectations of the coroner's investigation and inquest
- Experiences of the coronial process, including their participation in it
- Extent to which the process reflected their expectations, and how it affected them
- Views on the role of the bereaved in the coronial process, including the policy goal that they should be 'at the heart' of the process

Professional respondents

- Nature and extent of bereaved people's participation in the coronial process
- Extent to which the process tends to reflect bereaved people's wishes and expectations, and how it might better do so
- What it means for bereaved people to be 'at the heart' of the process and whether, why and how this should be supported

Witness respondents

- Experiences of providing evidence to a coroner's investigation, including any aspects that were challenging
- Views on how witnesses could be better supported
- Contact with or awareness of the bereaved, when acting as a witness
- Views on the policy goal of putting bereaved people 'at the heart' of the coronial process

[14] When the project proposal was developed, in 2019, the intention had been to carry out face-to-face interviews with bereaved people. We felt that this would be essential to build rapport and to respond empathetically to the highly sensitive and emotive matters under discussion. In the event, the interviews got under way in the late phase of the Covid pandemic, at which time remote interviewing was deemed safer and more practicable than in-person work. As the research proceeded, most of the bereaved respondents made it clear that they were comfortable with, or had an active preference for, being interviewed remotely. For our part, we found that remote interviewing did not undermine rapport-building or empathy, and the depth and richness of the data were what we would have anticipated from in-person interviewing.

All interview transcripts were subjected to thematic analysis. A detailed coding framework was iteratively created through a process of close reading and re-reading of all interview transcripts and the development of both inductive and deductive codes; the latter derived from the interview questions and prior conceptions of participation in judicial proceedings. The analysis software MAXQDA was used to code the data, with initial coding undertaken jointly by the members of the project team. A report was generated on each of the main codes comprising the framework, on the basis of which we then produced thematic summaries.

To sense check our interpretation of the interviews, we presented and discussed emerging findings at one in-person and six online feedback events for research participants, held from June to September 2023.[15] These events were attended by 40 of the bereaved and 32 of the professional respondents. We took notes of the discussions, which we used to inform ongoing analysis.

4.2 The samples

As a qualitative study, Voicing Loss has not sought 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 were bereaved in contentious circumstances or wished to raise concerns about difficult aspects of their experiences of the coroner's investigation and inquest. However, this does not detract from the value of the bereaved respondents' detailed, reflective 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 wide range of professional perspectives incorporated in the research significantly widens the scope and applicability of the findings.

4.2.1 Bereaved respondents

Of the **89 bereaved respondents**, 63 participated in one-to-one interviews; 18 in paired interviews; eight in a group discussion arranged and facilitated on our behalf by INQUEST, as a Family Listening Day;[16] and one provided a written response to the questions.[17]

The sample of bereaved respondents was predominantly female (over 80%) and White (around 90%). Ages of the respondents ranged from 20 to 83, with almost two-thirds in their fifties and sixties. Their relationships to the deceased person are shown in Table 4.2; this makes clear that the majority (56%) of respondents were parents of the person who had died.

[15] The in-person feedback event was organised for us by INQUEST, as a follow-up to the discussion group they facilitated for us during the data collection phase (see below).

[16] INQUEST's write-up of this event is available here.

[17] All respondents were offered the option of providing a written response rather than taking part in an interview.

Table 4.2: Relationship of bereaved respondents to the deceased (n=90*)

Parents	50 (39 mothers, 10 fathers, 1 stepfather)
Siblings	17 (14 sisters, 2 brothers, 1 sister-in-law)
Adult children	10 (9 daughters, 1 son)
Spouses/partners	8 (5 wives, 2 female partners, 1 husband)
Cousin	2
Mother-in-law	1
Aunt	1
Friend	1

*One respondent spoke about inquests relating to two people with each of whom she had a different relationship

The bereaved respondents spoke about the deaths of 80 individuals from 2010 to 2023.[18] Ages of the deceased at the time of death ranged from six to 82 years, and almost two-thirds were male. Like the bereaved, the majority of the deceased were White, with about 15% from Black, Asian and Minority Ethnic groups. Three deaths occurred abroad, and the others across all regions of England and one in Wales. A breakdown of the gender of the deceased, age at death and year of death is provided in Table 4.3.

[18] Most pairs of respondents spoke about a single death, while a few other respondents spoke about two deaths.

Table 4.3: Gender, age at death and year of death of deceased people (n=80)

Deceased gender		Age at death		Year of death	
Male	51	0-24 years	23	2010-11	4
Female (inc 1 transgender female)	28	25-44 years	36	2012-13	5
Non-binary	1	45-64 years	12	2014-15	11
		65+ years	6	2016-17	20
		Not known	3	2018-19	19
				2020-21	19
				2022-23	1
				Not known	1

All 80 deaths had been subject to a coroner's investigation, one of which had been discontinued after the post-mortem examination, while two were not yet complete at the time of interview (although the respondents had attended pre-inquest review hearings). Hence, respondents recounted experiences of **77 final inquest hearings**.

The inquests took place between late 2012 and early 2023;[19] around 70% were from 2018 onwards. The length of time between date of death and the final hearing was variable, as shown – along with date of death – in Table 4.4. A little under one-quarter of the inquests in our sample (for which this information is available) were held within six months of the death. The longest period between the death and inquest was 12 years, in a case in which there was a second inquest following a High Court ruling; the second-longest was seven years. Also variable was the length of final inquest hearings: approximately 40% lasted one day or less, another third up to two weeks, and the remainder were conducted over a period of weeks or, at the longest, 3.5 months.

[19] Our intention had been to interview people about inquests that had taken place since implementation of the 2009 CJA in 2013; however, one pair of respondents – who took part in the INQUEST Family Listening Day – spoke about an inquest held in late 2012.

Table 4.4: Date and length of inquest and time period between death and inquest (n=77)

Date of inquest		Time between death and inquest	
2012-13	2	2-6 months	16
2014-15	7	7-12 months	16
2016-17	12	13-24 months	16
2018-19	19	25-36 months	11
2020-21	21	3-5 years	7
2022-23	14	Over 5 years	4
Not known	2	Not known	7

Our data on the inquest conclusions are incomplete,[20] but it appears that there was a conclusion of suicide in over 40% of the 77 inquests in our sample.[21] The conclusion was natural causes in at least seven cases, and there was an open conclusion in at least six. There were small numbers of conclusions in each of the following categories: drugs/alcohol-related, road traffic collision, misadventure and unlawful killing, while most other inquests appear to have had narrative conclusions. Around 30% of the inquests engaged Article 2, and the coroner produced one or more PFD reports in about a quarter of the cases. Around one in six were jury inquests.[22]

In about half of the investigations, our bereaved respondents had received legal advice during the investigation process or were legally represented at the inquest. Legal advice and representation were variously self-funded, publicly funded or provided on a pro bono or conditional fee basis.

As noted above, our sample was not intended to be representative. The sample is dominated by bereaved parents and especially mothers. The 2023 *Coroner Statistics for England and Wales* (Ministry of Justice, 2024) reveal other ways in which the sample is skewed, such as its younger age profile. Over half (57%) of all inquests in 2023 related to those who had died aged 65 and above, compared to 8% of inquests in our sample. (However, the gender profile of the deceased in our sample – 64% male – reflects the national picture, for which the figure is 63% male.) The proportion of all inquests with a conclusion of suicide was 13% in 2023, compared to our over 40%. Jury inquests (1%

[20] This incompleteness reflects the fact that not all respondents had a clear recall of, or spoke about, the conclusion.

[21] Reflecting assistance with recruitment provided by the charity Gambling with Lives, gambling was a factor in eight of the deaths for which the coroner recorded a conclusion of suicide.

[22] An inquest must be held with a jury if it concerns a non-natural death in state detention, a death involving the police, or a death caused by a workplace accident. Article 2 inquests, inquests heard by a jury and inquests which give rise to a PFD report are different but partially overlapping categories.

nationally) and inquests resulting in a PFD report (569 reports across all 39,500 recorded inquest conclusions) are also heavily over-represented in our sample. Doubtless, the same applies to Article 2 inquests and the prevalence of legal advice and representation, although there are no national figures on these aspects.

Nevertheless, we succeeded in recruiting a sample that was reasonably diverse – if by no means representative – in terms of geography, duration of the coroners' investigations and final inquest hearings, ages of the deceased, and circumstances of the deaths. Collectively, our interviews thus provide insight into many of the complex and multifaceted realities of the coroner service.

4.2.2 Professional respondents

The 82 professional respondents all worked within the coroner service or had roles that brought them into close contact with the service. They included coroners, coroners' officers and staff, lawyers, CCSS representatives and others, as shown in Table 4.5, below. The respondents worked in many parts of the country and some had a national role across England and Wales. The coroners and coroners' officers and staff who were interviewed represented 15 local coroner areas from seven out of the nine regions of England.

63 of the professional respondents took part in one-to-one interviews. There were additionally two paired interviews and three small group discussions involving staff of an NGO (three participants), CCSS volunteers (five participants) and coroners' officers from one local coroner service (seven participants).

Table 4.5: Roles of professional respondents (n=82)

17 coroners	• 12 senior coroners • 2 area coroners • 3 assistant (fee-paid) coroners, of whom 2 are also practising as inquest lawyers
21 coroners' officers and other staff	Including coroners' officers, senior coroners' officers and service managers
20 inquest lawyers (+ 2 who were also assistant coroners)	Roughly evenly split between those who predominantly represent families and those who represent state bodies
12 CCSS representatives	• 2 paid staff • 10 volunteers
12 others	Individuals in a range of support, campaigning or other expert roles in relation to inquests, including from governmental bodies and NGOs

4.2.3 Witness respondents

The interviews with the 19 witness respondents, all of which were conducted one-to-one, formed a relatively small, exploratory component of the research. These respondents were individuals in a wide range of roles and organisations who had given evidence to a coroner's investigation in a professional capacity, and/or had supported colleagues who had given evidence. For some, this engagement with the coroner service was a one-off experience; for others, it was a not unexpected aspect of their professional role. The respondents' professional roles are set out in Table 4.6.

Table 4.6: Roles of witness respondents (n=19)

6 police staff	• 5 officers • 1 civilian (from 2 police forces)
4 prison staff	Various manager and non-officer roles (from 1 privately-run prison)
3 senior health practitioners	• 2 consultants • 1 nursing director (from 3 NHS trusts)
2 education professionals	Evidence concerned fatalities at a professional event
3 NGO representatives	• 2 managers from a substance use treatment NGO • 1 former CEO of a bereavement support NGO
1 Independent Mental Capacity Advocate (IMCA)	

5. Project outputs

The Voicing Loss project team have so far produced the following outputs based on the research findings; all available at www.voicing-loss.icpr.org.uk:

→ Voicing Loss Research Summary: 'I feel like I've been swept along on a tsunami'.

→ Three research reports addressing different aspects of the study findings:

- Research Findings No. 1: 'I needed more than answers': Bereaved people's expectations of the coronial process
- Research Findings No. 2: 'Playing a game you didn't fully understand, by their rules': The aspiration to locate bereaved people 'at the heart' of the coroner service
- Research Findings No. 3: 'The more traumatic inquests stick with you forever. But you can remember them all.': How witnesses experience the inquest process

→ Two policy briefs considering the implications of the Voicing Loss findings for future reforms to the coroner service:

- Policy Brief No. 1: Clarifying the role and remit of the coroner
- Policy Brief No. 2: Locating bereaved people within the coronial process

→ Three good practice documents intended to support the aim of putting humanity at the heart of the coronial process:

- Principles for Practice No. 1: Information and communication
- Principles for Practice No. 2: Quality of interactions at inquest hearings
- Principles for Practice No. 3: Respecting and including the deceased person

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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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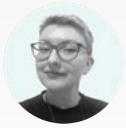

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