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Voicing Loss

Policy Brief No. 1

Clarifying the role and remit of the coroner

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The Voicing Loss project explored the role of bereaved people in coroners' investigations and inquests. The project involved interviews with 89 people who had experience of the coroner service following the death of someone they were close to, as well as interviews with coronial professionals and witnesses. This is the first of two Policy Briefs based on the study findings, intended for those involved in coronial policy-making and leadership.

Key messages

→ The Voicing Loss study found there to be a marked lack of clarity surrounding the coroner's role and remit. There are tensions and ambiguities relating to:

- the coroner's determination of the scope of the investigation
- the uncertain status of the coroner's preventive role
- adversarial conduct and courtroom formalities
- contested concepts of 'accountability' and 'justice'.

→ These tensions and ambiguities contribute to a problem of mismatch between bereaved people's hopes and expectations of the coronial process and what, in many cases, it delivers. Repercussions include feelings of frustration, mistrust and additional grief on the part of the bereaved.

→ Greater clarity and transparency with regard to the purpose, structure and operation of the coroner service would help to address the problem of mismatch and enhance public understanding of the coronial process.

→ Measures that might help to achieve greater clarity and transparency include:

- publication by the Chief Coroner, Judicial Office, Ministry of Justice and other leaders, as appropriate, of a joint **statement of purpose of the coroner service**.
- introduction of step-wise **guidelines on coronial decision-making** on the scope of inquests and the preparation of Prevention of Future Deaths reports.
- remodelling of **the physical and social space of the coronial courtroom**, to reinforce the inquisitorial and fact-finding character of inquest hearings.

→ Efforts 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.

Introduction

A major finding of the Voicing Loss project is that there is a lack of clarity surrounding the purpose and functions of the coronial process. In this policy brief, we describe several manifestations of this lack of clarity and the implications for bereaved people. We go on to propose three ways in which some of the tensions and ambiguities associated with the coroner service might be addressed. This would be of benefit to everyone who has a stake in effective systems of death investigation: that is, to all of us.

The endeavour to increase the clarity and transparency of the coronial process aligns with the Chief Coroner's recent call 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'.[1]

Tensions and ambiguities

The bereaved people who took part in the Voicing Loss study had variously hoped that the coronial process would provide them with new information about the death; that it would produce learning to help prevent future deaths; that it would hold individuals or organisations to account if their (in) actions had contributed to the death; and that it would deliver 'justice' for the person who had died. Although some of these hopes were fulfilled, many were disappointed – leading to frustration, mistrust and additional grief. These accounts thus reveal a problem of mismatch between expectations and outcomes of the coronial process – a problem to which many of the professional respondents also referred. However, while the professionals were inclined to see this as a function of 'unrealistic' expectations of what the coronial process can deliver, the bereaved respondents tended to speak of failings of the process itself.[2]

Closer examination of both the lay and professional respondents' accounts, and of the framework of law and policy within which the coroner service operates, suggests that the roots of the problem of mismatch lie in a lack of clarity about the coroner's role and remit. As we outline below, we have noted tensions and ambiguities relating to four aspects of the coronial process: the coroner's **determination of the scope of the investigation**; the **uncertain status of the coroner's preventive role; pressures towards adversarialism** in what is a nominally inquisitorial system; and the **contested concepts of 'accountability' and 'justice'** within the coronial jurisdiction.

[1] Extraordinary report: The coroner service 10 years post-reform, 11 January 2024.
[2] For a detailed discussion of the problem of mismatched expectations and experiences of the coronial process, see Voicing Loss Research Findings No. 1.

Tensions and abiguities:

Scope of investigation

The coroner's core statutory duty, under the Coroners and Justice Act 2009, is to answer the four questions of who died and how, when and where the death occurred. The question of 'how', or causation of death, is generally understood in terms of factors that 'more than minimally' contributed to the death. It is also understood to be distinct from the question of 'why' the death occurred, which is deemed to fall outside the coroner's remit. Yet, it is by no means self-evident where the line is drawn between the 'how' and the 'why' of the death; and all the more so given that the coroner is obliged to consider the wider 'circumstances' in which the individual died if the case engages Article 2 (right to life) on the basis that the state is implicated in what happened. Where Article 2 is not engaged, the coroner is also free, but not obliged, to consider the circumstances of the death.

Thus, the scope of an inquest is highly elastic; and the coroner's discretion inevitably results in wide disparities in where and how the parameters are set. It is therefore unsurprising that there are disputes over scope, and that the bereaved are sometimes aggrieved that the investigation cannot, or does not, address the questions they want answered. For coroners themselves, determining which questions are to be addressed is not always straightforward.

Scope of investigation: Some Voicing Loss interview extracts

“[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.” **- Bereaved mother**

“I don't expect a coroner's court to always answer all [the questions], but what I do expect the coroner's process to do is allow the parents to voice what it is they want answers to. Unless it's completely illogical, illegal, why shouldn't those questions be asked for them?” **- Father**

“The 'why' question isn't one for the coroner, but it gives family a better understanding if you do touch on the 'why'.” **- Coroner**

“There are some inquests where the .... family ask loads of inappropriate questions. You, as a coroner, sit there and let it happen... What I'm saying is, in a way, technically, that shouldn't be happening. Lots of coroners, I think, allow it to happen. I do. There are cases, though, where you simply can't allow it to happen.” **- Coroner**

Tensions and abiguities:

The coroner's preventive function

The coroner's preventive function is generally delivered through the preparation of Prevention of Future Deaths (PFD) reports, where an investigation gives rise to concern about risks of future deaths, and the coroner believes action can be taken to reduce those risks. However, the preventive role of the coroner is in some ways an ambiguous one. The ambiguity relates, in part, to the vexed issue of scope: whether and what lessons are learnt from the death depends on which factors the coroner has included within the ambit of the investigation. Also ambiguous is the status of the coroner's preventive function. On the one hand, this function has a statutory basis, and many bereaved people (and perhaps the wider public) perceive prevention to be the primary purpose of the coronial process. On the other hand, case law – reflected in Chief Coroner guidance – makes clear that prevention is 'ancillary to the primary purpose of an inquest'.[3] Further, as with most facets of their decision-making, coroners have wide discretion in relation to PFD reports, and hence practice is inconsistent. A related matter of wider concern and ongoing policy debate – and a cause of frustration and disillusionment for many bereaved – is the absence of mechanisms, outside the coroner system, for follow-up and oversight of actions by PFD report recipients.

The coroner's preventive function: Some Voicing Loss interview extracts

“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 dying, 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… Why [otherwise] put yourself through this gruelling process?” **- Sister**

“We came out of the court, punching the air, like [getting the PFD] 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.” **- Father**

“The coroner's role is … very narrow in what they can do… Yes, the coroner can do prevention of future deaths forms and bits and bobs like that, but… it all depends what the cause of death is, isn't it, and then what type of inquest.” **- Coroner's officer**

“If I can assist by presenting a report so that this organisation can have a look at their systems and perhaps prevent future death, then that's what we'll do. Families love these letters but their engagement in the process doesn't really make a difference to us, because it's a duty that coroners have in any event, in every case: to think about that, throughout the evidence.” **- Coroner**

[3] Revised Chief Coroner's Guidance No.5 Reports to Prevent Future Deaths, November 20, 2020.

Tensions and abiguities:

Adversarial conduct and courtroom formalities

Formally, the inquest is an inquisitorial process at which the coroner, sometimes with a jury, establishes the facts of the death. While individuals (family and others) designated as 'interested persons' (IPs) have rights to participate in proceedings, and may be legally represented, they are not opposing parties between whom the coroner must adjudicate. In practice, however, inquest proceedings can feel adversarial when lawyers are present, and particularly if there is a possibility that civil proceedings will follow the inquest. Adversarial conduct during inquest hearings is not only counter to their nominally inquisitorial character, but also risks alienating bereaved people who may feel marginalised by proceedings that seem to be all about the lawyers – and the 'games' they play – rather than their own concerns relating to the death. Perceptions, on the part of bereaved people, of excessive formality and courtroom ritual can further entrench this sense of marginalisation.

Adversarial conduct and courtroom formalities: Some Voicing Loss interview extracts

“Lawyers may say, 'It's inquisitorial,' but they can't help being adversarial. That's who they are.”
- Mother

“It's a quite thin line to try and explain to families because it's non-adversarial, but it feels incredibly adversarial – and, bluntly, it is. You know, you have people on both sides. They do have a case that they're hoping to put forward, albeit we'll pretend we don't.” **- Lawyer**

“The difficulty is: everybody knows that the coronial system, where it's meant to be non-adversarial, is a myth. We put on this pretence, don't we, that … there are no victories; there are no losses; that it's just a fact-finding inquiry to get to the truth… It's a nonsense.” **- Lawyer**

“There was a sense of playing a game you didn't fully understand, by their rules.” **- Father**

“All this nonsense: 'My learned friends,' and the way they address people. It's so antiquated, pompous and full of ceremony.” **- Mother**

Tensions and abiguities:

Contested concepts of 'justice' and 'accountability'

The coronial process is a formal judicial process that, although in some ways anomalous, has much in common with other parts of the justice system of England and Wales. Inquest hearings are formally inquisitorial, but – as we have seen – often feel adversarial. Coroners' courts are administered by local authorities, not HM Courts and Tribunals Service, but courtroom formality, language and lay-out tends to reflect that of other court settings. Coroners cannot assign blame or liability, but must examine the range of factors – including acts or omissions – that contributed to the death, and in certain circumstances must consider risks of future deaths. In Article 2 cases, their conclusions can be 'judgmental', but must not include 'words which suggest civil liability such as "negligence", "breach of duty", "breach of Article 2" and "careless"'.[4]

All this might suggest that bereaved people can reasonably expect the coronial process to deliver accountability for the death and justice for the deceased. On the other hand, both 'justice' and 'accountability' are contested concepts in the context of the coronial process – not least because they are sometimes understood to stray into the territory of 'blame'.

Contested concepts of 'justice' and 'accountability': Some Voicing Loss interview extracts

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

"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... But I still expected more of a sense of justice, I think, from the inquest." **- Mother**

"There was one hilarious point, with 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**

"I think people are looking for answers, information, closure, and in some instances – it's not a true purpose of an inquest, but they go into the process looking for accountability and someone to take some blame." **- Lawyer**

"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**

"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**

[4] Chief Coroner Guidance No. 17: Conclusions – short form and narrative September 7, 2021.

Proposals for achieving greater clarity and transparency

The Voicing Loss research findings suggest that lack of clarity about the coroner's role and remit contributes to a mismatch between what bereaved people often want and expect of the coronial process and what, in practice, it tends to deliver. We propose three sets of measures that would support greater clarity and transparency, and thereby improve public understanding of the coroner service and help to address the problem of mismatch.

First, we propose that the Chief Coroner, Judicial Office, Ministry of Justice and other leaders, as appropriate, should issue a joint **statement of purpose of the coroner service**. This joint statement should, in non-technical language to ensure accessibility for a lay audience, set out:

- The categories of deaths investigated by the coroner, the statutory questions to be addressed, and the requirement for 'enhanced' investigation in cases which engage Article 2;
- What is understood by the question of 'how' or causation of death, and the meaning of 'circumstances' of death, as must be considered in cases which engage Article 2 and can otherwise be considered;
- The coroner's obligation to issue PFD reports as appropriate and how this 'ancillary' function relates to the investigation's core purpose;
- How the line is drawn between (a) consideration of (in)actions which contributed to the death and factors posing risk of future death – which potentially falls within the coroner's remit; and (b) assignation of blame or liability for the death – which necessarily falls outside the remit;
- The public health and wider societal interests served by thorough, effective death investigations.

The second proposal is for the production of **guidelines on coronial decision-making** on the scope of inquests and on the preparation of PFD reports, to be incorporated within existing Chief Coroner guidance and structured as follows:

- The guidelines would set out a step-by-step process for determining the parameters of an inquest, whether it engages Article 2, and whether and to whom to issue PFD reports.
- They would thereby identify key considerations and actions at each phase of decision-making – including, where applicable, inviting representations from family and other IPs.
- They would explicitly reflect the statement of purpose of the coroner service, proposed above.
- They would not be binding on coroners or fetter their discretion; they would instead support the exercise of discretion in a structured and principled manner.
- Where an investigation culminates in an inquest hearing, the coroner would be expected to note briefly, as part of the written record of inquest, their reasoning at each decision-making stage.

Thirdly, we propose that greater consideration should be given to ways in which **the physical and social environment of coronial courtrooms** could counteract pressures towards adversarialism and the search for blame. The lay-out of a coroner's court is often similar to that of other courts, with the coroner's raised bench facing several rows of benches for the participants. Much of the etiquette and formality of the inquest likewise echoes that of other court hearings. In large, complex inquests, a level of formality and traditional court layout may be essential; and in some other cases, too, security risks necessitate careful organisation of space and physical separation of participants. However, a relatively informal style and use of space is a feature of many inquests: for example, where participants sit around a table, all at the same level. In our view, there should be wider adoption of informal approaches, wherever available facilities allow it. This would underline the distinctive – and particularly the inquisitorial and fact-finding – character of inquest proceedings. More egalitarian courtroom design, plain language and an absence of ceremony are entirely compatible with, and may even enhance, the seriousness and dignity of proceedings; and all the more so when parts of the process take place in virtual spaces.

The wide range of factors relevant to the courtroom environment – including the ever-present, severe resource constraints within which all local coroner services operate, and security considerations – point to the importance of flexibility and diversity in the provision of facilities for inquests. This suggests that a model of 'flexible justice spaces', as proposed by legal NGO JUSTICE in a report on the wider court estate,[5] might be applicable to the coronial system. In turn, this begs the question of whether the place in which an inquest is held should even be called 'a court' – especially given the uncertainty about whether 'justice' for the deceased is what the process should deliver.

[5] JUSTICE (2016) What is a Court? A Report by JUSTICE.

Clarity and transparency in the broader policy context

The proposals outlined above, if enacted, would only go a limited way towards achieving greater clarity and transparency in the coronial process. This is because the tensions and ambiguities encountered by bereaved people do not simply reflect a situation in which they are given inadequate explanations of what the process is about. Rather, they reflect more fundamental, deeply-rooted uncertainties and dilemmas over the functions of coronial death investigations.

Today, the coroner service faces multiple structural challenges. Like most public services, it is under-resourced and under-staffed, resulting in often unmanageable workloads and delays at many stages of the investigation process. Calls – from practitioners, campaigners, parliamentarians and others – are frequently made for specific structural reforms, including in relation to the creation of a national coroner service, mechanisms for oversight of PFD responses, introduction of an appeals system and an inspectorate, and further expansion of publicly-funded legal representation for families. Implications of the new statutory medical examiner system for the size and make-up of coroner caseloads are yet to be seen. At the same time, demands on the service are growing: investigations are increasingly complex; there are expectations that coroners should play a much greater part in tackling preventable deaths; and inquests are coming under close scrutiny in the media.

In this rapidly changing context, strategic policy decisions have to be made about the future of the coroner service – of which the most critical, perhaps, is whether the service should expand to meet the growing demands made upon it, or should retrench and refocus on more narrowly defined goals. The task of clarifying the coroner's role and remit should be regarded as an intrinsic part of these wider policy conversations. Accordingly, the development of a statement of purpose of the coroner service and guidelines for coronial decision-making, and any rethinking of courtroom spaces, will necessarily be ongoing, evolving processes.

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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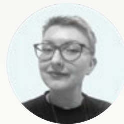

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