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When bereaved people are left more distressed by the inquest process, something needs to change. Findings from the Voicing Loss study.

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Summary

Jessica Jacobson is a Professor of Criminal Justice and Director of the Institute for Crime & Justice Policy Research (ICPR) at Birkbeck, University of London. In this blog, she talks about the Voicing Loss project.

Drawing on interviews with bereaved people who had experienced an inquest, she highlights how the process can cause further harm and distress. Jessica also explains that, when people are given the right support, an inquest has the potential to help rather than hinder the grieving process.

The majority of the bereaved people who took part in the Voicing Loss research believed that failings by state or other bodies, most often providers of health and social care services, had caused or contributed to the death.

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Background: coroners, inquests and prevention of future deaths

Coroners are a special type of judge, appointed by the local authority. They are responsible for investigating deaths suspected to have been violent or unnatural, where the cause of death is unknown, or where the person died while in prison or another form of state detention. The investigation must seek to determine who died and how, when and where they died.

Where necessary, a coroner's investigation culminates in an inquest: an inquisitorial, fact-finding hearing, usually held in public. In addition to determining the facts of the death, an inquest has a preventive function. If the coroner believes there is a risk of further deaths and that action should be taken to reduce that risk, they have a duty to write a Prevention of Future Deaths (PFD) report for relevant bodies.

In 2023, almost 200,000 deaths were reported to the coroner (34% of all registered deaths in England and Wales), and almost 37,000 inquests were opened.

Close relatives of the deceased person who are granted 'interested person' status by the coroner have certain rights to participate in the investigation process. These include the right to receive evidence that will be considered at the inquest, and to question witnesses. More broadly, policy leaders and successive Chief Coroners have frequently emphasised that bereaved people should be 'at the heart' of the coroner service.

Voicing Loss

The Voicing Loss study explored the role of bereaved people in the inquest process and how their inclusion and participation in the process can be better supported. It was funded by the Economic and Social Research Council and led by the Institute for Crime and Justice Policy Research (ICPR) at Birkbeck, University of London, and the Centre for Death and Society at the University of Bath

I am a Professor of Criminal Justice and Director of ICPR at Birkbeck. I was the Principal Investigator of the Voicing Loss project.

The Voicing Loss research included interviews with:

- 89 people who had experience of the coroner service following the death of someone they were close to.
- 82 coronial professionals (coroners, coroners' officers, lawyers and others).
- 19 people who had given evidence to an inquest in a professional capacity or supported colleagues who were witnesses.

It is the largest ever empirical study of public and professional experiences of the inquest process in England and Wales.

Risk of compounding harm

Findings of the interviews with bereaved people demonstrate that engagement with the coroner service can support the grieving process when:

- the inquest offers sought-after answers about the cause of death
- the bereaved are treated with compassion and consideration
- the personhood and individuality of the deceased is respected and reflected.

On the other hand, as recounted by many of our bereaved interviewees, the inquest process can also *add to* distress, anger and a sense of powerlessness in the wake of traumatic bereavement.

A variety of factors are associated with compounded harm, including:

- The difficulty of understanding and navigating the inquest process when in a state of deep grief and shock, and with limited access to information.
- Exposure to graphic, deeply upsetting evidence with little warning or preparation.
- Conduct by professionals that shows a lack of compassion and lack of respect towards the bereaved and the deceased.

Involvement in a coroner's inquest is inherently painful for the bereaved, but factors such as the above make the experience even more difficult. It adds further to the pain if the *outcomes* of the process are far removed from what might have been hoped for.

The majority of the bereaved people who took part in the Voicing Loss research believed that failings by providers of health, social care and other public services had caused or contributed to the death. Many emphasised that their overriding hope for the inquest was that any such failings would be identified and acknowledged, and that the resultant learning would help to prevent future deaths. The reality, however, was that this hope was frequently disappointed.

This was attributed to various things including:

- defensiveness on the part of public services
- coroners setting the scope of their investigations too narrowly

- weak content and negligible impacts of Prevention of Future Death reports.

Negative experiences of the inquest process can have far-reaching effects for the bereaved. Some of the interviewees said that these experiences caused grief and distress comparable to that caused by the death itself.

Implications for policy and practice

Evidence from the Voicing Loss study reveals a need for wide-ranging reforms to coronial policy and practice if the risk of compounded harm to the bereaved is to be reduced.

In terms of practice, there should be improved treatment of bereaved people, from the time they are first in contact with the coroner service through to the end of the final inquest hearing, if there is one. Such improvements should encompass:

- Easier access to clear and concise information about the purpose and process of coroners' investigations and inquests.
- More timely, responsive communication on case progression.
- Compassion, and respect in all interactions with the bereaved and concerning the deceased.
- Greater sensitivity in the handling and presentation of distressing evidence.

At a policy level, there is ongoing public debate about the future of the coroner service and how it can meet growing demands being made upon it. An area of particular concern is how the work of coroners can better contribute to public safety by helping to tackle causes of preventable deaths. There is wide recognition of shortcomings in the current system of Prevention of Future Deaths reports,

including the absence of any mechanism for follow-up of actions taken (or not taken) by report recipients.[1] These shortcomings must be addressed if the gap is to be narrowed between what many bereaved people hope and expect of the inquest process and what, in practice, it delivers.

More information

A range of research outputs, including policy and practice briefings, research reports, an Expert Insights blog, and information about the coroner service, are available at the Voicing Loss project website.

[1] See, for example, the campaign by the charity INQUEST for establishment of a National Oversight Mechanism: a new, independent public body which would analyse and follow up recommendations arising from inquests, inquiries, and other investigations into state-related deaths.

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