

VOICING LOSS: Bereaved people's expectations & experiences of the inquest process

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Voicing Loss





This presentation

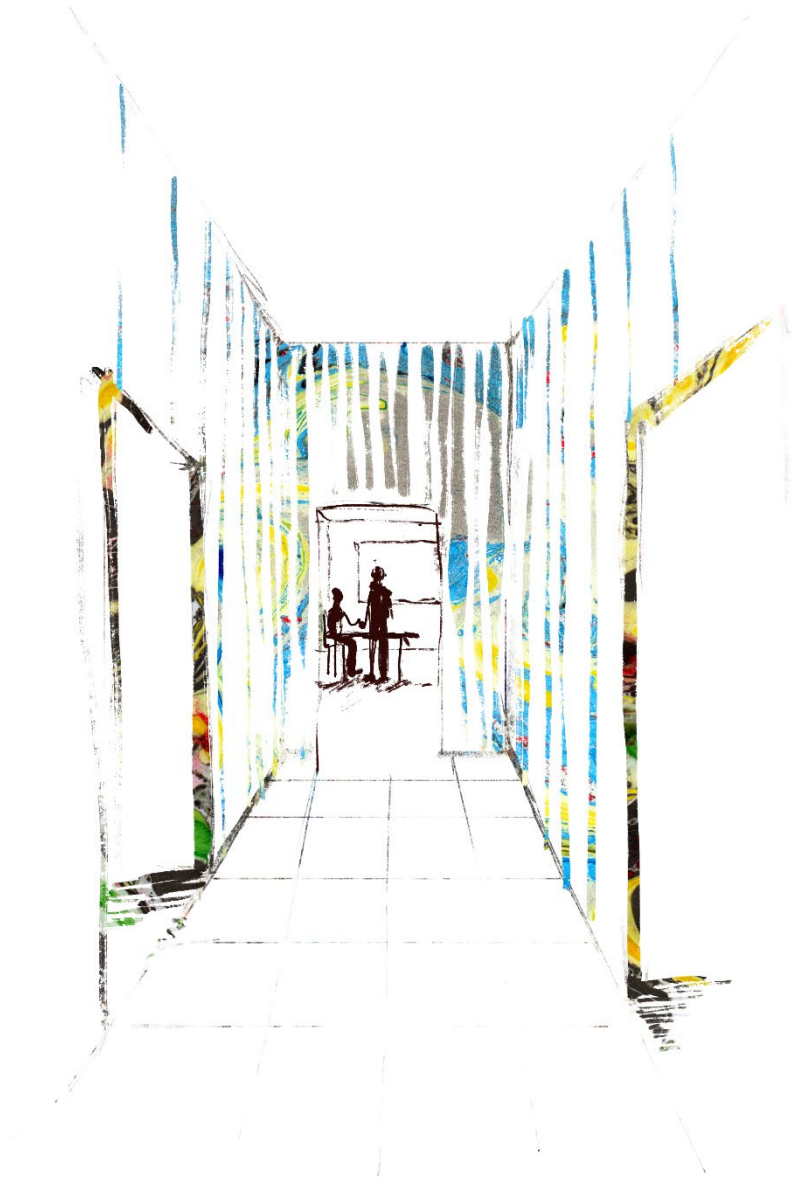
- Introduce Voicing Loss
- Coroner service of England & Wales
- Key findings
- Policy & practice implications

Voicing Loss

- Research & policy project
 - Institute for Crime & Justice Policy Research at Birkbeck, University of London
 - Centre for Death & Society at University of Bath
 - with Economic & Social Research Council funding
- Explored bereaved people's expectations & experiences of inquest process; how inclusion & participation can be better supported
- Review of law, policy, existing research; in-depth interviews

Research participants

- 89 bereaved people with experience of coroner service
 - 55%: parents of the deceased
 - Approx 40%: bereaved through suicide
- 82 coronial professionals inc. coroners, coroners' officers, lawyers, campaigners, support services
- 19 people who had given evidence in a professional capacity
- Largest ever empirical study of experiences of coroner service in E&W



The coroner service of England & Wales

Coroners' inquests

- Coroners: independent judicial officers; investigate violent, unnatural, unexplained deaths, deaths in state detention
- Inquest: final stage of investigation, usually public hearing in coroner's court (since 2022, sometimes in writing)
- Fact-finding, focused on 4 questions: who died, how, when, where
- Inquest does not attribute blame or liability
- Coroner sometimes sits with a jury
- Localised system: Coroners appointed by, based in local authorities; Chief Coroner provides leadership, guidance

Prevention of Future Deaths reports

- Coroner must issue PFD if they think: there's a risk of other deaths & actions can be taken to reduce risk
- PFDs do not specify what actions should be taken
- Recipients of PFDs (relevant individuals/organisations) must respond within 56 days, explaining what they will do or have done
- PFDs & responses published at www.judiciary.uk/courts-and-tribunals/coroners-courts/reports-to-prevent-future-deaths/
- Coroners have no powers to oversee, monitor or enforce actions

Role of bereaved

- ‘Interested persons’ (close family & individuals or organisations associated with the death) have some participatory rights, eg:
 - To be informed about post-mortem, inquest hearings
 - To receive evidence to be considered at inquest
 - To question witnesses
- General aspiration for bereaved to be ‘at the heart’ of coroner service – reiterated by govt & successive chief coroners

In 2024 ...

174,900 deaths reported to coroner
= **31%** of all registered deaths in E&W

Coroners opened **36,661** inquests

Of 39,586 **inquest conclusions** recorded in 2024:
25%: misadventure/accident
13%: suicide
12%: natural causes
12%: alcohol/drugs-related
28%: 'unclassified' (narrative or non-standard)



Some findings:
Mismatched
expectations &
experiences

Hopes & expectations

- Bereaved respondents variously hoped, expected inquest would:
 - Provide answers about the death
 - Closely scrutinise all factors relevant to the death
 - Help ensure future such deaths would be prevented
 - Achieve 'justice' for deceased person
- Sometimes, hopes & expectations were fulfilled; more often they were not → **problem of mismatch**
- Evident from accounts of respondents bereaved by suicide or where self-injury was a factor (all those quoted here were bereaved in these circumstances) and others

Hopes & expectations: Answers

- Answers were forthcoming for some:

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. [partner]

- But not for others:

Just to get the truth would have been great, but no, nowhere near it. [mother]

I was just angry after the Coroner's Court ... We didn't find out anything we didn't know before we went there. [mother]

[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 and, in my opinion is a terrible waste of public money and just prolongs the grieving process [mother]

Hopes & expectations: Scrutiny

- Realities of inquest often fell far short of expectation that all factors relevant to the death – esp possible institutional (eg health or social care) failings – would be thoroughly, robustly scrutinised.

Respondent's husband had died by suicide aged 50, when suffering from complex mental health problems in relation to which he was struggling to access help. His widow had expected the coroner to look at the limited availability of mental health provision, but found

There was a total lack of understanding of these factors – the coroner brushed over them ... I think the overwhelming thing was that [husband] wanted the help. He was speaking to all these agencies and he was telling everybody, asking for help. ... But [the inquest] was very short and brief, like: 'He meant to do that, and off you go.' ... All these people that have failed him, even at the inquest – before, during and after – all these people that have failed him, they've walked away from it, scot-free.

Hopes & expectations: Prevention

- Profound disappointment where inquest seemingly did little to prevent future deaths, because of absence of mechanisms for overseeing action
- ‘Nothing has changed’ a common refrain.

As far as I'm concerned, absolutely nothing has been done as a result of him dying. [mother]

- A father described initial relief that the coroner issued a PFD, which turned to despair

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. [father]

Hopes & expectations: Justice

- Answers, scrutiny & associated learning, prevention of future deaths – regarded by some bereaved as secondary to overarching goal of achieving ‘justice’ for the deceased
- But few were satisfied that justice had been, or could be, delivered

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]

We both kind of agreed after that it was very traumatic and we felt like we didn't do him justice. [mother]

Repercussions of the mismatch

- Anger, frustration, sadness
- Inquest caused additional harms – exacerbated grief & trauma
- Long-lasting emotional & psychological toll
- Mistrust in the coroner system & state authorities more widely

I would say it's probably deeply damaging to my own personal journey with the grief because disappointment is not something you want on top of trauma [mother]

I had total faith in objectivity and the law being based on fact ... And if I had anything to do with the law or the coroners [again], no, I don't trust them. Absolutely not. [wife]



Implications for policy & practice

Structural factors include...

- Chronic under-resourcing & backlogs
- Localised nature of service → 'postcode lottery' → case for a national coroner service?
- Access to publicly-funded legal representation for bereaved families – recently expanded; to be expanded further under 'Hillsborough Law'
- Need for mechanism to oversee, enforcing responses to PFDs

Better support for bereaved

- Advice & support with navigating process:
 - What it is & is not, about
 - Rights of bereaved interested persons to participate (or not)
 - Whether/how to obtain legal advice & representation
 - Familiarisation visits to coroners' court
 - Management of expectations of inquest – inc. re variability, scope, PFDs
 - Updates on progression of case
- Provision within (coroners' officers, CCSS) and outside the coroner service (bereavement services, other specialist services).

Reimagining the inquest

- Person-centred practice: prioritisation of compassion, dignity, respect, clarity in all interactions within & about inquest
- Respecting & including personhood of the deceased
- Improvements to physical, virtual & social space of inquest hearing to support accessibility, participation (eg less formality & ritual; seating participants around a table where appropriate)
- Possibility of incorporating restorative dialogue within or outside inquest hearing

Inquests and suicide: further lessons

- Need to address the mismatch many have about consideration of history &/or wider contextual factors to deaths by suicide.
- Perceived stigma, or experiences of stigma eg treatment, or language used.
 - Can be on top of other experiences of stigma eg if death is also associated with drugs/mental health/gambling, or occurs in a prison or in police custody.
- Feelings about 'official' recording of a death by suicide.
- Need for awareness of the particular impact that deaths by suicide can have on bereaved people, & implications for how they are supported by & throughout the coronial process.

Supporting Loss



- Builds on previous projects incl. Voicing Loss.
- Partnership: CDAS (University of Bath); Turning Point; ICPR Birkbeck (University of London).
- Develop an online Toolkit to support people bereaved by substance use when the death is subject to a coroner's investigation/inquest.
- Accessed directly by bereaved people; used by staff at a range of relevant services to support bereaved clients.
- Toolkit to be launch April 2026.

Voicing Loss: A research and policy project on the role of bereaved people in coroners' investigations and inquests



Visit <https://voicing-loss.icpr.org.uk/> for research reports; information and resources on the coronial process for bereaved people and others; policy and practice briefings; an Expert Insights blog.

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