Voicing Loss

Principles for Practice No. 1

Humanity at the heart of the coronial process:

Information and communication

Contents

May 2024

Information and communication – at a glance

This good practice document is based on findings of the Voicing Loss project on the role of bereaved people in the coronial process. 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 document aims to improve provision of information to, and communication with, bereaved people during coroners' investigations. It is intended for professionals and practitioners in the coronial sector. Three principles relating to information and communication are identified: **recognising and filling knowledge gaps; responsiveness and timeliness; and person-centred communication**.

Recognising and filling knowledge gaps	Responsiveness and timeliness	Person-centred communication
Clear explanations, at initial contact, of purpose, people and process of investigation.	Regular, proactive updates on progress of investigation.	Named individual as primary point of contact in the coroner's team.
Signposting to other information, resources and services.	Timely responses to ad hoc inquiries.	Tailored communication, taking into account needs, capacity, circumstances of the bereaved.
Reiteration of key information, as and when needed.	Acknowledgement of and explanations for unavoidable delay.	Language which reflects the common humanity of all concerned in the coronial process, including the deceased.
Comprehensive local webpage/site.	Help with preparing for attendance and participation at hearings.	Accuracy and consistency in content and provision of information.
Information about hearings, including structure, format and scope for participation.	Timeliness, care and sensitivity in disclosure of evidence.	

Introduction

This is one of three Principles for Practice documents based on the findings of the Voicing Loss research project, which examined the role of bereaved people in the coronial process. All three Principles for Practice documents support the overarching aim of placing **humanity at the heart of the coronial process**.

Throughout a coroner's investigation – from when it first becomes known that there is to be an investigation, to the end of the final inquest hearing, if there is one – bereaved people need information. In many cases, the bereaved may first learn of the (potential) involvement of the coroner from other agencies, such as the police or health bodies. But the local coroner service has primary responsibility for keeping the bereaved informed about and updated on the coroner's investigation – and faces a range of challenges in so doing.

One major challenge is that most bereaved people have little or no existing knowledge about the coroner system, and it is particularly difficult for someone to absorb new information when they are in a state of deep shock and grief. Explaining the coronial process is by no means straightforward, given its inherent complexities, and the fact that the process can take an enormously wide variety of forms. In the context of a chronically under-resourced service, coroners' officers and staff are typically managing caseloads far in excess of what is advised by the Chief Coroner's 'Model Coroner Area'.[1] This imposes severe limits on the time that can be devoted to providing bereaved people with information, explanations and updates.

In light of these challenges, it is perhaps unsurprising that many of the bereaved participants in the Voicing Loss study reported that they had not received sufficient information about the coronial process, or were unhappy about the ways in which the information was conveyed to them. Many spoke of having struggled to get responses to questions and requests, or of apparent carelessness and errors when responses were eventually received. Participants also described styles of communication that they experienced as impersonal and uncaring. The research findings reveal the significant implications of poor information and communication. It leaves bereaved people feeling highly uncertain and confused about, and excluded from, the coronial process. It also exacerbates anxiety and causes hurt and distress – making an already painful process even more difficult.

[1] As noted by the Chief Coroner in his recent Extraordinary report: The coroner service 10 years post-reform, 11 January 2024. See Annex A of the Chief Coroner's *Combined annual report 2018 to 2019 and 2019 to 2020* (2020) for the 'Model Coroner Area'.

Notwithstanding the pressures faced by under-resourced and over-stretched local coroner services, the critical importance of effective communication and provision of information should not be overlooked. This document sets out three principles and associated good practice points that would make a significant, tangible difference to bereaved people's experiences of the coronial process:

Principle 1:
Recognising and filling knowledge gaps

Principle 2:
Responsivity and timeliness in communication

Principle 3:
Person-centred communication

> "I remember getting a call, the very next day – I was still absolutely in shock – from the coroner's officer. And I'd never even really taken any notice of inquests… All they said was there will be an inquest and, 'We'll keep being in touch with you.'… Yes, so I just didn't have a clue really, what would happen." **- Sister**

> "We didn't know who to contact; we didn't know who to speak to; we didn't know where to go."
> **- Mother**

> "Educating yourself, doing your homework and negotiating the bureaucracy and legal language – at a time when you're absolutely in shock over the news and just all over the place." **- Father**

Principle 1:

Recognising and filling the knowledge gaps

Typically, bereaved people are entirely unfamiliar with the coroner service at the point at which they are first told that the coroner is going to conduct an investigation into the death. Therefore, the bereaved value clear explanations of what the process is for; the four questions about the death that the coroner must, by law, address; and what the process entails.

"When they got in touch with us, we had a letter and a leaflet explaining the process, and phone numbers and the name of the person who was the coroner's officer, who we could contact. And an explanation that a temporary death certificate would be issued and we could use that to close bank accounts and whatnot." **- Mother-in-law**

"The process itself was explained to us, very clearly, that it was all about 'how' and 'what', and not really about prescribing blame, but certainly looking at what did and didn't happen." **- Aunt**

Many bereaved people, however, report that a sense of bewilderment at hearing about the coroner's involvement in the death is compounded by a lack of information.

"When my son died, we just got this leaflet through the door about the coroner service – that we were going to have an inquest. You're sort of thrown into a new world all of a sudden." **- Mother**

"We never knew what an inquest was. It wasn't really explained to us. We didn't even know what a coroner was, to be honest." **- Mother**

"We never got a leaflet. We never got an opportunity to sit down and meet anybody. We certainly never got to have a look at the court, none of that." **- Sister**

Even where information is provided in some form, it can have limited impact when the bereaved are in a state of shock in the wake of a sudden or traumatic death.

"I can vividly remember an envelope coming through the door with a booklet, and I can remember where I put it: it was on my radiator in my bedroom. But I didn't really look at it... I couldn't think for myself – you live in this fog of just nothing really... Unless someone said to me, 'You haven't eaten for like eight hours,' it wouldn't cross my mind... And I suppose maybe if I'd read the booklet, I would have been more prepared, but I literally couldn't take anything in." **- Mother**

"I got a booklet and I can't remember who I got the booklet from... It was a booklet ... which at the time you don't want to read: you don't want to read anything; you just want to survive." **- Mother**

Bereaved people have a particular need for – but

often lack – information about their status and potential role within the coronial process and at the inquest hearing.

"We didn't know we could have [legal representation]. We didn't know, really, what our rights were, what we could have. Nobody told us." **- Mother**

"They didn't advise I could ask questions of other witnesses. I had absolutely no idea until the day before the inquest… I didn't know that that meant that I could have full advance disclosure. I just thought, 'Oh, I'm allowed to go to the inquest'." **- Partner**

Also important is information about what the inquest hearing, if there is to be one, will involve, and what it will be like to attend the hearing. In relation to this, some bereaved people take the initiative to visit the coroner's court in advance, to observe other hearings.

"I didn't realise it was going to be set out like a court, so I think that probably would have been nice to have known: this is what it's going to be looking like; this is the area where you would sit.; this is where the coroner's officer sits; that's where the coroner sits; and that you stand up and you sit down." **- Wife**

"I'm glad I went to see another inquest… I became familiar with the room. It gave me an opportunity to understand the process and formality of the process, where people were and where they stood, what was expected of them, and what the whole thing felt like." **- Mother**

Having found themselves in the 'new world' of the coroner system with little to guide them, many bereaved people embark on their own search for information and advice – by looking online and by approaching charities or other organisations they come across.

"The only way we prepared was finding out things ourselves. Also, I spoke to other people that have lost children… We didn't have an information pack; nobody briefed us; it was just like we were flapping around." **- Mother**

"[When writing a witness statement for the inquest], in my desperation, I turned to Twitter and was just like: 'Anyone got any experience of inquests?' I am totally lost. I know what I need to say; I don't know what I'm doing, though." **- Daughter**

"You're not given the information at the start of the inquest. If it wasn't for INQUEST, the organisation, we'd have gone into that inquest blindly, with no legal support." **- Sister**

Good practice points:

Recognising and filling the information gaps

- **Initial contact:** When coroners' officers are first in contact with the bereaved at the outset of an investigation, they should offer a clear, simple explanation of what the investigation entails; the key personnel involve; and the status, role and rights of the bereaved as interested persons. They should also direct the bereaved to the local coroner service webpage/site (see below).
- **Signposting:** As part of the initial contact, the bereaved should be provided with the link to the Ministry of Justice Guide to Coroner Services (in addition to being sent the guide in hard copy). They should also be signposted to other (local and national) sources of information, advice and support, including guidance on how legal advice and representation can be accessed, as needed.
- **Reiteration:** Taking into account the difficulty of absorbing new information following a sudden or traumatic bereavement and the length of some investigations, coroners' officers should check understanding at subsequent contact points; reiterate explanations of the process and people; and provide further signposting and information as required.
- **Webpage/site:** Information on local coroner webpages or websites is highly variable. All webpages/sites should provide comprehensive information – clearly structured, and in plain language – on the coronial process, the coroner's team, and other aspects of the system. Provision of information on webpages/sites should be treated as supplementary, not an alternative, to direct personal contact with the bereaved. (See the Annex to this document for more on webpages/sites.).
- **Hearings:** The bereaved should be informed about the purpose, structure and format of pre-inquest review and final hearings; their right to attend and ways in which they can participate if they wish to do so; the physical space, layout, accessibility and arrangements (as applicable) for remote attendance; and the scope for familiarisation visits to their local or other coroners' courts.

Principle 2:

Responsiveness and timeliness

As the coroner's investigation gets under way, the bereaved expect to be kept updated on progress and next steps – including in relation to the post-mortem examination, collection of evidence, any decision to discontinue the investigation, and the scheduling of pre-inquest review or final inquest hearings where applicable. In practice, however, they often struggle to find out what is happening.

"We knew there would be an inquest, obviously. We didn't know when. We didn't know anything about what you do, where you sit. We just roughly knew where it was... It was, kind of, 'There will be an inquest. We'll come back to you in January.' We all just were told when it was: 'Turn up at the Town Hall at this time', and that was it." **- Daughter**

"It got to the day before [the inquest]; I'm still thinking it's going ahead, but I've not heard anything. I looked up online, because you can see the listings, and [my brother] was no longer on that listing. I was like, 'Okay, right, it's not happening this week then'." **- Sister**

Lack of communication on case progression, and silence in response to queries, is disquieting and upsetting for bereaved people seeking to plan a funeral which has been held up by a post-mortem examination, or anxious about a forthcoming inquest hearing or the investigation more generally.

"Where is [my brother]? Where is he? Where is he being stored and when is he coming home? Nobody seemed to be able to answer the question." **- Sister**

"It was very late in the day that I knew that I was going to actually be sitting in court and being called as a witness. It was just a very basic line in the email saying, 'The coroner is expecting you to be there.'" **- Mother**

"Everything just took absolutely forever. We never got any answers for anything; nobody ever talked to us. I raised issues that were just completely ignored. Yes, you have to do all the running." **- Mother**

Delay is a feature of many coroners' investigations. This reflects existing backlogs, shortages of personnel, and wider resourcing constraints – as well as external factors relating to the complexities of evidence gathering and other review or investigative processes. Even if the bereaved understand that some delays are unavoidable, they can be a source of great frustration and further anxiety, particularly if they are not explained and acknowledged.

"Our expectation had been raised and then dashed; our expectation raised and dashed... You think something's going to happen, you're told it's happening and then actually you realise that nothing has happened for weeks." **- Mother**

"The inquest] got put back twice, and the waiting was one of the very hardest things... But it got put back. I got a call from the coroner's court officer and she's like: 'I'm so sorry.' ... And then, maybe a few days before it was due to go ahead, we got another call and they said, 'We're really sorry' – because of staff shortages or something – 'it's being put back.' Which is almost like a body blow. **- Daughter**

"There were so many long delays. And there was no explanation... Then I think there was over a year, where we didn't hear anything about the inquest." **- Sister**

Poor practice in disclosure of evidence to bereaved people causes a range of difficulties. Disclosure is often late (potentially reflecting internal delays or the delayed production of the evidence itself), which is especially problematic if there is a large quantity of material which the bereaved wish to review in advance of the inquest.

"I think that was the Wednesday before the inquest on the Monday, I had an email from a lady from the coroners' office, basically confirming the date ... and said, 'My colleague has just sent you 63 pages of disclosure documents.' And obviously my brain is in trauma... We were chucked in the deep end with, 'This is the date for the inquest, and this is 63 pages of paperwork which you have to read in this time.'" **- Wife**

Failure to disclose can mean that evidence is provided to the bereaved during the inquest hearing itself.

"The coroner suddenly realised that we haven't got the evidence. So, they just handed us a great big bunch of papers in the middle of the hearing. Told us to go away. I think it was 20 minutes, half an hour adjournment. How can you look at things like that? You've never seen the report... You can read it on the paper, but if you're crying that much about what has actually happened, it's not being absorbed into your brain. You actually need time to read it several times and really understand what has happened, and that should have been with us weeks, weeks and weeks before the inquest'" **- Mother**

Graphic and distressing evidence is sometimes sent by email or post without adequate warning.

"I received those [reports] on the train and rather stupidly, I started reading them... No warning. It was utterly shocking. I don't know quite what I expected but, obviously, there was a post-mortem. He had to be identified through teeth or something; I mean, he was so badly burnt. The descriptions were just mind-blowing ... I stopped reading them on the train when I realised they were gruesome beyond anything I'd imagined." **- Partner**

"It just came through in a big brown envelope and I opened it and I came straight to the page of [my son's] death... In some respects, they should've doubled, if not trebled, the envelope... It should've said it was going to be sensitive before you opened it, and then the real bit of how he died should've perhaps been in another envelope." **- Father**

Good practice points:

Responsiveness and timeliness

- **Updates:** Coroners' teams should have systems of routine, proactive communication to keep bereaved people regularly updated on the progress of investigations.
- **Responses:** Inquiries about progress of investigations or other aspects of the coroner service should be provided in a timely manner.
- **Acknowledging and explaining delay:** Where unavoidable delays to investigations arise, the extent and impact of delays should be acknowledged and explanations provided.
- **Preparation for hearings:** In advance of inquest hearings, bereaved people should be given as much notice and information as possible about dates, expected attendance of witnesses (and legal representatives), and whether they will be required to give evidence. Advice and support with presentation of 'pen portraits' and photographs of the deceased person should also be provided.[2]
- **Timely and careful disclosure:** Bereaved people should be fully informed of their right to receive evidence in advance of the final hearing, and how to obtain this. All possible efforts should be made to ensure timelines of disclosure, taking into account the quantity and sensitivity of evidence being shared. When evidence is sent to the bereaved by post, it should be double-enveloped; when sent by email, a prior email or phone call should first confirm that the recipient is prepared to receive it.[3]

[2] See Chief Coroner's Guidance No. 41: Use of 'Pen Portrait' Material, July 5, 2021; also the Voicing Loss Principles for Practice No.3

[3] Practice on disclosure should reflect the Chief Coroner Guidance No. 44: Disclosure, September 13, 2022.

Principle 3:

Person-centred communication

Addressing shortcomings in information and communication is not simply a matter of improving *what* bereaved people are told about the coronial process in general and the current investigation in particular. It is also about *how* they are told. Styles of communication that are impersonal and entirely process-oriented, rather than person-centred, cause discomfort and distress. (The theme of quality of interaction, with a focus on inquest hearings, is further examined in Voicing Loss Principles for Practice No.2.)

"It's a clunky system, which is not geared up for pain. It's geared up for process." **- Father**

As also applies to the delivery of many other public services, there is inevitably a tension between, on the one hand, dealing swiftly with large numbers of 'cases' and, on the other hand, providing personalised communication with individuals in unique circumstances, for whom this is likely to be their first ever encounter with the service, and who are likely to be profoundly affected by it.

"For the coroner and the coroner's staff, which I get, it's like this is a process that they've got to get through, and then tomorrow, there's another one, and I understand that. But there needs to be a recognition that it's not like that for families. That's not how it is. That's why I say it needs to be much, much more person-centred and, yes, the families need to be at the heart of what they're doing and what they're thinking about doing." **- Father**

Even in a time-pressured environment, it is possible to communicate with the bereaved in a manner that conveys empathy and respect.

"[The coroner's officer] was really helpful and always very supportive... always really kind. Everybody that I dealt with at the office was always very kind to us. I couldn't fault them." **- Mother**

"I remember getting a call, the very next day from the coroner's officer. I thought she was fairly sympathetic... She said to me, 'I'm sorry to hear about your sister; I work for [the coroner] and he's going to take on your sister's inquest.'... I thought, well, that's really good." **- Sister**

"[The coroners' officers] were all unfailingly polite and pleasant... Their customer care skills were very, very good. All I thought, at every point, was that they were probably overworked." **- Mother**

Where, in contrast, the manner of communication lacks empathy and respect, the bereaved can feel diminished and excluded.

"It was a case of lip service and trying just to tick a box. To me, there was no support

for us; there was no ability for us to sit down with anybody and try and understand what was happening. Don't get me wrong: we're both intelligent people, with good jobs. But we were very much excluded from everything." **- Mother**

"I spoke to the coroner's officer to find out about when [my son] would be having his autopsy... I remember standing in the kitchen. He said, 'Oh, let me check the list and see where he is.' He went, 'One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, oh, he's number sixteen.' All those fifteen numbers before. Number six is somebody's relative, somebody's son, somebody's granny..." **- Mother**

Another consideration is that if attempts to forge a human connection are made in a clumsy way, with little care or forethought, they can backfire badly, with effects that are harmful rather than helpful.

"[When the court officer saw my photograph of my son], she said to me: 'I had one like that. A jack the lad.'... It was obvious to me that she'd actually read the family statement, and she'd drawn conclusions ... and was thinking that he was some jack the lad.. But it's not for her to comment at all. So I was utterly shocked by that... Now I'm sure she believed that she was being really friendly, nice and all the rest of it. But it was completely the wrong thing to do." **- Mother**

Inaccuracies and errors in communication undermine effective delivery of the coroner service, and also give the impression of lack of consideration and care for the deceased and the bereaved.

"The coroner rang me back and left a voicemail on my phone, but that was for another person's daughter that her mum had died." **- Sister**

"The first death certificate I got back from the coroner, his name was wrong. It's like there's no excuse for that, because you're then like: I've now got to go back to the coroner to say, 'I need another certificate. You couldn't even spell my son's name correctly.'" **- Mother**

"I was sent a password-protected bundle [containing the evidence], with the password in the same email, which completely defeats the object of having a separate password." **- Mother**

As with the problem of delay, there is an expectation that apologies should follow – and can help to mitigate the impact – when errors have been made.

"You feel like you are the least important person, because there's just no consideration for the impact any of those mistakes have on you as a newly bereaved person. None at all; much less an apology to say, 'We got that wrong.'" **- Father**

"The only experience I had from the coroner's office was an incorrect death certificate, and no apology or anything for the mistakes that they had made." **- Sister**

"[After information was sent to the wrong person], I just got: 'Mistakes have been made. Something got mislaid, and cross-wired, and they didn't get told.' Which I didn't think was good enough, really. Because I had to wait all that time for any confirmation of anything. I was just waiting in the dark. I didn't have a clue what to expect. The lady at the coroner's office – I thought she was very heartless about it." **- Wife**

Good practice points:

Person-centred communication

- **Point of contact:** As far as possible, the bereaved should have a named individual within the coroner's team as a primary point of contact throughout the investigation process, who can build rapport and address specific concerns in a sensitive and empathetic way.
- **Tailored communication:** Individual needs, capacity and circumstances of bereaved people should be taken into account in all communication about the investigation, and reflected in the language and modes of communication used, and in the level and complexity of information conveyed.
- **Reflecting shared humanity through language:** Careless or inconsiderate language can cause significant distress. Coroners' officers and others should, at all times, use language that reflects the common humanity of everyone concerned in the coronial process, including the deceased.
- **Accuracy of communication:** Utmost care should be taken to avoid inaccuracies in documentation and other information provided to bereaved people, and to ensure that communication is accurate and consistent.

Annex:

Coroner service webpages/sites

All local coroner service webpages/sites should, at a minimum, include the following information:

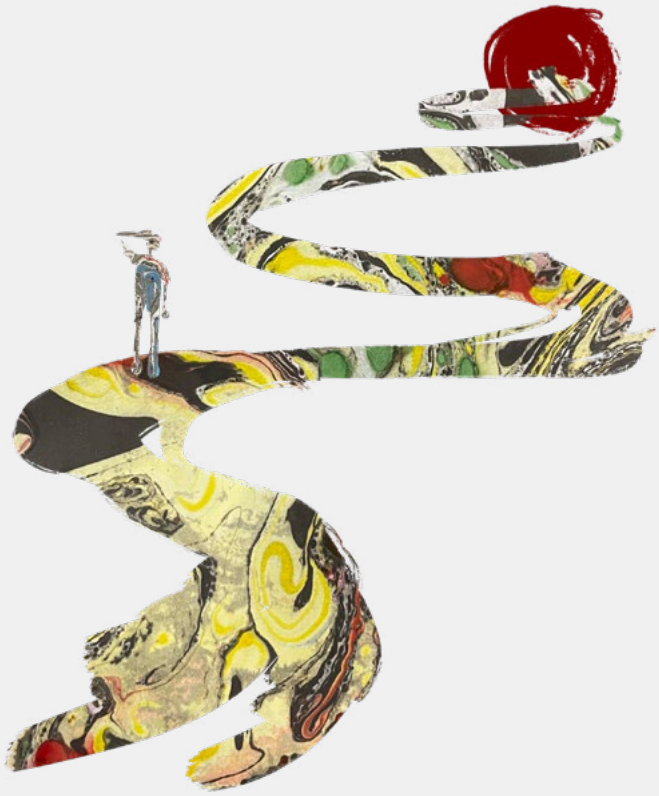
- Roles of members of the coroner team (including senior, area and assistant coroners; coroners' officers and other staff)
- Names of coroner team members
- Purpose and remit of coroners' investigations, including the four statutory questions and coroners' obligations in relation to reporting on identified risks of future deaths
- Explanation of the coronial process and key stages of a coroner's investigation, including pre-inquest reviews, inquest hearings and inquest conclusions
- Rights of bereaved people and other interested persons
- Listing of forthcoming hearings
- FAQs on the coronial process and attending inquest hearings
- Location of coroners' courts; transport and parking options; accessibility and facilities; including photographs of buildings (external only, if there are security concerns about internal photographs)
- Arrangements for remote attendance at inquest hearings (with an explanation that this is on a case-by-case basis only)
- Information on visiting coroners' courts to observe hearings (for example, if bereaved people or witnesses wish to observe a hearing for familiarisation purposes)
- Information on how the death will be registered (or links to other source of information)
- Information about the post-mortem examination, organ donation, tissue retention and release of the body (or links to other sources of information)
- How to raise concerns or complaints about the local coroner service
- Details of the Coroners Courts Support Service helpline, links to CCSS website and (if applicable) role of CCSS volunteers at court
- Specific information for witnesses and jurors
- Information for reporters and about media coverage of inquests
- Other aspects of, and information about, the local coroner service
- Information on the Medical Examiner system and its relationship to the coroner service
- Link to the Ministry of Justice *Guide to Coroner Services*
- Links to other relevant organisations, services and sources of information (potentially including INQUEST, local support services for bereaved people, coroner statistics, the webpage of the Office of the Chief Coroner)

Informed by the Voicing Loss research team's scoping review of existing coroner service webpages and websites.

Sources of guidance and about Voicing Loss

This Principles for Practice document should be read in conjunction with the following practice guidance:

- Chief Coroner's Guidance, Advice and Law Sheets, which are intended to assist coroners with the law and their legal duties, and to provide commentary and advice on policy and practice
- Equal Treatment Bench Book which aims to increase awareness and understanding – among all members of the judiciary – of the different circumstances of people appearing in courts and tribunals
- The Statement of Expected Behaviour, setting out the standards of behaviour expected from all judicial office holders – in relation to each other, staff and court users
- The Advocate's Gateway's practical, evidence-based guidance for legal practitioners on communicating with vulnerable court users
- Resources produced by the Bar Standards Board, Solicitors Regulation Authority and CILEx Regulation for legal practitioners practising in coroners' courts, which include a statement of competencies.
- The practitioner's guide on Achieving Racial Justice at Inquests, produced by JUSTICE in association with INQUEST.



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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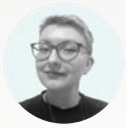

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