Voicing Loss

Research Findings No.3

‘The more traumatic inquests stick with you forever. But you can remember them all’:

How witnesses experience the inquest process

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This report is one of a series of Research Findings papers produced by 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.

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Summary

This paper explores witnesses' experiences of coroners' investigations and inquests, as part of the Voicing Loss project on the role of bereaved people in the coronial process. The paper presents the findings of interviews with 19 individuals who have given evidence to a coroner's investigation in a professional capacity and/or supported colleagues who were witnesses. The paper summarises the respondents' accounts of their involvement in the coronial process, and how they were professionally and personally affected. The experiences of professional witnesses is a subject which has to date received little attention in both research and policy. It is a complex subject, given that there are many contexts and circumstances in which professionals may find themselves caught up in a coroner's investigation. In some cases, they may have had a close – albeit professional – relationship with the deceased, and an ongoing relationship with the bereaved.

The Voicing Loss witness respondents demonstrated their willingness to work with the requirements of coronial investigations and inquests, and to consider bereaved people throughout. There was consensus among the respondents that death investigations have an important part to play in ensuring that employers respond to and learn from deaths – reflecting the preventive dimension of the coroner's role. This is the backdrop to the respondents' mixed experiences of participation in the inquest process, including in terms of how they were guided, supported and treated throughout by both their employers and the local coroner service. Generally, inquest hearings were experienced as difficult and emotive, with particular anxieties expressed about the presence of and interactions with bereaved people, being questioned, and recalling and reliving difficult events.

Accordingly, respondents articulated various ways in which they could be professionally and personally affected by their experiences of the inquest process. For some, this followed on from heightened emotions associated with the death itself and their experiences of other death investigations. Professional self-doubt or blame, along with grief, trauma and other mental health difficulties, were commonly recounted. Some changed or left their post following experience of an inquest, or the cumulative fatigue and impact of more regular exposure to death and death investigations. It is evident that practical assistance and support throughout, from employers and coroners' teams, coupled with fair treatment, kindness and respect in the coroner's court, can reduce anxiety, distress and other negative outcomes before, during and after hearings.

The majority of witness respondents were in roles and sectors that meant there was routine

engagement with bereaved families. Some shared experiences of constructive dialogue with bereaved people after a death, and of how they were able to support them throughout the coronial and other investigations. Others described missed opportunities for such dialogue and reflected on how this could affect everyone involved during the coroner's investigation and inquest. Respondents had mixed views on the quality of treatment that bereaved people received over the course of coroners' investigations, but most felt that the bereaved were compassionately treated at inquest hearings. Notably, some of the witness respondents believed that they were themselves less important than bereaved people within the coronial process, sometimes to the extent that they were willing to accept poor treatment at inquests.

The Voicing Loss witness interviews make a small but important contribution to an area in which little research has been conducted. The experiences captured here support other research, while highlighting the need for further work to extend understanding of how witnesses experience and are affected by the coronial process. The interviews also demonstrate the need for changes to practice, most notably to ensure consistently fair, respectful and compassionate treatment. There is also a need for increased awareness across the coroner service, and among some employers, of how bereavement, grief and trauma can affect professionals who encounter deaths in the course of their work, and of how the inquest process – particularly, experiences of presenting evidence and being questioned – can potentially aggravate or ease these problems. Employers and coroners' teams have shared responsibility to prepare and support witnesses throughout a coroner's investigation and inquest. For some employers, there would be benefits to new models of communication between employees and the bereaved, as good communication can significantly improve experiences of the coronial process for all. Overall, consideration of the needs of witnesses, and of their right to be treated with fairness, sympathy and respect, should be part of ongoing debates about reform of the coroner service in the context of the multiple internal and external challenges it is facing.

1. Introduction

In England and Wales, coroners are independent judicial officers with responsibility 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 coroner service is localised, although the Chief Coroner provides leadership, guidance and support for coroners at a national level.

Coroners' investigations must address four statutory questions: who died and how, when and where they came by their death. Where necessary, the investigation culminates in an inquest: a hearing, usually held in public and occasionally with a jury, focused on establishing the facts relating to the statutory questions. In order for the state to comply with its obligations under Article 2 (right to life) of the European Convention on Human Rights, the coroner's investigation must additionally consider 'in what circumstances' the person died, if a state body might be implicated in the death. Inquests cannot, however, consider questions of civil or criminal liability.

The coroner's statutory role includes a preventive dimension. The coroner must provide a report – generally known as a Prevention of Future (PFD) Deaths or Regulation 28 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 these risks. 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.

In 2023, about 400 coroners, working across approximately 80 local coroners' areas, had 195,000 deaths referred to them – that is, 34% of all registered deaths in England and Wales. Coroners opened around 36,900 inquests, and 569 PFD reports were issued (Ministry of Justice, 2024).

1.1 Professional witnesses and the coronial system

Professionals, in various roles and from a range of services and organisations, can find themselves involved as witnesses in internal and external reviews and investigations – including inquests – that follow the death of a client, patient or user of a service. In many cases, witnesses provided treatment, care or some kind of other service to the deceased prior to or at the time of the death. Witnesses who appear at inquests often include individuals from health, mental health and social care services (including emergency, in-patient and community services) and criminal justice organisations such as

prisons and the police, but could be from any other sector of employment.

The role of a professional witness may be limited to making a statement for the coroner's investigation, if they have information that can help the coroner determine the facts of the death. They may subsequently be called to give oral evidence (in person or remotely) at the inquest hearing, if there is one. Witnesses giving oral evidence are usually taken through their statement and then asked questions by the coroner and others, potentially including the bereaved, other interested persons, and legal representatives of the interested persons.[1] They may receive help and support from their employer to prepare for giving evidence and, if they or their employer is a designated interested person, have legal representation themselves. At some inquests, there are a large number of witnesses from the same or multiple organisations. Witnesses appearing at an inquest may also include lay people (such as family members), as well as 'expert witnesses' who provide independent opinion based on their specialist expertise. Over the course of this paper, the term 'witnesses' is used as a shorthand to refer to professional witnesses of fact, who are its focus.

Inquest hearings are inquisitorial, fact-finding proceedings. However, the findings of the Voicing Loss research make it clear that where there are contested aspects to the coroner's investigation – for example, concerns that poor care or treatment, or other failings in the delivery of a service, contributed to the death – the proceedings can feel adversarial to those involved. In such circumstances, bereaved family or friends may perceive witnesses to be antagonistic, defensive or dishonest, while witnesses may perceive the bereaved (or their lawyers) to be seeking to attribute blame or to lay the groundwork for civil or other legal proceedings that might follow the inquest. Even in less contentious circumstances, the relationship or any interaction between bereaved people and witnesses may be fraught or hostile. On the other hand, coronial investigations and inquests can potentially provide an opportunity for constructive dialogue between bereaved people and professionals who were engaged in the care or treatment of the deceased. This might involve (within or outside the formal proceedings) expression of condolences or apologies, or discussion of specific concerns of the bereaved in relation to the death.

Despite the central role of witnesses in coroners' investigations and inquests, it is a group about whom there has been limited UK or international research. They are also paid scant attention in coronial practice and policy debate. From the little research that has explored this topic, it is apparent that how the inquest process is experienced can positively or negatively affect witnesses in a range of ways, with some authors referring to witnesses as 'secondary' (Seys et al., 2012) or 'tertiary' victims (Taylor et al. 2013). A thematic synthesis of six studies of mental health practitioners' experiences of inquests and other formal inquiries following a patient's death found that professional engagement with these processes was often experienced as stressful and hostile, leaving practitioners feeling blamed and scapegoated. The authors concluded that:

> "The psychological impact of patient suicide or patient-perpetrated homicide could be exacerbated by the formal inquiry processes that followed. Generally, participants described the

[1] Interested persons, designated by the coroner, have certain rights during investigations and at hearings, including the right to ask questions of witnesses. Interested persons may include close relatives or other representatives of the deceased, others associated with the death, and representatives of government departments and other organisations.

process of attending the inquest or inquiry proceedings as stressful and frightening." (Tamworth et al, 2024: 9).[2]

The existing research suggests that how witnesses experience, and are affected by, death investigations is influenced by the amount and quality of training and support available to them from employers. Some sectors, most commonly healthcare, offer a range of information, guidance and support to their employees who have to give evidence at inquest hearings. Generally, however, witnesses have reported that the support from their employer is highly variable, and that limitations to what is provided can leave them feeling anxious, frightened, unprepared and emotionally vulnerable (Corteen et al, 2014; Tamworth et al, 2024).[3] It is also evident that there are a number of contextual variables surrounding the delivery of the coroner service across England and Wales that may directly or indirectly affect witnesses and potentially make their experiences more difficult. These include resourcing and staffing pressures; the increasing complexity of deaths reported to coroners; tendencies towards adversarial styles of questioning; debate about the role of coroners in relation to preventing future deaths; public visibility and scrutiny including media reporting; and the desire of many bereaved families (whether or not supported by their own legal representation) to stretch the parameters of the coroner's remit in their search for justice and accountability.[4]

Witnesses can be personally affected by the death that is under investigation, although usually in markedly different ways to relatives and friends of the deceased. Emotional repercussions for witnesses can differ according to, for example, their relationship with the deceased; the degree and nature of involvement in their care; and the circumstances of the death. Some are affected by more regular exposure to death by virtue of their role (Banwell-Moore et al., 2022; Allie et al., 2018). The nature of some deaths can result in trauma and post-traumatic stress disorder, which can be exacerbated by involvement in death investigations and the requirement to recall the detail of what happened (Roche et al., 2024; Banwell-Moore et al., 2022). For some, the emotional impact can be accompanied by a sense of guilt, blame, responsibility or professional self-doubt, all of which can have implications for mental and physical health, and there is also evidence that some make significant career decisions – such as to change or leave their role – because of the impact of deaths and investigations (McAuley and Forsyth, 2011; Tamworth et al., 2024).[5] Negative impacts of death investigations can be intensified if they are unrecognised and if witnesses are unsupported.

1.2 About Voicing Loss and the professional witness respondents

This paper is one of a series of Findings reports produced by the Voicing Loss project on the role of bereaved people in the coronial process. It is the largest investigation of personal and professional experiences of the coronial process that has been conducted to date in England and Wales. The main component of the project was a qualitative, empirical investigation, in the form of in-depth interviews

[2] Five of the six studies included in the analysis were UK based. The studies were mainly surveys focused on patient deaths by suicide or homicide, and participants were primarily psychiatrists.

[3] See also Croft *et al*;, 2022; Gibbons *et al.*, 2019; Hussain *et al.*, 2024; Roulston *et al.*, 2021; Wright *et al.*, 2012.

[4] See, for example, Corteen *et al.*, 2014; Taylor *et al.*, 2013; Wright *et al.*, 2012. See Chief Coroner (2024) for some of the contextual pressures on the coroner service in England and Wales at the present time.

[5] Also, for example, Corteen *et al.*, 2014; Croft *et al.*, 2022; Gibbons *et al.*, 2019; Hussain *et al.*, 2024; Roulston *et al.*, 2021; Seys *et al.*, 2012; Taylor *et al.*, 2013.

with 89 bereaved people who had experienced the coronial process, as well as interviews with coronial professionals including coroners, coroners' officers, inquest lawyers and many others.[6]

It was not part of the original project plan to interview witnesses. However, the relevance of the witness role to bereaved people's experiences emerged from our initial research and policy review, discussions with stakeholders and early interviews with bereaved people and coronial professionals. It seemed evident that witnesses' conduct throughout the coronial process, particularly during inquest hearings, and that of their legal representatives, can have significant implications for the bereaved. Further, there seemed to be a possibility of echoes of some bereaved people's experiences in the experiences of witnesses. We therefore decided to undertake a small number of witness interviews, as a way of broadening the insights to be generated by our research and contributing to knowledge on an under-researched topic.

We completed interviews with 19 professionals with experience of providing evidence to coroners' investigations (including, in most cases, giving oral evidence at inquest hearings) and/or supporting colleagues who were witnesses. The respondents' professional backgrounds are summarised in Table 1.

Table 1: 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[7] • 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)	

Of the 19 witness respondents, 15 had given oral evidence at an inquest hearing – some on one or

[6] Further information on the study, including its aims, methodology and the existing research evidence base, is provided in our paper, Voicing Loss: Research context and methodology. The dedicated project website provides access to a range of outputs including policy and practice briefings based on the research findings.

[7] One of the consultants was also a medical examiner: that is, a doctor who provides independent scrutiny of the causes of death. A new statutory medical examiner system will be in place across all of England and Wales from September 2024.

a small number of occasions; others relatively frequently over many years. Two respondents had provided witness statements to a coroner's investigation but had not been called to give oral evidence. The other two respondents had experience of supporting colleagues who were witnesses (several of the 17 who had themselves been witnesses also had experience of supporting colleagues in this role). Many of the 19 also had experience of other kinds of involvement in coronial investigations, for example, having supported bereaved families and assisted with collection of evidence. Two respondents also discussed, in their interviews, personal experiences of an inquest following the death of a close relative.

Although this was a small, exploratory component of the Voicing Loss project which has only scratched the surface of witnesses' experiences, it provides insights into some of the main challenges they face and the factors that can ease or, conversely, negatively affect the process and its impacts. Four aspects of witness experience will be discussed below, as summarised in Figure 1: preparation and support throughout the coronial process; giving oral evidence at inquest hearings; contact with bereaved people; and impacts of coronial investigations and inquest hearings. The discussion is supported by data from Voicing Loss interviews with bereaved and coronial professional respondents, where relevant.

Figure 1: Professional witnesses' experiences of the coronial process

Preparation and support throughout the coronial process	Giving oral evidence at inquest hearings	Contact with bereaved people	Impacts of coronial investigations and inquest hearings
• Engagement with coronial investigations • Preparation for inquest hearings • Support from employers • Perspectives on prevention of future deaths	• General experiences of giving evidence • Treatment of witnesses by coroners • Being questioned	• Interactions with bereaved people • Being questioned by bereaved people and their lawyers • Perceptions of treatment of bereaved people	• General personal and professional impacts • Recalling and reliving • Professional dilemmas • Impact on jobs and careers • Location of professional witnesses in the coronial process

2. Preparation and support throughout the coronial process

This section of the paper covers engagement with coronial investigations; preparation for inquest hearings; support from employers; and perspectives on prevention of future deaths.

2.1 Engagement with coronial investigations

Generally, respondents understood the importance of investigations, including by the coroner, following a death. They recognised the need for thoroughness in written evidence and reports provided to the coroner prior to any inquest hearing, and that this could have repercussions for whether they, or another representative of their organisation, were called to give evidence.

> "Our philosophy is, if you write a good report in the first place, you probably won't get called [to give evidence at the inquest], which generally works quite well." **- Substance use treatment NGO**

> "If we get the [coroner's] investigation right, if we get the interaction and communication with the family right, the coroner doesn't usually call people who were there on the day. They call people like me who've done the investigation to be a representative of the team, and therefore it's not so personal... We don't go to coroner's court that often, and when we do, it's a big deal for us. It's something that we have to get right." **- Health practitioner**

Another aspect of engagement with coronial investigations discussed by many respondents was their relationship with coroners and coroners' teams. Some talked about the importance of fostering good working relationships with coroners and their staff.

> "I'm the point of call for any coroners' enquiries... They know to come to me if something is running late, or if we've missed something, or if there's anything that they want to pick up. So, it's quite a good two-way stream of information. If you get a coroner's report request, you get it in on time. You don't make the coroner wait, because that just is going to annoy the coroner, isn't it? So, you do everything you can to prevent getting on their radar, if you like, as being difficult and challenging." **- Substance use treatment NGO**

> "Because I'm doing this as a full-time role, I've got a much better relationship with the coroners' officers, and basically we would keep in touch." **- Police**

Respondents valued help and support from coroners' officers, before and at inquest hearings, although one described their upset at encountering a lack of consideration.

"The staff are always really super friendly, super helpful, knowledgeable. I've always found them to be brilliant… If you're not sure of anything, just ask the staff members that are at the court… [They have] a lovely way with them. They'll go out of their way to make you feel as comfortable as you can." **– Police**

"We went to see the [coroner's court]… The people that ran the coroner's desk were beyond incompetent in terms of how they spoke to me. They kept talking to [my husband], and he had to keep saying, 'It's [my wife] that's going to be giving evidence'… I just remember thinking, 'This is just a joke. This is just embarrassing.'" **– Education professional**

Other respondents also described shortcomings in communication from coroners' teams, for example, regarding case progression and delays, demands from coroners perceived as excessive and unclear, and a lack of clarity about what was wanted by the coroner.

"We are getting increasingly grumpy because there's an increasing demand for statements, for attendance at inquest… The coroner is getting increasingly grumpy because things are coming back late… We're getting overwhelmed… We're certainly losing a day of consultant time every week at the moment to the coroner, either through a statement or attendance at an inquest."
– Health practitioner

"We're back to the, 'What questions do they need answering?' And we have no idea. The immediate panic, because we're being called, is, 'Have we done something wrong? Have they spotted something that we haven't spotted?' Whereas if they just said, 'We just need a bit more information on this or this,' it would be fine… It's always guessing what you may be about to be asked and then you can go other times thinking that everything's sorted, there is not an issue, and get absolutely blasted." **– Substance use treatment NGO**

A police respondent partly attributed poor communication to police and coroners' officers being located in different areas of the city, while two prison respondents commented that staff can feel excluded from the process when communication is managed by legal representatives. Some respondents thought that the coronial process, generally, lacked humanity and human contact in its dealings with witnesses who may be greatly affected by the events under investigation and highly apprehensive about the inquest.

"All they do is deal with people who've been through horrible, horrible situations. They should be better prepared to work in ways that are well organised, thoughtful. Just take a little minute before you press send, and maybe pick up the phone… If you want people like me to have faith in the system, there has to be a humanity at the heart of it… If the system isn't robust enough to hold people like me, or people like [the deceased person's parents], then it's broken."
– Education professional

2.2 Preparation for inquest hearings

In talking about preparation for giving evidence at inquest hearings, respondents tended to indicate that they received little direct support from the coroner's team to assist them.

> "When the coroner's office contacted me, there was nothing in their letter which said, 'We understand that there might be quite a lot of anxiety around this. So, to support you, here's a list of websites, or here's a list of resources that are available.' Like, basic stuff… No one ever sat me down and went, 'This is what's going to happen'." **- Education professional**

This same individual was told by the coroner's team that, if she had any questions, that she should go to her police liaison officer – on the mistaken assumption that she had access to support from the police.

The role of employers in preparing their staff for inquest hearings varies according to the experience of the witness(es) and whether the organisation's interaction with the coroner service is a relatively routine or exceptional occurrence. Some respondents reported having received little or no specific information, training and support from their employer.

> "I just think the police assume, because you've had your court training… 'Well, if you can give evidence in criminal court, then you're fine to give evidence at an inquest, because you know what you're doing.' It's not the same. It's certainly not." **- Police**

> "I suppose it's just the more generic training that you have within the role. It's considered sufficient… I suppose I could have emailed some colleagues if I really wanted to and said, 'Oh, look, I've got this inquest and I've never done one before. What do you think?' But it never really occurred to me." **- IMCA**

Some said that, as a result, they had to 'learn on the job', and subsequently drew on their own experiences to ensure that colleagues are better informed and prepared.

> "You just have to pick it up as you go along, I think." **- Health practitioner**

> "Kind of learnt by my own mistakes, I suppose." **- Substance use treatment NGO**

> "The junior doctors all get an induction twice a year and I go through the medical examiner death certification and the role of the coroner. They get a little bit of a structure to what the coroner is actually there to do." **- Health practitioner**

In contrast, other respondents talked about a range of ways in which their employer prepared them for an inquest, including from managers and senior staff, in-house legal teams, or sector-based support (e.g. from the central Safer Custody team of HM Prison and Probation Service). Although one police interviewee described input from a union representative who attended an inquest with her as 'useless', generally participants were positive about support when it was available. Prison respondents outlined a range of ways in which staff are prepared for an inquest.

"We do a lot of prep work with our staff before they go into an inquest… We've got a presentation… we show the coroner's room… we explain what an inquest is, what your role is, and then we bring experienced staff that have been in coroner's court and they can do a Q&A… They meet with our legal team and they refresh their statement. They are given tips as to how to manage questions… There is a debrief after with the staff." **- Prison**

Prison and police respondents further outlined the added value of having dedicated roles to support death investigations. Specifically, in the prison this was a safer custody coordinator: 'the point of contact and the coordinator for paperwork, documentation, arranging interviews, and notifying people of inquest dates.' In the police, this was a civilian investigator: 'an ex-police officer with the detective skills, making the enquiries, writing the report and then presenting it at the inquest… I think that's invaluable, for the family as well.'

Respondents in senior roles highlighted the importance of preparing less experienced or more junior colleagues for, and supporting them at, inquest hearings. Some were clear that they did not want their own poor experiences to be repeated.

"When we do put juniors into coroners' courts… we go with them. They should have top cover. Just because they were the one that wrote the report, the person responsible at every stage is the consultant or the Trust." **- Health practitioner**

"Because it was a recovery worker, and [the organisation] wouldn't usually ask a recovery worker to go, there was immediately support meetings put in for her… It wasn't necessarily that we were worried for [the organisation], it was just that they were worried for her, and they wanted to make sure as much support was in there for her as possible." **- Substance use treatment NGO**

In addition to any support received from others, some respondents described what they personally did to prepare for an inquest, including the importance of mental preparation.

"I felt really prepared to go up there. I knew all the information… I'd written my own notes. Rather than trying to search through the file, because it was so large, I had kind of separated stuff out." **- Prison**

"I think you just have a duty to understand the case really well before you go in. I think you have to prepare and you have to know what you're talking about. I think you have to be ready to accept that there are going to be a whole gamut of emotions potentially flying around that you need to be prepared for… Being mentally prepared that it's going to be a fairly difficult day." **- Health practitioner**

2.3 Support from employers

Respondents painted a mixed picture of the support available from their employer to cope with deaths of patients or service users, and subsequent death investigations where applicable. Some indicated there was no such support, or believed it to be their own responsibility to seek help.

"There was no support… You're just left to deal with it on your own… I would say in terms of

professional support, I've had nothing up to and including now... No one even ever rung me and said how are you doing? It's just not acceptable." **- Education professional**

"Nobody has really ever sat down and spoken to me and said, 'How has it affected you? How do you feel about it?' I've not had that, really. Maybe that's my own fault in that I haven't sought it out." **- Police**

The respondents who were education professionals elaborated that they accessed their own specialist counselling in the aftermath of the fatal incident they had experienced. However, many respondents listed a range of support available from their employer, including practical support, counselling, and access to help from external organisations.

"There are lots of different options in terms of what somebody might need, whether it be something in-house, or something more separate, so that you can deal with it away from work." **- Substance use treatment NGO**

"When I went to the inquest I just had someone drive me up and drive me back, which was helpful because I wouldn't have wanted to get behind the wheel after being on the stand for four or five hours. You're mentally exhausted, aren't you." **- Prison**

"The staff care and support stay there at the inquest, our legal team are there with them, so they're never on their own... On the way there, you would have a chat. On the way home, you would have a chat. When they break for lunch, you were all together... The detail office will get informed, so they don't have to worry about their shifts and, 'Oh, what if I'm on shift, what do I do?' You know, all of that kind of stuff is done for them." **- Prison**

The prison respondents also talked about the implementation of a specialist trauma intervention model, TriM,[8] to support staff following a death, with one explaining how this could help staff manage the inquest process.

"I think TRiM has helped us to structure support and to learn some really significant lessons in the way that we support staff... If you're giving people the opportunity to talk through all those feelings and put some context around those feelings and normalise those feelings that's less likely, then, to come out in the inquest." **- Prison**

Additionally, some respondents talked about the value of informal support received from, and offered to, colleagues.

"The one most dramatic inquest we've had, where quite a lot of staff were involved, the support from [the organisation] was quite amazing... A lot of people came down from head office and spent the day in our building supporting staff." **- Substance use treatment NGO**

"The people I knew were giving evidence... If I sent them a text and said, 'I'll be nearby in this café, come and have a cup of tea,' no one didn't take me up on that." **- Education professional**

[8] TRiM (Trauma Risk Management) was originally developed by the UK Armed Forces, and is now widely used by a wide range of organisations including the NHS, government departments, and charities. The approach aligns with trauma stress management guidance issued by NICE.

However, there was recognition of the broader cultural challenges within an organisation or sector that can discourage employees from asking for or accepting help. Some respondents highlighted efforts to overcome this.

"All these emails telling me that maybe I should be going to the virtual talk cafes and this, that, and the other. I'm probably that generation that just get on, crack on with it, to be fair." **- Police**

"We've challenged that perception that we've just got to get on with it and we are okay, because what we know is that people are not okay. There has been a focus on staff wellbeing and acknowledging that inquests are difficult. Deaths in custody are difficult." **- Prison**

2.4 Perspectives on prevention of future deaths

Some respondents commented on the readiness of their employing organisation to identify and respond to shortcomings in care that may have contributed to the death. They felt that supporting this – through internal review processes as well as their participation in the coroner's investigation – was an important part of their role as witnesses.

"In the summary at the end [of my reports for the coroner], if there is anything that I thought, 'That wasn't brilliant,' I'll put in an explanation as to what we've done since this that would improve that situation in the future, which seems to be being positively accepted by the coroners... We do try and learn something from each death... We are generally quite honest and a bit brutal with ourselves...It isn't about shame, and it isn't about guilt. It's about our service getting better and better." **- Substance use treatment NGO**

"It's recognising the problem, dealing with it and incident managing it correctly....[so] if we ever get called by the coroner to court, we're totally prepared because we're all as one saying, 'This is the outcome of our report. This is the learning'." **- Health practitioner**

However, other respondents expressed frustration with what they saw as the limited preventive potential of the coronial death investigation process

"Sometimes, you see those [PFD reports] and it still doesn't achieve what you want anyway because they're poorly thought through... From a clinician's point of view, in a weird sort of way, that is what we think the process is there for. ... Some of the frustration for the clinicians is there is so little output from the coronial processes when we're involved... You wonder what the point of it is a lot of the time." **- Health practitioner**

"I read [the PFD report] with this deepening feeling of, 'What is the point?'... This is about organisations covering their own arses and trying to ... defend what territory they have and make as few changes to what they'll really do, as they can get away with." **- Education professional**

3. Giving oral evidence at inquest hearings

Most of the witness respondents had experience of giving oral evidence to one or more (and, in some cases, many) inquest hearings. They talked about their general experiences of this, how they were treated by coroners, and what it was like to be questioned. (Respondents' more specific accounts of being questioned by bereaved people and their lawyers are discussed in the next section.)

3.1 General experiences of giving oral evidence

Respondents variously reported having given evidence for periods of a few minutes, several hours, or more than a day. Many described feelings of uncertainty, anxiety and intimidation, sometimes intensified by a lack of knowledge about the process or concern that their job was on the line.

> "One of my colleagues describes it as being airlifted into a strange country. You don't know the language, you don't have a map, and you don't have any of the local currency. You are just stumbling around in the dark, not knowing what to do, how to get information or anything." **- Bereavement support NGO**

> "It was that unknown of... I don't know who's going to be there. I don't know what the family are going to be like... I just didn't know what it was going to be like physically, the set-up. Is it going to be people with wigs and stuff?" **- IMCA**

> "There's this worry that you're going to go in and give evidence and then you're going to be found to be incompetent at your job and reported for remedial action. You'll be struck off your professional register because you gave a poor performance in the coroner's office... There is still that sense of myth and rumour around." **- Health practitioner**

Adding to their anxiety, many respondents recognised that bereaved people can be affected by the evidence presented at an inquest.

> "It can't be nice for the family to sit there, over a number of weeks, and listen to their family member's last hours. They look at CCTV footage, phone calls and hear his voice again. I mean, that must be horrendous." **- Prison**

> "One of the most difficult things for these families is sitting there listening to the pathologist's report." **- Health practitioner**

Accordingly, some respondents highlighted the importance of sensitivity, careful language, and being alert to the potential for causing further trauma to the bereaved.

"I'll have the legal speak opening couple of introduction sentences and then I drift into much more simple speak… I always provide a summary at the end of a report. It's done in a way the coroner can just read in a very family friendly way … With all the right wording for the right reasons, not just because I can write it, but 'comfort', 'dignity', 'pain free', 'peacefully'. Those palliative care words… When you write those reports knowing they will be read out, you should read them to yourself thinking, 'What if I was bereaved reading this report?'" **- Health practitioner**

"We speak in a completely different language, all of our acronyms and job speak… You have to remember that and tailor your answers to somebody that has no idea what you're talking about… The last thing you want to do is drag the family all the way back through that person's dying moments when they were really horrible." **- Police**

With hindsight, one respondent wished she had known that a bereaved relative was present in court as she would have changed some of her responses when giving evidence about a death by suicide.

"What I didn't know at the time was the wife was sat behind [the lawyer]… If I had known that, I would have answered my questions a bit differently. It has quite impacted on me because I feel like I could have helped her a little bit by answering my questions a little bit more clearly… Because I don't want her thinking that if she had just gone against advice and gone that she could have saved [her husband] because she probably does think that, and she'll always think that." **- Police**

3.2 Treatment of witnesses by coroners

Respondents shared their views on how they were treated by coroners, with some describing coroners who were kind and appreciative of their attendance at inquests to give evidence.

"After about two and a quarter, two and a half hours the coroner turns around to me and says, 'Thank you very much, you've been very, very helpful. You're now free to go'." **- Health practitioner**

"We met one of the coroners who, as she walked in the door, just went, 'Have you any idea how famous you are around here? It's so great to meet you.' And was perfectly lovely and was talking about how great I come across on the stand." **- Substance use treatment NGO**

Conversely, another respondent described a coroner's demeanour as aggressive and overly status-conscious.

"We have one senior coroner, who within minutes of an inquest starting, you're not sure of your name, and it feels like you're badgered from the second you arrive… That's really upsetting… [At one inquest], this same coroner went to another witness: 'Right, Doctor [name], can I thank you for your time today. We really appreciate you taking the time out to attend the court.'… I was just sat there thinking: 'There are two of us attending. That's just rude.'" **- Substance use treatment NGO**

Coroners, within and between coroner areas, vary widely in how they approach inquest hearings, including in terms of their expectations of witnesses. Some respondents drew attention to the lack of consistency, which can affect preparation and add to uncertainty and anxiety.

> "I like to find out who I've got as a coroner before the inquest... Some coroners will paraphrase from statements. Other coroners will read every report or statement verbatim, or expect the investigating officer to read them verbatim, during the inquest. Some can be quite curt, more harsh, towards witnesses; some are not. It's really subjective as to how they run their coroner's court." **- Police**

Some respondents underlined the benefits of consistency as well as specialist knowledge on the part of coroners. For example, a coroner who has a good grounding in the administration of a prison or the delivery of treatment services can take some of the pressure off those giving evidence.

> "We've had coroners, who are new to [the prison] and new to that particular scenario, who perhaps don't control the questioning quite so well... For lots of our coroners' inquests, we have the same coroner... They have an understanding of how the prison functions, so that's helpful... [and are] more attuned to the impact on staff." **- Prison**

> "My easier experiences are where you've got a coroner who understands treatment services and understands the limitations, I suppose, of what services are able to deliver. Then, when you have coroners who, perhaps, are less experienced or don't understand treatment systems, that can be more challenging." **- Substance use treatment NGO**

3.3 Being questioned

How witnesses are questioned by coroners and others is a key variable affecting how an inquest is experienced and its impact.

> "There are times when you feel like you've genuinely helped and other times when you just feel like you've just been bullied for the last hour and a half." **- Substance use treatment NGO**

Some respondents remembered appropriate and considered questioning, and mentioned the role of their own legal representatives in helping to manage the process.

> "The questioning and the way we were treated by the people that take part is very nice, I suppose, is the best way to put it. It's not adversarial. It's never come across like it, 'We're going to have a go at you,' or, 'We're pointing the finger at you, it's all your fault'... It's not designed to be adversarial or finger pointing or anything like that. It is not. Although it will feel like it, it is not like that." **- Police**

> "Our legal team were so much more supportive. When they had the opportunity, they clarified points and assisted in terms of getting me to my point that I wanted to make...It was a much better experience in terms of how we were handled by the defence [sic] team. I didn't feel like they were trying to apportion blame. I felt that they were trying to get to my decision-making." **- Prison**

In sharp contrast, however, other respondents used terms like 'daunting', 'bullying', 'cross examined', 'nerve-wracking', and 'really stressful' in describing experiences of being questioned – even, sometimes, by their own legal representatives. Similar comments about questioning of witnesses were made by some of the inquest lawyers interviewed for Voicing Loss.

"I've had really good people attend with me... [then] I had one barrister who was awful and just made it worse... Some of the questions he was asking felt almost like we had something to hide, and we didn't. So, it was trying to detract the blame, whereas you didn't need to do that. All of those different things can just change the dynamics and change how it feels to be there." **- Substance use treatment NGO**

"It's absolutely horrendous. The amount of time sometimes you have to stop because a witness bursts into tears and gets upset. That's fairly commonplace with medical professionals. Particularly the nursing staff get distressed, because ultimately, they're being accused of playing a part in somebody's death... They feel like they're on trial and it can be very adversarial... It's a daunting, pressurised experience." **- Inquest lawyer**

The way they were questioned left some witnesses feeling that they or their employer were under attack and, as a result, some were concerned about appearing defensive.

"The health authority lawyer... seemed very keen to blame me... It was like he was looking to blame me and get the health authority out of it. That is the impression I got." **- Bereavement support NGO**

"I always felt you were ... a bit on the back foot. I was quite defensive, if I'm perfectly honest... I felt they were trying to apportion blame to myself – not the prison: to me, personally... It was almost like a personal attack." **- Prison**

This could leave some feeling under pressure to change what they said or to respond to questions that they were not in a position to answer.

"I I felt like when I was getting questioned, the same question again and again, I felt like I should change my answer and say, 'Okay, maybe in hindsight I should have.' And I nearly did, and then I just went, 'No,' because my gut was saying no, and I got quite angry about it." **- Police**

"[You should be] prepared to be strong in your own opinions where you think that that's appropriate and willing to make your points repeatedly, if necessary, if you don't think they're getting through. But at the same time, actually if you don't know, you need to be absolutely honest ... and say, 'Look, I just don't know. I can't answer that. I just can't tell you,' and acknowledge that uncertainty." **- Health practitioner**

Of particular concern to some was that aggressive and persistent questioning could have implications for how the bereaved perceived witnesses.

"It doesn't look good, sometimes, when the coroner's really nit-picking and having a go, when you're thinking, 'I've explained this and it's a reasonable explanation. Why do you keep going back

to it?'... It just puts that question then in the family member's head." - **Substance use treatment NGO**

"You're trying to protect yourself ... but I want the family to see me as a human being; I don't want them to see me as a discipline officer... I want them to see me as, 'Right, do you know what, she did absolutely everything that she possibly could to look after him.' I want them to get closure from that, but I can't be human on the stand when you're being grilled." - **Prison**

Some respondents were of the view that inquest hearings have become increasingly adversarial, with some adding that there is a need for earlier intervention by coroners to prevent this.

"We've seen an increasingly adversarial process over the last probably 10, 15 years... That was getting much more pronounced towards the end of the last coroner's term in office. It really did feel like you were in criminal or civil court." - **Health practitioner**

"The coroner should step in earlier... Where it has been quite awful is when it's being allowed to go on... They're trying to be understanding and give the family a voice, but as a professional, or anyone else trying to give evidence, you can only give the evidence that you have. To keep asking it and getting cross doesn't make a difference to the answer." - **Substance use treatment NGO**

4. Contact with bereaved people

This section of the paper covers what respondents said about contact with bereaved people; being questioned by bereaved people and their lawyers; and perceptions of treatment of bereaved people.

Contact between witnesses and bereaved people throughout the inquest process is highly variable and potentially complex. There may be an existing relationship between a witness (and their employer) and the bereaved, if the former had been involved in providing care or treatment to the deceased. There may be contact at the time of or shortly after the death, including for purposes of notifying the bereaved of the death and providing other information (including about referral to the coroner). Professional representatives may attend the funeral, sometimes at the invitation of the family. Contact may then continue while internal reviews or inquiries, as well as the coroner's investigation, are being conducted. Such interactions may be characterised by mutual respect, and shared upset and concerns about the manner of the death. On the other hand, interactions between witnesses and bereaved people can be fractious, fuelled by suspicion, blame and distrust on the part of the bereaved, and defensiveness on the part of the professionals. At the inquest hearing, there may be a wish – from either or both sides – for direct communication, but senior staff or legal representatives may prevent this because of concerns about repercussions for any future civil proceedings. Overall, contact between the bereaved and witnesses, or its absence, can have a significant impact on how both groups experience the coroner's investigation and inquest.

4.1 Interactions with bereaved people

Some respondents talked about their experiences of contact with bereaved people at the time of the death, including to inform them about the death, offer immediate support (which may, for example, be provided through police or family liaison officers), write condolence letters, or attend funerals. For some, this contact naturally followed on from that in place before the death. Respondents emphasised the importance of subsequent open communication with bereaved people about the circumstances of the death, including by providing opportunities for them to ask questions and raise concerns.

"Usually, all the relatives are just really angry. They're stuck in their grief. They want answers, and if we meet with them in a timely manner … we can usually address it and it doesn't become

such a thing… [In one case, we met the family] and said, 'We failed your father.' … It never went to coroner's court because we'd done the full investigation. We'd met with the family. They weren't happy, understandably, but they understood and we were putting our hands up. There was no question about it. We were at fault." **- Health practitioner**

Where a coroner's investigation proceeded to an inquest, respondents reiterated the importance of continued communication with and support for the bereaved, where possible.

"The day you go out to inform the family, we leave information to explain some of the investigations that will happen. One of those is the inquest … explaining the process, bringing that process to life a bit… Being with the family through that process… sit with them, go out to their homes, talk through things." **- Prison**

"I always say, on the bottom of my emails [to families], 'I'm going to submit my report now, it's going to be a while before we hear about when the inquest is going to be. But in the meantime, if you've got any questions or if there is anything I can help you with, email me.' As long as the families know this and are told this and it's explained to them … then they can come to terms with it a little bit… They just need to be kept informed." **- Police**

For some, managing bereaved people's expectations of the inquest is a vital part of such conversations.

"The earlier that people can communicate their boundaries … the easier it would be for everybody… You can deal with that at a hearing prior to that inquest rather than have that build up and feel really let down on the day itself… All that wiggle room has been done beforehand and everyone is settled for that day rather than there be an argument on the day, which just upsets everybody even more than they're already going to be upset." **- Police**

"You have to try and work out what the family's expectations of the process are… You're trying to advise them or manage expectations… My general experience is that the inquests that I've been involved with, the families come out of it underwhelmed, shall we say, for a variety of reasons. Because I think, fundamentally, they don't really understand or had different expectations for what this thing is supposed to deliver." **- Health practitioner**

Some of the respondents felt that their communication with bereaved people was necessitated, at least in part, by inadequate communication between the coroner's team and the bereaved, even if this places additional demands on themselves or colleagues.

"Sometimes families report to me that there is a lack of contact between the coroner's office and them… Often families can be left for those initial weeks… It's also a language that perhaps they haven't been exposed to… They don't have the confidence to speak to a coroner's officer or have the confidence to ring the mortuary and say, 'Actually I want to see my loved one.'" **- Prison**

"I don't think they were dealt with very well at all… Any questions they had, they seemed to direct to me, as opposed to the coroner's office… I had met them in person, and I wasn't somebody who had rung them on a phone and just had a chat… I always felt like it was pushed, very much,

back onto the police… Sometimes, that contact was really non-existent between the coroner and the family… The families get thought about last." **- Police**

The extent and nature of interactions between respondents and bereaved people at inquest hearings were also highly variable. One respondent said, 'No one really talked to anybody' at the inquest she attended, while another described being deliberately kept apart from the family.

"You don't really get an opportunity to talk to them either. We're kept in separate rooms beforehand so that we don't interact… The family either aren't happy with what we've told them or we haven't communicated very well with them… It makes you feel like there's a them and us, but I do think [communication is] probably quite important." **- Health practitioner**

Others gave more positive examples of interactions with the bereaved, such as being thanked or receiving a kind response to an expression of apologies.

"There are times when I've been there, and the family have come over and thanked us for trying, and you just think, 'Oh, bless you.'" **- Substance use treatment NGO**

"[The family] understood that we had done everything in our power to look after him… The family could see how much work had gone into him to try to prevent this from happening. They actually said to us, 'If it hadn't happened in the prison, if he had been in the community, he probably would've died years ago.'" **- Prison**

Some respondents commented that the increased use of remote hearings during and since the pandemic has removed the potential for, or otherwise negatively affected, interactions with bereaved people. While there was recognition that remote hearings can be less intimidating or confrontational for witnesses, there remained a preference for attending in-person, with some indicating that they know this is often the preference of bereaved people.

"I think not having respect for that process of being able to turn up and be a physical presence that's there to answer questions, my sense is always that that's a bit of a disappointment to the families. That you've just remotely got somebody on a screen that asks a few questions, can't always hear and vanishes. I think you do lose more than you gain by that." **- Health practitioner**

"I always prefer to do it in person because it's a court and it's giving evidence. Maybe that's an old-fashioned way of looking at things… You're so much more detached looking through a computer screen than you are when you're sat somewhere live." **- Police**

A small number of respondents talked about contact with bereaved people after the inquest concluded. One said that she remained in touch, albeit sporadically, with the son of the person about whose death she had given evidence. A police interviewee said that a coroner leaving the family with the police investigating officer can be 'awkward … really, really difficult,' particularly if they still want answers or someone to blame.

4.2 Being questioned by bereaved people and their lawyers

Giving evidence in front of bereaved people could bring particular pressure and anxiety for witnesses.

> "It is quite a daunting thing... I've never met the family... I had a lot of anxiety almost about going there... I think it's the family that I was most concerned about." **- IMCA**

> "I wanted to present a professional image to the family and to the court, and to also make the family feel that enquiries had been done diligently and properly, and not be leaving them with any doubts in their mind that we hadn't done something correctly. So, yes, I was always a bit tentative when I went there." **- Police**

This anxiety stemmed, at least in part, from what was perceived to be an adversarial or overly confrontational approach to questioning taken by some bereaved people and their legal representatives.

> "I've seen a family who were quite vociferous in the inquest, and demanding. Several members of that family ... were firing questions out of sequence, to the coroner, to the investigating officer. The coroner had to calm them down, and say, 'You need to appoint one member of the family to ask those questions, and ask them at the appropriate time.'" **- Police**

> "The barrister for the family was normally a criminal barrister; the coroner had to stop the inquest proceedings constantly because of the nature of the questioning... It was really quite distressing for the staff." **- Prison**

One respondent reflected on the difference that competent or poor legal representation of a bereaved family can make.

> "The advocate on that case was outstanding... The kind of compassion on display was exceptional... He helped raise some interesting points that the family wanted clarification on... Then I've seen some terrible ones... You could almost see them trying to lay groundwork for a later civil claim... I think they can be incredibly destructive and you get the sense that they don't always understand the process themselves either." **- Health practitioner**

Some respondents recognised that there might be a need for flexibility to allow bereaved people to ask questions that are important to them even if they do not entirely fall within the scope of the inquiry.

> "If [the questions of the bereaved] can be encapsulated in what is going on, then why not? What harm is there? ... Sometimes we turn into just digital robots, 'This is what we do.' Anything outside of that doesn't matter. Well, it is a really difficult thing for people to go through. If it's that one question that they really have a burning desire to ask, as difficult as it might be for us, then so be it. You might have to take that one on the chin and deal with it." **- Police**

4.3 Perceptions of treatment of bereaved people

As part of sharing their own experiences of inquest hearings, the respondents gave their impressions of how they saw bereaved people treated by coroners and others. Some also commented on the policy aspiration – reiterated by government and successive Chief Coroners – that the bereaved should be 'at the heart' of the coronial process. Based on the inquests they had attended, the respondents were largely of the opinion that bereaved people are treated kindly and respectfully, and generally are placed at the heart of the process – a perspective that sharply contrasts with accounts given by many of the Voicing Loss bereaved respondents of poor treatment during of the coronial process.[9]

"I've always seen them being treated with absolute respect." **- Substance use treatment NGO**

"My general experience is that they're treated very well. They're treated with courtesy. I've never seen an inquest where a bereaved family are mistreated." **- Police**

"I think that the family's voice and the family are included in that process… I've never had a family be unhappy after an inquest… I've never heard a family say … that they didn't get what they needed from the process." **- Prison**

The witness respondents were broadly in favour of 'pen portraits' at inquests, whereby bereaved family members have the opportunity to present information about the character and life of the deceased person.[10] Some felt that this brought humanity to proceedings and comfort to the bereaved - further suggesting… that it should be a routine part of hearings.

"I think it would be good putting a person to that name. I think that should happen… I think at coroners [courts] it would give [the family] a voice and part of that closure and process." **- Police**

"I have wondered a few times whether it would be better just to let [the family] talk at the beginning, to make the introduction themselves… Make it feel more personal, more relevant to that person… Much less like just a cold case of dissection of what happened." **- Health practitioner**

However, some respondents commented that bereaved people are not well treated or prioritised by the coroner service and that, fundamentally, the aspiration to have them 'at the heart' is flawed and unachievable without further significant reform.

"I think they pay lip service to [the principle of the bereaved being 'at the heart'], but the reality of it is it is just a case to them, and they don't give any thought, really, to how the family feel." **- Bereavement support NGO**

"The current process … can't deliver its own aspiration in its current structure… If we're going to put families at the heart of this, I think there needs to be some pretty fundamental changes as to how we conduct these things… I don't think we ever really considered the harm that this is imposing on the relatives. So, to say that they're at the heart of the process I think is nonsense, to be honest." **- Health practitioner**

[9] See, for example, Voicing Loss Research Findings No. 1 and No. 2

[10] The role of 'pen portraits' at inquest hearings is discussed in other Voicing Loss outputs, including Principles for Practice No. 3

5. Impact of coronial investigations and inquest hearings

The ways in which witnesses are affected by the coronial process depend on a range of factors including their professional role and experience, and their involvement in the death and its aftermath. This section of the paper covers general personal and professional impacts of the process on witnesses; the challenges of recalling and reliving the events surrounding the death; professional dilemmas; impacts on jobs and careers; and the broader issue of what respondents thought about their position within coronial death investigations.

5.1 General personal and professional impacts

Impacts of coronial investigations and hearings on witnesses depend in part on how they have been affected by the death itself. This, in turn, may reflect such factors as the specific circumstances of the death, whether the deceased was known to them and the quality of their relationship, and if they were caught up in events prior to and at the time of the death, including efforts to save them.

> "Anyone that dealt with that job will never, ever forget... This is going to haunt me forever... I don't feel I'm ever going to really get over that." - **Police**

> "I was the only person visiting that guy. I was the only person he saw from one month to the next, other than the care staff. You do feel like you have, yes, a responsibility, a connection. So, when they die, then obviously it does affect you as well." - **IMCA**

> "Our staff have looked after these individuals... These staff know these prisoners and they know their families ... we've looked after these individuals and it means something to us when we lose them." - **Prison**

Some respondents noted that having to regularly deal with death and its aftermath, or the potential for further deaths in the same setting, does not make them immune to its impact.

> "It doesn't matter how many deaths in custody you deal with, it never becomes an easier situation to deal with." - **Prison**

> "You're dealing with grief all day, which is hard. It's a hard slog." - **Police**

In speaking about inquest hearings, a small number of respondents reported that they found the

process to be helpful or cathartic, as marking the end of an often long and difficult process.

"I don't really get emotional at inquests. I think because it's right at the end of the investigation. I think all the emotion has been felt before that stage. I think it's a bit of closure so I feel relieved in one way because that's the investigation finalised." **- Police**

"Most people say, following the inquest, they feel better, even if it's been a difficult inquest, because there is some closure to it. For many staff, there is no closure until that inquest has taken place." **- Prison**

However, more common were descriptions of being negatively affected by an inquest, sometimes regardless of how many times they had previously given evidence at the coroner's court.

"I still always feel nervous about attending an inquest... It's a very uncomfortable situation." **- Prison**

"The more traumatic inquests stick with you forever. But you can remember them all."
- Substance use treatment NGO

The following comment from an education professional illustrates how heavy a toll the prospect of giving evidence can take.

"The inquest formed quite a large part of my anxiety [that followed the fatal incident]... I started to have bad dreams; I started to imagine that I wouldn't be able to answer questions... My anxiety has never been around my professional capacity and my decisions I made. I always knew that would fine. It would have been my sense of self, and how I would represent myself; whether I would burst in tears, basically, under the pressure of it."

Subsequently, she found it difficult to be told very late in the day that she was not required to attend the inquest to give evidence.

"I didn't hear anything from the coroner's office to say that I wasn't needed as a witness. That went on for a week... Every morning, I would get a phone call saying, 'You need to be ready for tomorrow.' Then every night, I'd get a phone call saying, 'No, you don't. It will be the next day'... By the end of that week, I was like a complete nervous wreck." **- Education professional**

A prison respondent, who had experienced two very different inquests, compared the greater professional impact of the first – at which she had been harshly questioned and felt there had been an attempt to apportion blame – with the greater personal impact of the second – where she had been treated better, but reflected on her closer relationship with the prisoner who had died.

"I think it's more the personal where [the deceased] almost felt like family. It was a personal loss. That sat with me more than, 'Did I do the right thing?'" **- Prison**

5.2 Recalling and reliving

Potentially, one of the aspects of the coronial process that has the greatest negative impact for witnesses is having to recall difficult and distressing events, sometimes from months or years previously. This was certainly the case for many of our respondents, who described the impact this could have on their own and colleagues' mental health, in some cases extending to re-traumatisation.

"There might have been a bit of a delay. It's still so raw and it all then comes flooding back. Almost they're transported back to that day or that night, whatever it was." **- Police**

"When we're on that run up to that inquest, you can see the trauma levels increase … almost to the levels of what they'd been through when the death occurred … For most cases, because it's many years after when the inquest arises, you have naturally processed that, and life has continued. When it comes to the inquest … you're reliving the trauma again." **- Prison**

Some of the coronial professional and bereaved Voicing Loss respondents also recognised the potential impact on witnesses of having to recall past events, particularly in front of bereaved families.

"Sometimes, I think it can be as traumatic for the witnesses, as it can be for the family – the process, not the bereavement, obviously." **- Coroner**

"We have to do a lot of welfare checks [for witnesses]… They think they're to blame instantly… A lot of the time … the family don't seem to understand that this is actually quite traumatic for them to have to keep coming back and relive this experience…. Everyone forgets that these are witnesses; they're traumatised themselves from the death." **- Government lawyer**

"One should not underestimate the trauma for the individuals giving evidence. You've got the families sitting there staring at you." **- Bereaved sister**

"I had the opportunity to say [what] mattered to me [about the deceased and their death] and that was probably not very easy for the psychiatrist to hear… I did wonder about that, afterwards, how difficult it was for them." **- Bereaved aunt**

Two witness respondents who also shared personal experiences of an inquest following the death of a close relative, explained how attending an inquest in a professional capacity could result in memories resurfacing from that prior experience. One of them added that there is a need for coroners and other professionals to have greater awareness and understanding of trauma.

"This is where my husband's [inquest] was. So if I suddenly get up and leave, you know why… I'm absolutely fine, but just in case this brings back something I can't cope with, I will shut up and leave." **- Health practitioner**

"I think one of the most important things these professionals need to know is how traumatic memories are stored… That would be a huge step forward for people … because all the memories are in the here and now … Well, all the memories around her death are in the here and now."
- Bereavement support NGO

5.3 Professional dilemmas

Giving evidence, including but not solely when it entails being aggressively questioned, can raise professional dilemmas. Some respondents revealed that this can trigger professional self-doubt about the evidence itself or about whether more could have been done to save the life of the person who died.

"I've had staff in tears going, 'I so wish I'd done something different that day'... When my staff have been really upset, it's not necessarily because the coroner's been harsh. It's just because they empathise so much with, 'This could have been me. This could have been my mum. We didn't do everything that we should have done, and I was part of that.' And that's where the emotion comes in." **- Health practitioner**

"One by one they asked me questions and I was basically criticised... I was nearly in tears at the time, I said, 'No, I stand by what I did'... The family's lawyer was pushing, pushing, and pushing... I know now it was the wife, shook her head obviously to say enough, stop - and the lawyer said no more questions." **- Police**

Others grappled with how to strike the right balance between professional objectivity and the display of emotion, described by one police witness as, 'You've almost got two heads'. Some commented that it can be helpful for bereaved families to see that professionals have been emotionally affected by the death.

"I think what I find hard, is not to give opinions and not to share your emotional side of it, because I really felt for this gentleman and I really pushed about some of the things that were being done or the neglect that I saw. But I couldn't say all of that because you've got to stick to the facts... It was very clinical; it was very cold." **- IMCA**

"I think when you see the staff giving evidence that they had to perform CPR, as a family member, obviously, it's so difficult for you to hear that. The CCTV will be played. I think to see the emotion and to see how much the staff care, I think, gives the family a sense of reassurance." **- Prison**

5.4 Impact on jobs and careers

Some respondents described how deaths and subsequent investigations affected their work, some to such an extent that they left or changed jobs.

"It's haunted [my colleague] and she has now left her senior nursing role and has gone back to a less stressful working environment." **- Health practitioner**

"I moved roles last year... With any death in custody, there nearly always is some form of learning... I guess, in some ways, I did start to take that a little bit personally in terms of our failures have potentially contributed [to the death]... I often felt like I was taking the burden and becoming frustrated with failure... I was in a role where I was absorbing staff trauma, sometimes family trauma, other prisoners' trauma." **- Prison**

Some other Voicing Loss respondents also gave examples of witnesses who they knew had taken time away from, left or changed jobs.

"I've seen people leave their job, witnesses, as in clinicians, leave their job, and plenty tell me about their sleepless nights. I've seen people who've been off work with stress." **- Inquest lawyer**

"One paramedic retired that night… The police officer that restrained [my husband] has never gone back out and worked properly again. He's now in a desk job… It must have been really intense for everybody there." **- Bereaved wife**

A police respondent recounted how the police response to the death about which she had given evidence had been used as part of an internal training video. This, she said, meant that she could not put the difficult events behind her, and she found the video very hard to watch.

5.5 Location of professional witnesses in the coronial process

A government lawyer interviewed for Voicing Loss said, of professional witnesses, 'I think they kind of get forgotten in the inquest process.' This sentiment was echoed by some of the witness respondents themselves, who recounted feeling ignored both professionally but also as individuals affected by death.

"If I was a bereaved person, then I was on the periphery of the group of bereaved people, and if I was a witness, I was on the periphery of the group of witnesses… It really, really felt as though … you were just fodder for the process to chew up." **- Education professional**

Some respondents maintained that they were less important in the inquest process than bereaved people, sometimes to the extent that they were willing to accept or tolerate poor treatment in the coroner's court.

"That's a very strong message that comes across. 'It's not about you. It's about the families; it's about them getting the answers that they need.' So, you almost feel like you shouldn't ask for anything, because that's taking away from where the focus should be. It's not about what I need. It's about what I can give to other people who need something." **- Education professional**

"They always seem to be, 'This is about them. You lot, I'll treat however I like'… I have absolutely no problem with them coming first in court, even when I am being treated a little appallingly… At the end of the day, once that coroner's court is finished, it's the family that are then going to live with the outcome of that… Nobody else is getting anything out of that process. It's the family that are getting something." **- Substance use treatment NGO**

Some suggested that the coroner service should more clearly and equitably clarify the status of both bereaved people and witnesses in the coronial process.

"It is important that as a society we do look into unexplained deaths and we understand what has happened. Then I think secondary to that is the family. Then, thirdly, institutions and places like us then can reflect on our practice and be different." **- Prison**

"Usually, it was about the emotion and the grieving and the bereaved process for the family and therefore it has to be them at the centre of it. But it's also a legal process and therefore they can't dictate if they're not happy with the outcome." **- Health practitioner**

6. Reflections

This paper offers insights into the experiences of a small but diverse sample of professionals who have provided evidence to coroners' investigations and/or supported colleagues who were witnesses. This is a group whose input is vital to coroners' investigations and inquests, but whose rights and needs are often overlooked in policy, practice and academic debate. While not representative, the 19 accounts presented here are nevertheless significant because of the lack of research in this area. Respondents' descriptions of anxiety, fear and intimidation, the importance of support and preparation, and the professional and personal impact of investigations and hearings – particularly those perceived as adversarial – align with other research. Further, what respondents said about the importance of information, effective communication, humanity, and the far-reaching consequences of poor or kind treatment, echoes the narratives of the 89 bereaved respondents who participated in the Voicing Loss research.[11]

The witness respondents recounted mixed experiences of receiving information, guidance and support from coroners' teams throughout the coronial process – likely reflecting, at least in part, the many pressures facing local coroner services, coupled with the assumption that the responsibility to inform, prepare and support witnesses lies with their employers. This assumption, however, poses the risk that the needs of witnesses fall through the net. It is thus important to recognise that responsibility for informing and preparing witnesses is shared by employers and local coroner services.

Employers inevitably vary widely in terms of what kinds of support and assistance it is appropriate and practical for them to provide. Where relevant, specialist roles (sometimes covering all death reviews and investigations), such as police staff investigators or family liaison officers, are valuable. Staff in these roles potentially offer a twofold benefit, as a point of contact for both bereaved people and the local coroner service, thereby easing pressure elsewhere in the organisation, and a source of internal expertise on the coronial process.

Local coroners' teams could also do more for professional witnesses. In particular, information should be provided about the coronial process and case progression in as timely and responsive a manner as possible. Additionally, greater use could be made of local coroner service webpages and websites as an information source for witnesses, potentially targeted to different professional categories (e.g. medical, non-medical or expert witnesses).[12] Many witnesses may not be aware that the Coroners'

[11] See the range of Voicing Loss outputs available at the project website.

[12] A scoping review of local coroner service webpages/sites conducted for Voicing Loss found that these tended to have very limited information for witnesses. For more on this, see Voicing Loss Principles for Practice No. 1.

Courts Support Service provides support to professional witnesses, via the telephone helpline and volunteers who are present at about half of coroners' courts, in addition to the help they offer to bereaved people. The Ministry of Justice should consider producing a version of their Guide to Coroner Services that is specifically for witnesses.

Many of the witness respondents reported that they and their employers place great importance on death investigations, including by investing significant time and work into supporting the work of coroners' teams. Of particular relevance here is the question of whether and how failings which may have contributed to the death are recognised and responded to. This is one area where the accounts of witnesses diverge from what many of our bereaved respondents said. While some of the latter gave examples of organisations that had recognised failings and made changes, it was more common for the bereaved respondents to view organisations as resistant and defensive, and more concerned with reputation management than with admitting shortcomings and effecting change. The witness respondents, in contrast, were more inclined to speak of institutional openness to change. However, concerns about the perceived limited effectiveness of Prevention of Future Deaths reports were voiced by respondents in both groups.

Witness respondents described inquest hearings as often very difficult and highly emotive. Anxiety about the presence of bereaved families, coupled with the difficulties caused by recalling and reliving distressing events often long after the death, and by aggressive and adversarial questioning, can be particularly distressing and have long-term impacts for witnesses. Some also struggled to balance professionalism and objectivity with managing and appropriately displaying emotions, and, as a result, worried about how they were perceived by bereaved people. While inevitably different in nature and intensity, there are similarities between bereaved and witness respondents' comments on the emotional ramifications of the coronial process. Like the bereaved, witnesses talked of grief and distress, but also shared experiences of professional self-doubt and job changes, the far-reaching impacts of involvement with lengthy investigations and recall of difficult events, and the cumulative toll where death and death investigations were frequently experienced.

Most of the witness respondents were clear that negative emotional outcomes could be alleviated by kind and respectful treatment from a system centred on humanity, and by being well informed and supported throughout the process by coroners' teams and employers alike.[13] They painted a mixed picture of the emotional and psychological support available to them from their employers, indicating that much more is needed, particularly in some sectors, to develop multi-faceted models of practical and emotional support and, where required, to facilitate culture change such that employees feel able to ask for help.

Better treatment of witnesses by coronial professionals and lawyers is likely to depend on improved understanding of the potential emotional impacts of the coronial process on witnesses. These impacts potentially include re-traumatisation of those who were closely involved in traumatic deaths and are required, when giving evidence, to revisit the events, sometimes over an extended period of time. The adoption by the coroner service, as has occurred across many spheres of public service provision, of

[13] See the Voicing Loss Principles for Practice documents for suggestions on how this can be achieved within the coroner service.

the six principles of trauma-informed practice – safety, trust, choice, collaboration, empowerment and cultural consideration – would therefore be beneficial.[14]

The Voicing Loss findings reveal the complexity and variability of interactions between witnesses and bereaved people throughout the coronial process. This is another area where views differed between our witness and bereaved respondents. For some of the bereaved respondents, interactions with witnesses were unwelcome, experienced as fraught and antagonistic, and shaped by the perception that professionals and their employers were focused on professional or institutional reputation and protection. However, witness respondents described open and sensitive interactions with bereaved people throughout the coronial process, often informed by prior communication with families following a death, and by a desire for open dialogue about lessons to be learned. Some witnesses described difficult interactions with bereaved people at the coroner's court, and recognised that this stemmed, at least in part, from inadequate or absent communication prior to the hearing. In many cases, it seems that employers and bereaved people could be better supported to communicate after a death, perhaps aided by specialist colleagues and by learning from hospital-based bereavement teams and the Medical Examiner service (Hepple, 2023; Payne-James and Lishman, 2023).

The witness respondents were generally of the view that bereaved people are well-treated at inquest hearings, although some believed that local coroners' teams could do more to inform and support the bereaved in advance of hearings. In stark contrast, bereaved respondents more frequently reported encountering disrespect and a lack of care and compassion from coroners' teams. A small number of the witness respondents suggested that good treatment of witnesses matters less than that of the bereaved, and even went as far as to suggest that they would themselves accept poor treatment, as long as bereaved families are treated well. Some of the coronial professionals interviewed for Voicing Loss agreed with the witness respondents that witnesses are often overlooked in the coronial process. Thus our findings support the call from other researchers for greater recognition of witnesses within coroners' investigations. The following statement could be applied to all deaths (not just those which are self-inflicted) and to all professionals who have to engage with the coronial process:

> "We suggest that practitioners are not only tertiary victims of service user self-inflicted deaths but that they are also potentially tertiary victims of the coronial inquest… It is possible that tertiary victimisation including vicarious traumatisation endured by practitioners as a result of a self-inflicted death may be exacerbated by visible participation in coronial processes… The victimising effects are overshadowed by the public, legal and at times political scrutiny." **- Taylor *et al.*, 2013**

Finally, this paper, and the small amount of other scholarship in this area, should serve as a springboard for further research, which could explore experiences of coronial investigations across a wider range of professional groups. There would be much to gain, in particular, from close examination of the complexities of interactions between witnesses and bereaved people, and the personal and professional impacts of participation in the coronial process.

In conclusion, this small but important part of the Voicing Loss project offers insights into the

[14] See, for example, HM Government's 'Working definition of trauma-informed practice'.

overlooked experiences of witnesses, and adds to what we have learned about the role of bereaved people in the coronial process. Witnesses' experiences are highly varied, sometimes complex, and inevitably affected by the increasing internal and external pressures facing the coroner service: a service that is seriously under-resourced, struggling with large and complex workloads, and burdened by the weight of ever-growing expectations of what it can achieve. Overall, consideration of witnesses, and their right to be treated with fairness, sympathy and respect, should be part of ongoing debates about the scope and need for reform of the coroner service, and the feasibility of the policy aspiration for bereaved people to be 'at the heart' of the service.[15]

[15] See the two Voicing Loss Policy Briefs.

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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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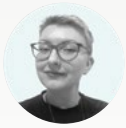

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