‘We were not included – there was no thought about our loss’:

Experiences of the inquest process among families bereaved by gambling-related suicide

Lorna Templeton
Jessica Jacobson
Alexandra Murray

January 2025

Voicing Loss

GAMBLING WITH LIVES

ICPR Institute for Crime & Justice Policy Research
Birkbeck University of London
Centre for Death & Society (CDAS)
University of Bath
UKRI Economic and Social Research Council

Table of contents

This report is based on a sub-set of data collected for the **Voicing Loss project** and was produced in collaboration with the charity **Gambling with Lives**.

Gambling with Lives is a charity which was founded in 2018 by families who had been bereaved by gambling related suicide. The charity provides a range of support for families and advocates for changes to gambling and gambling regulation to reduce gambling suicides and harms. Support for families around the inquest process is one of the core activities of the charity, to ensure that families achieve a level of justice for their family member and that lessons are learned from the deaths to prevent future harms and deaths from gambling.

The Voicing Loss project examined the role of bereaved people in coroners' investigations and inquests. It 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. Voicing Loss was funded by the Economic and Social Research Council (grant reference ES/V002732/1) and ran from May 2021 to May 2024. Outputs of Voicing Loss are available on the **project website**.

The Voicing Loss research team gratefully acknowledge the help and support of many individuals and organisations who contributed to the research, and particularly to the many bereaved people to speaking to us about their experiences in an open, honest and reflective manner.

Artwork by Tyla Scott Owen

Foreword

The idea of being researched on the most traumatic experiences of your life is obviously awful but we all go into the inquests with hope. That is hope that at least the investigation of the lost life can generate learning that could prevent another death and also hope for justice for our family member who has died. For so many of the families who are part of Gambling with Lives that hope was devastatingly crushed and the inquests joined the process of trauma. The team from Birkbeck and Bath have been exemplary in their compassion and care and have captured the sense of disappointment and loss of faith in the state that has characterised the inquests experienced by the participants in this research.

The findings of this sub-report on gambling deaths echoed many of the issues raised across the wider research, but importantly highlighted the failure of so many inquests to include gambling in the scope of the investigation and inquest despite the best efforts of families to raise the issue and produce evidence. Gambling may be called the 'hidden addiction' but most families knew about the gambling or found out about it very soon after the death of their family member.

We do not want to lay the blame for this failure at the door of any individual coroner, but see it as part of the wider lack of understanding about the dangers of gambling and ignorance of the long-established link between gambling and suicide, which has been perpetuated by the gambling industry. The information and training needs are obvious – and these extend far beyond the coronial system. To ensure that future gambling deaths are prevented it is vital that the government ensures that every death is fully investigated and lessons are learned.

All the work of everyone at Gambling with Lives is in the name of those who have died as a result of predatory gambling, so this report is dedicated both to the research participants and to the thousands of others who have not had a thorough investigation of the circumstances of their death. We miss you all so much and still live in hope that the deaths can be stopped.

Liz and Charles Ritchie, Gambling with Lives

Executive Summary

As part of a larger research project exploring the role of bereaved people in coroners' investigations and inquests (Voicing Loss), interviews were conducted with 14 individuals from nine families with experience of the coroner service between 2013 and 2023 following a gambling-related suicide. Experiences of coroners' inquests among families bereaved by gambling-related suicide have not been previously been the subject of research.

Overall, the experiences of these individuals align with those of other bereaved people interviewed for Voicing Loss. Namely, while a few recalled kind treatment and positive experiences of the coroner's investigation and inquest, all recounted at least some negative experiences which left them feeling despair and frustration, and continuing to struggle with their grief. Poor experiences centred on limited or absent information and support from the coroner team, a lack of compassion, feeling excluded from or otherwise unable to participate meaningfully in the investigation and inquest, missed opportunities to have the life of the deceased recognised, and not getting the desired answers about the death.

The families also raised a number of specific concerns regarding the coroner's investigation and inquest. They generally perceived there to be an unwillingness for the deceased's gambling and the role of gambling companies to be included within the scope of the investigation and inquest. Some families had gone to considerable lengths to provide details of the gambling and submit detailed evidence to the coroner, but they subsequently felt that this was accepted without question or ignored altogether by the coroner. Families were further disappointed that gambling was not named specifically in the coroner's Record of Inquest and, subsequently, on the final certificate of death. Finally, frustration was expressed that investigations too narrow in scope resulted in missed opportunities for learning that could help to prevent future deaths and inform debates about broader gambling reforms.

Two recent inquests (in 2022 and 2023 respectively), following the deaths of Jack Ritchie and Luke Ashton, indicate that a more satisfactory approach following a gambling-related suicide is possible. The *Dove* ruling by the Court of Appeal, the forthcoming Hillsborough Law, and the Bishop of St Alban's introduction of a Bill regarding coroners'

recording of gambling as contributing to suicide where applicable, all have the potential to significantly influence how the coroner service investigates a range of deaths, including gambling-related suicide. There is a need for significant reform to the coroner service to ensure that causes of preventable deaths, such as those associated with gambling, are more effectively examined and addressed, and that evidence submitted by families is adequately interrogated by the coroner during their investigation. Combined with improved information and support throughout the coronial process, and compassionate and respectful treatment, bereaved families should have a more positive and inclusive experience, rather than feeling that they and the person who died did not matter.

1. Introduction

1.1 Coroners in England and Wales

Coroners are independent judicial officers who investigate violent, unnatural and unexplained deaths, and deaths in prison or other state detention. Where necessary, a coroner's investigation culminates in an inquest: an inquisitorial, fact-finding hearing, usually held in public and occasionally with a jury. Every year in England and Wales, around 200,000 deaths are reported to the coroner, and over 30,000 inquests are held (Ministry of Justice, 2024). The primary purpose of the coroner's investigation and inquest is to answer four questions: who died, and how, when and where they died. The coroner also has a statutory duty to write a Prevention of Future Deaths (PFD) report if they consider there to be a risk of future deaths, and action could be taken to prevent or reduce that risk.

Bereaved people who are designated 'interested persons' have certain formal rights to participation during the investigation and at the inquest, such as to be informed about post-mortem examinations, receive evidence before the final inquest hearing, and question witnesses at the inquest. Further, central to coronial policy is the ambition to have bereaved people 'at the heart' of the process, but this can be criticised for being vague and overly broad.[1]

1.2 Gambling-related harms and deaths

Gambling is widely recognised as an issue of great significance for public health, because of its scale and the related harms for both those who gamble and those around them as well as wider society.[2] The UK gambling market is one of the largest in the world. Approximately half the adult population in England gamble, although this reduces to just over a quarter if those who only participate in lottery draws are excluded.

[1] For further discussion of this issue, see the Voicing Loss Policy Brief No. 2: Locating bereaved people within the coronial process

[2] See, for example, Collard, Davies & Cross (2023).

Gambling-related harms are significant and widespread. Of the nearly 10,000 respondents to the Gambling Survey for Great Britain (GSGB) in 2023, 2.5% were classified as suffering 'problem gambling' with a further 3.7% at 'moderate risk' (Gambling Commission, 2024): 2.5% of the population is 1.3 million people. These figures are over six times higher than shown by the most recent Health Survey for England (NHS England, 2023).[3] The GSGB also found that gambling through 'online slots' was associated with 'problem gambling' rates six times higher than other gambling; and of those who had gambled through 'online slots' in the last 12 months, almost half (45%) fell into the 'moderate risk' or 'problem gambling' categories.[4]

Such statistics have triggered debates about the role of government and the gambling industry with regards to, for example, access to various means of gambling, gambling-related advertising, and responsibilities for monitoring and supporting those with, or at risk of developing, gambling-related difficulties (e.g. Orford 2011; 2020). Policy developments in response to these issues include a government White Paper (DCMS, 2023) on gambling reform, while the current national suicide prevention strategy (DHSC, 2023) highlights gambling as one of six 'common risk factors linked to suicide at a population level' and recognises 'that gambling can be a dominant factor without which the suicide may not have occurred'. However, these policy developments are contested and critiqued, with urgent calls being made for further and deeper reforms.

Although there are no official data on gambling-related deaths in the UK, there is evidence of an association between gambling and suicide. Estimates suggest that there are several hundred such deaths in the UK each year, particularly among younger aged males (OHID and PHE, 2023). Over 10% of the nearly 10,000 respondents to the Gambling Survey for Great Britain reported suicidal thoughts or an attempt to end their life in the previous 12 months, with 4.9% saying that this was 'a little' or 'a lot' related to their gambling (Gambling Commission, 2024).[5] Other research has found that 44% of those suffering 'problem gambling' are at 'high risk of suicidal behaviour' (Gosschalk et al, 2024). The nature of many gambling-related deaths – suicide or otherwise unnatural – means that they are reported to the coroner and subject to an inquest. However, due to limited knowledge about gambling on the part of coroners, gambling is generally not recognised or investigated as a possible factor in the death. There are currently no data on the number of coroners' inquests that deal with gambling-related deaths.

[3] Findings of the 2021 Health Survey for England in relation to gambling found rates of 0.6% 'moderate risk' and 0.3% 'problem gambling' (NHS England, 2023, data table 7).
[4] Gambling Commission (2024), data table D.5.
[5] Gambling Commission (2024), data table D.7.

1.3 The Voicing Loss project and families bereaved by gambling-related suicide

Voicing Loss examined the role of bereaved people in coroners' investigations and inquests, and how their participation can be better supported. A total of 89 bereaved people with experience of a coroner's investigation between 2012 and 2023 were interviewed.[6] Recruitment of interviewees was supported by a number of charities, including Gambling with Lives (GwL), who circulated information about Voicing Loss to families with experience of the inquest process who they had supported or were currently supporting. Contact details for those interested in participating in the study were passed to the research team who secured informed consent and completed interviews.

Nine interviews (eight online and one in-person) were completed with 14 individuals (from nine families) across England who had been bereaved following a suicide that they believed to be linked to gambling. The 14 interviewees were nine female and five male; they were primarily parents of the person who had died, but included a partner, adult child, sibling and cousin. Those who died were all male and aged in their 20s to 40s. The deaths were between 2014 and 2021, and one had occurred abroad. Seven of the deaths were subject to short inquests held within a year. One inquest was held more than five years after the death, and engaged Article 2. The inquest into the ninth death had not yet taken place at the time of the interview although a pre-inquest review hearing had been held. The families in the latter two cases had legal representation, while the majority of the other families had no legal advice or support throughout the coronial process.

Some of the families were unaware of the deceased's gambling until after the death, while others knew about the gambling but not its extent or severity, thereby often missing the final period of crisis before the death. A small number of the families knew about their relative's gambling and had supported them with, for example, managing finances or accessing treatment.

This report summarises the experiences of these families with reference to the three over-arching themes identified by the analysis of the full sample of bereaved respondents interviewed for Voicing Loss. Overall, while some of the 89 bereaved respondents talked positively about the investigation and inquest, and resultant feelings of relief or catharsis, the majority described poor experiences and having been

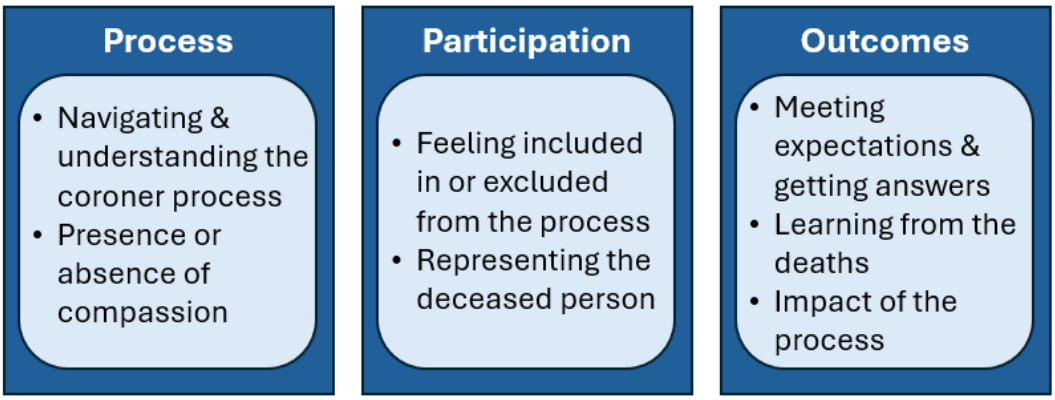
[6] More information on all aspects of Voicing Loss can be found at https://voicing-loss.icpr.org.uk/

negatively affected. The factors which shaped their positive or negative evaluations of the coronial process related to the nature of the **process** itself; their experiences of **participation**; and the **outcomes** of the process.[7]

Experiences of the **process** were influenced by respondents' capacity to navigate a complicated system about which they had limited or no prior knowledge; by the quality of information from and communication with the local coroner service; and the extent to which they were treated with or without compassion, respect and sensitivity. Experiences of **participation** reflected how able and supported respondents were to voice their concerns and have them heard; ask questions; and talk about the person who had died. Many reported multiple barriers to participation that left them feeling excluded and disempowered, including when they felt the coroner did not consider evidence and other reports that they had painstakingly compiled. Finally, in terms of **outcomes**, while some respondents were satisfied that the inquest brought them the answers they had sought, and reported a degree of peace or resolution, many more were left with unanswered questions; felt that justice had not been done; and believed there were missed opportunities for learning and prevention of future deaths. Respondents also talked about the multiple short- and long-term impacts of the coroner's investigation and inquest on them and their grief.

The three broad themes of process, participation and outcomes, and the related sub-themes, are shown in Figure 1. Over the remainder of this report, each sub-theme will be discussed in turn, considering their relevance to the 14 respondents who had experienced the coroner process following a gambling-related suicide.

Figure 1: How families bereaved by gambling-related suicide experience the coronial process



[7] See, for example, discussion of the three overarching themes in the Voicing Loss Findings Summary.

2. Navigating and understanding the coroner process

Overall, the families bereaved by a gambling-related suicide had had limited or no knowledge or experience of the coronial process before their relative died. Some said that good information about, and support with, navigating the process was forthcoming from the local coroner service. For example, one family were told how to get the temporary death certificate; another said that the coroner's assistant was 'incredibly helpful' regarding arrangements following a death overseas; and another was able to visit the coroner's court before the inquest hearing which helped alleviate anxiety. However, others felt that such general information and support from the local coroner service was lacking.

> We never knew what an inquest was. It wasn't really explained to us. We didn't even know what a coroner was... We weren't offered any [legal advice]. We didn't know we could have any. We didn't know, really, what our rights were. Nobody told us.

> We were supposed to receive a bereavement pack from the coroners... We didn't receive any of that... And there was no contact at all... The people that are supposed to be bringing you closure and understanding about the situation you're in, are the people that seem like they really just don't care.

Furthermore, regardless of the length of time between the death and the inquest, some families felt that the onus was often on them to chase for information and updates from the local coroner service.

> It was a three month wait, but it was gruelling, because almost nothing seemed to be happening for the first two-and-a-half months of it and everything seemed to happen in the last two weeks... We had many times where we were emailing, and they weren't replying. Phoning and they weren't responding.

> We had to ring and badger and email and whatever else just to get any snippet of information... We didn't expect to have to ring coroners to find out when he'll be released back to the funeral home. We didn't expect to have to ask them if they

> want the [suicide] note that he left, because it didn't seem of any importance. It was always us chasing things up, and still is.

Lack of information and support extended to the inquest hearing itself, with some feeling that they could not ask questions about the progress of their case, or noting limitations to the support available from the local coroner service or court-based volunteers[8].

> Maybe they should have had an officer with us to explain to us maybe some of the things that were being said, about why they were saying it... I think that would help a little bit because I think a lot of it went over our heads. We were afraid to ask questions... I think they should give people more of an idea of what is going to happen beforehand.

> This helper lady was of no use... She was there to tell you where the toilet was, or get you a cup of tea, or whatever, really, I think, which is fine.

> We went in. Just sort of sat in silence and waited until it was time to go in. The woman who had been speaking to my husband a few times before from the coroner's office, she came up to us and asked if we were alright and gave a briefing... this is where you sit... she explained that bit, but [it was only minutes, probably].

3. The presence or absence of compassion

Shortcomings in the way the coroner's team communicated with them were reported by many families. Examples of poor or absent communication included:

- Finding out there would be an inquest by seeing a report in the local paper;
- Late disclosure of evidence and documents;
- Being told after the fact that a post-mortem examination had been completed, or being told the results of toxicology tests over the phone;

[8] Court-based volunteers are provided by the CCSS (Coroners Courts Support Service), and are available in approximately half of coroner courts.

- Finding out that delays were because a part of the body (which the family did not know had been missing) could not be found;
- Receiving the deceased's suicide note via e-mail, or experiencing delays with the return of the deceased's personal belongings;
- A coroner leaving a voicemail message for a relative from a different family;
- Communication that did not take account of limited understanding because English was not their first language.

Inadequacies in communication with the local coroner service are further illustrated by the following three respondents:

> When I was ringing and asking for an update on when we can see [the body] and stuff, he was like, 'Well why are you calling me, I don't understand why you're calling me?' And I'm like, 'Well we haven't had any contact from you and it's been a good few days now.' And he's like, 'I have so much to do.'

> I think that was the Wednesday before the inquest... I had an email from a lady from the coroners' office... 'My colleague has just sent you 63 pages of disclosure documents... have a read through this information, and [let me know] if you've got any questions or anything unanswered from what you've read - in the next 24 hours, basically, because I need to give them to the coroner who will be holding the inquest'.

> I think it was about four weeks before I saw the [suicide] note... boom, it came through my emails. Even that [was] totally insensitive, totally, totally, totally insensitive... His iPad and iPhone didn't get back to us for three months... All of this stuff affects the family.

A rare example of thoughtfulness was described by one parent, who said that the coroner's officer phoned when the post-mortem reports had been posted to say, 'I'm not sure if your wife should read this. You might want to keep it from her because it's not very nice, but it will get read out in court at the inquest.' More commonly, however, the way that they were communicated with left families feeling that the coroner service did not care, and lacked compassion and awareness of their distress. As one said, 'It felt like we weren't important'. These respondents shared the same opinion:

> I felt like there was no compassion there at all... From the beginning there was no, 'I'm sorry for your loss.' There was no condolences, there's no, 'We're here if you need support.' Nothing.

> They just see it as another dead person, rather than that's someone's son, someone's brother, someone's nephew, someone's cousin, someone's uncle. I don't feel that they have enough compassion for the job that they do.

> [It] made things infinitely worse… no thought to how close it was to the [one year] anniversary. And no acknowledgement of the trauma we're going through because of what [he] did… you think they would have some real understanding of that sort of loss… So, they should have a real understanding of how to look after people and guide people in that process.

Some respondents described a similar lack of compassion at the inquest hearing. They talked about the courtroom being bland, impersonal and unwelcoming; brief hearings which created the impression that the deceased person was no more than the next box on the list to be ticked; and rude or inconsiderate behaviour of the coroner. Examples were recounted by these respondents:

> It was very sterile, very simple… It was a bare, blank room really where we were sat at the table at the back… It wasn't friendly… It was nothing.

> It was so quick it was unbelievable… I just found it cold. It's like a conveyor belt. We seemed to be in there, out there and they disposed of 30 years of life… It was as if they wanted to get the next one in, and nobody seemed to be bothered that my son had taken his life.

> I think our expectations were for it to be a lot more professional… He just kind of strolls in… He's meant to have read the documents beforehand, and he clearly hasn't… And he's not speaking loudly or clearly, he's just mumbling into the microphone… It felt horrible… I felt really small. He was just sitting up there on his pedestal, while we were sitting down there, tears in our eyes, crying… no eye contact with anyone, he was just constantly looking down, looking down. If you're going to be explaining and talking to me about what my [relative] used and stuff, what happened to him, I want you to look me in the eye when you're talking to me.

Being treated with compassion could make a tangible difference, easing the anxiety and pain of an inherently difficult occasion, as illustrated by these two respondents.

> The coroner, she was lovely and said, 'Do you want me to stop?' She was really nice… I remember she said to me, at one time, they were going to go into his injuries, and she asked me if I wanted to leave the court. I should have done, but I didn't. I wished I had done, now… she was very respectful.

> I was so dreading the inquest and it was such a relief. The coroner was ever so mindful. It was a really good experience for what it was.

Overall, families described a coronial process that failed to offer adequate information or support, and in which a lack of compassion and consideration was manifest. As one parent explained, 'It's a clunky system, which is not geared up for pain. It's geared up for process.' This could affect how prepared and able the families were to participate and feel included in the proceedings, and this will be explored next.

4. Feeling included in or excluded from the process

There was consensus among the families that they felt excluded from the investigation and inquest. For example, one said, 'I hardly had any voice at all', while another recalled, 'It was like we didn't exist.... I lost hope.' Respondents described coroners who did not directly interact with them or prevented other relatives from speaking; spoke of having struggled to understand legal aspects of proceedings and the formality of the language; and described courtroom layouts that felt intimidating and exclusionary because of, for example, the seating arrangements.

> Why can only one parent speak? Why not have two? It wasn't a crowded event. It wasn't tight for space. It should take whatever time is sensible. So, I would suggest that's not very good practice.

> He didn't actually speak to me directly. I felt the family was completely out of the process, just really not important to the process at all.

> A sense of playing a game where you didn't fully understand the rules.

> The court building is not set up, talking about it architecturally, to put families as the heart of it. We weren't allowed to sit with our legal team. We had to sit on the benches behind... We were scribbling notes to the legal team, on Post-it notes, and somebody had to run round and give them to our legal team.

One family felt that the presence of multiple legal teams meant that the formally inquisitorial process inevitably became adversarial, which also produced a sense of exclusion from the proceedings.

> There were four other sets of barristers, all with their clerks behind them, doing research, running up to them with notes, then making arguments against what we wanted. So, it's nonsense that it's inquisitorial. If you're putting the family at the heart of that, it doesn't feel like that, because it plainly isn't, because there are people who are protecting their position.

Two other families believed that the lack of information and support, both before and at the inquest, negatively affected their ability to participate because they did not feel prepared to ask questions or to challenge what was being said.

> [If we had had more information], we would have been more prepared going in there. We would have understood the process better. We wouldn't have come away the way we did, thinking, God, what was that?'... we should have been prepared. I think it's wrong that we weren't.

> I suppose, for me, in hindsight, maybe I would have challenged things more... And I feel cross with myself really that I haven't challenged them.

Some families also struggled to have their own knowledge about their relative's gambling, and other related concerns where relevant, included and addressed as part of the inquest. Some had undertaken their own inquiries and research to understand gambling and gambling-related harms (in some cases, after finding out about their relative's situation only after the death) and the deceased's struggles and communication with gambling companies, and they then went to great lengths to prepare and submit evidence to the coroner. However, some, such as this parent, felt that their efforts were not recognised or properly considered by the coroner.

> If you read the Coroner's Office's reply.... they've, basically, ignored all of that. Other than saying, 'Well, let the other regulators worry about gambling. Not for me,' and, 'We'll call the policeman, who will testify to a couple of bits and pieces,' they ignored references to other people who had valid input to the inquest.

Another family, as illustrated below, considered it essential to pass on their knowledge to the coroner, as they believed there to be a lack of understanding on the part of the legal teams and the coroner alike.

> It became more apparent... that [the coroner] knew, literally, nothing about gambling, and had, obviously, never considered it in a case before... They [our barristers] were real, real specialists in [inquests]. However, their knowledge of gambling was absolutely zero. All of that came from us... it really took us to drive forward the centrality of gambling, and the issues that needed to be picked up.

However, this family, like others, felt they were fighting an uphill battle to have gambling considered as part of the investigation and inquest (as will be explored later in this report). Overall, as summarised by the respondents below, the experiences of many of the families led them to conclude that they were not 'at the heart' of the coronial process.

> I mean, it was just so far removed from our experience that I don't really know even what to say about it. It just sounds like a statement that people make that sounds good... If their mission statement is that family is meant to be at the heart of what they do... Why isn't that the experience of people that are going through the inquest process for suicide?

> We should have been at the centre of it, rather than being on the outside of it, and then being dragged into it all last-minute. We were not included, there was no thought about our loss, what we are going through, and continue to go through... Just not being included or thought about in a compassionate way.

5. Representation of the deceased

Like other Voicing Loss respondents, those who had been bereaved through gambling-related suicide reported mixed experiences of how the deceased was represented at the inquest. As illustrated below, one parent shared the positive impact of having a photograph of their son on the bench in front of them in the court, while another was upset with the coroner referring to their son by his surname only.

> I felt it was so important that my son was in the room

> That got me, you know what I mean? I was thinking, 'That's my son you are talking about'... they could have asked us on the day how we wanted him to be called.

In 2021, the Chief Coroner issued guidance welcoming and supporting the practice of allowing time for bereaved people to read (or have read for them) a statement about the deceased person at the inquest, commonly referred to as a 'pen portrait' (Chief Coroner, 2021).[9] Three families, for whom the inquest predated this guidance, described being denied the opportunity to talk about the deceased, as illustrated by this parent:

> We were told we would be able to make a family statement… [then the coroner] gave his decision. Got up, and I said, 'What about my family statement?' And he said 'I've given my decision, and it is finished'… [he] turned tail and walked out… So, we were unable to make our family statement… I've no idea why it went like that.

Two of the inquests took place after the Chief Coroner guidance on pen portraits was published, and the experiences of these families indicate that coroners continue to be inconsistent in relation to this practice. One did not seem to have an opportunity to talk about the deceased, who they felt was included or acknowledged 'in passing' only, while the other recounted a mixed experience, as described below:

> The Coroner was quite kind… we started with a little video of [our son], which was, actually, very powerful… so [he] was there, in the courtroom. Then I gave my opening family statement, which, again, I felt was important. Then that was followed by a number of statements from [his] friends… [but] he took each statement, and he sort of went, 'Dah, dah, dah', and then he'd go, 'Blah, blah, blah, blah, blah, blah.'… I just found that insulting… these young people who had made the statement about their friend, and he wasn't even dignified enough to read out the words in court.

With a few exceptions, the families reported that they had limited participation throughout the coronial process, and that the deceased person was poorly represented. Together, experiences of the coronial process and participation in it could affect, first, how the families viewed the outcome of the inquest and, second, how they were personally impacted by their experiences. These issues will be explored next.

[9] The primary catalyst for this was the second Hillsborough inquests (held 2014-2016), where several days at the start were devoted to allowing each family to talk about their deceased relative.

6. Meeting expectations and getting answers

While coroners are required, by statute, to address the four questions of who died, and how, when and where the person came by their death, they have wide discretion over how they set the parameters of their investigation: that is, which specific issues are to be considered in the process of seeking answers to the core questions. There was agreement from the families that, in their experience, the coroner's investigation and inquest was too narrow in scope and therefore fell far short of what they had wanted or expected.

> There were a lot of contributing factors surrounding [his] death, it wasn't just a straightforward thing... I do think that there was a total lack of understanding of these factors, he brushed over them. And they were very key, each and every one of them... a complete lack of understanding of how that linked up to where he was... he did touch on these factors, but didn't really give them any gravity really.

> To me, now, an inquest is looking into everything... he was focusing on the actual time that he died rather than what led up to that... he was ashamed of his gambling and that was reflected in his letters, but that wasn't why he died. It was because the company, the industry wouldn't leave him alone. He couldn't escape. That's different from being ashamed, isn't it?

Many did not understand why the coroner would not look beyond the basic facts of a death by suicide to understand the underlying causes of, or contributing factors to, the death. Some did not understand why (in)actions of mental health services or an employing organisation were largely ignored, and one family (for whom the inquest had not yet taken place) wanted the response of the ambulance service to be considered. Two families argued that a wider scope was necessary because they believed that their relative had not intended their actions to result in their death.

Of particular concern to many families was the reluctance of the coroner to consider the contribution of their relative's gambling, and by extension the role of gambling companies and the gambling industry, to the death. Families were frustrated that this reluctance was evident even when the coroner was presented with evidence (often painstakingly collected and collated by the families themselves) in the form of financial

reports, communication between the deceased and gambling companies, or a suicide note where the deceased directly attributed their intention to harm themselves to their gambling difficulties and the actions of gambling companies. All of this, in the minds of many families, clearly demonstrated a direct association between gambling and the death.

> In his note… He said, 'I've done it again. I've been stupid.' So, we knew that he meant that was to do with the gambling… deep down, I knew that [he] would not leave a note if he wasn't to go through with what his intentions were.

> His suicide note could not have been clearer about the role of gambling, and finding that he'd never be free from it.

> I still think that gambling killed him. I know it did, because I saw the emails, what they were offering him and everything, these gambling companies that are awful.

Some families were left feeling ignored and dismissed because their efforts to contribute what they believed to be vital evidence were not considered, within an inquest which they felt was far too narrow in scope. This left some feeling that there had been 'only a partial investigation of facts.'

> You'll see, from my report, I'm sort of leaving breadcrumbs for them going to talk to people who might have some more relevant information… A lot of the questions I raised in my, 'What about this evidence?' had been dismissed out of hand, erroneously.

> I was hoping that something was going to be said about his gambling… That's the question all the time, is why, why, why? We wanted to know why. We were hoping that maybe we would find something out when we went to the inquest. We weren't sure what it was, but I think we were just hoping.

> I explained to the coroner's officer that I was certain that it was gambling that was the problem. And his words to me were something like, 'Well, the coroner is not going to be interested in that.'

Two families recall below that they were initially given the impression that the coroner was prepared to conduct an investigation and inquest with a broader scope. They were subsequently let down when this did not transpire.

> I saw from the gambling history, that he was gambling on the night he died… The coroner's officer rang me straight away… he was interested. He included it in the

> evidence, in the file, and he thought it was an important piece of information… I was also expecting to find out not only how but why as well, especially if it's a suicide, so what led to it, and it wasn't met… so I really still do not understand the whole 'how'.

> The impression given… was that they were interested in knowing more about why [our son] had died… [that] the process was something different than it actually was… The mismatch is that the encouragement that we had to do this and for them to know why completely changed on its head… we were led to believe that we could be instrumental in taking something to the inquest, taking information to the coroner, but actually that is a tick box exercise.

The exception to these concerns and frustrations with the scope of the inquest was one family who welcomed the support of the coroner's officer which, they felt, had influenced the coroner's decision that the inquest engaged Article 2.

> I think he was an inquisitive coroner, and, therefore, was prepared to think, 'Okay, let's make sure we do investigate this properly.'… We were very clear that… [our son's] addiction to online gambling was both the immediate trigger and the root cause of his death… We were wanting to make sure that that was, therefore, going to be included in the investigation.

In general, however, the families believed that their relatives' gambling had been largely or entirely ignored throughout the coroner's investigation and inquest.

7. Learning from the deaths

Following on from dissatisfaction with apparently incomplete investigations and inquests were similar frustrations with what many saw to be missed opportunities to learn from the deaths. The absence of any mention of the deceased's gambling in the coroner's Record of Inquest (which includes the final medical cause of death and the short-form and/or narrative conclusion) meant that it was also not included on the final certificate of death subsequently issued by the registrar.

> Gambling does not appear anywhere on the death certificate… gambling doesn't appear on a lot of people's death certificates who died because of gambling. It's wrong.

> What I wanted, more than anything, on [my son's] death certificate, was that gambling killed… What I wanted was what was clear in [his] note… That was incredibly important to me… [I was] devastated [when this did not happen]… Four-and-a-half years to get that [my son] died of multiple injuries was the biggest insult that I could have ever, ever have taken… I think [the coroner] failed us at the last minute, absolutely.

> Every parent we've met would like, 'Gambling-related suicide,' on the death certificate, but people think it's shameful.

One family took some comfort in the fact that, although gambling was not formally recorded by the coroner, the coroner did refer to the deceased's gambling in their summary at the end of the inquest.

> Although the reasons were not stated on the death certificate… the coroner mentioned the gambling and debts. He actually made our concerns be important… Although I didn't get the answers I wanted… because all we have on his death certificate is 'suicide'.

Many families raised further concerns that failures to record gambling on formal documents such as the coroner's Record of Inquest or the final certificate of death mean that there is a lack of data on gambling-related deaths at a national level, which impedes efforts to reform gambling policy. Some families thought that such reporting is essential if the coroners are to perform their function of preventing future deaths effectively.

> What I didn't understand is, it is not even recorded anywhere in statistics that the gambling even played some part in this.

> What we feel is that the coroner should be feeding back information to the government, on a basis of their own expertise and skill, of where they feel the consequence of a suicide is from either drugs or alcohol, or whatever… I've always thought that if the process was improved, in terms of coroners start to say, 'These are the issues that we can see coming through our courts. There's a problem within society here, of how people are handling these modern-day problems, and some people are taking their lives over it.'

> There was no great desire or interest, from what I could see, to look at any Prevention of Future Deaths messages… it is the prevention of future deaths that should be important, and you'd hope someone would care about that, and they don't seem to.

On the other hand, in the case in which an Article 2 inquest was held, the family's expectations of the coroner's PFD report were exceeded.

> His further judgements… those then ended up all being more powerful than we could've thought. He did mention regulation. His terms about woeful treatment and woeful information availability, those all went way beyond what, probably, our expectations had been, and that was important.

However, this same family went on to comment on the coroner's lack of power to follow-up on and check for progress by the organisations which were recipients of the PFD report. This family, and others, were ultimately left frustrated and distressed by a process that they felt neither brought them the justice they wanted for their son nor led to the actions they felt were required to prevent future deaths.

> There's giving justice for [my son], and then there's saving future lives. He gave a lot to saving future lives… I think that's why… [we] feel let down, because we didn't get justice for [our son]… the person at the heart of the process should be [our son]… [but he] was incidental, and justice for him was incidental.

> Other people will career down this path, will lose their lives, and still nothing will be done about it because the coroners are not looking to even tick a box that says causation… That was a mismatch with what I knew to be the coroner's role, which was to protect families… process takes over and nobody's interested in the human cost at the end of it… I didn't want other people to experience the same trauma.

> The fact is, nobody is interested. We know, and have got proof, as in [our son's] report, that he died from a gambling addiction. There's – be it bank records and his emails, and all that – evidence to show that, and nobody cares. To us, he's dead; nothing can be done. But it is the prevention of future deaths that should be important, and you'd hope someone would care about that, and they don't seem to.

8. Impact of the coronial process

As the coroner's investigation got under way, the families were grappling with difficult and complex emotions following a sudden and traumatic death, and finding out (in some cases for the first time) about the nature of the deceased's gambling, and its severity, financial ramifications and other related harms. The build up to the inquest, the hearing itself, and the aftermath, often exacerbated their pain as illustrated by the following comments.

> Especially before the inquest, there is nothing else you think about, just that inquest, that you want it out of the way. I was physically sick on the day, like my stomach was not working then.

> It wasn't a nice experience at all... we weren't at the heart of it. We just felt like it was just something we had to go through, with no support.

> For us it was really a torturous process. The whole inquest, the coroner, the coroner's office, and the whole system... the people that were supposed to be looking after us on the day, it was a terrible, terrible experience that I would not wish on anyone... I am utterly, utterly despondent and disappointed in the whole system.

Some respondents further explained that their experiences of poor treatment and exclusion, and disappointed hopes and expectations, negatively affected grieving processes. Some were also left feeling that they had somehow 'failed' the person who died.

> I suppose I thought there might be some sort of closure, but it didn't close anything up, nothing at all... I suppose I wanted the gambling companies to be mentioned more. I suppose I wanted to know what his feelings were in the last day... and piece together what happened.

> It's probably deeply damaging to my own personal journey with the grief because disappointment is not something you want on top of trauma... I feel my bereavement's been made worse... when you are silenced by your grief.

> In a way, I kind of think it made us feel like we'd failed [him]. There was no justice for him whatsoever… I felt really defeated… To be honest, I think literally within the first five minutes, I sat there and I just thought… we're fighting a losing battle with this.

9. Discussion

As part of the Voicing Loss project, which explored the role of bereaved people in coroners' investigations and inquests, 14 individuals from nine families bereaved by a gambling-related suicide were interviewed. To date, there has been no research which has considered the experiences of such families. The families had little or no prior knowledge or experience of the coroner service, and were all coming to terms with an unexpected and sudden death, with some only finding out about their relative's gambling and its severity after the death.

Overall, these families' experiences of the coroner's investigation and inquest align with the broader findings from Voicing Loss. While some recalled kind treatment and positive experiences, all recounted at least some instances of unkind treatment or other negative experiences. Poor experiences centred on limited or absent information and support from the coroner team, a lack of compassion, feeling excluded from or otherwise unable to participate meaningfully in the investigation and inquest, and lack of opportunity to recognise the life and personality of the deceased. Moreover, the families believed that they did not get the relief, answers and accountability that they hoped the inquest would bring, and faced ongoing struggles with their grief as a result. There was a consensus that neither they nor those who died – or, indeed, the issue of gambling - mattered or were 'at the heart' of the coronial process.

The families also raised some specific areas of concern about investigations and inquests following gambling-related suicides. First, there seemed to be an unwillingness for the coroner to include the deceased's gambling and the role of gambling companies within the scope of their investigation and inquest. Families had often invested significant effort and time, while grieving and otherwise preparing for the stress of the inquest, in collecting, collating and submitting evidence and supporting information for the coroner - in particular in relation to the deceased's gambling, their financial situation, harms experienced, and the interactions with or absence of

communication from gambling companies. Yet, this evidence and information was generally ignored by the coroner, or simply accepted at face value with no follow-up with the families at the inquest or impact on the broader investigation.

Second, at an individual level, families were disappointed that gambling was not included in the coroner's Record of Inquest, and subsequently on the final certificate of death. Furthermore, at a broader level, there was disappointment and frustration that narrow (deemed by many to be incomplete) investigations were a missed opportunity to identify areas in which actions were needed to prevent future deaths. As a result, many felt that gambling companies, the broader gambling industry and indeed the government were not being held to account, and the consequent lack of knowledge and understanding about the extent of gambling-related deaths impedes desperately needed policy reforms.

Two recent inquests, following gambling-related suicides, indicate that a different approach to the investigation of such deaths is possible, can be satisfactory for the bereaved family and can potentially contribute to prevention of future deaths and policy reform.[10] In 2022, the coroner in Jack Ritchie's inquest wrote the first PFD report to address gambling-related deaths; this covered failings in regulation, public information about the risks and dangers of gambling, and treatment availability. In 2023, the coroner in Luke Ashton's inquest, also for the first time, included gambling disorder within the final Record of Inquest, and named a gambling company as an interested person (who were also sent a PFD report). However, sustained improvements to coronial investigations of gambling-related deaths are likely contingent on wider, structural reforms to the coroner service. This is a service that is facing multiple challenges – including in relation to resourcing, staffing, complexity of cases, and societal expectations of the coroner's preventive role. There is therefore an urgent need for informed debate about the future direction of the coroner service and how it can best meet the growing demands being made upon it.[11]

Some recent developments offer scope for cautious optimism that death investigations will start to address some of the shortcomings identified by the families interviewed for Voicing Loss – those bereaved by gambling-related deaths and others. First, in 2024, the government announced that the 'Hillsborough Law' will be introduced in April 2025, to 'force public bodies to cooperate with investigations into future disasters and scandals' (Critch, 2024). It is hoped that this will ensure that investigations (including inquests)

[10] Calls for improved coronial responses to other kinds of preventable deaths have also been made – for example, domestic abuse related suicides (as discussed by Roberts, 2024), and alcohol or drug-related deaths.

[11] For further discussion of the need for broader reform to the coroner service, see the Voicing Loss Policy Brief No. 1: Clarifying the role and remit of the coroner.

are characterised by greater openness and candour, and will thus more effectively hold public services to account than has hitherto been the case. Second, in 2022, the Bishop of St Albans introduced the Coroners (Determination of Suicide) Bill [HL] Bill to Parliament,[12] which would require coroners to record, as part of their conclusion, the factors relevant to a death by suicide, and thus would help uncover the true extent of gambling-related suicide could be uncovered. Although there was no expectation that this Private Members' Bill would become law, its introduction did raise the profile of gambling-related deaths within policy debate. A third development is the campaign by the charity INQUEST for a National Oversight Mechanism: an independent public body with responsibility for collating, reviewing and – crucially – following up on recommendations emerging from coroners' investigations and other inquiries and reviews of state-related deaths.[13]

Relevant case law also continues to evolve. A significant case is that of *Dove*,[14] in which the Court of Appeal held that a fresh inquest should be held into the self-inflicted death of Jodey Whiting which followed the withdrawal of her disability benefits. The Court ruled that 'it is open to a coroner to record the facts which contributed to the circumstances which may or may not in turn have led to death', citing cases which demonstrate 'the wide discretion conferred on coroners to establish the background facts, and then determine whether those facts were or were not causative of death'. As highlighted by the legal team who represented Whiting's mother, Joy Dove, the ruling has implications for a range of deaths, including those related to gambling.

> Bereaved families now have the benefit of Court of Appeal authority to support their argument for coroners to investigate factors which contributed to their loved one's mental health deterioration, and the decision to take their own life, where the public interest requires it. As we have already seen in inquests raising similar concerns to those in Jodey's case…for example, in inquests involving gambling harms (such as the inquest into the death of Jack Ritchie)… investigation of these factors by coroners can be a powerful tool for significant public learning and the prevention of future deaths (Varney and Webster, 2023).

The experiences of coroners' investigations and inquests among families bereaved by gambling-related suicide have hitherto not been researched. Their inclusion in Voicing Loss has therefore provided new insights, in the context of the wider data-set on bereaved people's expectations and experiences of the coroner service. These findings demonstrate the need for recognition and examination of a deceased person's gambling

[12] https://bills.parliament.uk/bills/3176
[13] https://www.inquest.org.uk/no-more-deaths-campaign
[14] Dove v HM Assistant Coroner for Teesside & Hartlepool & Others [2021] EWHC 2511 (Admin).

– and the role of gambling companies, the wider gambling industry and government policy on gambling – within the coronial process. This, combined with improved information and support for bereaved people throughout the process, and compassionate and respectful treatment, will help ensure that coroners' investigations and inquests provide answers and assurances that lessons are being learned. All too often, the opposite is the case with the process instead exacerbating grief and leaving families feeling bereft, angry and, above all, profoundly disappointed that there appears to be little prospect of meaningful change.

References

Chief Coroner (2021) *Chief Coroner's Guidance No. 41: Use of 'Pen Portrait' Material*

Collard, S., Davies, S., and Cross. K. (2023) *The Family Dynamics of Gambling Harms* Personal Finance Research Centre, University of Bristol

Critch, N. (2023) *Hillsborough law planned for 2025 – what it will mean for future disasters and scandals*, The Conversation, September 25th 2024

Department for Culture, Media and Sport (2023) *High Stakes: Gambling Reform for the Digital Age*, London, DCMS.

Department of Health and Social Care (2023) *Suicide prevention in England: 5-year cross-sector strategy*, London, DHSC

Gambling Commission (2024) *Gambling Survey for Great Britain - Annual report (2023): Official statistics*

Gosschalk, K., Webb, S., Cotton, C., Harmer, L., Bonansinga, D., Gunstone, B., Bondareva, E. and Zabicka, E. (2023) *Annual GB Treatment and Support Survey 2022: On behalf of GambleAware*, YouGov

Ministry of Justice (2024) *Coroners statistics 2023: England and Wales*

NHS England (2023) 'Gambling behaviour', *Health Survey for England 2021, Part 2*

Gambling Commission (2024) *Gambling Survey for Great Britain*, Gambling Commission

Office for Health Improvement and Disparities and Public Health England (2023) *Gambling-related harms evidence review: summary*

Orford, J. (2020) *The Gambling Establishment: Challenging the Power of the Modern Gambling Industry and its Allies*, Routledge

Orford, J. (2011) *An Unsafe Bet?: The Dangerous Rise of Gambling and the Debate We Should Be Having*, Wiley-Blackwell

Roberts, Y. (2024) 'Domestic abuse drove our daughters to suicide, say families. So what stops coroners acknowledging that?' *The Guardian*, 01/06/2024

Varney, M. & Webster, D. (2023). 'Court of Appeal judgment in the Dove case: what comes next and what does it mean for other inquests?' Leigh Day blog