Ashes to Ashes; and the Dust on the Coroners Court:

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Abstract:

This short report first outlines the current legislation surrounding the function of the Coroners' Court before launching into four key recommendations to address these failures: implementing standardised bereavement care and training for coroners; expanding legal education and accessible guidance on the inquest process; strengthening the use of narrative conclusions and Prevention of Future Death reports to drive systemic change. Throughout the report also weaving personal experience from time spent volunteering with citizens advice and drawing comparisons between systems of grief and humanity.

Introduction:

"Whilst the Coroner services had improved substantially… bereaved people are not yet sufficiently at its heart". This was the main takeaway from the 2021 House of Commons Justice Report on reforms to the Coronial system[338]. There has been a fundamental failure to include and accommodate bereaved people during the inquest process, which this policy report seeks to address through recommendations on legal education, the provision of standardised care, encouraging new inquest outcomes such as greater use of narrative conclusions, and giving increased weight to Regulation 28 reports.

The Coroners' Court's main purpose is set out in The Coroners and Justice Act 2009. Section 1 sets out that "A senior coroner … (must) conduct an investigation into the person's death if subsection (2) applies". This results in an inquest in which the coroner will rule on the cause

[338] C Fairbairn, "Reforms to the Coroner Service in England and Wales" (*House of Commons Library*, September 24, 2021) <https://commonslibrary.parliament.uk/research-briefings/cbp-9328/> accessed December 16, 2024

of death based on the information provided by post-mortems, pathology reports and sometimes reports from the people involved. Some inquests will require the families to read through their witness statements in person, and questions can be asked by the coroner or other interested parties. This can be an incredibly emotionally charged process which has provoked the creation of services like the Coroners' Courts Support Services (CCSS)[339]. The organisation trains volunteers to offer emotional support to the bereaved families as grief can operate as a major barrier to accessing justice.

Throughout my placement at Citizens Advice Liverpool (Garston), we were often faced with clients experiencing grief which had a severe impact on their ability to interact with Citizens Advice Services. One example that stayed with me was an individual who lost both her brother and mother within the same year and subsequently developed traumatic depression. In the process of applying for Personal Independence Payments[340] (PIP), they struggled to keep appointments and engage in phone conversations, and showed little willingness to discuss the impact of grief on their mental health. Failing to discuss certain parts of your condition can have a detrimental effect on the amount of financial aid you receive and is important in maximising the chances of a fair PIP Form decision.

Grief and Mental Health issues are rampant among users of Citizens Advice Services. Interacting with the welfare system brings about poor mental health[341] and the same can be said for a person's dealings with the Coroners' Court. Key Findings from a report by the Bereavement Commission found that 61% of adults had difficulties with at least one practical

[339] Coroners Courts Support Service, "Support at Court" (*Coroners Courts Support Service*, July 19, 2017) <https://coronerscourtssupportservice.org.uk/support-at-court/> accessed December 17, 2024
[340] Citizens Advice, "How Much PIP You Can Get and for How Long" (*Citizens Advice*, March 2, 2022) <https://www.citizensadvice.org.uk/benefits/sick-or-disabled-people-and-carers/pip/before-claiming/how-much-you-get-and-how-long/> accessed December 16, 2024
[341] SL Senior,W Caan and M Gamsu, "Welfare and Well-Being: Towards Mental Health-Promoting Welfare Systems" (2020) 216 The British Journal of Psychiatry 4

or administrative task following bereavement[342]. Preparing for an inquest is a new administrative process for many people and most struggle with it to the point where inquests are viewed as less 'relieving' and 'cathartic' but rather 'alienating' and 'daunting'[343]. The Research Project 'Voicing Loss'[344] explores the participation of bereaved people within Coroners' investigations and inquests through interviews. It is the largest empirical study on the Coronial Process and the failings uncovered within the system must be worked upon as a matter of utmost importance.

Personal Recommendation 1: Standardised Care Within the Coroners Court System.

There is difficulty in implementing a standardised level of care within the Coroners' Court, just as there is difficulty in providing a standard of care within Citizens Advice. It can be down to the Coroner's personality, experience, and even the funding of the coroner's area. The 2021/2022 Coroner Service report from the House of Commons Justice Committee[345] provided a lot of evidence to support their finding of inconsistent and conflicting services. Deborah Coles, Director at INQUEST (The only Charity providing expertise on state involved deaths) found that whilst some people had extremely positive experiences, others were treated "with a lack of dignity, respect and empathy"[346]. There are guidelines for Coroners[347] on proceedings,

[342] The UK Commission on Bereavement, "Bereavement Is Everyone's Business" (*Bereavement commission*, 2022) <https://bereavementcommission.org.uk/media/o5obuive/ukbc-england_briefing.pdf> accessed November 10, 2024

[343] J Jacobson, L Templeton and A Murray, "'I Feel like I've Been Swept along on a Tsunami': Bereaved People's Experiences of Coroners' Investigations and Inquest" (*Voicing Loss*, May 2024) Page 5

[344] J Jacobson, L Templeton and A Murray, "'I Feel like I've Been Swept along on a Tsunami': Bereaved People's Experiences of Coroners' Investigations and Inquest" (*Voicing Loss*, May 2024) <https://voicing-loss.icpr.org.uk/research> accessed December 11, 2024

[345] House of Commons Justice Committee, "The Coroner Service First Report of Session 2021–22" (May 18, 2021) <https://committees.parliament.uk/publications/6079/documents/75085/default/> accessed December 12, 2024

[346] House of Commons Justice Committee, "The Coroner Service First Report of Session 2021–22" (May 18, 2021) <https://committees.parliament.uk/publications/6079/documents/75085/default/> accessed December 12, 2024 Page 15, Section 42.

[347] The Chief Coroner's Guide to the Coroners and Justice Act 2009

including on niche kinds of inquests like Railway cases, where individuals die in railway yards and yet there may be benefits to providing a guidelines sheet directly based on the coroner's behaviour or manner. The way they handle interested parties and provide bereavement support may be best done through the Chief Coroners Guidance.

Another option would be to implement a mandatory session of bereavement training – simply to ensure that Coroners are on an equal playing field when handling inquests. Charities such as Cruse, which provide bereavement support to people across the UK, also offer training to organisations to help them deliver compassionate support to customers and employees, thereby enhancing well-being and performance[348]. These courses cover areas such as suicide bereavement, supporting families and children, and a range of other scenarios. The government should explore the viability of commissioning a training course specialised for the coroner's role that is created by bereavement counsellors and has bereaved people at its heart. This could also be done through the UK Commission on Bereavement, as then it could include various charities and receive Government funding from the Commission. The training course could include various techniques when talking to interested parties, including the deceased within the inquest process and specific wording which may be needed when dealing with suicide bereavement. The benefits would include interested parties gaining more out of their experience with the Coroners' Court as they will have incorporated the deceased's life and memory into the inquest and will feel more comfortable with the process since they are treated with respect and empathy. It could also be argued that it could reduce the load of The Coroners' Courts Support Service as the Coroner would be able to provide very baseline support and understanding to bereaved families.

[348] Cruse Bereavement Support, 'Managers' Guide to Grief' (Cruse Bereavement Support, [no date]) https://www.cruse.org.uk/organisations/grief-awareness-training-for-hr-and-managers/ accessed 19 September 2025

Personal Recommendation 2: Increased legal education surrounding Inquests and Coroners Court.

Whilst on placement at Citizens Advice, I observed that the organisation is a well-established and trusted source of guidance, covering issues such as benefits, housing, and workers' rights. These are recurring problems that people face throughout their lives and are increasingly being discussed more openly. By contrast, individuals only encounter the Coroners' Court system when faced with death. Despite death being one of the few certainties of life, it often remains a taboo subject, meaning that many approach the system without prior knowledge or understanding of the coronial process.

This recommendation proposes placing information stalls in settings where people are likely to encounter bereavement. One example is Hospital Bereavement Services, which provide vital support by working with doctors to complete necessary legal documents and advising on local funeral directors. If these services also explained the inquest process, clarified the role of the coroner, and set out in simple terms why a loved one must go through the system, families would be better prepared. In addition, a specialist lawyer could be made available to offer advice in cases where an institution such as the NHS is involved in the inquest and there is a potential claim of negligence. The National Pro Bono Centre, which connects lawyers with specialist pro bono organisations, could facilitate this, with groups such as Action Against Medical Accidents (AVMA) and Advocate offering free legal assistance and representation. Strengthening education in this way would help to reduce the power imbalance between litigants in person (LIPs) and institutions like the NHS. As bereaved families often find themselves opposing government bodies, this imbalance can place them at a significant disadvantage. A report by Professor Grainne McKeever[349] sets out that a system that

[349] G McKeever, "Litigants in Person in Civil and Family Courts in Northern Ireland: Overview of Research & Policy Developments"

disadvantages LIPs' is a system in need of reform which is why legal education is increasingly important.

Other areas that may benefit from legal education are charities that are at an increased likelihood that their service users will need education on being a LIP. One example would be Charities supporting prisoners and their families. Since 2013, on average 300[350] people die in custody each year and these cases will go through an Inquest due to Section 1 Subsection 2C of The Coroners and Justice Act 2009[351] stating that a Coroner has a duty to investigate if "the deceased died while in custody or otherwise in state detention". A charity like Prisoners' Families Helpline, would benefit from offering advice, providing education and engaging with LIP. Currently, the website[352] offers information on families going to the Crown, Magistrates and even youth court and provides information on what they can expect. However, at around 300 cases a year, these families will have to attend Coroners Court with no understanding of what to expect, especially if expected to represent their loved one against the prison services.

Furthermore, by targeting specific services and charities where people are most likely to encounter bereavement, there is a greater opportunity for both litigants in person (LIPs) and those who can afford representation to engage more effectively with the Coroners Service. However, a wider societal issue persists: education about death and the coronial process is hindered by the fact that death remains a taboo subject that people actively avoid discussing. To create an effective education system – the way we view death has to change. One way this could be done is by commissioning documentaries on the subject matter. The BBC has often commissioned documentaries[353] using public funds from TV licensing and its commercial

[350] INQUEST, "Deaths in Prison" (*Inquest*) <https://www.inquest.org.uk/deaths-in-prison> accessed January 9, 2025
[351] The Coroners and Justice Act 2009 ((S1) SS2C)
[352] "Prisoners' Families Helpline" (*Prisoners' Families Helpline*) <https://www.prisonersfamilies.org/> accessed January 2, 2025
[353] E Kessler, "BBC Commissioning Process Framework"

limbs. This can be extremely effective in educating and opening up discussion around the systems in our society surrounding death. Compelling media coverage could be used to empower people for a potential future in which they attend an inquest.

Recommendation 3: Making Legal Changes to the Conclusions of an Inquest (i.e. Encouraging more Narrative Conclusions and PFDS).

When at the placement and even in my public lawyering module, there has always been a negative view of the Department of Work and Pensions (DWP). The application process for benefits as previously mentioned is negatively impacting the mental health of those engaged with the system. Many clients had depression and anxiety as a result of dealing with the lengthy application forms, the rejections and the lack of empathy they had received from the DWP[354]. The deterioration of mental health by claimants observed by sectors like Citizens Advice is further solidified by the suicide of Kevin Gale. Mr Gale was suffering from severe depression and anxiety and was constantly set back in his Universal Credit applications due to failings within the DWP. The Coroner Kirsty Gomersal of Cumbria made a Prevention of Future Death (PFD) report[355] to the DWP voicing concerns over systemic failings, however, the DWP dismissed this call to action.

Following an inquest or investigation into a death, a Coroner may issue a PFD report to an organisation, individual or service provider. Under paragraph 7, Schedule 5 of The Coroners and Justice Act 2009[356], and Regulations 28 and 29 of The Coroners (Investigations) Regulations 2013[357], where an investigation gives rise to concern that future deaths will occur,

[354] R Dunne, "Regulation 28 Reflections: The Unseen Mental Health Impact on Inspected Entities" (*Hill Dickinson*, March 11, 2024) <https://www.hilldickinson.com/insights/articles/regulation-28-reflections-unseen-mental-health-impact-inspected-entities> accessed December 15, 2024

[355] K Gomersal, "Kevin Gale: Prevention of Future Deaths Report" (*Courts and Tribunals Judiciary*, November 8, 2023) <https://www.judiciary.uk/prevention-of-future-death-reports/kevin-gale-prevention-of-future-deaths-report/> accessed December 20, 2024

[356] The Coroners and Justice Act 2009, Paragraph 7, schedule 5.

[357] The coroners (Investigations) Regulations 2013, Regulation 28 and 29

and the investigating coroner believes that action should be taken to prevent future deaths, the coroner must make a report to somebody they believe may have the power to take such action. Furthermore, as it is the statutory duty of the coroner to make these reports, it's understandable to believe that there should be more weight put on PFDs. The 2021/22 statistical data on Suicide-based PFDs showed that there were 25 concerns related to "Improvements not being implemented" from 20 PFD reports (12% of all reports)[358] meaning that there isn't enough power within the PFD to make change. By encouraging Coroners to make more PFDs from inquests with Narrative Conclusions, there would be more areas of society where the coroner could provide guidance and advice on actions to be taken. Narrative conclusions are an outcome where a short-form conclusion on the cause of death is not enough and a small paragraph with details of the death is allowed. It can also be the preferred conclusion for some people as it allows for a bit more of the deceased's story to be involved in the conclusion which puts "Bereaved People at the heart". It takes into account the bereaved families' need for the deceased person's story to be told at their inquest and still allows data to be drawn out from the narrative conclusion. These two methods have a positive impact on the coronial process,providing the most supportive environment to those it serves whilst being able to guide on preventing deaths in every sector.

Recommendation 4: Prevent the Digitalisation of the Coroners' Court.

Another thing that I noticed with my placement at Citizens Advice was how digitalised all communications with clients were. Each session would comprise one or two phone calls to clients in distress and a few times, the connections were cut or the audio would cut out and the

[358] Office for National Statistics , "Prevention of Future Death Reports for Suicide Submitted to Coroners in England and Wales: January 2021 to October 2022" (*Office for National Statistics* , October 2022) <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/preventionoffuturedeathreportsforsuicidesubmittedtocoronersinenglandandwales/january2021tooctober2022> accessed December 12, 2024

whole point of the call would be lost to "Can you hear me?" back and forth. The only in-person form-filling session was the one I remember most because I was able to form a genuine connection with the people I was trying to help. Unfortunately, I felt like I was able to offer them a better service simply from the fact they came in person and could talk to me about the struggles surrounding the PIP form. They had access to all their documents, and I was able to access what I needed – something that can be difficult when over the phone, especially when the issue concerned medication.

The Judicial Review and Courts Bill introduced by the House of Commons in 2021[359] suggested that Coroners' should enable rules to allow all participants to participate remotely in pre-inquest interviews and inquests. Some may argue that this is the best-case scenario for bereaved families as remote participation prevents the inquest from disrupting the families' lives severely; they would not have to disrupt their grief, or worry about travelling to the courts. On the other hand, some may argue that framing the inquest as a disruption to grief is oxymoronic. Inquests have often been seen as vessels for closure[360] and an empathetic coroner can assist families in navigating their journey in grief by providing answers. As previously discussed, in-person communication can provide a richer rapport between clients which can enhance understanding and trust in the system – all of which can be lost with remote communication. There is also a higher reliance on technology, which can be incredibly difficult for older generations. In 2023, 39% of all deaths reported to the coroner concerned those aged between 25-65,[361] meaning the older generation is responsible for handling that percentage of

[359] Ministry of Justice, Judicial Review and Courts Bill 2021

[360] J Waldman, "Through The Looking Glass: Curiosity v Closure in Inquests and Research - Frontiers of Socio-Legal Studies" (*Centre for Socio-Legal Studies, University of Oxford*, June 25, 2025) <https://frontiers.csls.ox.ac.uk/curiosity-v-closure-in-inquests-and-research/#continue> accessed September 17, 2025

[361] Ministry of Justice, "Coroners Statistics 2023: England and Wales" (*Gov.uk*, May 9, 2024) <https://www.gov.uk/government/statistics/coroners-statistics-2023/coroners-statistics-2023-england-and-wales> accessed December 17, 2024

inquests and will struggle with remote inquests. Evaluating the impact of technology on the ability to provide better care almost takes away the ability for families to tailor their experience. Is the goal of putting bereaved people at the heart of the Coroners Court system taken back by assuming that the system will understand their grief better than themselves? As noted earlier, I found the service I provided was more effective and compassionate in person than over the phone. Nevertheless, for some clients—particularly those experiencing anxiety—remote communication offered greater comfort. The most appropriate approach, therefore, is to preserve in-person attendance at court as the default option, while also allowing digital participation where it better serves the needs of the bereaved. Bereaved families will always understand their grief and circumstances better than the Government and often, providing the best level of care means tailoring the experience so that every individual receives the best care for them.

Conclusion:

The coroner service, despite its statutory foundation in ensuring accountability and truth surrounding death, continues to fall short in placing bereaved families at its core. The reforms proposed are not merely administrative improvements but essential measures for restoring trust and dignity in coronial processes. At its heart, the coroner's role is not only investigative but also relational as it involves guiding families through one of the most difficult times of their lives. By embedding compassion, transparency, and empowerment into practice, the coronial system can transform from a process often described as alienating into one that truly delivers justice for the deceased and meaningful closure for the bereaved.