Between legality and empathy: an examination of the coroner's inquest and its impact on the emotions of those bereaved by road death

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Abstract

The general acceptance of the – often fatal – risks associated with high–speed transport, can be seen as a global public health issue. In the UK, 'survivors' groups' are condemnatory about the trivialisation of road death by a system of justice which overlooks victims' rights and increases the suffering of the bereaved. For those who suffer the loss of a family member in a road collision, the traumatic and complicated grief they experience sees them as 'co–victims' of such a death. This difficulty is compounded when they find that the collision event is deemed to be non–culpable, forcing them to encounter part of the Justice System in England and Wales which is little known and less understood: the coronial system. As an administrative system encapsulating the inquest, the coronial system sets itself up to establish the 'truth' of how a person has died in order to categorise, commit to record and ultimately register a sudden death, while at the same time investigating without apportioning blame. From the moment of the death, through the initial coronial investigation and into the inquest hearing itself, a number of mismatches between what the bereaved expect – both morally and symbolically – from the State and what it seeks to provide, are apparent. Policymakers' reforms and coroners' comportment have attempted to balance these needs, and families' ability to cope with their grief is moderated by their agency and outlook. However, in investigating whether the emotions of the bereaved were negatively impacted by the coronial system, this thesis examines the proposition that the process and the conduct of those working within it, amounts not only to an acceptance by the State of a road death, but moreover as a justification *for* it. In so doing, the thesis aims to confirm or deny the status of the bereaved not only as co–victims, but as *secondary* victims of that system.

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1. Introduction: the social administration of road death

On 7th February 2019, one of the main news stories run in the national press following the release of new information by the Office for National Statistics ('ONS'), was that recorded homicides for the year ending March 2018, at 726 lives lost, had increased by 15 per cent[1] in England and Wales compared to the prior year (Office for National Statistics, 2018). Yet, on 25th July 2019, the Department for Transport ('DfT') published its road casualty statistics for year ending December 2018 in England and Wales, revealing a total of 1,622 road fatalities – just 25 fewer than the previous year (Department for Transport, 2019). Despite this figure representing more than double the number of those lost to homicide, media coverage of this statistic was sparse, a situation which becomes more extraordinary when the global picture of road deaths is revealed.

1.1 Death on the roads

Given that these figures show road fatalities to account for more than twice as many deaths in England and Wales as homicides – leaving correspondingly greater numbers of people bereaved and traumatised – and that interpersonal violence is increasingly conceived of as a public health issue (Mastrocinque, et al., 2015; Mitton, 2019; Wolf, et al., 2014), commentators have suggested that the public health argument can be extended to road death in the same way (Ozanne–Smith, 2004; Richter, et al., 2006). Whilst increasing traffic levels in the UK and other developed countries have been associated with a general trend of road fatality levels coming down (albeit at a much slower rate in recent years), this is not the case in developing countries. The World Health Organisation projects that road injury will move from being the 10th leading cause of death in low–income countries in 2016 to the 5th leading cause by 2030. Moreover, road injury is currently the leading global cause of death amongst children aged 5–14 and young adults aged 15–29 (World Health Organisation, 2018). Given its impact on global

[1] Homicide statistics are affected by the recording of exceptional incidents with multiple victims such as the terrorist attacks in London and Manchester, and the Hillsborough football stadium disaster in 1989. The percentage change figure of 15 per cent provided here is based on figures which exclude those deaths.

health and its recognition as something of a pandemic issue, a consideration of the 'fallout' from death and injury through road traffic collision is paramount.

The level of injuries incurred from being involved in a road crash (whether as a driver, passenger or pedestrian) depend on numerous factors such as the speed involved, whether another car or stationary object was hit, whether the victim was wearing a seatbelt, and the design of the vehicle itself. For every person killed in a road collision in Great Britain in 2018, another 14 were seriously injured, with the DfT (2017a: no page number) defining serious injury as:

> An injury for which a person is detained in hospital as an 'in–patient', or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushings, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident. An injured casualty is recorded as seriously or slightly injured by the police on the basis of information available within a short time of the accident.

This is not new. Road traffic fatalities have been reported almost since the first introduction of motorised forms of transport. The death of Bridget Driscoll after being hit by a car as a pedestrian in 1896 was the first of its kind recorded in the UK (BBC, 2010; Dorries, 2014) with the coroner on the case purportedly saying that 'I trust this sort of nonsense will never happen again' (Yates and Ibrahim, 2014: 4). Contemporarily, the consequences of motorisation are easily discovered. For instance, in February 2019, a 12–year–old boy became the third in his family to die in a road collision, with his step–father and father both having been killed in separate road traffic collisions some years earlier (https://metro.co.uk/2019/02/17/boy-12-dad-step-dad-killed-separate-car-crashes-8649090/); in December 2017, six people were killed and another critically injured in a multiple–vehicle crash at the entrance to an underpass in Birmingham (https://www.bbc.co.uk/news/uk-england-birmingham-42383464); and in November 2011, a multiple–vehicle collision on the M5 motorway in Somerset left seven people dead and injured another fifty–one (https://www.bbc.co.uk/news/uk-england-somerset-15606278).

1.2 Accepting the risks

Despite these examples, most societies accept the risks associated with, and remain ambivalent towards, the consequences of high–speed transport. These risks appear to be not only accepted but encouraged, with car manufacturers glamorising cars and relying on our consumerist desires to drive sales (Ferrell, 2003; Tombs and Whyte, 2015), by seeking to persuade us that owning a 'prestige' motor vehicle will enhance our status and make our lives more exciting (see figure 1).

This situation – what has been called the 'hegemony' of the car (Dant, 2004; Ferrell, 2003) – has been acknowledged and is vociferously objected to by organisations that have developed to provide practical and emotional support to those bereaved by death on the roads. As 'survivor groups' (Rock, 1998), RoadPeace and Brake are the leading national charities in the UK dealing with injury and death from road collisions, campaigning for changes to a system that they believe increases and compounds suffering for victims' families.

Figure 1. The hegemony of the car

A consequence of these divergent discourses is a dichotomy between the perception of road traffic injury as a 'scourge' on global public health (Ozanne–Smith, 2004; Richter, et al., 2006), and the portrayed gratification obtained from the 'harmony, independence and control' that driving a vehicle provides (Blake, 1974). As Johnston, et al. (2013: 1) describe with reference to the global road death toll:

> How strange that we are willing to accept, with mind–numbing equanimity, such a level of human suffering while we simultaneously express outrage at the collateral damage that occurs in the current wars in the Middle East …

Ferrell (2003) discusses the issue at length, pointing to the loss of thousands of people through road death as an example of critical criminology's 'blind spot' (Ferrell, 2003: 195) given its neglect of '… the everyday criminality of the automobile – the daily automotive degradation of community life, the daily victimisation of passengers, pedestrians, and bicyclists by the thousands'. In comparing the numbers of people lost in the War on Drugs with the (comparatively high) tally of those lost to road death in the United States, Ferrell comes to a conclusion very similar to that which underpins this thesis, namely the disproportionate level of attention paid to those lost through homicide: 'How is that stories about crack babies and crack attacks, about eight–year–old heroin addicts and superhuman meth junkies are so readily believed, yet the stories written by countless roadside shrines so seldom read?' (Ferrell, 2003: 192).

1.3 Assessing the damage

The consequences of this global irony can be seen much closer to home. When a road fatality occurs in England or Wales, the circumstance surrounding the death is assessed initially by the police, who consider whether they believe the event to have been an 'accident' or whether a prosecutable offence – for which they can provide enough evidence – has occurred. In the latter circumstance, the case is passed to the Crown Prosecution Service ('CPS') and, as such, although decisions around whether a person or persons are criminally liable for a road death are ultimately made by the CPS, they are heavily influenced by the perspectives of the initial police investigation. This arguably 'secret trial' by the police potentially sees them fitting the crime – or not – to the legislation, which then informs their treatment of those with whom they deal and 'provides the moral framework within which they can rationalise their own conduct towards those they process' (McConville, et al., 1991: 189).

Once received by the CPS, the 'Full Code' test, constituting two stages, is used to determine whether the case will be followed through to prosecution. The first stage, known as the 'Evidential Stage', is similar to that carried out by the police and looks at whether there is enough evidence of driver culpability for there to be a realistic prospect of conviction. The second stage, the 'Public Interest' stage, requires prosecutors to consider a number of factors relating to the offence which tell them whether the public interest would be properly served by the prosecution. These factors include the seriousness of the offence, the suspect's level of culpability (as mitigated by factors such as premeditation and level of maturity), the impact on the community, and whether a prosecution is felt to be a 'proportionate' response. Importantly, the 'public' of 'public interest' here does not necessarily pertain to those who have been bereaved by the event, and CPS guidance is clear on where victims' families sit insofar as any prosecution is concerned. For example, the CPS 'Code for Crown Prosecutors' guidance document outlines:

> 4.14c) What are the circumstances of and the harm caused to the victim?
>
> Prosecutors should take into account the views expressed by the victim about the impact that the offence has had. In appropriate cases, this may also include the views of the victim's family.
>
> However, the CPS does not act for victims or their families in the same way as solicitors act for their clients, and prosecutors must form an overall view of the public interest.
>
> (Crown Prosecution Service, 2018)

If the Public Interest test is not passed, or evidence is deemed to be lacking, there will be no prosecution. In such a circumstance – where no–one is deemed to be culpable for a death on the road – the families and friends of the deceased person or persons face part of the Justice System that has undergone little academic scrutiny: the inquest. This stands true for cases where there has been a collision involving more than one driver but, in single person fatal collisions or where the person who may have been responsible has also died, these cases automatically proceed to inquest because of the sudden and unnatural nature of the death.

The format of the inquest is inquisitorial, as opposed to the adversarial nature of the UK criminal court system. There are thus no 'sides' representing a prosecution and a defence. An inquest is a fact–finding inquiry whose formal ambition is to establish the facts of a death and categorise the outcome. As such, an inquest is a forum which does not rule on liability or 'blame', regardless of a family's belief about any person's involvement in the death of the deceased. In this way, a car–driver who has hit and killed a pedestrian, for example, as long as the CPS and police have deemed there to be no criminal case to answer, may stand as a witness in the coroner's court but not as a defendant. This leaves those who have died and, by implication their families, the victims of 'accident' rather than crime. Consequently, this thesis goes on to consider whether this situation calls into question their status as victims and the degree to which coroners' courts, despite their inclusion within the UK Justice System, are actually forums for 'justice'.

It has been found that for those families who are bereaved by violent crime, the death of their family member leads them to suffer the most abject trauma, leading to great emotional instability (Black and Kaplan, 1988; Zedner, 2002). In this context, their grief can be exacerbated by the Criminal Justice System which, it has been said, can have a deleterious impact on the families and friends of primary victims who find themselves caught up in the process, earning them the label of 'secondary victims' (Rock, 1993; Sanders and Jones, 2011; Shapland, et al., 1985). There are various reasons given for this in the criminal court system, ranging from feelings of the process being a 'contest' (Parsons and Bergin, 2010), through loss of control over the body of the loved one (Casey, 2011) to criticism of the portrayal of events with regards to what happened in the perpetration of the crime itself (Thiel, 2013).

This raises the question of whether losing someone in a road collision where there is deemed to be no criminality, given the similarly violent, sudden and traumatic nature of the death, and the fact that families must then face an alien legal process, makes them no less 'secondary victims' – or perhaps more fittingly 'co–victims' (Gekoski, et al., 2013) in this context – than if they *were* casualties of crime. Despite this, and the increasing academic attention the coronial arena

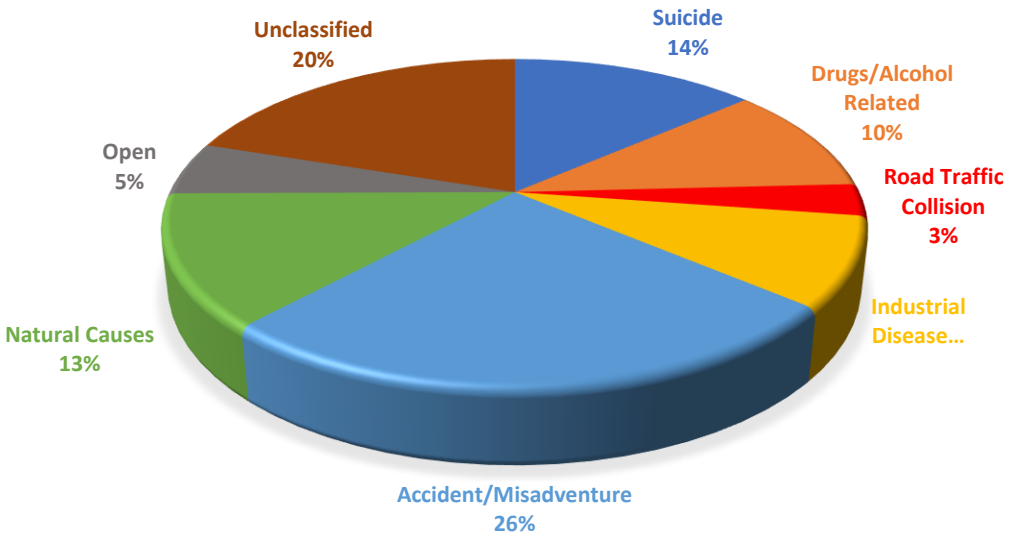
is attracting (Freckelton, 2016; Mclean, 2015; Scott Bray and Martin, 2016a; Scott Bray and Martin, 2016b; Trabsky, 2016), the consideration paid to the bereaved family members of those killed on the roads remains gravely lacking, particularly within broader society which appears largely unaware of how the coronial system functions and what it is for. In light of the under–investigation of the emotional impact of the coronial system on this bereaved subpopulation and, given the high numbers of people for whom dealings with the system are inevitable, filling this gap in our sociological knowledge is critical.

The following sections look more closely at the statistics relating to non–culpable road death and highlight the circumstances in which it occurs. They also consider how the CJS classifies and deals with fatalities on the roads in England and Wales, as well as introducing the inquest as a forum for categorising sudden death in more detail. The final part of this introductory section elucidates the specific questions which are addressed by this research, as well as outlining the overall scope and structure of the thesis.

1.4 The coronial system

In 2018, a total of 220,600 deaths which were classified as sudden, violent, unnatural or had occurred in custody, were reported to coroners in England and Wales. This amounted to 41 per cent of all registered deaths that year. There were 29,100 inquests opened, and post–mortems were carried out in 39 per cent of these cases. In categorising the death at the end of an inquest, and as shown in the chart at figure 2, there were thirteen possible 'short–form conclusions' available to coroners, with just four of the thirteen accounting for 73 per cent of all conclusions recorded in the year: accident and misadventure, 26 per cent; natural causes, 13 per cent; unclassified, 20 per cent; and suicide, 14 per cent (Ministry of Justice, 2018b). All other conclusions, including: killed lawfully/unlawfully; attempted or self–induced abortion; cause of death aggravated by lack of care, or self–neglect; and stillborn, were not included in the chart as they represented less than 1 per cent of the short–form conclusions.

Figure 2. Short–form conclusions used in England and Wales, 2018



The law around the short–from conclusions of 'lawful killing' and 'unlawful killing' in a coroner's court is complex, and the use of these terms would at once appear antithetical to the purpose of the inquest. This is further touched on in section 6.1 but, for the purposes of definition, the conclusion of unlawful killing is restricted to the criminal offences of murder, manslaughter and infanticide, and would most likely result from a circumstance where prosecution was impossible rather than deemed to be unnecessary, as laid out by the Crown Prosecution Service (2019: no page number):

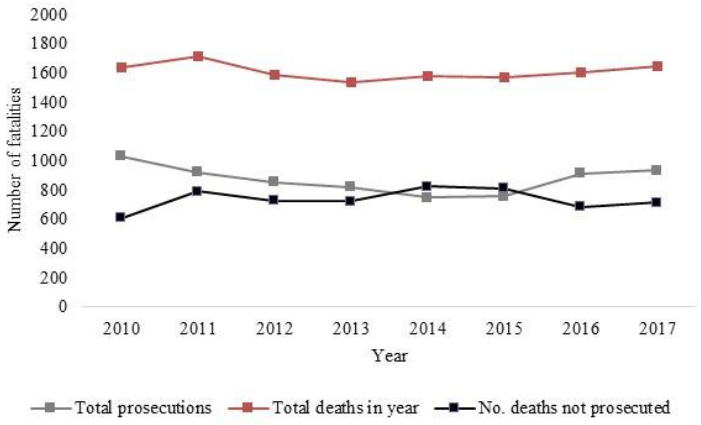
> … it does not follow that an inquest conclusion/determination on unlawful killing will automatically result in criminal proceedings. The chief suspect may have died, be immune from prosecution or in fact lack responsibility proved to the criminal standard.

Chief Coroner's Law Sheet No. 1: Unlawful killing, is specific in setting out what this means in cases of road death, although such conclusions are extremely rare in a coroner's court:

> Bad driving cases causing death may… only be regarded as unlawful killing for inquest purposes if they satisfy the ingredients for manslaughter (gross negligence manslaughter) or where a vehicle is used as a weapon of assault and deliberately driven at a person who dies (murder or manslaughter depending on the intent). (Ministry of Justice, 2016: 1)

In 2017, the Ministry of Justice recorded 933 prosecutions where the charge was one of causing a death or deaths through a serious motor offence[2]. Given that the total number of fatalities for 2017 in England and Wales was 1,647 (Department for Transport, 2017b), it can be seen that *culpable* road deaths are only a proportion of the number of deaths that occur (see figure 3).

Figure 3. Road deaths prosecuted as a proportion of total deaths (Ministry of Justice, 2018c)



The two newest short–form conclusions available to a coroner: 'Alcohol/drug related' and 'Road traffic collision', were introduced as part of the Coroners and Justices Act 2009, and only came into use in 2013, with the latter brought into being in recognition of the growing number of deaths that warranted this grouping. While the percentage of total inquests returning 'Road traffic collision' as a conclusion has remained relatively stable, at between 2 per cent and 3 per cent each year since 2014, absolute numbers have shown a general increase, from 602 in 2014, to 962 in 2018 (Ministry of Justice, 2018b). This generally increasing trend makes sense, given that the Department for Transport (2017b) reports an overall increase in the total number of road deaths in England and Wales across the four years, from 1,575 of all road users killed in 2014 to 1,647 in 2017[3]. However, there appears to be no record produced which directly tallies prosecutions with inquests and the number of deaths outlined. Indeed, when asked for this data,

[2] These are recorded as causing death by: 'dangerous driving'; 'careless driving under the influence of drink or drugs'; 'careless or inconsiderate driving'; 'driving without due care/consideration while over prescribed limit – specified controlled drug'; 'driving unlicensed or uninsured'; 'driving whilst disqualified'; and 'aggravated vehicle taking' (Ministry of Justice, 2018)

[3] Department for Transport statistics for year ending December 2018 were not available at the time of writing.

the Department for Transport was very quick to point out that ‘We do not collect data on ‘blame’’ (Department for Transport, personal communication, 2 February 2016).

Thus, while the inquest, and with it the coroner’s ruling, stands as a formalised account by the State of the manner of death, the category chosen – as a public declaration of the means by which a person died – is not always popular with the families of the victims. It is however, for the most part, unchallenged, by both the bereaved and wider society, and to understand why this might be it is important to look more closely at the coronial system itself.

1.5 Bureaucratising death

The coronial system has a hoary and somewhat convoluted history. Primarily existing as a kind of State accountant, the coroner’s role was largely to keep fiscal records of monies owed to the Crown by its subjects. As outlined in chapter 4, this function underpinned the coroner’s duties as overseer to the medieval inquest, with records and writings also showing crossover into matters of criminality.

Today in England and Wales an inquest is ‘a public fact finding-inquiry to establish who the deceased was, when and where they died and how they came about their death’ (The Coroners' Society of England and Wales, No date). A death must be investigated by a coroner if: the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in State detention.

The most recent legislation governing coroners is the Coroners and Justice Act 2009. Following various attempts at reform over the last century, which is looked at more closely in chapter 4, the 2009 Act largely replaced previous legislation (namely the Coroners Act 1887) for reasons set out by Helen Grant, the then Parliamentary Under–Secretary of State for Justice:

> Successive reviews and inquiries have identified much that is good in the current coroner system. But these also identified some fundamental problems including a lack of consistency across England and Wales, an absence of national supervision or leadership and most importantly a lack of clear rights for bereaved families to participate in the

> process, and of standards for the treatment and support of all those who come into contact with coroners. (Ministry of Justice, 2013b: 3)

The fifth and most recent annual report by the Chief Coroner to the Lord Chancellor (2017–18) addressed the issues of consistency and rights identified by Helen Grant, referring to the 'package' of reforms that have been put in place and continue to be the focus of future planning by the coroner service. Importantly, clause 11 of the Chief Coroner's report outlines where, from his perspective, the bereaved sit:

> In these reforms, statutory and otherwise, the Chief Coroner maintains as central to his thinking the essential concept that *bereaved families must at all times be at the heart of the coroner process* [emphasis added]. (Ministry of Justice, 2018a: 7)

With this declaration of the centrality of the bereaved in mind, this thesis takes a socio–legal perspective in considering the emotional impact of the system of inquest on those bereaved by death on the roads in England and Wales. Through the use of in–depth, qualitative interviews – both structured and semi–structured – with bereaved families, coroners and others involved in the administration of the coronial system, as well extensive observation of inquest proceedings around the country, I spent eighteen months in the field collecting a huge amount of rich and descriptive data. In so doing, I asked whether this section of society – the families and friends of people who have lost their lives as drivers, passengers or pedestrians in a road collision – in being forced to encounter part of the Justice System which is arguably a historically perpetuated relic (Burney, 2000; Higgs, 1996; McKeough, 1983), is actually served *by* such a system, or whether its continued use is merely a by–product of attempts by the State to bureaucratise – and legitimise – accounting for death by those in authority (c.f. Foucault, 1981).

Certainly, and as will be shown, the bereaved suddenly come to expect a moral response to their plight from a society which has somehow 'allowed' the death to happen. In looking for a sociological explanation as to why this might be the case we can firstly turn towards Durkheim, who tells us that in a cohesive society, individual liberty is paramount, although – and

importantly – this is on a moral rather than egoistic level, which respects the needs of society as a whole (Cristi, 2012; Giddens, 1995; Thompson, 2012). As such, members of society – 'sacred' individuals (Cristi, 2012) – come to expect a certain 'social solidarity' and when this 'collective unity' is ruptured, by such an event as unexpected death, people feel failed and vulnerable (Fisher and Chon, 1989; Vejar, 2019).

Similarly, and according to both Locke (1967) and Rousseau (1993), justice is the result of 'tacit consent' by a society through an unwritten social contract which legitimises State power over citizens, in return for the protective capacities of that State. Consequently, if harm happens, this contract is broken. It can be argued that, in this context, the inquest stands as a vehicle for the State to assert that the death 'could not be helped', particularly in the case of road death which appears as 'collateral damage' (Johnston, et al., 2013) in a society for whom high–speed transport – and the risks that go with it – are accepted and even valorised. In this way, it is implicit that the death was *not* a fault of State protection, and the social contract has therefore *not* been broken.

Furthermore, it has been suggested that the nature of pre–modern systems of administration – with the coronial system being a fundamental one – were partial and corrupt, and this led to '… a decision–making process that was wholly unsystematic, unpredictable, and highly idiosyncratic' (Lutzker, 1982: 123). Despite recent attempts at reform having gone some way towards remodelling the coronial system, the expectation of the bereaved, manifested as an erroneous belief that the coronial court exists as a forum for getting to the 'truth' – *videlicet*, a version of events that makes sense to *them* – is very much at odds with the inquest's primary function of administratively categorising sudden death and, in the case of road death, exculpating it.

It has been shown that dealings with the Criminal Justice System for those bereaved by violent crime, despite the somewhat unremitting representations of the adversarial system presented in the media, is an alien experience (Casey, 2011; Jacobson, et al.; Thiel, 2013). Commentators have suggested that the prevalence of misleading television crime and courtroom dramas distort

society's perceptions of how the Criminal Justice System 'really' works (Johnson, 2017; Pandiani, 1978), and where 'Courtroom dramas pit unruly and even uncivilized human impulses against abstract codifications of justice' (Cooper, 2016: 24). In a similar way, this thesis sets out to inquire whether those bereaved by non–culpable road death – in their capacity as part of an incognisant society prior to the death event – do not really understand the purpose of the coronial system, and whether this is compounded by society's tendency to make certain assumptions about what a court is and does, and then erroneously apply this to the coroner's court.

1.6 A personal perspective

I myself encountered the effect of non–culpable road death when in 2014 the partner of a friend of mine was hit, and instantly killed, by a Heavy Goods Vehicle after he had stopped on the hard shoulder of a motorway in the South of England. As an outsider, removed from the immediate bubble of grief that my friend and her young daughter found themselves in, I nonetheless felt stricken. How could someone I had spoken to not two weeks before, someone I had shared a laugh with, be so suddenly removed from the world as I understood it to be? This was by no means the 'Just World' (Lerner, 1980; Lerner and Clayton, 2011) that I had learnt to trust; I felt outraged, wronged and, above all, profoundly and deeply affected by my friend's suffering.

In the immediate aftermath of her partner's death, my friend's grief was palpable. In seeking to understand his death she ruminated constantly on the questions of *why* he was parked on the hard shoulder, whether he had suffered and whether the event was a deliberate act on his part. In the absence of any definitive answers, she appeared to oscillate between self–recrimination on the one hand, and anger aimed at the driver of the Heavy Goods Vehicle on the other. The fact that her partner's body was so physically damaged meant that when she attended the funeral home for a viewing she was strongly advised not to see him, and instead was shown a photograph of his hands, only added only to her distress.

Some five months after his death, I attended the inquest into it. What struck me at the time were two things. First, an overarching sense of disorientation. In a formal court setting, 'witnesses' were called to give 'evidence' under oath, and yet no–one was accused of an offence. A judge (coroner) oversaw the proceedings, in an atmosphere that was formally deferential, and while the barrister instructed by my friend was very much volitional on her part, no counterpart presented themselves as representing any other faction – because there was none to be represented. At the close of the proceedings the 'short–form conclusion' – an attempt to categorise the death based on the coroner's findings – was presented: an 'open verdict'. After clinging to the hope that her partner's death had not been intentional, my friend was appeased; she would never have a definitive account of the minutes encapsulating the collision, but there was valuable vindication in the coroner's ruling which represented a judgement by someone in authority that the event had not been intended. For the bereaved, such conclusions are the culmination of a part of the Justice System whose origins in England and Wales can be traced back over eight hundred years, and which remains an unavoidable legal process for those who are bereaved by non–culpable road death today. In so doing, the inquest provides a 'version' of the truth that the State declares to be representative of the means by which the death came about and to which families must therefore be resigned.

The second thing I observed on the day of the inquest was the fact that, despite countless offers of assistance and emotional succour from companions and supporters immediately after her partner's death, I was the only person who accompanied my friend to the hearing. It was as if, suddenly, people were very busy – they had children to attend to and other places to be. This raised sociological questions for me: how is it that attending the funeral into my friend's partner's death was a 'must', but when confronted with attendance at an inquest – where my friend would arguably still need support – people were reluctant to accompany her? It was also notable that other friends and acquaintances had an opinion about what had 'actually' happened, which continued after the inquest was finalised and the ruling made. Consequently, while the conclusion had apparently drawn a line under the process for my friend, this was not the case

for a wider society whose fear of such violent death engendered a protracted period of speculation behind closed doors.

1.7 Research questions

This thesis thus seeks to elucidate three main research questions which stem from apparent mismatches between the expectations of the bereaved, the role of the State and the reaction of wider society when it comes to death on the road in England and Wales.

Commencing with the death collision, leading through to the coronial investigation, and continuing into the inquest hearing itself, the first of these hinges on the manner of the loss. Road death is not only unexpected and traumatic, but also violent and horrific to imagine, both for the bereaved themselves and also for much of wider society who seek to shun such difficult reminders of their mortality. For example, the stigma that attaches itself to the family of someone who has died in the case of homicide or through a drugs overdose has been shown to have insidious effects on the bereaved (Guy and Holloway, 2007; Mastrocinque et al., 2015; Rock, 1993). Yet, similar judgements are likely to be made in the case of death by road collision, given that appraisal and assessment comes both from those outside the inquest system – who have difficulty relating to and communicating with the bereaved – as well as those inside the system who make decisions – and assumptions – about the circumstances surrounding the death and who is 'to blame'?

The second research question considers whether there stands a discrepancy between what the bereaved seek from the State in response to the death of their family member, and what the coronial system not only sets itself up – but also exists – to provide. Given that the public are generally unaware or misinformed about the role of the coroner as what could be called a 'death judge', and that the bereaved necessarily encounter the system when they are in a highly emotional state, is the bureaucratic nature and outcome of the inquest divergent to their expectations? In seeking to allocate responsibility for the death and finding a system which not only does not lay blame but which actively shuns the laying of liability, commentators have

asserted that families feel frustrated and let down, believing that they have been conspired against by a system for whom the death is unimportant:

> It is very important that the family of the deceased are aware of this, otherwise there can be considerable frustration or anger if it is perceived that no blame has been apportioned or there has been some form of cover–up. (Calthorpe and Choong, 2004: 148)

Thirdly, this research inquires as to whether there exists an incongruity between what families – given their traumatic grief – perceive themselves to be entitled to in terms of their treatment by those in authority, and how those involved in the 'death system' (Kastenbaum, 2007) operate. This is achieved through a consideration of bereaved families' dealings with the police, the Coroner's Office and the coroner him or herself – in terms of these officials' behaviour, manner or their general capability in administering the coronial system.

In answering each of these questions, the overall aim of this thesis is to draw a conclusion as to whether – despite reforms by policymakers and coroners' attempts at balancing the needs of the bereaved with those of the system – the emotional impact of the coronial system leads some of the bereaved towards a status as co–victims in the context of the road traffic collision. By undertaking in–depth qualitative interviews with bereaved families, coroners and others involved in administering the inquest, as well as attending and observing numerous inquest hearings around the country (see chapter 3 for detailed methodological explanation) the views of those directly involved in, and impacted by, the coronial system are sought, elucidated an analysed in relation to these three main research questions

1.8 Thesis scope and structure

As indicated, given the numbers of road users killed each year on our roads where there is deemed to have been no criminal intent, exposure to the micro–culture of the inquest is inevitable for some. What remains unclear is whether, and how, the families' who suffer such a loss are impacted emotionally by the State machinery which exists to categorise that death – the coronial system. This thesis sets out to answer that question.

In so doing and following this introductory chapter, Chapter 2 reviews the literature on topics pertinent to an investigation of coroners, inquests and road death, namely: the global risk associated with motorised vehicles; a consideration of the grief associated with traumatic and unexpected death as against the notion of a 'timely' death; and finally the treatment – and secondary victimisation – of the bereaved, by systems of justice in England and Wales. More specifically, and with this in mind, the chapter sets out the statistics and commentary that raises road death to its status of what can be considered a 'public health issue', including a discussion around the acceptance of the risk we are taking when we climb into a motor vehicle. This is followed by a consideration of scholarly views on the grief experienced by the bereaved when a death is considered to be 'pathological' or 'complicated', in terms of how it affects sufferers, and why it is different to a grief that is considered 'normal'. Subsequently, the concept of 'emotion work' is examined, as an often-unconscious effort taken by the traumatically bereaved in the face of those who seek to distance themselves from road death as a stark reminder of their own mortality. Finally, the academic literature on the Justice System in England and Wales is investigated, both in terms of that which deals with acts of criminality and, though much more limited, that which covers the coronial system. This is important as it highlights how the bereaved can often be seen as 'secondary victims' within the context of the criminal court and leads to a later discussion around, and conclusion as to whether, the bereaved can be said to be similarly victimised – 'co–victimised' – by the coronial system.

In chapter 3, the methodological approach adopted in obtaining answers to the research questions is described, together with the epistemological assumptions followed and reflexive observations made. The maintenance of ontological humility (Holland, 2013) in presenting a personal interpretation of the world of the inquest, while at the same time endeavouring to understand and explain one's own biases and perspectives, should enable readers to see clearly how the data was produced and understand how it was interpreted.

Chapter 4 goes on to provide some wider context to the topic by firstly outlining the history of the coroner, from its origins in medieval times to its contemporary position as part of the Justice

System in England and Wales. The workings of the inquisitorial system of law are explained, as against the adversarial system used in the criminal court, followed by an explication of the operation of the process of inquest in England and Wales as a 'hybrid' of those systems. As part of this, its place within the wider judicial system is contemplated, including a summary of the attempts made by government to update and modernise the process in line with narrative around victims as 'consumer–citizens'.

The next chapter, chapter 5, the first of three analytical chapters, anatomises unexpected death and complicated grief in the context of losing a family member in a road collision. From the viewpoint of the bereaved, the initial experience and impact of sudden and violent death through road traffic collision is considered. This is in order to ascertain whether victim–blaming takes place within a society where responsibility is placed squarely at the door of the person who has died, simply to make sense of an event that cannot be easily understood. As part of this, chapter 5 considers attempts by the bereaved to 'manage' their emotions for the benefit of others; it asks if the information–seeking which characterises such sudden and traumatic loss provides this group with reasons for, and meaning around, an event which is often perceived to have been either avoidable or preventable. Finally, the process that the police, in their capacity as investigators of the collision, go through when making decisions around culpability is investigated. In so doing, the question of whether families' initial interactions with the coronial investigation have a bearing on their experience of the system as a whole, is highlighted and clarified.

Chapter 6 goes on to consider what families' expectations around the purpose, workings and deliverables of the coronial system – with which they are forced to engage – are, once the coronial investigation is underway and the death has been proclaimed as non–culpable. An examination of whether families experience their interactions with officials as a superficial 'performance', is important in aiming to understand whether the bereaved – as part of an incognisant society prior to the death – perceive themselves to be entitled to a certain level of moral response from the State (as protector of its subjects), given their need to allocate

responsibility for, and 'understand' the death. Furthermore, an investigation of what 'justice' means to families *vis–à–vis* coroners in the context of the inquest, enables conclusions to be drawn as to whether there is a correlation or, indeed, a mismatch, between the expectations of the bereaved and the motives of the State.

The final analytical chapter, chapter 7, considers whether both the physical court environment, together with the manner and behaviour of those who administer the system of inquest – from the police, to court staff and coroners – have a part to play in impacting families' emotional experience of the process. While policymakers and organisations involved with the bereaved explicitly acknowledge that their dealings require sensitivity, diplomacy and an appreciation of the enormity of their situation, this does not always translate into practice. Furthermore, although the Coroners and Justice Act 2009 set out new requirements regarding the qualifications of coroners, what it has not been able to do is set out in statute what the demeanour and manner of a coroner should be. Taken together, and, with a specific focus on the families of those killed on the roads, a determination is made as to whether families can be said to be 'co–victimised' by that system.

Finally, chapter 8 concludes by combining and drawing together the various strands of literature review, methodological approach, data collection and data analysis in order to answer the research questions explicated at section 1.7 and resolve the overarching question of whether, and how, bereaved families are further victimised by the emotional impact of the inquest in the case of non–culpable road death.

2. Literature review: death, emotions and the official 'death system'

There has been comparatively little academic research done on the coronial system and its impact on the bereaved, as part of the Justice System in England and Wales, and this is particularly true of those inquests which deal with death on the roads. Chapter 4 looks more closely at the development of the coronial system from its first recorded appearance in 1194 to the forum for categorising sudden death that we see as part of a contemporary system of justice in England and Wales. In setting the stage for the examination of that system in the context of death by road collision, this chapter undertakes to review the literature on those themes which are central to it, namely: the general acceptance of risk as a public health issue; traumatic bereavement; and the impact on the bereaved of the criminal and coronial systems of justice, including a consideration of the research on secondary victimisation.

The aim of this literature is to identify and make explicit the questions that are raised but remain unanswered. These include: whether the point in the lifecycle reached by the deceased when they are killed in a road collision can make the death easier (in the case of an elderly person), or more difficult (in the case of a young person), to accept for the bereaved; whether the social stigma experienced and the emotion management undertaken by those bereaved by a violent death such as homicide, or an injurious death such as that from a drug overdose, is also seen in those whose family member was lost in a road collision; whether, and how, the 'blameless' nature of the death is socially recognised, both within communities and by those State institutions with whom the bereaved necessarily come into contact; how the court environment and formal setting of the inquest affects families; and, whether the secondary victimisation identified as affecting the bereaved who encounter the criminal court can also be applied to those who encounter the coronial system after suffering a road death, particularly given historical and contemporary attempts at reform.

2.1 Risk and public health

A recent Global Status Report on Road Safety published by the World Health Organisation in 2018 in its capacity as lead agency in the United Nations 'Decade of Action for Road Safety (2011–2020)' initiative, outlines that road death is currently the leading global cause of death amongst children and young people aged between 5 – 29 years. In addition, and in revealing that road death stands as the 8th leading cause of death for people of all ages, it asserts that:

> Between 2013 and 2016, no reductions in the number of road traffic deaths were observed in any low–income country, while some reductions were observed in 48 middle– and high–income countries. Overall, the number of deaths increased in 104 countries during this period. (World Health Organisation, 2018: xi)

Thus, one of the World Health Organisation's major goals – that of halving road traffic death by 2020 – will not be met unless 'drastic action' is taken.

Despite increased traffic levels in the UK and other developed countries being coupled with road fatality levels coming down – albeit at a much slower rate in recent years – this is not the case in developing countries, where the choice of mode of transport is largely influenced by income. Affordable methods of transport in these countries include walking, travelling by bus or truck, or cycling and, as such, vulnerable road users represent a higher proportion of fatalities. Moreover, even though people are aware of such risks – commuters in Nigeria refer to commuter buses as 'danfos' (flying coffins) or 'molue' (moving morgues) for example (Nantulya and Reich, 2002) – they have little choice but to accept them given the lack of any affordable alternative.

This raises the question of why society readily accepts such risks, and explanations have been put forward. For example, Blake (1974) tells us that the sheer enjoyment that comes from being 'in harmony' with a vehicle, as well as the independence in terms of the freedom – to travel and to not be constrained – it allows, explains our desire to drive. For Dant (2004) however, it is something more complex; the mobilisation that results from the marrying of cars and people is mesmerising to us. Separately, neither the human nor the car can accomplish the social action

that is achieved by the 'assemblage' of the two. It is amazing, says Dant (2004: 74), that we have the cognitive capability to learn to habitually carry out the complex set of tasks that enable us to drive:

> For most people in late modernity the experience of the driver–car becomes an aspect of bodily experience that they carry into all their other perceptions and engagements with the material world in a way that they take for granted and treat as unremarkable.

For these authors, driving becomes second nature and an inherent part of our daily lives, which is partly how we justify or deny the risk that ensues from such an activity – we simply do not provide ourselves with a choice. Others concur, explaining that in this way society can be seen to perform a 'continual balancing act' because risk is part of life and, as such, it must be managed and adapted to (Morgan, 2013; Wilde, 1998). Individuals accept a certain level of risk to their safety in exchange for the benefits they believe they gain in undertaking a particular activity. Since the acceptable level of risk differs between individuals, the impact of a fatality varies depending on one's viewpoint. For example, a study by Slovic, et al. (1984: 464) found that people have a tendency to view one single multiple fatality accident as more serious than many small ones, an inadequate situation we are told: 'Assigning disproportionate weight or seriousness to multiple–fatality accidents would tend to prevent such accidents at the cost of increasing the risk from smaller accidents'.

Morgan (2013) agrees, although at the same time pointing towards the 'availability heuristic' – the tendency for people to underestimate the likelihood of high–probability, less publicised causes of death and overestimate those they are less aware of – which conceals the conscious awareness of such stasis. In a similar vein, Innes (2004) uses his 'signal crimes perspective' to conceptualise people's view of criminogenic risk. People are able to 'tune' out of crimes that occur on a regular basis, perceiving those that are more visible socially to be more risky. These signals of riskiness are different for different people and factors such as age, social class, lifestyle and media awareness may affect the interpretation of such signals. Despite these individualised interpretations, Innes purports that risk perception with regards to crime is

'… socially grounded and shaped... It is an approach that helps to explain… why it is that some incidents assume profound significance in shaping community life' (Innes, 2004: 353) and others do not.

Such studies highlight our propensity to socially construct risk and they aid our understanding of the tendency to overstate the threat of homicide in comparison to death from a fatal road collision. This has implications for the UK, where the most prolifically used contributory factor recorded on police statistical forms in the aftermath of an accident is 'failing to look properly' followed by 'loss of control', very much highlighting the impact that human error can have (Burns, 1998; Grippenkoven and Dietsch, 2016; Parker, et al., 1995). Indeed a study by Musselwhite (2006) aimed at classifying car drivers into groups based on their self–reported tendency to take risks while driving, found that, overall, drivers were significantly more likely, when late, to dangerously overtake, use other lanes at roundabouts and junctions, and undertake fast acceleration and braking. Of their sample, 0.6 per cent reported that they 'always' performed 'dangerous overtaking' and 1.1 per cent that they drive over 30mph even when they feel it is unsafe to so do. Extrapolate these percentages to the whole of the driver population in England and Wales – where there has been a very significant, but largely inconspicuous, increase in traffic levels over the decades – and as the author suggests, '… this could have a devastating effect on road safety, particularly in light of vulnerable road users… ' (Musselwhite, 2006: 332).

Despite such statistics, few people, even those convicted of 'culpable' road crimes such as dangerous or careless driving, deliberately set out to kill others. Yet, on average, more than four people per day were killed in a road traffic collision in England and Wales in 2018, a number that may surprise the UK public given the lack of media interest in the topic that was discussed in the opening section. Furthermore, those who die in a road collision, whether as driver, passenger or pedestrian, leave behind them a multiplicity of mourners. The following two sections draw attention to the literature pertaining to the traumatic and 'complicated grief' (Boelen and Prigerson, 2007; Bowlby, 1963; Burke, et al., 2010; Neimeyer and Burke, 2011;

Parkes, 1986; Riches, 1998) that is said to ensue after such a loss, as the unhealthy counterpart to that which is considered 'normal'.

2.2 'Normal' grief and loss

We have to live with death, but that does not mean we have to like it. Indeed, many suggest that we do not even accept it despite knowing of its inevitability. When putting forward Terror Management Theory, for example, Greenberg, et al. (1986) built on Becker's (1973) *Denial of Death* to explain how we, both collectively and as individuals, deal with the knowledge – and accompanying fear – that we will die. This knowledge, they say, prompts such terror within us that we seek to control it to counteract the potential threat of social disorder, via two mechanisms. First, by seeking to endorse cultural worldviews in the form of laws, religious and belief systems, and cultures, we provide a moral structure around which we can live that provides us with purpose and a reason to exist. Second, as individuals we measure our worth – and thus improve our self–esteem – by judging ourselves against how well we adhere to these cultural worldviews.

Such thinking, despite having been called into question by others (Kirkpatrick and Navarrete, 2006; Leary and Schreindorfer, 1997), serves to highlight the enormous quandary that we find ourselves in when it comes to thinking about death. Yet the fact remains that at some point in our lives we are forced to confront it, if not our own then that of those around us. Notions such as how to die 'successfully' (Meier, et al., 2016), what constitutes a 'good death' (Bradbury, 1996; Kastenbaum, 2007), and the defining of a 'timely' as against an 'untimely' death (Scruton, 2012; Weisman, 1973), are much discussed with one commonality: the opportunity to prepare. Those who have lived a long life are said to succumb to the 'natural order of things', and those who mourn a loss where death is the conclusion to a period of illness have often been forewarned. Thus, their so–called 'anticipatory grief' (Fulton and Gottesman, 1980; Kastenbaum, 2007; Lindemann, 1994; Rando, 1989; Weisman, 1973):

> … is alleged to possess natural adaptational value. It is considered a 'rehearsal' of what to expect after an impending loss. An individual will partially work through emotional

> reactions, normally observed after the loss, and will anticipate as well as prepare for certain social adjustments… As a general statement of agreement, where there is an impending death the process of grief, or 'grief work,' begins well before the actual death. (Gerber, et al., 1975: 225)

Those who suffer a loss for which they have been able to prepare suffer a grief which is no less powerful, but is deemed to be less 'complicated' (Burke, et al., 2010; Neimeyer and Burke, 2011; Shear, et al., 2011). In fact, a longitudinal study by Gerber, et al. (1975) found no significant differences in initial bereavement adjustment between those who were suddenly bereaved by an acute illness, and those bereaved by chronic illness, where there had been some forewarning of the death.

Moreover, grief generated by the loss of a significant other, and the mourning that accompanies it – our 'public face of grief' (Parkes, 1988: 54) – has been much studied and commented upon. Some authors assert that death and dying is so prevalent a topic amongst 'experts' such as counsellors and psychotherapists that it can be deemed to have been 'sequestered' – awarded its own territory within both the professional and academic domains (Giddens, 1991; Mellor and Shilling, 1993; Willmott, 2000). Indeed, it is suggested that the continual push towards specialist ideas through the use of diagnostic tools and therapy manuals is an unconscious attempt at social control, leading to the continual highlighting of the 'positive' side of death and inducing a: '… continued degradation of our understanding of mourning: pathology is defined by a standard measure and 'correct' feelings are laid out… The job becomes getting the machine back on the road'. (Craib, 1998: 164)

This assertion was confirmed with a simple internet search for 'bereavement self–help books' which returned a proliferation of tomes designed to enable the 'handling' of bereavement, the 'overcoming' of grief and the 'healing' of one's heart; Yet, surely if healing one's heart were quite so easy it would be perspicuous to suggest that there would be little to heal in the first place. Indeed, this is affirmed by Giddens (1991: 198) in a discussion around the commodification of the self and its capitulation to market criteria:

> Self–help books… stand in a precarious position with regard to the commodified production of self–actualisation. In some ways such works break away from standardised, packaged consumption. Yet in so far as they become marketed as pre–packaged theorems about how to 'get on' in life, they become caught up in the very processes they nominally oppose.

Self–help aside, whichever way one looks at it, when someone dies those left behind are forced to 'deal' with their ensuing grief. There are social processes that assist them in doing this, and many theorists stress that there is a certain amount of 'grief work' (Freud, 2001; Lindemann, 1994; Parkes, 1986; Rapoport, 1962) that must be done to enable the bereaved person to move on from their grief towards creating new bonds with others. Part of this, as suggested by Worden (2018), is that 'actualising' the loss by viewing the body of the deceased for example, is instrumental in severing bonds and important in facilitating grief.

Counter to such arguments condoning cognitive separation from the dead, other authors tell us that bereavement is a never–ending cognitive process. People do not 'get over' grief but rather should feel unrestrained in having a continuing relationship with the deceased (Hutton, 2015; Klass, et al., 2014). This appears substantiated by empirical studies. For example, in a study by Riches and Dawson (1997), thirty–two bereaved parents felt angered by perspectives suggesting that there are 'stages of grief' (Bowlby, 1961; Kübler–Ross, 1973). Rather than 'breaking bonds' (Bowlby, 1961; Worden, 2018) there was a 'defiant refusal to 'let go' of the dead child' (Riches and Dawson, 1997: 69). In support of such sentiments, other authors have put forward alternative theories. For example, Walter's (1996) 'new model of grief' is an attempt to realign such 'counter–cultural' sentiments (Riches and Dawson, 1997). By encouraging the bereaved to continue to remember, share and talk about their loved one:

> Bereavement is part of the never–ending and reflexive conversation with self and others through which the late–modern person makes sense of their existence. In other words, bereavement is part of the process of (auto)biography, and the biographical imperative—the need to make sense of self and others in a continuing narrative—is the motor that drives bereavement behaviour. (Walter, 1996: 20)

In this search for how best to 'deal' with grief, emphasis is placed on the importance of recognising a distinction between 'normal' grief and 'abnormal' or 'pathological' grief (Bowlby, 1963; Freud, 2001; Middleton, et al., 1993; Mitchell, 1986). The manifestations of pathological grief from a clinical perspective, and which put it outside the realms of normality, have been put forward as forms of chronic illness and hypochondriasis (DeVaul, et al., 1979), neurosis, anxiety, psychosis (Lehrman, 1956), and, for Parkes (1965), difficulty in accepting the death, feelings of guilt and self–blame, and hostility towards, and social withdrawal from, others including family members. Common to all of these symptoms is an element of time, in that those whose grief can be said to be 'normal' 'are able to adjust and return to daily functioning' (Schnider, et al., 2007: 344) with Prigerson, et al. (1995) suggesting a time frame of between several months to one year. For this reason, pathological grief – which often falls outside this timeframe – is often referred to as 'prolonged grief disorder' (Boelen and Prigerson, 2007; Shear, 2015; Shear, et al., 2011).

For some authors, the experience of pathological grief is a psychologically innate reaction to death occurring in those who are to some degree predisposed to it and resulting in particular 'features' of mourning (Bowlby, 1963; Freud, 2001; Mitchell, 1986). For others, grief should be seen as a mental illness that falls within the psychiatrist's domain and as such should *always* be considered a pathological condition (Parkes, 1986; Parkes, 1988). Although as Craib (1998: 162) asks '… where do we draw the line – should we regard the divorced, the redundant, or anybody suffering from an upheaval in their lives as mentally ill?'.

Such an argument appears reasonable, if somewhat uncompromising, and leads us towards the consideration of a more nuanced kind of complicated grief: that arising from a complicated death.

2.3 Traumatic bereavement

As has been demonstrated, it is the suddenness of a death, quite aside from the manner in which someone died, which can complicate grieving for a family. For example, a study by Cameron

and Parkes (1983) compared the reactions of families whose relatives had died of cancer on a support–orientated palliative care ward with those of cancer sufferers where death was not forewarned. They found significantly higher instances of irritability, anger and hostility towards others amongst the bereaved in the latter group. Despite the fact that both groups anticipated the death, when the opportunity to prepare mentally was withdrawn, difficulties ensued.

So, when a sudden death is coupled with violence, as in the case of homicide, the prevalence of grief is further increased. Complexities arise when people lose loved–ones unexpectedly and as a result of a traumatic and often violent event, their grief is confounded and exacerbated by the 'amputation' of that person from them by death (Rynearson and Salloum, 2011). In such circumstances families not only lose a person biologically and socially from their lives, but possession over their body is also lost. The bereaved must seek permission to see the body of their family member (Awoonor–Renner, 1991; Illich, 1977), from which 'evidence' may be needed, meaning that power and ownership of the deceased body is in the hands of the State (Foucault, 1981; Walter, 1994). Thus, those bereaved by a violent death – something very much separated from our 'normal', everyday experience – are left feeling powerless, vulnerable and precarious. Their belief and trust in life and the world that makes them who they are, is brought into question (Guy and Holloway, 2007; Lerner, 1980) through the arousal of their sense not only of horror, but of the unfairness of the event. There is a collapse in the moral meaning of their world which, as found by Rock (1998) and Thiel (2013) with regards to the survivors of homicide, left them with a deep sense of injustice and a feeling that they had somehow been wronged.

Furthermore, the impacts of such a loss have been recognised as not only emotional but behavioural, cognitive, social, physiological (National Bereavement Alliance, 2017) and financial (Tehrani, 2004), affecting not just the bereaved as individuals but also their wider familial relationships. This breakdown within families has been acknowledged within the literature (Cameron and Parkes, 1983; Guy and Holloway, 2007; Moos, 1995; Riches, 1998) with Gilbert (1997) suggesting that in the case of bereaved couples, for example, differing

perceptions of the cause of death, together with a tendency for one to blame the other, as well as differences in grieving and coping mechanisms, make it difficult for them to provide each other with the mutual validation and support required. Indeed, Lehman, et al. (1989) found that bereaved parents were significantly more likely to divorce or separate than those who were not bereaved.

In consequence, scholars considering the period that follows such a death event have found attempts by the bereaved at repairing the damage by recapturing their moral foundations (Parkes, 1986; Rock, 1998), in part through the development of 'strong moral images' (Thiel, 2013: 30) of the lost person, idealising them both in terms of their own recollections and in the way that they spoke about them to others. Prompted by the moral inversion caused by sudden death, the bereaved would look for meaning in the death, seeking diverse reasons and explanations:

> Disturbances in the moral universe evoked such turmoil that they incited many to embark on a compelling search for pattern and meaning… For some, it was as if they were being tested by God. For others, it was tempting to blame oneself or other members of the family for not exercising proper care or foresight (Rock, 1998: 96–97)

It has been suggested that in addition to this meaning–seeking, one of the manifestations of such traumatic grief is the threat felt by the bereaved to their sense of stability and order – what has been termed their 'ontological security' (Giddens, 1990; Giddens, 1991; Laing, 1990; Richmond and Valtonen, 1994). For example, in the aftermath of homicides in the United States, a study by Mastrocinque, et al. (2015) saw family and friends of the deceased changing the way they viewed the world. Some participants became afraid when the phone rang late at night because it prompted feelings associated with receiving the phone call notifying them of the murder. Other problems related to family members being excessively afraid for their own safety: '… one participant described a granddaughter as 'just really scared. She's afraid to die. And it's really bad'' (Mastrocinque, et al., 2015: 336).

Furthermore, scholars have asserted that individuals' differing responses to grief, including how more or less intense one person's grief is in comparison to another, are affected by both the type of event that has led to the death as well as the relationship that the deceased had with the bereaved. Although studies of a comparative nature appear to be generally lacking, those that do exist have looked at death by suicide as against death by accident or illness for example (Dyregrov, et al., 2003; Matthews and Marwit, 2004; Murphy, et al., 1999; Séguin, et al., 1995). Studies that compare the bereavement outcomes of particular groups have also looked at bereaved twins as against other relatives (Segal and Ream, 1998; Segal, et al., 1995), family as against friends (Peskin, 2000), and the loss of a parent as against a sibling (Pollock, 1962), with the general consensus being that the death of child leads to greater devastation in survivors than the death of spouses or parents for example (Middleton, et al., 1998; Murphy, 2008; Sanders, 1980).

Despite these studies, the comparative grief of those bereaved by road death is less studied, and research which does consider how bereavement trajectories are affected by a person's death from a road collision, as against another 'type' of death or within relationship groups, disagree on the result.

One of these few is by Sanders (1980) who, in comparing the bereavement intensities across three types of death: spouse, child, and parent, again found that the death of a child produced the highest grief intensities. However, and surprisingly, this was regardless of whether the death was a result of illness or accident. This is very much at odds with a study by Shanfield, et al. (1986) who investigated differences between two groups of bereaved parents: those who have lost adult children in traffic collisions, and those who have lost adult children from cancer. In finding higher grief complications amongst the accident parents, the authors concluded that the suddenness of the loss along with closer emotional ties to their (usually younger) children accounted for this. For the cancer parents, the anticipation of the death, coupled with the relative emotional distance from a grown child, provided them with some insulation from grief effects.

Other studies, in finding that grief is more intense amongst parents whose relationship with their child had been ambivalent, where the child lost was the earlier born (Shanfield and Swain, 1984), or where the bereaved was a mother (Dyregrov, et al., 2003; Murphy, et al., 1999; Murphy, et al., 2003), suggested that it was the relationship between the bereaved and the deceased, rather than age or point in the lifecycle that is more indicative of the extent of grief. Ultimately, as suggested by Murphy (2008) in their comparison of parents bereaved by sudden and violent death against those bereaved by cancer:

> Although they defy direct comparison, parents under both bereavement circumstances reported devastating effects of the deaths of their children. Regardless, of the cause of death, parents reported that their lives had changed forever. Parents in all cultures studied commented on the death of a child 'being out of order', which is most difficult for them to comprehend because the death of a child violates the parents' beliefs about a just world. (Murphy, 2008: 390)

In summary, while it appears that the death of a child is generally likely to yield more intense grief symptoms, it remains unclear as to how reaction to a road fatality is mediated, if at all, by a person's age at the time of their death. In other words, if an elderly – as opposed to a young – person dies from a road collision for example, does the fact that they are nearing the end of their life when they die, rather than beginning it, mean that the associated grief is more complicated or felt more profoundly by the bereaved? This is a question that remains to be answered.

Nonetheless, one emotional consequence of a sudden and violent death that is agreed upon in the literature, is the need felt by the bereaved to undertake 'emotion management' in some form or another. More specifically, in negotiating their way both through their grief and through the death system, the bereaved feel the need to 'manage' their emotions in front of, and for the benefit of, others. In so doing and according to G. H. Mead (Cox, 2017), these 'social acts' see the bereaved viewing themselves from the perspective of others, making judgements about and mediating their own thoughts and behaviours in order that they portray themselves – both

inwardly and outwardly – in a particular way. What is less clear, is whether, and how, those who are bereaved by a road death which is subsequently deemed to be an 'accident', feel the need to manage their emotions in a similar manner.

2.4 Emotion management

It is clear from the literature that the emotional impact of traumatic death on the bereaved is significant, and the shock and immense distress experienced by families and friends is not in question. Not only must they find their way through this grief but, it has been suggested, they must do so while coming under scrutiny from a wider society which appears to attach a negative label not only to the traumatic death but also to the deceased. Since people may struggle to explain such events as happening to an 'undeserver' (Lerner, 1980), either something must happen to restore the social–moral order, or the death must have been deserved, and this is exemplified in the study by Mastrocinque, et al. (2015: 337): 'I had somebody ask me, 'What'd she [the victim] do?' I said, 'She was a teacher,' and they said, 'No, what did she do wrong?''.

It can be argued that this label of deservingness results from the *shared* threat that the event poses to collective ontological security. The portent of a horrific and untimely death, particularly given the 'terror management' that accompanies even the knowledge of a 'normal' death, leads us towards such negative branding. Furthermore, such branding is attached not only to the deceased but, by implication, encroaches itself upon the experience of the bereaved, who themselves feel judged, as if 'there is something wrong, morally and spiritually, with those who die from illicit drug use and, by association, with those who mourn them' (Guy and Holloway, 2007: 85).

Such findings are common in the literature on homicide, suicide and drugs–related deaths, with the ensuing social 'stigma' pervading the lives of the bereaved. As Goffman (1990) suggests, the impact of such stigma is the denial of full social acceptance coupled with a constant striving by the sufferer to adjust one's social identity. When this does not happen ostracism results:

> … an individual who might have been received easily in normal social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us… (Goffman, 1990: 15)

In consequence, the families and friends of the deceased are forced to incorporate such stigma into their lives, managing not only their emotions but their relationships accordingly. In looking at the commentary on the way that the bereaved manage their emotions following a traumatic death, a good starting point is early work done on what Sudnow (1967) calls the 'social organisation of dying'. Here, even in the context of a 'normal' death, he tells us that: 'Persons are engaged, so it seems, in the continual de–emphasis of their feelings of loss, out of respect for the difficulties of interaction facing those less intimately involved in the death than themselves'. (Sudnow, 1967: 140)

This is interesting and suggests a kind of co–operative relationship between the bereaved and those with whom they interact. This was confirmed by Clark (1987: 290) who, in examining 'how sympathy flows between sympathiser and sympathisee in our society's 'emotional economy' sets out what she considers to be the 'rules of sympathy etiquette' that exist in such relationships. For sympathisees, these include the rules: 'do not claim too much sympathy' and 'do not accept sympathy too readily', whereas sympathisers 'are expected to enforce these rules; people who under– or overinvest are considered deviant sympathisers.' (Clark, 1987: 290)

For Hochschild (1979), such 'feeling rules' are important in the establishment of a sense of obligation or entitlement in our social exchanges, leading us to undertake what she calls 'emotion work'. Hochschild (1979: 65) goes on to speak more specifically about how these feeling rules are applied to grief:

> We can offend against a feeling rule when we grieve too much or too little, when we overmanage or undermanage grief… Even if we very much love someone who has died or is about to die, how much of what kind of stoicism is appropriate for a given situation? This can be a problem...Ordinarily we expect the bereaved to be shocked and surprised at

> death; we are not supposed to expect death, at least not too confidently. Yet many deaths – from cancer, stroke or other terminal illness – occur gradually and come finally as no surprise. Not to feel shock and surprise may show that even before a person dies physically, he or she can die socially.

Since there has been no time for such a 'social death' when a person dies very suddenly, the question of how much grief is 'too much or too little' is evoked. After all, it is hard to offend against a feeling rule when one is unsure of what the rules are, although for Breen and O'Connor (2009: 42) it is something of an iterative process whereby '… the bereaved engage in a process of 'identifying their supporters and non–supporters, and then altering their behaviour accordingly'. This 'impression management' (Goffman, 1969) is very pertinent to a discussion not only around those bereaved by traumatic death but also in the context of the coroner's court. Goffman explains how those involved in the death system take on particular roles and carefully manage the impressions they give out in order to fit those roles. Put this together with the bereaved seeking to decipher who their supporters are as against their non–supporters, and one would anticipate a misalignment between families' expectations and provision on the part of the professionals – something which is analysed in detail in the following chapters in the context of the coronial system as a powerful 'social stage' (Goffman, 1969).

A further complication emerges from the disallowance of emotional expression, which in turn – according to Elias (2001) – is a function of our stage of development within a civilised society. Elias (2001) writes about the difficulties of communicating with dying people, explaining that 'socially prescribed rituals and phrases' in response to those who are dying become less about the person's death, and more about the discourses that accompany it. Thus:

> The way people live together, which is fundamental to this stage [of civilisation], demands and produces a relatively high degree of reserve in expressing strong, spontaneous affects… Unembarrassed discourse with or to dying people, which they especially need, becomes difficult. It is only the institutionalised routines of hospitals that give a social framework to the situation of the dying. These, however, are most devoid of feeling and contribute much to the isolation of the dying. (Elias, 2001: 26–27)

Such assertions around the isolation precipitated by social institutions is highly pertinent in the context of the coroner's court. Indeed, Walter (1994) maintains that Elias' assertions could easily be applied to the bereaved and, in this regard, he suggests that 'Many bereaved people would add that they do not even have the benefit of institutional routines' (Walter, 1994: 22), and it is here that a major complication arises. If, as Walter (1994) suggests, the bereaved suffer from the fact that there is no collective framework to provide structure and outlet to their grief rhetoric, how do they manage when those for whom they grieve have suffered an unexpected and violent death such as that in a road collision, for which there appears to be no reason, is felt to have been avoidable, *and* requires them to interact with a social institution which they feel is working *against* them? Furthermore, for Guy and Holloway (2007), those whose loss results from a traumatic and often violent event such as that from a drugs overdose fall into the 'special deaths' grouping since there is a managed care pathway and procedure that is in place to assist bereaved families to deal with the death. However, the authors assert that this does not include road traffic fatality because the 'blameless' nature of the death is broadly recognised, and a sympathy evoked from the State which provides a 'cloak of care' to assist families in navigating their grief and thus removing them from the 'special' category – an assertion quite at odds with that put forward by Walter (1994).

Nonetheless, ultimately, according to these theorists, grief is socially constructed. As such, the bereaved not only undertake – but are *expected* – to manipulate the presentation of themselves to the world in some way. Thus, according to Hochschild (1979: 68) 'The ways in which people think they have grieved poorly suggest what a remarkable achievement it is to grieve well – without violating the astonishingly exacting standards we draw from culture to impose on feeling'.

Thus, the question here is: how do the bereaved seek to manage their emotions in a situation where their loss is deemed to have been an 'accident', not only in the face of speculation and 'victim blaming' by others, but in confronting a system which appears to play down the importance of the loss?

In seeking to answer these questions the academic literature and commentary surrounding the treatment of bereaved families within the Justice System in England and Wales is now reviewed, including a consideration of their status as 'secondary victims' in that context.

2.5 Systems of justice and secondary victims

To date, academic interest in secondary victimisation, in focussing largely on the victims of violent crime, has suggested that the Criminal Justice System can detrimentally impact those caught up in the process, including the family and friends of the primary victim (Casey, 2011; Parsons and Bergin, 2010; Rock, 1998; Shapland, 1984; Thiel, 2013). Such analysis has been undertaken against a backdrop of the emergence and continued development of the victims' movement, which derived in the 1970s from the recognition that victims – as a distinct group with consequently distinct rights – were generally overlooked and on the peripheries of the Criminal Justice System.

This progression from victims largely being ignored both by the Criminal Justice System and academically – was a 'significant oversight' (Newburn and Stanko, 2002) – to the development of such services as victims' groups finding their own field within criminological research has led to a '… veritable industry of 'services'' for victims (Newburn and Stanko, 2002: 263). Indeed, beginning in the USA with The Families and Friends of Missing Persons in 1974, the evolution of the movement quickly moved to the UK with the launch of an early version of, and forerunner to, today's Victim Support. Later forums such as Support After Murder and Manslaughter (SAMM), Justice After Acquittal and the Zito Trust have made headway not only in terms of highlighting the plight of their members, but also in the political arena by campaigning for, and achieving, some changes in the Criminal Justice System.

Commentary on such groups' *raison d'etre* from the perspective of their members is abundant. For example, we are told in Walter's (1991) examination of the mourning rituals evidenced after the 1989 Hillsborough disaster, that there is a 'communitas'– a collectively felt and spontaneously expressed outburst shared between bereaved parents as part of a sub–culture of

grief. Further, Riches and Dawson (1997) describe how many of the interviewees in their study on parental responses to the death of a child became members of – or indeed themselves founded – 'self–help' groups, suggesting that this somehow helped to 'mitigate' their sense of isolation:

> Pat, whose son was murdered, overcame feelings of frustration with her close relatives and friends when she founded a self–help group for relatives of other murder victims. Possessing elements of a counter–culture, bereavement networks are bound together by their common experience of loss, of frequently feeling excluded from mainstream society and of being stigmatised because of the embarrassment of others: 'A lot of people keep their distance... They are frightened of catching it.' (Riches and Dawson, 1997: 67)

Indeed, some authors have asserted that it was exactly the relationships formed with *non*–family members within these groups that were more beneficial in providing emotional support than were members of secondary victims' own families. In bringing people together and enabling them to share their common experience outside of the family domain – where other family members' suffering left them in a less of a position to expend the emotional energy needed (Burke, et al., 2010; Lehman, et al., 1986) – victims' groups found a place for themselves. Furthermore, and as suggested by Rock (1998), 'survivors groups' enable members to feel part of a strong and unified whole – not to feel cast out, ostracised, and underrepresented as auxiliary to a process that goes on without and despite them:

> Part of the project of the new groups… was to attack alienation by giving that inner turmoil an outer cladding of structure, stability, communality, and direction. Different words were employed to convey what was sought – accountability, answerability, respect and rights – but the theme was always clear: symmetry, purpose, and sense had been lost and had to be regained. (Rock, 1998: 325)

Despite their importance to secondary victims, some support and campaign groups set up by bereaved families have struggled to have their victim–status recognised. One such group, RoadPeace was set up to provide support and practical help, and to improve the experience of those affected by death on the UK's roads. Indeed, it has been suggested that for those bereaved as a result of culpable road deaths, the impact and effects are 'similar' to those of homicide

(Casey, 2011). Yet Brigitte Chaudhry MBE, founder of RoadPeace, explains that the way those deaths are recognised and treated by society is very different to the actions of the Criminal Justice System in responding to homicide. Unlike crime victims, for whom there is at least some level of support, those bereaved by road death appear ignored, lacking proper information and rights, and are often left feeling side–lined and unrecognised by broader society as a consequence. Rock (1998) endorses this view, in commenting on the frustrations felt by those families bereaved where the death is not considered to be 'fully criminal', with various labels being applied to such losses in the form of 'accident' to 'homicide'. The function of survivors' groups in these circumstances, Rock (1998: 325) tells us, is to regain some control for the bereaved family:

> Groups could seem objective and authoritative in a fashion denied to individuals, and it was a result that the organisations that were so founded came to labour under a heavy weight of meaning and expectation.

Indeed, with specific regards to the coronial system and road collision, RoadPeace campaigns for inquests to be 'less traumatic' and 'more effective', and their campaign demands are set out at table 1.

Another group dedicated to highlighting the plight of those affected by death on the roads, Brake, the 'road safety charity', is involved in a number of campaigns including: Driving for Zero: campaigning for zero tolerance of impaired driving', and 'Roads to Justice: campaigning for a legal system that delivers just and safe outcomes'. The perspective of both Brake and RoadPeace is that the narrative used within Justice Systems and by a wider society around road death diminishes the seriousness of such events. At the same time as agreeing that there is rarely anything premeditative about a road collision, they also explain that the use of such rhetoric:

Table 1. RoadPeace campaign demands (RoadPeace, 2018)

Call for inquests to be:	
Less traumatic	An end to the practice of Second Post-Mortems with the requirement that should they be necessary, that they are conducted within days of the first.
	Bereaved families to be better informed and more prepared for the inquest. RoadPeace suggest that families are encouraged to attend another inquest so they are familiar with the structure and process. Local guides to inquests should be produced as coroner practice varies. Guidance on disclosure should be produced.
	Bereaved families should have more rights. They should be allowed to read an opening statement about the deceased. Coroners should be encouraged to respect bereaved families' requests for inquest conclusion and Prevent Future Deaths reports.
	Bereaved families should be asked for feedback and thus test if the bereaved are truly at the heart of the system, as claimed by the Ministry of Justice.
More effective	Coroners to prioritise thorough investigations, even if these take longer than the recommended timelines. Police investigations should not be cut short.
	A cadre of specialist road death coroners should be developed, as already exist for military deaths.
	Coroners to view road deaths as preventable and issue more Prevent Future Deaths reports. They should have to explain where these are not considered relevant.
	Coroners to allow campaigners to be listed as 'Interested Persons' and allow them to give evidence.
	National consistency to be promoted by the identification of good practice key performance indicators for coroners. RoadPeace has called for a national stakeholder working group to be established to help the government achieve its aim of putting the bereaved at the heart of the inquest system.

> … also suggests something that was beyond control… The phrase 'it was just an accident' serves both as a claim of innocence and as an exoneration… Those who have been bereaved or severely injured by a reckless driver do not want to hear the incident being described in the same terms as a milk spillage.' (RoadPeace, 2011)

Such argument has been adopted by other organisations in the field. For example, a more recent report put forward the World Health Organisation asserted that:

> … road traffic crashes are not 'accidents'. They are completely preventable. (World Health Organisation, 2018, p. ix)

In a similar way, Brake purports families' suffering to be '… compounded by a flawed legal framework…' (Brake, 2019b), with their 'Place for People' campaign highlighting the complacency of a society which appears content to pay such a high price for motorisation:

> Since the invention of the car, road space has been increasingly robbed for motorised vehicles, meaning people have often been forced to the sidelines, facing danger, becoming casualties and breathing polluted air when trying to move around their communities and between places. (Brake, 2019a)

It has been acknowledged by some that the victims' movement of the 1970s onwards – and the concomitant survivors' groups – has undoubtedly made progress in increasing victims' agency in coping with the aftermath of a crime (Kunst, et al., 2015; Mawby, 2011), it has also been suggested that moves towards a more active role in the Criminal Justice System has led to only few tangible outcomes (Beloof, 1999; Kenney, 2004). Part of the problem has been attributed to the adversarial nature of the criminal justice process in that the professionals involved are not engaged on an emotional level but rather participate in a fight or battle to which they are insensitive, with rules and procedures that are legally obliged to be followed sometimes deviated from, and court appearances staged and choreographed (Rock, 1993; Sanders and Jones, 2011). Moreover Rock (1993: 61–62), in a – now dated – study of the Crown Court at Wood Green, suggests that even the way a witness behaves in a Crown Court can have a bearing on how they are perceived by the judge and jury:

> More than once, barristers looked like the calmly reasonable, successful, and confident representatives of a rational order who were effortlessly superior to the ungainly and emotional creatures coming to be judged and give evidence.

Such findings are very much allied with those of a more recent report by the Criminal Justice Alliance. Cogently entitled 'Structured Mayhem', the report asserts that since prosecutions are carried out on behalf of the Crown, those who stand to be most directly affected by a trial – such

as crime victims and witnesses – have little influence on, or control, over the proceedings. Indeed, one of the key findings of the report was that: 'The undoubted drama of the Crown Court trial is one in which those who might be presumed to be key players – the witnesses, victims and defendants – are in fact side–lined and tend to play only minor roles'. (Jacobson, et al., 2015: 2)

It is clear then that the Criminal Justice System has the capacity to re–victimise the bereaved. What is less clear, is whether this potential for 'co–victimisation' is also endemic within the coronial system.

On this note, in 1997, Howarth (1997: 154–55) wrote the following in her commentary on the role of the English coroner's court in the social construction of the accident:

> In an era in which death is medicalised and people encouraged to think of mortality only in terms of individual pathology – whether victims of disease or violence – it is inevitable that when people come into contact with the coroner system (whether through bereavement or via media reports) there is an expectation that death will be explained. They expect that it will be elucidated according to the medical model but, more notably, through the language of *knowledge* and *causation*; a discourse which inevitably leads to blame and ultimately to the criminal Justice System. To be confronted with a structure which purports to investigate all the 'facts' of death *without* apportioning blame can appear incomprehensible… As long as – unreflectingly – we continue to refer to traffic fatalities as 'accidents', road death will continue to be dealt with by the coroner… If the language we use to explain road fatalities is the language of accident and blamelessness, then death on the road will continue to be constructed and defined as accidental, and hence as an essentially uncontrollable feature of modern living.

For more than two decades, and in line with her comments, there have been attempts at reform of the coronial system, which are considered in more detail in chapter 4. Furthermore, the introduction of a 'Road Traffic Collision' short–form conclusion – or death category – open to the coroner, in light of increasing numbers of deaths on the roads in England and Wales, has put road fatality even more firmly within the realms of the inquest. The question that must be

answered however, is whether the secondary victimisation identified as affecting the bereaved who encounter the criminal court, given the reforms that have taken place and the seeming recognition of them as a distinct group with their own 'death category', can be applied to the coronial system and the inquest in the same way. The following section looks further at the literature relevant to this question.

2.6 The coronial system and co–victimisation

The previous section described the literature pertaining to bereaved families and their feelings of being victimised by the system in the context of the criminal court. This is augmented here, through a consideration of the work that has been done towards determining whether those who are 'co–victimised' by the trauma and shock of a road death can also be identified as 'secondary victims' in a coroner's court.

Even though 'open disputes and negotiation' (Holstein and Miller, 1990: 113) accompany attempts to define the 'ideal' victim (Christie, 1986; Strobl, 2004; Van Wijk, 2013), generally speaking the use of the term 'victim' to describe a person who has suffered at the hands of another, whether that be an individual or an impersonal agency, is accepted. However, in the context of the coronial system and while theoretical commentary on the inquest is increasing (Freckelton, 2016; Mclean, 2015; Scott Bray and Martin, 2016a; Scott Bray and Martin, 2016b; Scraton, 2007; Scraton, 2016; Trabsky, 2016), few ethnographic studies have been carried out using primary data gathered from the coronial arena. Amongst those that do exist (Biddle, 2003; Gregory, 2014; Tehrani, 2004), even fewer studies have sought the views of bereaved families on how the system affected them.

Thus, discussions as to whether those who come into contact with the coronial system as co–victims following a road death are concurrently secondarily victimised *by* it, are few. For those small number of studies that *have* been undertaken on the effects of the inquest on co–victims, bereaved families have been be positioned as downtrodden, ill–treated, lacking 'voice' (Biddle, 2003; Gregory, 2014; INQUEST, 2002; RoadPeace, 2011), and purportedly made

stereotypically powerless by a State system that 'takes over' when someone has died in a road collision.

Biddle (2003) for example, interviewed sixteen individuals bereaved by suicide to ascertain if and how the inquest affected them. Her study highlights several aspects of the inquest that can be distressing for families, from the formality of the court environment, through its procedures – such as giving and hearing evidence – to its eventual outcomes. Part of the problem, she says, was with families being upset by the language used, with one participant saying: 'It shouldn't be held in a court, a court's not the right place. I mean give evidence? Give evidence against what? My brother wasn't a criminal'. (Biddle, 2003: 1036)

In addition, Biddle shows how the experience of the bereaved was very dependent on the 'sensibility and discretion' of the coroner, and since there is a lack of protocol for good practice, poor demonstrations of such conduct can perpetuate. Furthermore, in positing that only one of her interviewees – out of a total of sixteen – encountered an informal setting at the inquest, she describes how the 'full ceremony' (Biddle, 2003: 1036) of the – usually formal – court environment led to some considerable emotional disturbance when that ceremony was contrary to what had been expected. As one of her interviewees described:

> The courtroom was one of the most stressful things. I wasn't prepared for that at all. I had the idea that we would sit round a table and it would be very informal not that you've got to swear an oath and 'all rise' and then there was the coroner with the coat of arms behind him. (Interviewee 12) (Biddle, 2003: 1036)

Another study by Tehrani (2004), saw fifty–seven bereaved individuals with a mean age of forty–three years old asked about the collision event, including where the responsibility for the collision lay from their perspective, and the quality of immediate and ongoing support. It also measured post–traumatic stress symptoms. The study found that satisfaction levels with the quality of support from the coroner was 45.9 per cent, compared with 75 per cent for mortuary staff and 73.7 per cent for hospital staff. Interestingly, the lowest satisfaction level, at 11.1 per cent, was with psychiatrists. In terms of where the bereaved placed responsibility for the crash,

3.9 per cent of the injured and bereaved who completed a questionnaire indicated that the road conditions were the likely cause, with a further 3.9 per cent believing that there was some shared responsibility for it. However, and regardless of whether the result of the collision had been injury or death, the great majority of subjects laid the blame at the door of the 'other' driver, at 94.6 per cent and 88.7 per cent respectively.

Finally, a study of homicide–suicide inquest practices by Gregory (2014), found that coroners demonstrate considerable awareness of the issues faced by bereaved families, and had put in place a range of supports to assist them to cope with the hearing. This highlights a major difference between the Crown Court and the coronial court, in that a coroner *is* able to use his or her discretion when choosing whether to read out particular pieces of evidence such as suicide notes or text messages that the family might find distressing. As long as the coroner has had sight of such things, if he or she then feels that they may cause undue distress or sensationalist news stories in the media, they may be entered as 'evidence' at the inquest without it being made public. In this way, not only do coroners have the potential to exacerbate the suffering of families in their capacity as what can be called 'death judges', but conversely they have the facility to alleviate some potential difficulty for a family. Providing a family with the facts about what happened while being cognisant of material which may cause families additional suffering is a matter of balance, as is the general parity required in ensuring that both legal requirements and the needs of the bereaved are met simultaneously. Gregory (2014) is of the opinion that coroners are successful in achieving these aims, although her views come from a methodology which used record examination, inquest observation and interviews with coroners, but not bereaved family members, a situation which this research seeks to address.

What can be seen is that given that the perspectives of those bereaved by road death on their encounters with the coronial system are little known, and the social construction of them as ill–treated casualties of a predominant Justice System, families' status as victims in the context of the inquest is ambiguous. However, while academia has shown little empirical interest in the coronial system, families' views on its adequacy have been sought by policymakers seeking to

make changes and improve the process for families. These views have been reflected officially in investigations such as those by Tom Luce in 2003 and Peter Hutton in 2015 amongst others, and these are looked at more closely in the subsequent chapter which explicates the history and process of the coronial system. Suffice here to say that these reports serve to highlight the tension that exists between the perceived 'necessity' for the system after a sudden death and the awareness of those affected that living through it is likely to have on the bereaved.

One of the major problems highlighted by these reports is families' feelings of detachment from the investigation into the death, and their perception that they are uninformed – by those involved in orchestrating the investigation – in terms of what has been discovered and concluded about the way their family member met their death. The findings from these reports have been accompanied by recommendations that the bereaved are kept informed about the investigation as it progresses and allowed greater involvement in the process, something that would very much adhere to assertions by the likes of Tyler (1992: 444) who suggests that the bereaved '… benefit from hearings in which they can participate, in which they are treated with dignity, and in which they believe that they are dealing with trustworthy authorities who are motivated to be fair to them.'

Involvement of this nature in systems of justice has been called 'therapeutic jurisprudence' (Freckelton, 2007; King, 2009; Petrucci, 2002; Tait and Carpenter, 2013; Wexler, 2000), with commentators pointing to more recent attempts to reduce counter–therapeutic effects and maximise potentially therapeutic benefits. Through encouraging coroners – not only in the UK but also in Australia and New Zealand – and other agencies involved in the system to use more compassionate, 'trauma–informed' ways of dealing with the bereaved, the profound impact that such an experience can have on them is recognised. For example, the value of allowing families to make a statement in court, enabling them to talk about the impact of the loss of the deceased on them – something akin to the Victim Impact Statement found in some criminal courts – has been espoused (King, 2009; Wertheimer, 2013). This is a practice that has been seen more recently at both the Hillsborough and Grenfell inquiries, with Scraton (2016: 454) describing

the ‘profound impact’ on the court when those bereaved by the events at the Hillsborough Stadium in 1989 were allowed to speak about their relatives.

However, Freckelton (2016) would raise an eyebrow of caution here. Even though he acknowledges the value of research pointing towards the worth of therapeutic jurisprudence and restorative practices in the coroner’s court, there is danger, he tells us, in enabling complete latitude towards the bereaved in the context of the inquest:

> The challenge for the coroner's court is to facilitate the centrality of the deceased person to the inquest process and to enable some measure of latitude for relatives if it has the potential to be therapeutic for them, while maintaining the dignity and integrity of proceedings and avoiding unduly counter–therapeutic consequences for others who may have played some role in the person's death. (Freckelton, 2016: 27)

This is key. The seeming recognition by those in authority of the potential plight of the bereaved when having to face the inquest system certainly chimes with attempts by the likes of RoadPeace and Brake to assist what they perceive to be the ‘victims’ of that system. The question thus becomes, do the bereaved themselves have greater expectations of the coronial system than it is able, or willing, to meet, and is the label of ‘secondary victim’ appropriate when that expectation falls short? Certainly, even if expectations are mismatched, Howarth (1997) would argue that there is value in the social process of the system alone. Indeed, in line with Tyler’s ideas around people’s acquiescence to a system that they perceive to be fair, Howarth explains that:

> The medical and legal discourse within which the coroner’s system functions is supported by a social discourse which is meaningful to the families and to some ‘popular’ or ‘common sense’ notion of justice. By submitting to the system, families may not simply become victims of the system; instead, they may interpret the ritual and make it significant for themselves. (1997: 154)

However, for Kenney (2004: 225), secondary victimisation is defined ‘… in terms of the interplay between victims’ social and institutional interactions, on the one hand, and their

agency to cope on the other'. Given that the agency of those bereaved by sudden road death is likely to be significantly reduced by the coronial system coming to take control of the death, and the fact that lawmakers have recognised the difficulty for the bereaved of those social and institutional interactions, it would appear that secondary victimisation in the context of the coroner's court is very much a possibility – and this is something which is focussed on more fully in chapter 7.

2.7 Conclusion: administrating 'complicated' death

As a recognised risk to public health, death as a result of a collision on the road – whether as a pedestrian, passenger or driver – is increasing on a global scale. Not only this but, in the UK, the high incidence of human error in contributing to death on the roads, together with our tendency to socially construct risk in that context, combines to create an environment where the fatal results of our acceptance of high–speed transport as a 'necessary' adjunct to our modern lives is accepted and even valorised

It has been shown that when a death is sudden and traumatic, the 'new relationship' (Hutton, 2015; Klass, et al., 2014; Riches and Dawson, 1997) that the bereaved have with the deceased is highly likely to be affected by the manner in which they died. In looking for sense or significance in the loss, and at the same time as desperately searching for knowledge in the face of their 'complicated' grief, the bereaved exist within a broader society which fears contamination and questions the 'deservingness' of the death. This raises the question of whether those bereaved by a road death which is subsequently deemed to be a chance – albeit tragic – event, sees the bereaved managing their emotions in the same way. Furthermore, does this emotion management also play out in the interactions the bereaved with the coronial system and those who work within it, a system which obligates families to engage with it, and concurrently plays down the importance of the death?

The final question that remains unanswered, is whether the coronial system, integrated into the Justice System in England and Wales at the same time as standing as a distinct socio–legal

system in its own right, secondarily victimises the bereaved in the same way that the Criminal Justice System has been said to do. In order to further elucidate all these questions, the next chapter goes into some detail about the methodology used to collect the data which informed the research questions and overall research aim.

3. Methodology

The data which informed my research question came from qualitative interviews, *ad hoc* conversations and SMS messages exchanged between myself and my three main participant groups – which I had developed prior to commencing my fieldwork – and sixty–three hours of informal inquest observations. My discussions – both formal and informal – were conducted over an eighteen–month period over 2016 and 2017, during which time I also undertook observations at inquest proceedings around the country, and analysed a number of relevant policy documents and NGO reports. This chapter considers the research methodology, describing how I collected the data, why I chose to analyse my data in the way that I did, and how I went about answering questions about what the data represented.

A highly significant objective of my work was for me to capture and interpret the feelings invoked within me by my discussions with my interviewees, in order that analysis of the data was reflexively interpreted and balanced. I therefore also use this chapter to consider the impact that my personal feelings and past experience had on my research, something Hammersley (2010) calls 'methodology–as–autobiography'. As part of this, I outline the challenges I faced during the data collection period, and consequent lessons I learned. Finally, I look at the data I chose *not* to collect and explain why, and I attest an argument for the validity of qualitative case studies in raising and answering broader theoretical and empirical questions.

Traumatic loss has the capacity to debilitate even the strongest of personalities and thus bereaved families fall within the 'vulnerable' grouping for the purposes of interviewing. Those bereaved by traumatic circumstances potentially face one of the lowest points in their lives, not only emotionally through their complicated grief but also behaviourally, cognitively, socially, physiologically (National Bereavement Alliance, 2017) and financially (Tehrani, 2004). It was therefore vitally important that I approached those who would become my interviewees – regardless of which participant group they were in – with empathy, sensitivity, discretion and with a focus on the highly confidential nature of what I was being told. This was why, in a sense, I commenced my fieldwork even prior to commencing the project itself. In anticipation

of receiving funding for my thesis and a formal start date at the university, I contacted the Gatekeepers who I felt would be instrumental in providing me access to the bereaved families – one of my three participant groups – who were to be the subject of my research.

The following section looks in more detail at who these Gatekeepers were, and the effect that necessarily having to involve them in my fieldwork had on the research process.

3.1 Gatekeepers

Brake and RoadPeace are the leading national charities in the UK dealing with death from road collision. These institutions exist to provide practical and emotional support to their bereaved members, as well as campaigning for changes in laws about driving, and changes to what they perceive to be an inadequate justice – including the inquest – system. My aim in contacting these groups prior to the commencement of my research was twofold: not only did I feel it was going to be difficult to define the parameters of my research, and more specifically my fieldwork, without having them 'on board', but I also had a sense of how protracted these types of relationships, and any subsequent dealings with these organisations, might be. I knew that my enthusiasm to collect data was likely to far outweigh any inclination by busy charities, to go to the trouble of getting to know me sufficiently well that they would be happy to vouch for me to a bereaved client. Thus, I wrote a letter, outlining what I was hoping to achieve through my research and explaining that I was applying for research funding to carry it out. When I re–established contact with these charities after being awarded funding, the case for allowing me access to their members was stronger, as not only had I been allocated funding by the Arts and Humanities Research Council, but I had 'passed the test' in terms of my sincerity, by following up on my initial contact. Such difficulty in accessing vulnerable groups illuminates a potential reason why ethnographic literature on the coronial system is scarce.

Brake operates a 'Victim helpline' which is open from 10am to 4pm, Monday to Friday, and support can also be accessed via email (helpline@brake.org.uk). As advertised on their website, Brake promotes their helpline as quality accredited, freephone and with limitless call–time.

Interestingly, Brake as an organisation will not support defendants or perpetrators who have been accused, or found guilty of, a serious driving offence. Through attending a meeting with the Helpline Supervisor at Brake's offices in Huddersfield, I was able to outline what I was looking for in terms of interviewees. In the case of RoadPeace and, unlike Brake, they did not at that time have a support helpline in place. Since the same point of contact was unavailable to me, I found I was unable to engage with RoadPeace in quite the same way.

It is important to acknowledge here that my reliance on these charities for the provision of participants did, to some degree, frame my sample – something not at all uncommon in studying survivors' groups (Rock, 2004). When speaking with Gatekeepers, I strove to be as unrestrictive as possible in terms of the demographic status of families in order to reduce the risk of my sample size being constrained. What I did explain was that I was hoping to access families as early in the inquest process as possible, with the intention of developing a relationship with them such that I could then attend the inquest into the death of their family member with them, when the time came. In addition, I provided Gatekeepers with a Participant Information Sheet – as detailed in section 3.2 – which explained the purpose of my research and which they could then pass onto bereaved families prior to any interviews taking place.

As hoped, both RoadPeace and, in particular, Brake, were extremely helpful in terms of introducing me to bereaved family members, providing me with all of the eight participants (four individuals and two couples) in the bereaved families grouping. However, my sample was restricted to those families for whom Gatekeepers deemed an approach to be appropriate and who they were willing to refer to me. Even though I was able to develop strong relationships of trust with both groups, and despite my efforts in contacting them early, it took some time for these relationships to come to fruition. Ultimately, this reduced the amount of time available for me to work with families.

Nonetheless, to aid the initiation and continuance of these relationships, and after having been provided with details of new participant families, I ensured that I provided regular updates to Gatekeepers in terms of which families I had spoken to and when, including any developments

in their cases *vis–à–vis* the inquest process. While this may have been a duplication of information for them, I believed it added to the overall impression of professionalism and capability that I was attempting to convey. Further, once I had conducted two or three family interviews, Gatekeepers could assess my probity through direct feedback from families, which resulted in access to other families becoming more straightforward.

Added to this was the fact that two families I made initial contact with, who had come to me through Brake, felt unable to continue being part of my research. In both cases I reassured the families that this was perfectly understandable and that I would be more than happy to recede into the background and allow them to contact me – if they were inclined to do so – at a later date. Ironically, the result of this was fewer participants for my research, but it had the effect of further convincing Brake that I was earnest in my approach: 'Thank you so much for so sensitively responding to his needs.' (Brake, personal communication, 4 October 2017)

3.2 Data collection

In total, I conducted twenty–seven interviews, totalling over thirty–four hours, with twenty–two individuals. I also spent approximately sixty–three hours observing nineteen inquests and one Death by Careless Driving Crown Court trial[4] in courts around the country. As I explained in the introduction to this chapter, I developed three main participant groupings for my data collection, and these included: bereaved families, coroners and 'other' participants. The infographic in figure 4 provides a diagrammatic representation to illustrate these groupings, and section 3.2.2 provides more detail on them.

Throughout my fieldwork I took notes of all observations and the conversations I undertook with all involved parties, from professionals such as coroners and the police, to bereaved families and the groups who supported them. It took some time before my fieldwork notes – particularly those taken at inquest observations themselves – became less 'factual' and more

[4] While in section 4.5 I lay out the differences between the adversarial and inquisitorial systems of justice, my ambition was never to provide an extensive 'compare and contrast' presentation of the two systems. However, I felt that my attendance at a Careless Driving Crown Court trial – as an example of the adversarial system – would further clarify for me the differences between the two in terms of atmosphere and the treatment of families.

'reflective' in terms of incorporating my thoughts on what I was hearing and seeing around me, rather than simply documenting what was happening before me. In recognising this very early on in the process and feeling concerned that my fieldnotes were not reflective enough, I now understand that this is very much a case of experience and technique, which did develop over time. Moreover, the fieldnotes I kept were in a number of different formats, and included not only the notes I took when observing, but also emails and text messages between myself and the various parties involved, namely: bereaved families, coroners, the police, barristers, solicitors and the various support groups I have contact with.

Furthermore, collecting qualitative data both from vulnerable and professional groups was an inherently uncertain and highly responsible process. During this period of my fieldwork, I was asking difficult questions during highly confidential, in–depth, unstructured interviews, and as a researcher, it is important to acknowledge the 'duty of care' that one has in such dealings. Throughout my thesis I have used pseudonyms in order to protect participant identities and privacy and this is further outlined in the following section.

3.2.1 Ethical approval and gaining consent

Prior to the commencement of interviewing I made a submission to the University of Essex Research and Enterprise Office for ethical approval of my research. At the interview stage I provided respondents that had agreed to being interviewed with a Participant Information Sheet and, within it, a Certificate of Consent (a copy of which can be found at Appendix 1). This hard copy remained on file as evidence of consent.

The Participant Information Sheet explained that I would be asking participants if I could record interviews, and this request was made again verbally prior to an interview taking place. In such an event, none of the respondents were identified by name on the tape and I used a bespoke digital audio device which I felt professionalised and formalised the interview more than if I had used a mobile phone – which provides its own distractions. It was acknowledged, both on the Participant Information Sheet and again at the beginning of interviews, that the information

that I was recording was confidential, and that myself and my research supervisor were the only ones who had access to the full interview data. The Participant Information Sheet also explained that digital voice recordings were to be kept as electronic files and coded and secured using password protection, and that any recordings would be destroyed when the research project was completed. I took written notes of those interviews where respondents preferred not to be tape–recorded, although in practice this was only one out of a total of twenty–seven interviews.

I assured interviewees that I would be happy to return transcripts of tapes for comment in order to ensure they accurately reflected our conversations. Finally, I explained to participants that real names or addresses would not be used in any project reports, or given out to any members of the public, but ensured they were aware that the content of the interviews may be used as part of my thesis or in academic published papers. I explained that pseudonyms would be used in place of both people and places, to ensure identity and privacy was protected.

3.2.2 Participant groups

The three participant groupings I developed for my fieldwork are shown in the infographic in figure 4, with the following sections providing greater detail on each of these groups, in terms of how many participants were contained within each, who they were and my reasons for interviewing them. Section 3.2.3 then goes onto outline in more detail exactly how the fieldwork – in terms of both interviews and observations – was conducted.

3.2.2.1 Bereaved families

My interviews with bereaved families, the first participant group, were in–depth, unstructured interviews with four individuals and two couples who had lost family members in incidents on the road. Table 2 provides details of each of these participants, together with the particulars of their relationship to the deceased, the age of the deceased, and a brief summary of how they died. A total of ten interviews were carried out, with eight of these being pre– and post–inquest interviews with the same person or persons, and the other two with individuals I was introduced to after the inquests into the deaths of their family members had taken place. Interviews were

between fifty–five minutes and four hours and thirty–eight minutes in length, giving a total of twenty hours and forty–seven minutes of formal interviews. In addition, I undertook informal conversations with interviewees, both on the phone and using SMS messages, which I made notes on and filed confidentially with my other data. During this time, I felt I 'got to know' the families with whom I was in contact given the considerable time I spent both with, and talking to, them, and the difficult issues that we discussed. In order to try and gain vivid insight into what these people were experiencing, it was important to travel part of their inquest journey with them, and this was possible with four of the families I worked with.

I first met, and interviewed, Nadia, Vivien, Gary and Tania and Naomi and Phil between nine weeks and two–and–a–half years after the deaths of their family members. I then attended the inquests of their family members as an observer, interviewing them again between five days and nine weeks afterwards. In most cases I also spoke with these families on the phone numerous times in the weeks throughout the process, making notes of these conversations as I went. This provided me with individual narrative 'stories' of a small part of the course the bereaved had followed after their loss, and it gave me an insight into the dealings they necessarily had with the 'death system' (Kastenbaum, 2007). All the interviews provided a wealth of information about the effect on, and impact of, the death and the inquest system upon these families. Throughout my thesis I draw on these interviews, using some verbatim quotations where I feel it is appropriate, to support and emphasise the various points made.

As outlined in section 3.2, a consideration of ethics and consent was paramount before individuals were even approached, using a language that conveyed an appreciation of the delicacy and enormity of their situation. Both ethically and morally, individuals needed to feel that they were protected from any type of backlash which might have resulted from comments they would make in interviews when discussing their experiences of a system which some felt had let them down. For example, Janet, whose husband David had died in a head–on collision some seven months earlier, sought reassurance at the beginning of our interview when saying:

'I have to know that, whatever I say to you today, is just to you and, it won't be getting back to the police'.

In providing assurances and ensuring that their anonymity would remain intact both during the data collection phase and in any published work that resulted from my research, interviewees were empowered to 'open up' and feel comfortable in divulging events and thoughts that they might otherwise not have felt able to do. My success in maintaining a sensitive approach to obtaining information is illustrated by comments from the families: 'I know you don't think you have, but you've really helped' (Nadia), as well as feedback from Gatekeepers:

> Your help, support and guidance for our callers, and our staff, has been outstanding. It felt good to give you recognition for the difference you are making and will make in the future in the lives of families who have been devastated by a road crash. (Brake, personal communication, 22 January 2017)

3.2.2.2 Coroners

I undertook unstructured interviews with five Senior Coroners and two Assistant Coroners, in their offices at five coroner's courts around the country. Table 3 provides details of the courts visited and interviews undertaken.

Table 3. Coroner Participant Group

Coroner number	Coroner Level	Coroner pseudonym / name	Court pseudonym / name	Interview length
1	HM Senior Coroner	Andrew	Easttown	00:56:49
2	HM Senior Coroner	Michael	Uptown	00:00:00[8]
3	HM Senior Coroner	Alex	Lowertown	00:22:32
4	HM Assistant Coroner	Asha	Lowertown	00:31:08
5	HM Assistant Coroner	James	Uppertown	00:53:18
6	HM Senior Coroner	Daniel	Uppertown	00:28:23
7	HM Senior Coroner	Carl	Downtown	01:00:30
8	Chief Coroner for England and Wales	Judge Mark Lucraft	Royal Courts of Justice	00:55:42
			Total	**05:08:22**

Figure 4. Participant Groupings

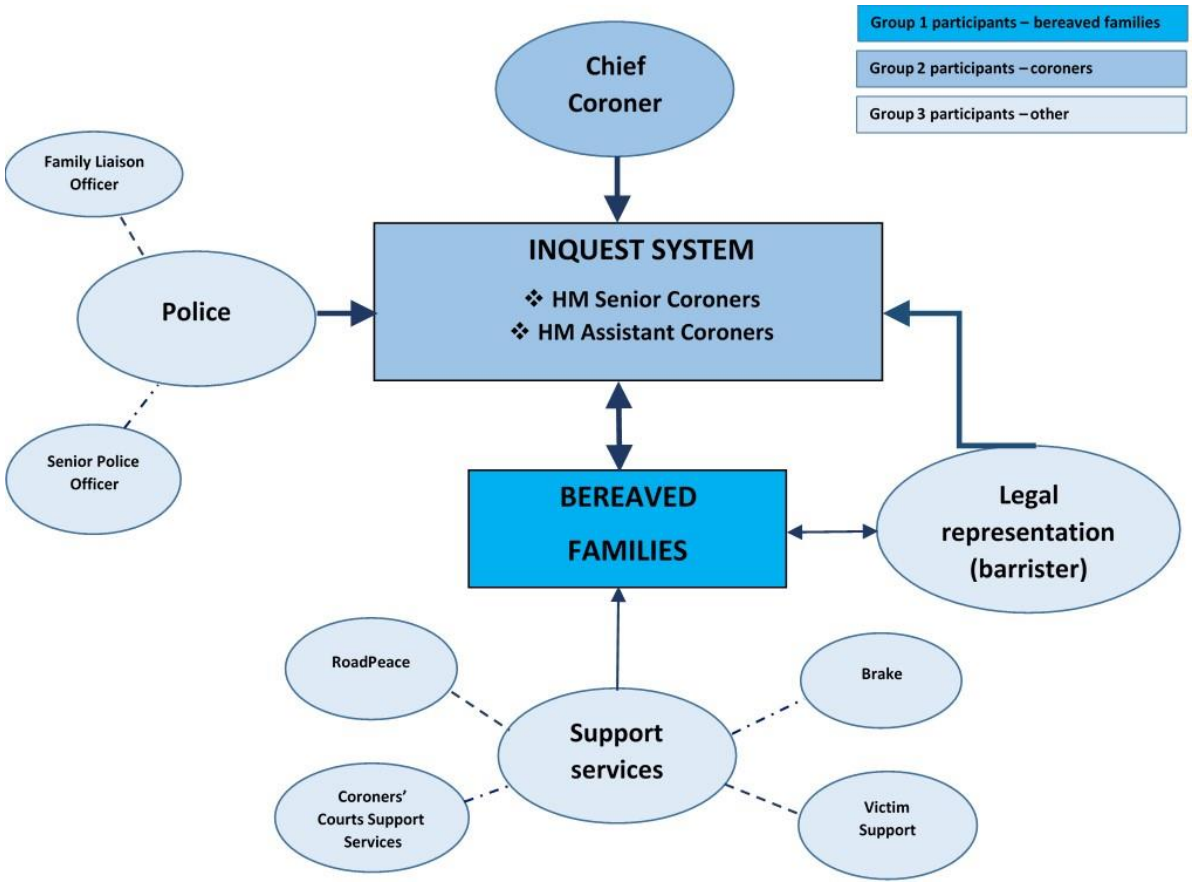


Table 2. Road death typology and bereaved family group

Participant		Relationship to deceased	Name of deceased	Age of deceased	Circumstance of death	Pre–inquest interview?	How long after death?	Attended inquest?	Post–inquest interview?	How long after inquest?	Total interview length
Number	**Pseudonym**										
1	Nadia	Partner	Jeremy	45 years	Deceased's bicycle collided with bus	✓	9 weeks	✓	✓	>2 weeks	02:42:27
2	Vivien	Mother	Anthony	46 years	Deceased's van collided with HGV after deceased entered opposite carriageway	✓	20 weeks	✓	✓	<1 week	03:33:57
3	Janet	Wife	David	69 years	Deceased's car collided with a vehicle travelling in opposite direction but in deceased's lane	x	x	x	✓	27 weeks	04:22:15
4 & 5	Gary and Tania	Parents	Edward	12 years	Deceased's bicycle hit by car overtaking a queue of traffic	✓	124 weeks	✓	✓	9 weeks	04:38:07
6 & 7	Naomi and Phil	Brother and sister–in–law	Richard	48 years	Deceased's HGV lorry involved in collision with another HGV and a car	✓	13 weeks	✓	✓	25 weeks	04:35:05
8	Sophie	Daughter	Mary	66 years	Pedestrian hit by car	x	x	x	✓	75 weeks	0:55:22
										Total	**20:47:13**

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The decision to use an unstructured interview format with coroners one to seven and 'other' participants (see section 3.2.2.3) was a deliberate one, as I felt that the use of the semi–structured interview would inhibit the 'flow' of the conversation. Often a coroner interview would follow on from my observation of that person 'in action' in a coroner's court, which then threw up questions of clarification and enlargement on something I had directly observed. Therefore, given that the gathering of opinion from a coroner often came as a response to my queries about a particular circumstance that I had witnessed either on the day or recently, my feeling was that the use of a pre–set semi–structured interview would not capture this. Similarly, while I did have some general 'topics' that I was keen to explore within each interview, I found that simply allowing coroners – and in a similar way police officers and support workers – the freedom to talk, provided much richer narrative.

Despite this, there was very much a sense of the need for expeditiousness when interviewing coroners, not necessarily explicitly spoken – although on several occasions this was the case – but likely, at least in part, due to their culture as coroners and characterised by a briskness and succinctness to their answers (which I elaborate on in chapters 6 and 7). The impact of this was that, in general, these interviews were much shorter than those I conducted with bereaved families, the longest being an hour in length.

Gaining access to coroners, where public access is limited, proved rather more difficult than I had anticipated. My initial, face–to–face encounter with one coroner, prompted suspicion about the work I was doing, and I was subsequently refused an interview. Of course, this goes, to some extent, with the territory of fieldwork, and tenacity is surely one of the signs of a good researcher. Further and, as Seidman (2006: 106) explains, even though interviewing those in a position of power is one of the most difficult interviewer–interviewee relationships, it is valuable:

> Although I see in–depth interviewing as most appropriate for getting at the details of everyday experience of those in less power–laden and status–oriented positions, still the attempt to gain the inner perspective of elites is worthwhile and important.

In the same way that I commented earlier in the chapter on the scarcity of ethnographic studies on the bereaved as a vulnerable group, the lack of sociological work conducted on 'elites' can also be attributed to access difficulties. The less powerful are more easily studied because ingression is more easily achieved with this more 'open' group – primarily as a result of their lack of power.

The challenges of interviewing hard–to–access groups is something I touch on further in section 3.5.2, suffice to say that after a short period feeling disheartened, but determined to elicit interviews from a group who I saw as fundamental to my research given their potential capacity for '… exacerbating or alternatively alleviating some of the distress relatives may be feeling' (Gregory, 2014: 238), I set off down the networking route.

After approaching a Justices' Clerk whom I knew from my time as a Magistrate (see section 3.4 for further detail on my background), he subsequently put me in touch with a local coroner he himself had a relationship with. This led me directly to my first of eight coronial interviews, and a much greater level of success as I was able to then 'recruit' coroner interviewees on the basis of having spoken with others. It is important to note here that being granted access by some coroners and denied access by others, means that my sample was skewed towards those coroners who were more open to being catechised. However, I feel that the numerous observations of coroners 'in action' that I undertook went some way to towards negating this effect.

My final coroner interview with the Chief Coroner was a different matter, and the process was not straightforward. The Chief Coroner, an office created by the Coroners and Justice Act 2009, is head of the coroner service, providing national leadership, support and guidance to coroners in England and Wales, something on which I provide more detail in chapter 4. After both posting, and emailing a letter requesting an interview, and hearing nothing for several weeks, I enlisted the help of a Senior Coroner I had interviewed previously. He provided me with relevant names and contact numbers for staff at the Chief Coroner's office, and suggested that I 'mention' his name, which I duly did. As he explained in an email to me:

> The reason for the failure of contact will be that the Chief Coroner splits his time between being a criminal judge at the Old Bailey and being Chief Coroner, plus he will get a lot of research requests. (HM Senior Coroner, personal communication, 22 March 2017)

In total I had waited some eleven weeks after sending my initial letter to the Office of the Chief Coroner before hearing that I had been granted an interview. Confirmation of my appointment was coupled with a formal request for 'a list of questions that you intend to ask at least one week prior to the interview' (Chief Coroner's Office, personal communication, 10 May 2017) which I duly provided, finally travelling to the Royal Courts of Justice in London, to undertake a semi–structured interview with the Chief Coroner for England and Wales.

3.2.2.3 'Other'

My third and final group, of 'other' participants, were also interviewed in an unstructured, open–ended way (see table 4). These interviews were with people who were very much involved in the area of the inquest, but who did not fall within my other two participant groupings. Their work is an integral part of the social architecture I was investigating, in terms of how such groups both effect (in the case of the police and barristers) and influence (in the case of support and survivors' groups) not only individuals but also procedures and outcomes. These interviews lasted between fifty–three minutes and ninety–five minutes and are considered in more detail below. In addition to these more 'formal', albeit unstructured interviews, I conversed with many other police and Family Liaison Officers – often those who were tied to the particular cases I was following – throughout my time in the field, keeping records of all these conversations, including names, dates and what was discussed, and these very much formed part of my later analysis.

In terms of the police, I interviewed one police officer who worked as a Family Liaison Officer within a dedicated Collision Investigation Unit, as well as a very Senior Police Officer. These provided two interesting perspectives from police officers at each end of the scale as it were: one operating 'on the ground' and conversing daily with bereaved families and coroner's court staff; the other acting more in a managerial role as an overseer of her specialism.

Table 4. 'Other' participant group

Participant			Interview length
Number	**Role**	**Pseudonym**	
9	Police Officer & Family Liaison Officer	Nancy	01:18:07
10	National Support Group Contract Manager	Darren	01:15:33
11	Director, Support Group	Belinda	01:35:41
12	Barrister	Colin	00:53:27
13	Very Senior Police Officer	Tamsin	00:55:31
14	Survivors' Group Advocate	Anthea	00:42:27
		Total	**06:40:46**

Interviewing a barrister in his office in London who was very familiar with the process of the inquest gave me insight from yet another perspective. I had come across this barrister when he delivered a presentation at a conference hosted by Brake in 2016, where he spoke with regards to several topics, including families accessing legal representation as part of both inquest and criminal cases.

Finally, I felt it was important for me to interview representatives from support groups who had an interest in either the inquest system or those bereaved as a result of a road collision. I spoke with an advocate employed by a survivors' group at their offices in London whom I had met on several occasions, including at an inquest that we attended together in November 2016. Also included in this group were a Contract Manager for a national support group and the Director of another support group also based in London. Again, these participants enabled me to gain different perspectives on the current system and the way that it impacts the families they deal with.

3.2.3 Conducting the fieldwork

Sections 3.1 and 3.2 above outline how I recruited participants, including my somewhat forced reliance on gatekeepers for participants in the bereaved families group, the difficulties I experienced recruiting coroners – including being reliant on a 'snowballing effect' once I had

found one who would speak with me – and my efforts to identify participants who were representative of those 'other' parties involved in grouping 3.

In terms of the interviews themselves, and aside from one interviewee in the coroner grouping requesting that I did not record our interview, all other interviews undertaken with the three participant groups were recorded using a digital audio device. As soon as the opportunity arose, each audio recording was transferred as an electronic mp3 file onto a computer where it was coded and secured using password protection. Once safely stored, each mp3 file was uploaded to 'Sound Organiser' software, which enabled me to listen back to the recording while at the same time typing the spoken words into a Microsoft Word document on the screen. After transcribing *verbatim* each file, it was removed from Sound Organiser, with the associated Word document also coded and secured using password protection. Appendix 2 provides samples of the transcribed interviews – one from each participant grouping – in order to illustrate the data gathered.

From the perspective of inquest observations, these numbered nineteen at various inquest proceedings around the country and amounted to sixty–three hours of data collection. Included in these were the inquests attended by family members of my group 1 (bereaved families) participants. However, also included were inquests that took place at the courts I attended in order to carry out coroner interviews (participant grouping 2). I ensured that whilst visiting the courts I sat in on a minimum of one, and often up to four – in the larger court buildings – inquests that were scheduled to take place while I was there. Thus, in addition to the formal interviews that I conducted at each site, my fieldwork notebook reflected my informal description, commentary and remarks – such as that shown at figures 10, 11, 12 and 19 – as well as annotations such as the diagram shown at figure 20. Moreover, Appendix 4 provides fuller excerpts from two separate inquest observations into road collision deaths, at different coroner's courts. All of this constituted a substantial quantity of qualitative data, and section 3.3 goes on to consider how I went on to analyse this, as well as the epistemological assumptions underpinning it.

3.2.4 Documentary evidence

In addition to the primary data which I collected during my time in the field – which, as outlined above in section 3.2, included not only fieldnotes, but emails and texts between myself and the various parties involved – a number of secondary data sources also provided additional material for analysis.

For example, in order to gain an insight into the legalities of the coronial system, I analysed various legal documents, including: House of Commons Committee reports and briefing papers, reports of inquiries and reviews, law sheets, parliamentary Acts and government statistical reports. This provided me both a historical perspective in terms of how the coronial system had formally changed and developed over time, as well as informing my research into how the system operates today. Additional material of a legal nature was provided by two coroners, Andrew and Michael, who sent me documentary evidence pertaining to inquest hearings that I had attended. These included an audio recording (CD format) of a death by road collision inquest that I had been party to, a Cause of Death report and a Road Death Investigation Report, both pertaining to the same case, and a witness statement relating to another road collision inquest that I attended on the same day. In addition, I collected available hard copy campaign literature when visiting both Brake and RoadPeace, and, when attending different coroner's courts to undertake investigations, I collected, for example, numerous support leaflets available as information for bereaved families.

Bereaved families themselves provided me with a variety of information sources which often provided further clues to individuals' internal states and ways of feeling. For example, Vivien gave me a copy of the Order of Service for her son, Anthony's funeral, and Naomi gave me a photograph of her brother-in-law Richard, together with a copy of the Coroner's Certificate of the Fact of Death (issued in the event of commencement of a coronial investigation). Both Vivien and Janet allowed me to take photographs: in Vivien's case, a copy of the Coroner's Certificate of the Fact of Death in regards to her son, Anthony, and for Janet, the ring in which she had had some of her husband, David's, ashes set.

Thus, this amalgam of different sources of information was important not only in increasing my understanding of 'the facts', but also in providing me with a view of the highly important symbolic 'equipment' used by both families and professionals. When combined with the words and actions that I witnessed, such symbols provided clues as to the intersubjective nature of the social world that I was studying.

3.3 Data analysis and epistemology

In order to manage the great quantity of data I gathered, in terms of fieldnotes, interview transcripts, notes of conversations with participants, photographs, emails and SMS messages, I used a qualitative data analysis software package in the form of NVivo 11 to organise, collate and analyse my work. This assisted me with linking and following themes throughout the various data forms, and it helped to keep everything together in one place.

Epistemologically, the debate over whether research into emotions has any scientific basis is long–standing and protracted. Positivists' reluctance to substitute the place of fact and logic with 'meaningless' (Ayer, 1936) emotional explanation gave way to the acknowledgement that the study of emotions very much has its place in any attempt to produce and further knowledge, as: 'Behind the history of ideas lies the history of emotions' (Feuer, 1963: 1). Latterly, arguments about *whether* emotion studies should form part of the furtherance of sociological knowledge are fewer, with the psychosocial evolution of the study of emotions resulting from a shift towards emotional extraversion, the advancement of scientific knowledge about the workings of the mind and brain, and ultimately, the verification by anthropologists and sociologists that emotions are fundamental to our understanding of how we organise, shape and integrate ourselves as individuals and as members of society (Karstedt, 2002; Rustin, 2009).

The question then becomes one of *how* we go about interpreting the emotions of others, given Goffman's (1969) 'impression management' and Hochschild's (1979) 'emotion management'. These authors suggest that we manage and construct our emotions in order that they fit in with societal, cultural and gender norms (Shields, 2002), making the interpretation and

understanding of feelings a difficult task. Indeed, how can behaviour and responses be explained – not least understood – if each one of us is able to represent our feelings differently and very much in line with how we wish to appear, rather than how we actually do, feel? Moreover, and as Cromby and Philips (2014: 64) explain, for the bereaved, there may be: '…no ready name for how you feel when a loved one dies. Quite possibly, no mere word could do justice to the rawness, depths and convolutions of your felt experience…', to the point where even the suggestion that the words can adequately be used to describe one's feelings is an 'insult' (Nightingale and Cromby, 1999).

On the other hand, for Cromby and Philips (2014: 69), it is precisely the 'organisation of feeling' that is required by these discourses and narratives that enable analysis to be carried out and conclusions to be drawn. Thus:

> To emphasise this is not to challenge the constructionist analysis of death, but to extend and situate it. We extend it by including the socialised body in the processes of meaning making, producing from this meshing of feeling and discourse a minimal notion of subjectivity adequate for many social scientific or psychological analyses.

Furthermore, given the assertion that emotions are both socially and culturally framed (Karstedt, 2002; Thoits, 1989), and therefore shared to some degree, it is arguably possible for the researcher to know and understand something about them. While words alone may not enable one to grasp such complex emotions, the combinations of those words, with observations of actions and actor's symbolic equipment, would go at least some way towards this. Moreover, emotional feelings and responses of interviewees – in this case the bereaved – will not only be reflected in those of the researcher but also brought to bear *by* the researcher in the research itself. As McConville, et al. (1991: 13) tell us, this does not mean the process is flawed, but rather requires an acceptance that:

> Research, like the world of its subjects, is a process of construction. In describing the 'realities' presented by police and prosecution, we set up another 'reality'. The fact that researchers do not and cannot have unmediated access to the 'truth' is not a strength or a

> weakness of the research and is not a deficiency in our method, it is an epistemological reality.

Thus, while my sample sizes were small for each participant group, my research was very much exploratory in nature and represented an abundant compilation of emotions, attitudes, feelings and opinion. Through analysing the data and rich, descriptive testimony that I had collected in the context of the world and the individuals being studied, I went about 'situating knowledge' as described by Widdowfield (2000:205). Moreover, by adding material that I collected as I went along, I was able to use my personal experience of interviewees and dialogue, as well as my own thoughts and assumptions about the data, to test ideas, draw conclusions and generate theory throughout the whole course of the fieldwork, something which has been termed abductive analysis (Charmaz, 2006; Glaser and L., 2017; Strauss and Corbin, 1994; Van Breda, et al., 2012). Such a use of grounded theory, particularly using this less procedure–driven, constructivist approach as traditionalised by the Chicago school (Gilgun, 2019), enables '… a process of constructing rather than discovering theory' (Charmaz, 2006: 9). By focusing on the relationships between people and their environmental interactions, and very much at odds with the 'scientific' stance favoured by positivists, I used intuition – or what Swanwick (1994) would term 'personal vision' – to explain what interviewees were telling me, thus avoiding the over–use of any preconceived ideas or theories in explaining the social processes that my participants were part of. This intuitive interpretation is necessary when one understands, as Myers (2000) explains, that there can be multiple realities, with individuals portraying, and often justifying, their experience within their own minds and dependent upon context. The use of intuition by the researcher in this way is something Hollway and Jefferson (2013: 64) tell us 'is unavoidable once the researcher has posited a psychosocial subject', particularly given the fact that qualitative research is, by its very nature, subjective (and thus creative and intuitive).

This importance of the bearing of the researcher's emotions, not only on the collection, but also the interpretation of qualitative data has been oft–identified in recent years (Holland, 2007; Hollway and Jefferson, 2013). Discussions around this contribution of the 'self' to the creation

of knowledge (Berger, 2015) abound in the literature on reflexivity. Indeed, for Widdowfield (2000), the writing of emotions into research accounts can lead to a more in-depth understanding of the research undertaken, as well as being important in the process of situating that knowledge within a particular social community. Such views are extremely pertinent to my research, both in terms of how I was impacted by what I was seeing, hearing and understanding, and what I was myself bringing to the process.

However, and in relation to this, whilst writing emotions into the research is valuable, it is also important to be clear about the motives for undertaking such a study. Fetterman (1998: 131) points to the importance of academic researchers being aware of '… their role in relation to the maelstrom of vested interests operating in any given study'. For example, promising to 'give voice' to families is tempting at the commencement of a project like mine, but would have been a questionable motive in the case of this research, for two reasons.

First, from the perspective of my research, promising the bereaved in my sample the 'reward' of being heard in exchange for their emotional disrobement, is unhelpful if one is unable to 'come up with the goods' at the end of the day. This is partly about expectation management and partly about being realistic. Giving voice as part of a published thesis has its value, but – particularly given the socio-legal rather than political nature of this work – is not the 'marching on parliament to make a change' that families might presume. Despite undoubtedly having value as a contribution to knowledge in its own right – as Ragin and Amoroso (2010: 34) suggest, 'The goal of giving voice to a marginalised group contributes to the larger goal of generating transformative knowledge' – one needs to be realistic about the impact – or not – of academic work like this. Indeed, for Venkatesh (2016: 4):

> If the researcher controls the question and decides in the final instance how the subject's world is re-presented in text, then how could the subject ever really have voice and be recognized in this process—one of the central promises of ethnographic research.

Secondly, 'giving voice' suggests the anticipation of a plight and the presumption that there is something important to be said which requires (and is not being provided) an outlet. It would

have been disingenuous of me as a researcher to make such a promise prior to discovering, through the analysis of the data being collected, whether such a mechanism was necessary or not.

Saying all that, commentators have described how simply allowing an individual to speak candidly and without fear of criticism can have great therapeutic advantage, particularly when their perception is one of an unfair and harsh system (Clarke, 2009; Venkatesh, 2016), with McClatchey and Wimmer (2012) demonstrating decreased traumatic grief symptoms amongst parentally bereaved children when they were enabled to 'give voice' at a bereavement camp. Whilst such commentary may well strengthen the ambition of a researcher to 'give voice' as part of the research process, it is perhaps an outcome that should remain tacit rather than explicit.

In summary, unexpected and traumatic death is highly personal and highly individual (in part due to the uniqueness of each road death itself) and, as a researcher, it would be easy to feel inadequate when attempting to gather, analyse and interpret the traumatised inner–worlds of these families. This is something I will touch on later in the chapter as part of a consideration of challenges and lessons learned, suffice to say that at the end of the period of fieldwork, and through not only hearing the stories of these people but engaging in regular discourse with them throughout the aftermath of the loss, I *did* feel that I had gained an awareness of, and an appreciation for, their struggle, their anguish and their frustrations. Without exception, all the families I interviewed felt that, at some point, and to a greater or lesser extent, their feelings were circumvented for the convenience of the system or others, and while such perspectives are clearly highly individual and touched by introspection, they do demonstrate a commonality that cannot be overlooked in any attempt at analysis or interpretation. Being privy to such concerns, particularly where I was then able to provide assistance of an information–seeking or sounding–board nature, enabled me to gain entry to personal provinces that I felt would, ironically, be inaccessible under 'normal' circumstances.

It is thus pertinent in any discussion of a qualitative methodology such as this, to consider not only the circumstances that led the researcher to the field of study – which I touched on in my

introductory chapter – but also the researcher's background, past experience and personal disposition. In so doing, and by looking at reflexivity more closely in the following section, I consider how collecting the data affected me emotionally, how I myself impacted on the data, and how this influence was assimilated into my research.

3.4 Reflexivity

Crucial to the success of this research was my ability to communicate effectively with the parties involved, particularly the bereaved families who were central to my research question. It was essential that individuals felt they were being dealt with, not only sensitively, but professionally and with a degree of empathy, yet also in a way that assured them it was important to me to hear their stories. Having spent some time providing support to families as a volunteer within Victim Support's specialised Homicide Division, as well as performing duties as a Magistrate between 2007 and 2011, I felt I had some first–hand knowledge of the impact traumatic bereavement can have on families and how emotionally difficult the Criminal Justice System can be.

There is little doubt that 'who I am' had a bearing on how participants related to me, and how I related to them. The fact that I am a middle–aged, white woman, positively impacted on my experience of gaining, not necessarily access to people (who were agreeing to see me over the phone or by email), but certainly their acceptance of me once we met in person. Had I been younger, I think participants would have questioned my ability to empathise with them: how can a younger, childless person (for example) have enough 'life experience' to enable them to appreciate what someone who has lost a child might be feeling?

The constructivist, psycho–social approach, discussed in section 3.3, and also adopted by Walkerdine, et al. (2001), outlines that not only is it important to acknowledge the reflexive nature of such in–depth qualitative interviews, but it is also necessary. In order to even have a chance of empathising with participants on any level, one must be in touch with the emotions and feelings that the dialogue invokes in oneself: '… to be able to examine other people's unconscious processes, you must be willing and able to engage with your own' (Holland, 2007:

201). An example of such a time was following a four–hour interview with bereaved wife Janet, when she described her journey from receiving the news of her husband David's death in a head–on road collision, through to the weeks after the inquest had taken place. Absorbed in our dialogue, during which time we both cried and laughed together, we had no awareness that such a length of time had passed until we both realised we had other places to be. In leaving her house and preparing to go and collect my son from school, I was struck by two overarching feelings: first, that I should 'pull myself together' in order to present myself in a 'socially acceptable' way, and second, that regardless of the depth of feeling which she and I had both been embroiled in only minutes before, I was now so easily transitioning to what – in comparison to her experience – can only be considered 'mundane'.

Duncombe and Jessop (2002) refer to the work of Hochschild (1983) in raising questions about whether this empathy is manufactured, commercialised or 'simulated' in order to serve a purpose – that of the interviewer consciously using rapport to persuade interviewees to speak with them. On this note, I feel it is pertinent and important to recognise (and not to underestimate) the emotional effect that interviews such as those I conducted can have, not only on the interviewee themselves but also on the person conducting the interview. For instance, Hubbard, et al. (2001) describe an interview where the researcher offered to stop when the interviewee became upset, and she, as the interviewer, could feel herself struggling to keep her own emotions in check, something which the interviewee could sense. The interviewee spent some time 'pulling himself together' after which the interview continued, but the researcher was acutely aware, and distressed by the fact, that from this point on he was making a great effort to control his feelings. Furthermore, subsequent interviews found the researcher trying to distance herself emotionally such that she did not encounter any further distressing situations.

In my case, I found that I was 'carrying around' a lot of the sorrow that my participants had expressed in their interviews, and such experience has been recognised as an 'issue' by commentators (Hubbard, et al., 2001; Liamputtong, 2006). In one way this was a positive thing and showed that I was able to feel some level of empathy with the families with whom I was

engaging. However, it was also problematic on occasion when I was unable to access support soon after the interview had taken place. On one occasion I struggled to maintain my composure during a conference when a mother described the loss of her husband and young son (roughly the same age as my own) when they were killed crossing the road eleven months earlier.

Clearly, such examples highlight the impact (potentially on the researcher and the quality of the research) that not having access to some sort of therapeutic provision can have, something which Hammersley and Atkinson (2007: 94) tell us is to be expected: '… field researchers do not always leave the field physically and emotionally unscathed'. Ensuring support is available on a regular and sustained basis throughout this type of fieldwork would be a recommendation I would most definitely make to researchers embarking on a study involving vulnerable groups. Yet, unlike with therapeutic or 'care worker' type roles whereby therapeutic/emotional support is often (though not always) provided, there is no formal support of this nature available for researchers (Corden, et al., 2005).

In my case I was able to speak on an informal basis with two friends who are therapists, but this necessitated my acceptance that I had to live with my emotions until I was able to access them. Furthermore, the residual effect of hearing my interviewees' stories has been a heightened sense of the risks that we as a family, and in particular my children, take when we leave the house every day. I have fought to keep a balanced perspective of this, telling myself I do not need to phone and check everything is alright when my husband is ten minutes later home than he suggested he would be. The visions of people pinned and suffering in the cabs of Heavy Goods Vehicles, being thrown into the air before suffering the blow to the back of the skull that actually killed them (rather than the impact of the car itself), or strangers rushing to the aid of a twelve–year–old who has been fatally injured, have stayed with me. This is one of the challenges of this type of research, and the following section considers some others.

3.5 Challenges and lessons learned

It was inevitable that, as a researcher, I would encounter some challenges along the data collection road. In studying vulnerable, hard–to–access and professional or 'elite' groups, there were problems associated not only with gaining access to them, but also in terms of actually conducting the interviews, and these are considered further in the sections below. In addition, given that I was reluctant to turn down any offer of contact with a potential interviewee or inquest observation opportunity, the resultant wide geographical spread of my participants and visits meant that I constantly needed to factor location and timing considerations in. Finally, deciding which groups I was *not* going to engage with was a challenge in itself, something I examine more closely in section 3.5.5.

3.5.1 Interviewing bereaved families

In my initial contact with participants I made it very clear that I was open to meeting them at a time and a location that was most convenient and uncomplicated for them. For most of my participants, this meant interviews were conducted at their homes. Only one interviewee chose to meet me at a hotel on the basis that she felt she may find it difficult to engage with me in the presence of her (autistic) husband. As such I was entering households where people were still very much in shock, having suffered their loss only weeks before we met. As I outlined in section 3.3, though not a direct part of my remit, being able to act as a 'listening ear' was valuable in itself (Clarke, 2009), particularly as the provision of counselling services to the bereaved is by no means assured, and even where it is provided does not necessarily come without a cost.

3.5.2 Interviewing hard–to–access groups

As I explained in section 3.2.2.2, after an initial rebuff from a coroner very early on in the fieldwork process, the access that I gained – through the use of networking – to my first coroner interviewee, was invaluable in terms of provoking a 'snowball' effect. Not only was my credibility with other coroners enhanced (as each one vouched for me to the next) but I could

take advantage of the leverage that having now spoken with a 'colleague' provided me. I was aware that this would have an effect on the structure of my sample, in that a number of the coroners I interviewed therefore knew each other and, in some cases, had stood as Assistant Coroners to the more senior amongst them. However, as I was undertaking individual coroner interviews, which were unstructured and so led in very different directions, I felt that any impact of this on my sample was not only minimal but necessary in order for me to gather the data. Furthermore, Seidman (2006) suggests that such peer access is actually preferable because it provides equity in the interview process, rather than there being an effect of gaining participants from 'above' or 'below'.

The early rejection by a coroner was thus a steep learning curve with an important lesson attached. Such declination inevitably leads one to draw (potentially negative) conclusions as to the reasons, particularly in the absence of any definitive explanation being provided. In an email sent to me by the coroner's Personal Assistant, I was told:

> Thank you for your email dated 17th May 2016 and for the letters which have been passed onto the Coroners. Unfortunately, it is not possible to arrange a meeting at this time. (Personal Assistant to HM Senior Coroner, personal communication, 26 May 2016)

It would have been easy for me to assume that such an initial negative response was going to eventuate with all coroners; either I must have made my approach in the 'wrong' way, or all coroners lack transparency and openness.

However, not only does perseverance reap rewards, but when it comes to hard–to–access professional groups, outside links, however tenuous they may appear, can prove invaluable. In this respect networking was, as with countless others before me, a fundamental part of my fieldwork and where possible I took advantage of the fact that people had a multitude of links within the world I was investigating. I ensured that I cultivated contacts I had made early on in the process, even if I did not return to them until much later. However, while these networks provided me with participants, my reliance on these relationships did mean that my sample size and shape was restricted. Also, networking in itself can be very labour–intensive and requires

a great deal of input and nurturing of relationships if it is to be of value, which can be very time–consuming. Overall, and as I alluded to in section 3.5.2, the gains I made in terms of contacting coroners, mitigated any impact that the networking process had on my sample.

3.5.3 Interviewing 'the professionals'

As a researcher, maintaining the balance between taking what one is told at face value and remembering that individuals have a vested interest in reporting their actions in a positive light can be difficult (Goffman, 1969). Interviewing the police and aiming to glean information from them as a researcher, brings its own set of challenges and this will always be the case with anyone who has a position to protect, and is interesting data in itself. The bereaved families with whom I spoke were divided in terms of their dealings with the police, with some finding them very helpful and others having overall negative encounters which clouded their experience of the system as a whole. Furthermore, it appeared of crucial significance, that when talking about the same case, the police and family members could relay the same conversations and information very differently to me.

In terms of my dealings with Brake, one issue that arose was the way in which they were 'selling' me to the bereaved families who they were approaching on my behalf. It became evident that even though helpline staff were explaining the basis for my research to some degree, they were pairing this with a promise of some type of therapeutic input from me. My sense was that they felt compelled to do this, in part because counselling services for the bereaved are in such short supply that they are desperate to find a way to provide support. However, I suspect that it was also because they were more comfortable posing the question of my involvement as a reciprocal arrangement. Fortunately, my background as a Magistrate and a Victim Support worker is such that I felt comfortable in the provision of the empathetic listening ear that these families were seeking. I made sure that they had read the Participant Information Sheet and that I had fully explained my research aims and how the interviews would work prior to them taking place. This helped to ensure that families understood that while I was happy for our discussions to be therapeutic in some way, my aims were first and foremost to gather data about their

experience. This highlights the potential difficulty that *might* be caused when Gatekeepers' motives are different to those of the researcher, although I found the Gatekeepers to be of great value during my fieldwork, as I described in section 3.1. Indeed, rather than '… fraught with complications' (Seidman, 2006: 45) in the way they might have been, my contact with both Brake and RoadPeace led me to the six families who form a central part of this research project.

3.5.4 Location and timing considerations

Underestimating the time commitment of the data collection part of a project such as this, whereby lengthy, in–depth and unstructured individual and couple interviews which are central to the fieldwork, would be simple but problematic. It became clear that I would need to be prepared to travel to any location to interview a bereaved family or a coroner, given the reduced emotional capacity of the former and the demands on the time of the latter. This meant travelling between 200 – 300 miles on many occasions to collect data in a location which sometimes was not ideal. For example, one of the families I went to visit at their home had a disabled child upstairs and two dogs in the kitchen who all required tending intermittently, meaning that our interviews were regularly broken. Despite not being ideal, it is common, as Hammersley and Atkinson (2007: 29) explain: '… the ethnographer is rarely in a position to specify the precise nature of the setting required'. Furthermore, it enabled me to 'step into' and so better understand the lives and backgrounds of my participants.

When possible, I attempted to visit more than one participant on a fieldwork trip, including interviewing more than one coroner on a visit to a court where there were several available. Yet I learned never to make assumptions about whether people would actually be available when I arrived, how amenable they would be to being interviewed (regardless of whether they had agreed to it in the first place), and how long interviews would take. As a qualitative researcher, flexibility and patience are thus paramount. One must expect that it may be necessary to invest twenty–four hours to get three hours of data and that these interviews are inherently tiring and stressful to undertake (Hammersley and Atkinson, 2007). In this vein, Everhart (1977) warns against the dangers of 'fieldwork fatigue', outlining how this, coupled with his becoming too

used to being in the field, led to some diminishment of perspective on his part. Since my fieldwork lasted only eighteen months in total, I did not find this to be the case. However, what I did note was that approximately two–thirds of the way through conducting my observations at various inquests, the environment of the coroner's court – which had fascinated me initially – was in danger of becoming somewhat mundane and taken for granted.

In summary, the types of difficulties I have identified here were very much down to lack of control which is an inherent issue in this type of fieldwork (LeCompte and Schensul, 1999) and although this can be mitigated through planning and organising as much as possible, an element of adaptability and creativity are necessary to 'make the best' of the opportunities for collecting data that present themselves. In this way, it is important to recognise that while the final sample may often not be as one would have wanted, fieldwork is an inherently limited, difficult and messy process which requires that parameters must be worked within rather than fought against.

3.5.5 To include or not to include…

In the end, I had interviewed twenty–two individuals, which amounted to over thirty–four hours of rich, in–depth interview data, in addition to the numerous notes taken of dialogue and inquest observations that I collected during the eighteen months I was in the field. As a microcosm of the world I was seeking to explore, I felt the picture it painted of families' experience was detailed, deep and expansive.

However, being aware that my sample size within each of my three groups was small, I considered later in the process whether I should incorporate the views and opinions of other parties, namely car drivers, Coroner's Officers and coroners overseeing the inquests I attended with my participants. After much thought however, I made a conscious decision to exclude these groups from my study. In essence, the whole world is connected, and social researchers thus necessarily have to limit the multiple sites (Marcus, 1995) which impact on the specific worlds they are focused on.

3.5.5.1 The 'other' driver

On several occasions, I was present at inquest observations where a driver who had either caused or been involved in a collision was occupying the 'same space' in a coroner's court as the family of the deceased. This was a fascinating dynamic and one which I consider at length in chapter 7 when I look at the process of the inquest itself. After some deliberation over whether my research would benefit from analysing the thoughts and feelings of these drivers (who, as I go on to explain in chapter 5, were considered not to have perpetrated a crime either due to lack of evidence or it not being deemed to be 'in the public interest' to prosecute them) I decided that such application was outside the scope of my thesis. I was of the opinion that the thoughts and feelings of a driver, although certainly a fascinating topic, would require a very different set of questions and investigations, as my focus was on the emotions of the bereaved families as *they* experienced the process rather than others involved in it.

3.5.5.2 Coroner's Officers

Another group I chose not to interview were Coroner's Officers at the various coroner's courts I was attending. The role of a Coroner's Officer, according to the Coroners' Officers and Staff Association (2008), is as follows: 'To act as the representative of HM coroner in the investigation of any death referred to his office and to make enquiries into potential finds of treasure'.

Coroner's Officers are either employed by the police or are funded through the Local Authority depending on the Coroner Area, and their role is something I consider further in chapter 5. In some cases, Coroner's Officers deal directly with families, although it appears to be more usual for this to happen towards the end of the inquest process, and closer to the hearing itself. Often, Coroner's Officers act in an administrative capacity only, leaving the great majority of dealings with families to the police. For this reason, and the fact that the coroner is the face that families see (and are often only interested in seeing) at the inquest itself, I chose to interview coroners and not Coroner's Officers about their thoughts on the inquest process.

3.5.5.3 'Sample' coroners

Finally, on several occasions I interviewed coroners after observing them conducting an inquest when visiting 'their' court. What I chose not to do was interview a coroner who had overseen the inquest of a family whose case I was involved in. I felt that doing so may 'muddy the waters' in some way, with the relationship between myself and the family – possibly impacting on rapport and thus the quality of the interview and subsequent data. I was keen to avoid a coroner feeling defensive, for example, in the knowledge that I was in some way connected to the family he or she had just dealt with, and furthermore, felt concerned that the family might have expectations of a further outcome for them from my interview with the coroner who had investigated the death of their family member.

In conclusion, it would have been relatively easy for me to assuage my curiosity in this field by speaking with all manner of interested parties. The 'other' drivers, Coroners' Officers and 'sample' coroners were integral to the machinery of the inquest process, forming part of the wider discussion of the coronial court and the system of inquest. However, the impact of the system as a whole is far–reaching, and it would have been futile for me to attempt to hear the views of everyone who might at some point be touched by it. For the sake of practicality, it was necessary for me to put a limit on the number of groups I interviewed, compelling me to make exclusion choices that interfered least with the fulfilment of my research aims.

3.6 Conclusion: a coronial ethnography

For Stenbacka (2001: 551), validity as an object of measurement in qualitative research is 'useless', because '… the purpose in qualitative research never is to measure anything'. Quality is what is at stake, she goes on to tell us, and this can be assessed by several means, including ensuring that 'informants' are able to speak freely according to their own 'knowledge structures' and describing in a systematic and careful way the world being studied (Stenbacka, 2001: 555). In this way, although my sample was relatively small, it was detailed, in–depth and highly revealing.

Ultimately, the in–depth interview, particularly when undertaken with vulnerable groups like bereaved families, and the different challenges of hard–to–access and professional groups, are an unpredictable and often onerous task. However, the rewards in terms of the knowledge of the emotional sounding-board that you as a researcher are able to provide to someone who is suffering, together with the richness of the data that can be achieved, more than makes up for the intractability of the effort in the field.

In this way, the data that I collected was not only abundant but straddled several fields. Indeed, Holland (2007) describes the polemic between the approaches of psychoanalysis, psychology and psychotherapy and the field of sociology as to who can best understand the role emotions play in the human experience. For example, even a high–level analysis of the data I gathered from bereaved families suggests little doubt that personality traits and individual differences have a part to play in how people 'cope' with their loss and grief and this is agency something I consider further in chapter 7 when I discuss the bereaved as 'co–victims'. In this context, the issue is less about who 'owns' the knowledge gleaned, and more about what one does with it. Through submerging myself emotionally in the field, and appreciating that emotion is socially constructed and not only a biological, instinctual (Holland, 2007) phenomenon, I have been able to develop an understanding of both the issues surrounding traumatic loss and the impact of the State on the individual as part of this.

In setting out the qualitative methodology that I used to collect and analyse my data, together with a discussion around concerns of an epistemological and reflexive nature, this chapter set out the background to, preparation behind and framework for my research. The next chapter puts my study in context, by looking in more detail at the history and process behind the coronial system, before moving onto the first of my analysis chapters at chapter 5, which focuses on the traumatic loss which follows a road death.

4. The coronial system: history and process

In his discussions around the 'mechanisms of power' which characterise Western society, Foucault (1981) describes the historical origins of State power over life as existing primarily as the power over *death*. Through a right of seizure – of taking things away from the population, including life itself – the early judiciary sought to 'subjectify' or, control, the population. Consequently, in medieval times, 'Criminals paid heavily for their crimes, not only through loss of life or privileges but also financially' (Knapman and Power, 1985: 1). This right to *take* life that had characterised sovereign dominance up to the point of democratisation and modernisation later became a power over fostering life or *disallowing* it to the point of death. This, Foucault tells us, was a direct result of the development of capitalism, and with it an explosion in the techniques available to the State for organising, controlling and subjugating the population, something he labels 'bio–power'. Thus, '… the old power of death that symbolised sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life'. (Foucault, 1981: 139–140)

Furthermore, the rapid development seen in the 18th century of the agricultural and economic spheres, together with increases in resources and productivity, and improvements to knowledge in fields such as medicine, saw not only increased populations but a reduction in the threat of death. This, Foucault (1981: 142–143) tells us, changed the dynamic of the control held by the State over society, such that:

> Power would no longer be dealing simply with legal subjects over whom the ultimate dominion was death, but with living beings, and the mastery it would be able to exercise over them would have to be applied at the level of life itself; it was the taking charge of life, more than the threat of death, that gave power its access even to the body.

In 'taking charge' of life, and as elucidated by Rose and Miller (2010: 279), government set itself up as a '*problematizing* activity', in that:

> … it poses the obligations of rulers in terms of the problems they seek to address. The ideals of government are intrinsically linked to the problems around which it circulates, the failings it seeks to rectify, the ills it seeks to cure. Indeed, the history of government might well be written as a history of problematizations, in which politicians, intellectuals, philosophers, medics, military men, feminists and philanthropists have measured the real against the ideal and found it wanting.

By analogy, the inquest, as a regulating mechanism, can be seen to be part of the State accounting for the 'problem' of death. It is what Foucault saw as a 'political technology' enabling the State to remain in control of – and moreover justify that control as necessary to – the population. The population acquiesces to these regulations as part of the expected social order, and, in this way, the coronial system – a 'fossil' (Cooper, 2011) – has subsisted through 'layers of almost every era of legal history from feudal policing, to nineteenth century Statehood construction and twenty–first century human rights culture' (Cooper, 2011: 39).

This chapter sets out the historical progression of the inquest and the role of coroner from its origins as a form of medieval tax collector–cum–policeman to the modern–day lead in the categorisation of sudden death. Is so doing, it enables the comparison of the contemporary coronial system that we see today – a system shaped by reform and marked by vicissitude – with its provenance as a system for '… the furtherance of the King's financial interest' (Knapman and Power, 1985: 1) with the addend of a policing sub–role. This knowledge is important given the changing role of the coroner and his or her court. Not only have changes to the form and process of the system caused something of an imbroglio but, in attempting to 'keep up' with the requirements of a contemporary society which has arguably embraced and redefined victimhood as a central tenet within the Justice System, the necessity for, and function of, the coronial system is somewhat obscured. This is particularly true in the case of fatal road collision where the adoption in recent times of a specific 'Road traffic collision' conclusion at the inquest legitimatises such a death in line with the perspective of it as a 'political technology'.

4.1 From medieval duty collector to unofficial policeman

Literature on the history of the coroner and the inquest is generally sparse, being confined to a small selection of books and journal articles which vary enormously in terms of the detail they provide and how much they concur with one another on the 'facts' of the coronial system's development. However, there appears general agreement that formal establishment of the role of coroner in England happened early in the 12th century (Burney, 2000; Cooper, 2011; Hunnisett, 1958; McKeough, 1983), with the main purpose of ensuring that revenues were collected for the Crown, from its feudal subjects, as efficiently and effectively as possible.

4.1.1 Keepers of the pleas of the Crown

During this time period, King Richard I was often away crusading on the continent, earning him the epithet 'Richard the Lionheart' given his reputation as a great warrior and military leader (Turner and Heiser, 2013). This warfare, and all the associated costs, required funding which, in addition to the inevitable King's ransoms that ensued from such trips, led to heavy demands on the treasury (Hunnisett, 1958). The King and his court, aware of increasing corruption amongst the judiciary – in the form of sheriffs – who had previously been tasked with revenue collection, saw an opportunity to protect the income streams to the Crown by appointing officers specific to that role: 'In the closely integrated interests of good order, justice and royal revenue a new local official was urgently needed' (Hunnisett, 1986: 2). The first coroners were required to hold knighthoods, and by implication be landowners and although the requirement for land ownership was not abolished until 1926, after 1354 coroners were no longer required to be knights due to the difficulty in recruiting them (Hunnisett, 1986; Thurston, 1980). Thus:

> Hubert Walter, Justiciar during the absence of Richard I, decided that by utilising the country gentry and middle classes whom he felt he could control, certain sources of revenue could be safeguarded. Because the execution of justice depended a great deal upon local knowledge and not very much upon the expertise of professional judges, the county court was very important and it was here that the coroners would enrol the pleas of the Crown to

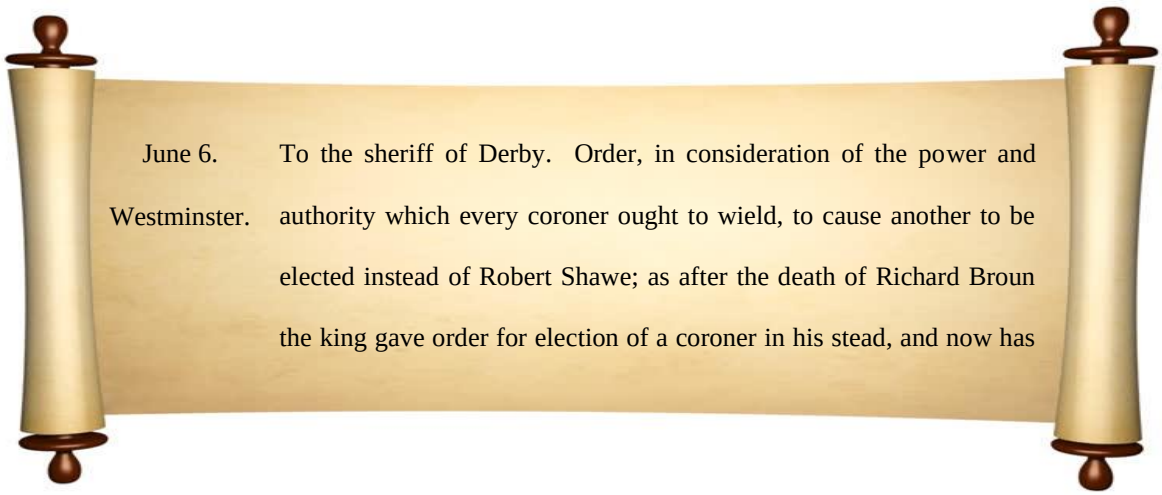
> be presented to the eyre upon its arrival as a record of local events as they affected the King's interests. (McKeough, 1983: 191)

The 'Eyre' referred to here was the system by which, during the 12th century, Royal power would travel the country to hear matters of local, pecuniary interest to the Crown, visiting localities once every four to seven years to hear the 'Articles of Eyre'. Article 20 of the Articles of Eyre set out the process for the election of coroners as 'keepers of the pleas of the Crown' – in Latin, '*custos placitorum corone*' and it is likely that this is where the title originated (Hunnisett, 1986; McKeough, 1983; Thurston, 1980). The meaning of the word 'keepers' here reflected the coroner's role as a record–keeper; it was not his duty to hold any monies collected, which was the premise of the sheriff, as Pollock and Maitland (1968: 534) describe:

> The function implied by their title is that of keeping (custodire) as distinguished from that of holding (tenere) the pleas of the crown; they are not to hear and determine causes, but to keep record of all that goes on in the county and concerns the administration of criminal justice. And more particularly must they guard the revenues which will come to the king if such justice be duly done.

It is also likely that medieval coroners, operating within defined territories, were somewhat eminent within their local communities, a legacy which remains to this day (Thomas, et al., 2014). Often noblemen, they were highly respected and usually literate. A writ which appears in the Calendar of the Close Rolls for A.D. 1441–1447 (see figure 5) describes the standing down of a coroner from his role precisely because he was deemed not to be so.

Figure 5. Details of a writ from a Calendar of the Close Rolls for A.D. 1441–1447

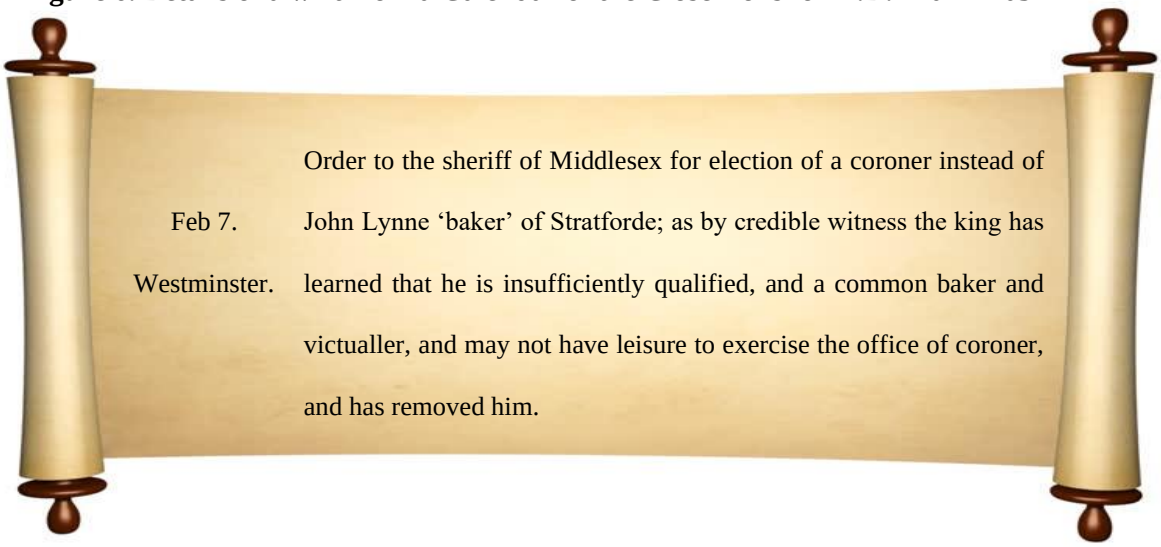


June 6. Westminster. To the sheriff of Derby. Order, in consideration of the power and authority which every coroner ought to wield, to cause another to be elected instead of Robert Shawe; as after the death of Richard Broun the king gave order for election of a coroner in his stead, and now has

> learned that the sheriff, taking little heed of that command, secretly and unlawfully advanced the said Robert to be coroner, an illiterate man altogether unqualified to serve in that office, and not duly elected according to the said command.

Moreover, a second writ from A.D. 1402–1405 (see figure 6) again illustrates the importance of coroners' status within a community where they had been elected by the freeholders – landowners – of the county (Hunnisett, 1986; Matthews and Foreman, 1993) – a practice which continued until 1888 when it was replaced by appointment by local authorities (Matthews and Foreman, 1993).

Figure 6. Details of a writ from a Calendar of the Close Rolls for A.D. 1402–1405



Feb 7. Westminster.

Order to the sheriff of Middlesex for election of a coroner instead of John Lynne 'baker' of Stratforde; as by credible witness the king has learned that he is insufficiently qualified, and a common baker and victualler, and may not have leisure to exercise the office of coroner, and has removed him.

As suggested by Hunnisett (1986: 177) with reference to this writ, '… a social disqualification is implicit here', serving to illustrate that the coroner's standing within the community was vociferously protected (Cooper, 2011). This was, in part, precisely *because* they were elected by freeholders, affording them an independence from higher established authority – unlike the sheriff, who was appointed by the King (Thurston, 1980). In consequence they were, in these early times, more popular amongst the population than their more judicious counterpart (Havard, 1960; Thomas, et al., 2014).

4.1.2 A 'murder' fine

It was during this early –period that the most important and enduring coronial function – the requirement to inquire into sudden, violent, unnatural death – was laid down. Originating as a practice in the time of William the Conqueror, who wished to protect his fellow Normans, the discovery of a dead body was required to be accompanied by proof that it was, in fact, an Englishman. If inhabitants local to where a body lay could not *prove* 'Englishry', it was presumed to be one of William's concomitants. Subsequently, if the local community were unable to bring forth a suspect within five days (Cooper, 2011) the community as a whole would face the '*lex murdrorum*' – more commonly known as the 'murdrum' – fine (Dorries, 2014; Hamil, 1937; Havard, 1960; McKeough, 1983), and the suspected precursor to the modern–day word 'murder'.

This practice lasted long after William's death in 1087, with the recording of the fine subsequently becoming a coronial duty. Thus, the 1276 statute '*De Officio Coronatoris*' reads:

> A Coroner of Our Lord, the King ought to enquire of these Things: first, when coroners are commended by the Kings Bailiffs or by honest Men of the Country, they shall go to the Places where any be slain, or suddenly dead or wounded, or where Houses are broken, or where Treasure is said to be found, and all forthwith command four of the next Towns, or five or six, to appear before him in such a Place; and when they are come thither, the Coroner upon the Oath of them shall enquire in this matter, that to wit, if it concerns a Man slain, whether they know where the person was slain whether it were in any House, Field, Bed, Tavern or Company, and if any, and who were there… and how many soever be found culpable by Inquisition in any of the Manners aforesaid, they should be taken and delivered to the Sheriff… and their Names shall be written in the Rolls of the Coroners. (Cited in Cooper, 2011: 6)

Accordingly, the coroner began to oversee an existing procedure which was then 'rigidly enforced… to as great an extent as was possible in the medieval period' (Havard, 1960: 11),

whereby the 'first finder' of a dead body was required to raise the 'hue and cry', thus summoning the community and in turn the coroner.

Upon being notified and summoned to investigate a death, the coroner would travel to the site of the body, summon a jury – who would all view the body[5] – from the four nearest townships, and conduct an inquest into the death. After a viewing of the body had taken place, a determination as to whether the deceased had died where he or she lay or elsewhere was made, through the tracing of blood, footsteps or other tracks such as from a horse and cart. The coroner, together with the jury, took evidence from witnesses – often jurors themselves (Knapman and Power, 1985) – and if a person was deemed to have come about their demise through felonious actions, any suspect was named, recorded and could be committed to gaol to await trial – a practice which continued into the 20th century.

It is here that the inquisitorial – as against the 'accusatorial', now 'adversarial' – nature of the proceedings originated. These inquiries were always held with juries who were familiar not only with the local area but also often the circumstances of the death. The whole community was very much involved, not only through the calling of – up to twenty–three (Thomas, et al., 2014) – jury members from its number, but also through its duty to bring the deceased's family to the scene. This, together with the viewing of the body as essential to the process and, the fact that the *lex murdrum* fine was imposed on the community as a whole, emphasised that 'law and order was the responsibility of the whole population' (Thomas, et al., 2014: 14). Thus the inquest system in England and Wales was very much rooted in, and informed by, the local community and it had developed using elements of the inquisitorial system as opposed to the adversarial system found in the criminal court. Given that the responsibility for the preservation of law and order at this time lay with the community at large, the fact that a felony had taken place implied that the local neighbourhood had failed in its duty (Knapman and Power, 1985).

[5] Indeed, the viewing of the body by a jury remained a compulsory part of inquisitorial proceedings until 1926 (Thurston, 1980)

4.1.3 Pecuniary police

However, as Havard (1960) explains it would be a mistake to attribute this procedure to any moral ambition to discourage homicide or arrest perpetrators. Instead, it was informed by pecuniary motives. If no suspect could be brought forward, the coroner could attach sureties to jurors (Knapman and Power, 1985), compelling them to produce the accused felon or otherwise face a financial penalty. In any case, a death deemed to be homicide would lead to the collection of the financially lucrative *murdrum* fine, which would have been an 'invariably harsh' fine on the local community (Dorries, 2014: 2). Indeed, during the medieval famine of 1257–58, leading to the starvation of between fifteen and twenty thousand peasants, the death of so many peasants by the roadside meant that coroners were unable to view all the bodies. As such, '… permission was therefore granted for the bodies to be viewed and buried by the men of the neighbourhood without the coroner, unless a wound was found or there was any suspicion of homicide' (Hunnisett, 1986: 9). However, these deaths were still required to be enrolled in the coroners' rolls, with communities being constantly exposed to the fine as punishment for the unnatural nature of the death and the impossibility of proving 'Englishry'. This brought the mounting discontent associated with the fine to a head and, in 1259, the Provisions of Westminster associated the *murdrum* fine only with cases of felonious killing (Havard, 1960).

Thus, in addition to their fiscal duties, there was some crossover for the coroner into, and from, the criminal Justice System. Indeed, commentators seem in agreement that coroners would regularly have been involved in hearing confessions, arresting witnesses (Hunnisett, 1986) and hearing criminal cases (Dorries, 2014; Matthews and Foreman, 1993; McKeough, 1983) – despite their having no legal authority to do so. Indeed, as a result of coroners' tendency to ignore the correct legal procedure in this way, the Magna Carta of 1215 contained a specific proclamation that 'No sheriff, constable, coroner or other of our bailiffs, shall hold the pleas of the Crown' (Cited in Knapman, 1985: 2) – in other words, they should not act as a criminal judge. Nonetheless, coroners continued to exist as 'the principal agents of the Crown in bringing criminals to justice' (Gross, 1896: xxiv), and it soon became the case that aside from

hearing cases pertaining to homicide the coroner emerged as an inquirer, not just into death, but into notable events of any sort. Coronial inquests were held for, amongst other things, arson, rape, burglary, robbery[6] (Matthews and Foreman, 1993) and dead bodies. They were then known as the *inquisito* (Havard, 1960; McKeough, 1983), and any goods or chattels remaining – including when a person was found guilty of 'self–murder' — were seized by the Crown.

Given that suicide was an apparently relatively rare occurrence in medieval England, most coroners' inquests were concerned with homicides and death by misadventure (Hunnisett, 1986). There was no system of medical investigation at all at this time, and it is important to remember that the system of prosecution in medieval times was mainly by private appeal (Havard, 1960; McKeough, 1983). As such, if one individual accused another of an offence, both names were noted down, and the complainant had to provide sureties that the allegation was genuine. In turn, the accused – or *apelle* – had to provide sureties that s/he would appear at the county court. The coroners' rolls were important in recording all such information, leading Milsom (1981: 15) to describe the early coroner as 'a permanent local accountant'.

Interestingly, coroners were also required to investigate deaths in gaols. In fact, inquests were mandatory on prison death from the earliest days of the office of coroner, and although coroners were duty bound to arrest gaolers who were found to have caused a prisoner's death, it is suggested that they were rarely critical of institutional policies themselves (Sim and Ward, 1994). Thus:

> The coroner had to inquire whether death had been caused by long imprisonment or torture, and if he found that the gaoler or others had hastened death by harsh custody or pain inflicted on the prisoner they had to be arrested as homicides immediately. (Hunnisett, 1986: 35)

The reason for this was the strong alliance in medieval times between sovereign dignity and profit (Burney, 2000) and the appanage this provided the Crown to imprison and inflict bodily

[6] Although Hunnisett (1986) refutes this as an 'erroneous' view of the situation, put forward by writers such as Bishop Joannes Britton in 1865 and Henry de Bracton c. 1235. Thus: 'Far from dealing with nearly all felonies *ex officio*, he [the coroner] was necessarily concerned only with homicide and suicide' (Hunnisett, 1986: 5).

punishment on its subjects. Custody was a measure often used against individuals awaited a trial (Forbes, 1977), or to compel a subject to pay a debt or a fine to the Crown (Burney, 2000). Moreover, since, 'All prisons are the King's, but a subject may be keeper' (Coke, 1797, cited in Burney, 2000: 183), any death in prison which could be attributed to mismanagement or abuse was seen as resulting in '… direct losses to the fiscal well–being of the Crown… ' (Burney, 2000: 25) – reiterating the importance of the coroner to pursuing such potential losses, in addition to his role in ensuring that the chattels of the deceased were adequately harnessed.

4.1.4 A changing status

Throughout the 13th and early 14th centuries – a time when the office of coroner was at its 'zenith' (Hunnisett, 1986) – it is suggested that the coroner continued as a leading county figure, although his popularity had waned, affected by '… his preoccupation with what was considered (not without justification) to be financial extortion… ' (Knapman and Power, 1985: 4). Then, in the late 14th and 15th centuries, a number of factors combined – including the disuse of the general Eyre and abolition of the murdrum fine together with the beginning of the centralisation of the administration of justice – to cause a decline in the scope of the coroner's duties. Furthermore, the roles of 'escheator' and Justice of the Peace, or Magistrate, came into being. The former oversaw the transference of a person's land to the Crown after a death without an heir or following commitment of a felony. The latter role included the power not only to arrest and enquire into potential felonies, but also to hold rather than simply record the Crown pleas, something that a coroner – in theory – did not have the power to do. Thus:

> This naturally reduced the financial activities of coroners. Coroners also gave up their criminal work other than inquests, for the keepers or justices of the peace took the place of coroners in becoming primarily responsible for maintaining law and order locally. The only important duty that coroners retained was that of holding inquests into cases of violent or unnatural death. (Matthews and Foreman, 1993: 5)

Following these changes, the first significant attempt at emplacing consistent work conditions on the coroner – and thus improving the 'moribund state' which the office of Coroner found

itself in (Knapman and Power, 1985: 6) – was seen with the passing of the Coroners Act 1751 (see figure 7). This put forward that coroners should be paid for their services at an inquest into 'a body slain' either from the goods of the accused felon or from a fine imposed on the local community – an 'amercement' – should the felon escape.

Figure 7. Extract from the Coroners Act 1751

> **III and for Inquisitions on a Body slain, 13 s. 4 d. over and above.**
>
> III. Provided nevertheless, That over and above the Recompence hereby limited and appointed for Inquisitions taken as aforesaid, the Coroner or Coroners who shall take an Inquisition upon the View of a Body slain or murdered, shall also have the Fee of thirteen Shillings and four Pence, payable by virtue of the said Act made in the third Year of the Reign of King Henry the Seventh, out of the Goods and Chattels of the Slayer or Murderer, or out of the Amerciaments imposed upon the Township, if the Slayer and Murderer escape; any Thing in this Act contained to the contrary thereof in any wise notwithstanding. (Coroner's Act, 1751)

This rationalisation of the coronial system synthesises with Foucault's (1979) assertions regarding developments to the criminal systems of justice across Europe in the mid–18th century. As a vehicle for more effective control by the State – rather than related to the welfare of the incarcerated; and changes to the way prisons were designed and prisoners were treated, both physically and morally, saw 'gentler' methods of imprisonment standing in great contrast to previously adopted methods of torture and execution. In encompassing a dual role of punishing *and* correcting – or of knowledge and domination – the juridical was mixed with the scientific, and this spilled over into many aspects of society. Thus, Foucault (1979: 24) tells us, the development of scientific knowledge, rather than offering universal scientific truths about human nature, was instead an expression of a particular society's ethical and political commitments, and:

> … by an analysis of penal leniency as a technique of power, one might understand both how man, the soul, the normal or abnormal individual have come to duplicate crime as

> objects of penal intervention; and in what way a specific mode of subjection was able to give birth to man as an object of knowledge for a discourse with a 'scientific' status.

Justices of the Peace were also given the power to hear indictments on the misdeeds of coroners themselves, and while coroners were now legally allowed to take fees for the holding of inquests, they had to be approved by Justices who could be obstructive, deeming many inquests to be unnecessary owing to differing opinions on the constitution of a 'duly held' inquest:

> The eighteenth–century justices on the whole took the view that the coroner was never intended to inquire into sudden deaths unless there was manifest evidence of violence, whilst the coroners contended that their jurisdiction was to include all sudden and unexplained deaths (Knapman and Power, 1985: 7)

The consequence was that the number of inquests being held fell dramatically, and although it is acknowledged that there may have been an element of the judiciary – in the form of Justices – wishing to protect public funds through withholding coronial fees, it is suggested that they were also jealous of the continued coronial power to commit for trial in the case of felonious death (Havard, 1960; Thurston, 1980). Indeed, this conflict between the two office–holders lasted, we are told, for more than five centuries (McKeough, 1983; Thurston, 1980), and raises the question of how it was that the role of the coroner survived at all (Anderson, 1987), something that is considered in the following section.

4.2 The Victorian coroner as 'magistrate of the poor'

The early 1800s, as the harbinger of the Industrial Revolution and increasing urbanisation, brought the 'impetus for reform… from those who were anxious to improve the recording of causes of death, to promote more effective investigation of crime, and to advance the cause of public health' (Sim and Ward, 1994: 262). A rapidly increasing population, technological advancement, and what Caraker (1951: 362) describes as the 'scandalous' conditions at the time led to '… the deaths of early industrial victims in unregulated factories and mines… the neglect and maltreatment of children, the fate of human outcasts in workhouses and poor law

institutions… ', and this meant that the numbers of unnatural deaths which required investigation increased (Dorries, 2014).

4.2.1 The bio–politics of population

Amidst a social backdrop marked by what Foucault (1981) has termed the 'bio–politics of population', the focus shifted towards scientifically measuring, recording, and reporting the biological processes of birth, health, life expectancy and death, stemming from State efforts towards power over life at a time when 'death was ceasing to torment life so directly' (Foucault, 1981: 142). Thus:

> The disciplines of the body and the regulations of the population constituted the two poles around which the organisation of power over life was deployed. The setting up, in the course of the classical age, of this great bipolar technology – anatomic and biological, individualising and specifying, directed toward the performances of the body, with attention to the processes of life – characterised a power whose highest function was perhaps no longer to kill, but to invest life through and through. (Foucault, 1981: 139)

The consequent change in the attitude of the legislature to investigating the medico–legal nature of sudden death opened the way to changes to a legal system that was up to that point 'widely regarded as a shambles, reflecting the manner in which English law had failed to keep pace with economic and social change' (Higgs, 1996: 118). Thus this period saw the creation of the Inspectorates of Anatomy (1832) and Prisons (1835) (Thomas, et al., 2014), together with the passing of the first Births and Deaths Registration Act in 1836 which, along with the establishment of the General Register Office and at its head, the Registrar–General, marked the beginning of our medico–legal system into death investigation, including statutory fees for medical evidence at inquests and for post–mortems. This was largely in response to two factors.

First, civil registration *per se* was lacking, in any formal sense, mediated by the realisation by the State that the establishment and tracing of property rights was – in such times of rapidly increasing population coupled with the expansion of cities and associated claims on land – necessary (Higgs, 1996). Furthermore, a Select Committee on Parish Registers in 1833 had

found that when compared with other western countries such as Austria, Belgium, Spain, North America and France, for example, England fell behind in terms of its death registration system, which was virtually non–existent[7] (Havard, 1960). Indeed, during a House of Commons sitting scheduled to discuss the appointment of the committee, notes made of the speaker provided the following observation:

> He repeated, then, though with more of grief than exultation, that we were behind the age; and that foreigners might regard our municipal arrangements with wonder and contempt. Unhappily it was proved that in no other country did there exist so confused a system of registration—in no other country was property so endangered—in no other country were the rights of children so compromised—and in no other country were municipal rules, so practically intolerant, allowed to remain. (HC Deb 28 March 1833, c 1220)

The second reason for the passing of the 1836 Births and Deaths Registration Act, was that lax procedures regarding the determination of the cause of death not only from such epidemics as cholera but also owing to easy access to poisonous substances by any who wished to acquire them, meant that homicides often went unexposed (Dorries, 2014). At this time and – as outlined in section 4.3.1 – up until 1926, the only requirement for coroners other than literacy, and in terms of qualifications, was the possession of property. Thomas Wakley, a well–known London coroner who, as well as being the coroner for West Middlesex from 1839 until his death in 1962, also founded and edited *The Lancet* and later served as a Member of Parliament, was the first coroner to be medically qualified. He campaigned for the requirement for coroners to be medically qualified owing to his belief around the dangers of undiscovered homicides by coroners who were not doctors (Emmerichs, 2001), writing in the Lancet that:

> … case after case was reported in which the most favoured verdict of 'visitation of God' was returned when the real cause of death had not been ascertained owing to inadequate medical evidence and insufficient knowledge on the part of the coroner. (Brook, 1945: 152–153)

[7] The only record comparable to death registration in England and Wales prior to the 1936 Act was that of the registration of burials by the Established Church (Havard, 1960; Higgs, 1996).

On the back of this, resultant increased public concern led to a ‘complex dialectic’ (Sim and Ward, 1994: 246) at a time when coroners were still elected by county freeholders and concern around ill–health and medical care was increasing. For example, Forbes (1977: 668–9) analysis of inquests into the death of 376 prisoners in Coldbath Fields prison between 1795 and 1829 revealed:

> … an apparent lack of official interest in determining why prisoners died. Indeed one wonders whether the vagueness of the record represents an effort to conceal actual causes of death – a state of affairs which would not be surprising in a prison in utter disrepute. No cause was recorded for almost one third of the deaths. Almost one–fifth were piously ascribed to a Visitation of God', a whitewashing phrase that also was frequently used by coroners' juries of the time for deaths in prison; it was as nonspecific as it was unassailable.

What can be seen is that pressure for change came both from above in the form of a government more committed to reform, and below from a local electorate who desired change and who were themselves called to take part in the inquest process as jurors, since the inquest was the only legal forum in which working–class people could participate as jurors:

> Unlike other jurymen, coroners’ juries needed no qualifications. In a rural area, it might be difficult to get together any jury at all, and ‘poor and uneducated labouring men’ were often summoned in such places… In a town, a few layabouts might make themselves perpetually available for the sake of a drink… To guard against these weaknesses it was common by the end of the century in efficient urban jurisdictions either to work through the voters’ list, or to summon juries by streets… ; the coroner for Liverpool, for example, was by then giving his officer standing orders to ‘avoid the day labourer’ and ‘get tradesmen, shopkeepers and merchants’ and make sure of a jury equal to ‘a delicate question’ by choosing ‘a better class of street’. (Anderson, 1987: 28)

Thus, within the context of increased regulatory power and State codification, strategies were adopted by the State which were designed, in Foucault’s (1979) view, to dominate and subjugate, not only within the juridical sphere, but in all walks of life.

4.2.3 Magistrates of the poor

For Sim and Ward (1994), such disciplinary strategies were designed to instil an improved work ethic, together with acquiescence towards, and respect for, the State. The effect of this was twofold: debates around conditions and medical care, both in terms of sickness and death, intensified but, on the back of this, the inquest emerged as a symposium for the challenge of disciplinary institutions and the medical profession by some of society's most marginalised groups. In this context, the inquest:

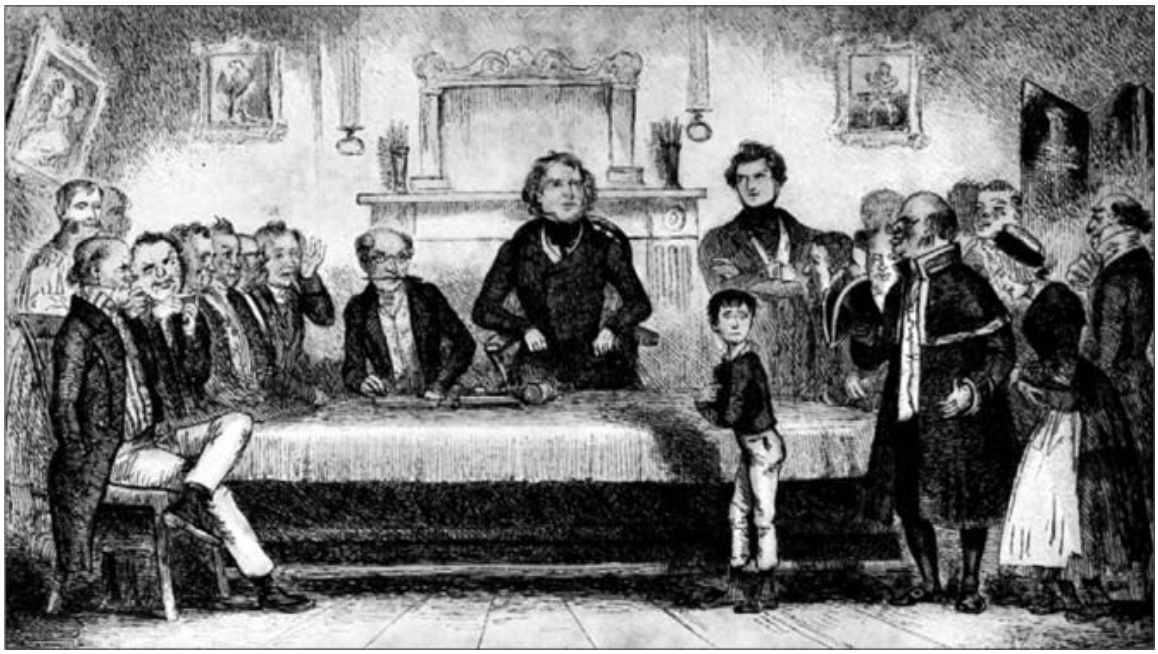
> With its coroner elected (in most districts) by the county freeholders, its jury of local people and its relatively informal proceedings… the coroner's inquest could take on a distinctly 'popular' flavour and in some cases it provided… a forum in which the poor could challenge the powerful. (Sim and Ward, 1994: 246).

This did however mean that these proceedings were 'irretrievably undignified', often taking place in public houses, involving drunk jurors, '… amidst the coming and going of stray cats, dogs, infants, and members of the public… ' (Anderson, 1987: 33), and quite at odds with the level of formality that is often seen in the coroner's court today (see section 7.2). Nonetheless, the importance of coroners at the time as 'magistrates of the poor' (Sim and Ward, 1994; Thomas, et al., 2014) is well–illustrated by further consideration of the Victorian coroner, Thomas Wakley (see section 4.2). In investigating the death in the workhouse of one James Lisney in November 1840, Wakley's remarks to the jury upon opening the inquest demonstrate the increasing importance placed not only on the investigation into death, but also the safeguards it provided those who were not in positions of power (see figure 8 for an artist's impression of a Wakley inquest). Despite accepting that Lisney had died from diabetes, his daughter maintained that his death had been expedited by the damp conditions he faced on being confined for impertinence within the workhouse, with Wakley pronouncing that:

> … the allegation of the daughter was of a very serious import; and it is quite clear that, if allegations of this kind get forth without inquiries being instituted, and investigations too, somewhat of a searching nature, the poor would very soon believe, whether rightly or

> wrongly, that the inquest afforded them no protection whatever. (Sim and Ward, 1994: 251)

Figure 8. An artist's impression of a Thomas Wakley inquest[8] (Sharp, 2012)



In this way it has been suggested that the office of coroner was 'a very peculiar one' which stood 'between all persons in authority and the people' (Sim and Ward, 1994: 250). Thus, despite continued attempts by Magistrates to limit coronial powers – including the attempted abolition of the role in 1851 – to purely medical–administrative concerns, and after several centuries as 'a rather unimportant appendage of the criminal law' (Sim and Ward, 1994: 245), efforts by the likes of Wakley and others began to pay off. These 'others' included strong support for the coroner's role from the first statistical head of the Registrar–General's Office, William Farr[9], who articulated the public health role of the coroner in investigating death quite aside from his criminal interests:

> … the principal utility of the inquest is the security which it affords the public mind; and its tendency to prevent crime, by convincing the evil–minded that murder cannot be committed with any chance of impunity. But inquests, in which the 'cause of death' is not

[8] It is suggested that the figure with his arms folded to Wakley's left is Charles Dickens, who was a juryman at a Wakley inquest around the year 1840 (Sharp, 2012).
[9] Farr was head of the General Registrar's Office from 1837 to 1880.

> inquired into, can neither inspire criminals with dread, nor the public with confidence. (Farr, 1841: 95–96)

Coroners had thus began to carve out a more formalised role for themselves, and, the inauguration in 1846 of the Coroners' Society of England and Wales, led by Sergeant William Payne, the then HM Coroner for Southwark and the City of London (The Coroners' Society of England and Wales, No date), further supported this. However, despite the inception of the Society standing to promote regulation and the uniformity of practice, fewer than fifty per cent of coroners had taken membership of it some forty–seven years later, leading Anderson (1987: 17) to suggest that many of them '… remained quite unaffected by the growth of professionalism within their own body… '.

Then, in 1860, the County Coroners Act allowed coroners to collect a salary rather than be paid fees, with rules worked out regarding which deaths should be reported to coroners by police constables, and some county regulations including the provision that coroners should be notified of all sudden deaths (Anderson, 1987). Furthermore, a Parliamentary Select Committee report on coroners in the same year, recommended the formalisation of the jurisdiction of a coroner in investigating all cases of violent or unnatural death, sudden death where the cause was unknown, and any death which, while appearing natural, was accompanied by the reasonable suspicion of a criminal act (Knapman and Power, 1985). As suggested by the then Registrar–General – William Farr – coroners were important:

> … for the denunciation of the guilty, for the comfort of the innocent, and for the information of the public, who should be taught the nature and the extent of the dangers by which they are surrounded: for some of those dangers they will learn to avoid, and many of them can be diminished or entirely removed. (Farr, 1856: 198)

Since an inquest began with an unexplained death, and its purpose was to settle on an explanation which was satisfactory, its format continued to be investigative rather than adversarial, using information that was often passed on by the local community (Burney, 2000), very much in line with its medieval origins. This widening of a coroner's jurisdiction from only

inquiring into sudden deaths where there was manifest evidence of violence to hearing inquests on all sudden deaths meant that informally, inquest numbers increased discernibly after the 1860 Act. Despite this, the Committee's recommendations were not implemented statutorily until 1887, when the Coroners Act of that year – a 'watershed' in the development of the office of coroner (Knapman and Power, 1985) – made significant legislative changes to the coroner's remit. This confirmed a change in emphasis from protecting the Crown's financial interests to investigating the circumstances surrounding, and the cause of, a death for the benefit of the whole community. Throughout this time, the duty of the coroner's jury to name the person who they had found to be culpable for murder, manslaughter or infanticide in the inquest verdict, continued, making the inquest: '… something of an appendage of the criminal law, dealing with the very issues of liability and blame that were subsequently deemed to be beyond its province.' (Thomas, et al., 2014: 15–16)

A year after the implementation of the 1887 Coroner Act, the Local Government Act 1888 transferred the appointment and salary of coroners to local authorities, thus creating coroners independent from the central State who began to record instances where death was deemed to have resulted from neglect or failure by the State, particularly with regards to prison death. At the same time, permanent coroners' court rooms began to be provided in cities by local authorities, with rooms within institutions such as working men's clubs and village halls being booked in smaller towns. This undoubtedly played a part in augmenting the role from the satirical depths seen in popular fiction at the time; the coroner in 'Bleak House' '… frequents more public–houses than any man alive' (Dickens, 2003: 102) we are told. However, as Anderson (1987: 15) suggests, while there was a remodelling of English administration throughout the 1800s, '… there was no revolution in government, and the traditional English reliance upon the initiative, responsibility, and the money of local officers, corporate bodies, and even private individuals persisted everywhere'. Hence, coronial practice continued to be idiosyncratically administered into the twentieth century, continuing the piecemeal development of the coronial system that had preceded it. The new Act conferred coroners'

appointments on local authorities, but many were in pre–existing posts which had never been appointed or approved centrally, and the role itself required no professional qualification, thereby leading to the continued autonomy of the office:

> Even as late as 1911 the diversity of practice between the eight London coroners was a constant annoyance to the tidy bureaucrats of the London County Council. It was thus always probable that when a particular set of tendencies was strong in one coroner's jurisdiction, those operating within his neighbours' areas would be very different… however much administrative or socio–economic similarities in similar kinds of places or within a single region might promote similar patterns of under– or over–registration, these patterns were always likely to be disrupted by an individual coroner's personal interpretation of this office. (Anderson, 1987: 18)

This is arguably a feature that very much continues to this day, with the contemporary system still existing as a network of independent coroners which some see as fundamental to the role – '… an important safeguard for society' (Dorries, 2014: 2) – rather than a centralised system acting as a unified whole, and this is something discussed in the following section.

4.3 Moves toward a contemporary system

The recognition in the early 1900s of sufficient development within the police to enable their competence in handling the investigation of homicides (Dorries, 2014; Knapman and Power, 1985) saw the Coroners (Amendment) Act 1926 set this in statute. Coroners were now obliged to adjourn an inquest where a criminal charge had been made until after the proceedings had been concluded, indicating a further demarcation away from the coroner's original role (Thomas, et al., 2014). Other changes brought about by the Act included: the empowerment of coroners to order a post–mortem without having to proceed to inquest where a death was found to be by natural causes; the requirement for new coroners to be medically or legally qualified with qualification gained not less than five years prior to appointment; and the power for coroners to sit without a jury in cases of suicide. The abolition of the coroner's power to commit to trial following the determination by police of a charge of murder, manslaughter or

infanticide – a link between criminal proceedings and the coronial system which was by this time 'widely regarded as anomalous' (Matthews and Foreman, 1993: 7) – was recommended by a committee into Coroner's Law and Practice in 1936 chaired by Lord Wright, the then Master of the Rolls[10]. After asserting their 'unequivocal condemnation' of the practice, the committee findings illustrate a recognition – even at that later time – of the bifurcate position of the coroner, explaining that:

> It believes that the root of the trouble lies in Section 4(3) of the Coroners Act, 1887, which requires the jury, if they find that the deceased died by murder or manslaughter, to name the persons responsible. The coroner now faces a well–nigh insoluble problem: on the one hand the law seems to oblige him to press to the utmost limit the examination of a suspected person, and on the other hand he desires to treat the suspect fairly according to the rules of common law. If this provision of the statute is abolished then in the few cases where the police, in spite of rigorous investigation, have not seen fit to arrest anyone, the coroner will no longer have to ask the jury to fix the guilt on any particular person, nor will anyone be charged on the coroner's inquisition. The Committee adds that where there is a suspicion of murder, but not enough to justify a charge against an individual, the legal rules of evidence should be strictly observed. If a person is suspected he should not be put on oath unless he desires to give evidence; if he gives evidence the questions addressed to him should be directed simply to eliciting his statement, and he should not be cross–examined on the consistency of his evidence with that of other witnesses. (Wright, 1936: no page number)

Despite this recommendation by the Wright Committee of the abrogation of the coronial court's power to make such judgements – which had the effect of committing the accused to trial at the Court of Assizes in medieval times and later the Crown Court – and in line with the coroner's early role as a kind of feudal police officer (Cooper, 2011; Matthews and Foreman, 1993), it continued until 1977 when it was finally abolished as part of the Criminal Law Act of that year. However, the criticisms put forward by the Wright Committee laid the foundations for a number

[10] The Master of the Rolls is the Head of Civil Justice and the second most senior judge (after the Lord Chief Justice) in England and Wales.

of important pieces of secondary legislation in the form of 'Coroners Rules' (emplaced in 1953 and amended in 1984). Indeed, clause 42 of the Coroners Rules specifically provides that: 'No verdict shall be framed in such a way as to appear to determine any question of— (a) criminal liability on the part of a named person, or (b) civil liability' (1984: clause 42)[11], with the suggestion that the latter often led to misrepresentations by the coroner on an individual's character or behaviour. The resultant report was thus conspicuous in its change of emphasis away from the utility of the inquest as a means of exposing crimes and – amidst pre–welfare State concerns associated with reputation and good governance rather than the accountability of the State – towards an interest in reducing the reputation–damage that had resulted from some coroner's inquiries (Dorries, 2014; Knapman and Power, 1985; Thomas, et al., 2014).

Following the emplacement of the Coroners' Rules in 1953, another shift in the development of the coronial system was brought about soon afterwards with the evolution of the victims' movement in the context of the criminal Justice System. This would see those directly impacted by sudden death – bereaved families – given more perspicuous consideration by academics and policy–makers alike.

4.4 Recognising the bereaved

The emergence during the 1970s of the victims' movement (see section 2.5) was characterised by a huge increase in the number and variety of victims' groups with a common ideological stance. For some, the enhanced status for victims in the context of the criminal Justice System was part of a wider 'social movement' (Zedner, 2002). However, other scholars, in commenting more on the UK experience of victim's groups as a loose coalition, as opposed to being centrally organised (Byrne, 1997), have questioned this definition: '… victims of crime are difficult to corral into a movement, not least because many types of crime involve only transitory contact with any kind of criminal justice or voluntary agency'. (Williams and Goodman, 2007: 242)

[11] This clause was carried into the most recent legislation governing coroners, the Coroners and Justice Act 2009, which replaced the Coroners Act 1988 and the Coroners Rules 1984.

Regardless of whether it is agreed that a 'social movement' was or is in existence, this 'transitory contact' is very similar to that experienced by those bereaved families who find themselves caught up in the coronial system following a death, and this has been recognised by some. In 1971, for example, the Broderick Committee, chaired by Norman Broderick QC and, following a significant analysis of the coroner's role, highlighted a number of failings in the contemporary coronial system and in so doing provided 'an important commentary on modern inquests' (Thomas, et al., 2014: 22). It was noted in the committee's report that families often suffered through miscommunication, lack of resources and the continuing ill–defined nature of the role of the coroner, including family members feeling unable to ask questions despite it being their legal right to do so. Furthermore, it recommended compulsory legal qualifications for coroners, coronial appointments made by the Lord Chancellor's Office, legal aid for 'Interested Persons'[12], the non–appointment of police officers as Coroners' Officers (see sections 3.5 and 5.4), and the proposal that not all inquests should be accompanied by a jury. It also supported a fundamental recommendation that had been made previously by the 1936 Wright Committee, that the number of serving coroners be reduced. Lord Wright had noted that a large number of part–time coroners with small coronial jurisdictions were consequentially inexperienced in their roles (Dorries, 2014), and it was felt that merging some jurisdictions would remedy this. Thus, the 309 coroners in 1936 reduced to 254 in 1962, further again to 144 in 1998, and stand at 97[13] according to the most recent guidance (Dorries, 2014; Ministry of Justice, 2018a).

Such changes to coroners' territorial jurisdictions were to continue the year after the Broderick report, when local government bodies were abolished in favour of metropolitan counties, through the Local Government Act 1972. As coroners became 'county' coroners, appointed by the new county authorities, a number of redundancies ensued and the opportunity for the rearrangement of coronerships – with coroners now presiding over a number of districts within a county – presented itself (Knapman and Power, 1985; Thurston, 1980). However, the impact

[12] 'Interested Person' is a legal term for those who are deemed to have an interest in the inquest. See section 4.5 for further discussion.
[13] Figure includes Area Coroners, Senior Coroners and 'Acting' Coroners

of this reorganisation was one of the major difficulties. Given the reduced number of coroners, the continued requirement for them to actually view a body – '… an ancient custom, going back to the origin of the coroner's office' (Knapman and Power, 1985: 14), and the fact of dramatically increasing numbers of reported deaths resulting from a general population explosion over the preceding half a century, meant coroners were struggling to adequately fulfil their roles. As a consequence, the Coroners Act 1980 which, it is said, made only one significant change to the work of the coroner, and it abolished the requirement for coroners to view bodies *in situ* (Dorries, 2014; Thurston, 1980).

It is interesting to note that the coronial system, despite the merging of jurisdictions, the difficulties with resourcing, and the view of its organisation as 'archaic' (Falconer and Harman, 2006; Pitman, 2012), was one of only a few public services to escape the increasing centralisation of government under the authority of Margaret Thatcher during the 1980s, and it continues to do so, something which is considered further below. At a time when 'consumer–citizenship' (Clarke, et al., 2007; Coalter, 1990; Needham, 2007) was the focus of increasing debate academically and politically, the notion that – as 'users' of public services – the public has a choice, and exercises that choice, was emerging as a key element of Thatcherite anti–welfarism (Clarke, et al., 2007). Thus:

> Choice was identified as the defining characteristic of the consumer's relation to public services and had a complex relationship to marketizing processes. The 'right to buy' in housing dissolved (partially) the distinction between the public and private sector, and shifted public resources (at a subsidised price) into private ownership. Choice in schooling gave parents (as the proxy consumers of education) the non–cash mediated right to choose schools for their children. (Clarke, et al., 2007: 31)

Yet, for Needham (2007: 86) – and in the context of the Justice System – those involved in the services around law and order were often 'unwilling consumers', but this did not stop the State announcing their intention to apply the same ideals to users of the Criminal Justice System. Following the Conservative John Major government which further propagated notions of

consumer–citizenship through his 'citizen's charters', a speech by Tony Blair (2001) outlined that: 'The key to reform is re–designing the system round the user – the patient, the pupil, the passenger, the victim of crime'. Indeed, for Rock (2004: 147), such a change in focus was welcome:

> What Power called 'a technology of mistrust' had, on paper, edged political confidence away from officials and towards a greater confidence in customers, the consumer–victims, and, I and many of the principals in this history (the then officials of the Justice and Victims Unit and Victim Support above all) might add, pleasing victims was no bad thing in its own right.

However, it appears that the coronial system – as a part of the Justice System which was not concerned with the 'victim of crime' – was overlooked, both in terms of centralisation and nationalisation, and as a public service which required, at that time, reforming and moving towards a much more public–focused institution. More than two decades later, this situation led to the following commentary – not dissimilar to many others – on the state of the coronial system:

> Despite the fact that the independence of the coronial service is crucial, particularly where investigations expose governmental failings, coroners are not accountable for decisions. Under an archaic system of devolved funding, salaries and resources are provided by the local authority, the police authority or both, resulting in pronounced geographical inequities. (Pitman, 2012: 2)

For Scraton (1987: 232) at that time, there was a deleterious reason for the perpetuation of this non–accountability: 'Our work establishes that at all levels State institutions are reluctant to operate mechanisms which make their regimes and practices properly accountable'. For others, however, it was a financial consideration, as put forward in the next important piece of commentary on the coronial system, the 'fundamental review' into death certification and investigation which took place in 2003 and was chaired by Tom Luce, former Head of Social Care Policy Department of Health.

This commentary was another orientation towards the plight of the bereaved in the context of the rise of victims' rights. Thirty years earlier, and despite being critical of the coronial system, the 1971 Broderick Report had asserted that the public were generally satisfied with the system as it stood at that time. The Luce Report was now not only acknowledging that little progress had been made in response to either the Wright Committee or the Broderick Committee reports, but also identified 'serious neglect' within the systems of death and coronial investigation. Indeed, a number of high–profile cases increased public scrutiny of the coronial and death certification systems, including: the murders of 250 patients over a 25–year period by GP Harold Shipman resulting in his murder conviction in 2000[14]; the Hillsborough football stadium disaster in 1989 when 96 people were crushed to death during a football match[15]; and the collision of the Marchioness and Bowbelle boats on the River Thames in the same year, when 51 people died[16]. Such cases were deemed to illustrate inadequate protection against malpractice as well as raising significant issues about the role and practice of coroners (Luce, 2003; Luce, 2010; Smith, 2003).

Within the Luce Report, a number of 'critical defects' were identified which were directly pertinent to bereaved families, including: a lack of supervisory structures within the coronial service resulting in a lack of leadership, accountability or quality assurance; a lack of clear participation rights and set standards for treatment and support for bereaved families; the lack of sustained and consistent training of coroners and Coroners' Officers, as well as unsatisfactory levels of skill required to work with bereaved families; and a lack of full–time dedicated service leadership in most localities or nationally. Thus, in submitting its report, the Luce committee concluded that two changes were essential: first, the restoration of public confidence in the process of death certification; and second, the need 'to improve the response of the coroner service to families' (Luce, 2003: 3).

[14] 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated, by The Right Reverend James Jones, KBE, November 2017
[15] The Shipman Inquiry: Third Report: Death Certification and the Investigation of Deaths by Coroners, by Dame Janet Smith, July 2003
[16] Public Inquiry into the Identification of Victims following Major Transport Accidents, by Lord Justice Clarke, March 2001.

Recommendations for change within the systems of death certification and coronial processes were made which included: an obligation on coroners to continue to account factually for the cause and circumstances of a death together with the highlighting of any systemic failings which – had they not existed – might have prevented it; an amalgamation of coroner districts which would therefore reduce in number and become 'coroner areas'; an obligation on the relevant coroner's office to make contact as quickly as possible with the nearest relative of the person who had died regarding the body location; and clarifications on the arrangements for viewing, investigating and releasing the body. In addition, it recommended that all coroner areas should make arrangements to provide families with practical support to guide them through the inquest process – either through their own staff or voluntary bodies – and issue a Family Charter which they would be obliged to follow to the maximum extent practicable, covering the provision of essential and timely information to families, about rights, processes and practical help. Finally, it was written that the inquest should so far as possible be conducted in a style that is accessible to 'unrepresented lay people' (Luce, 2003: 148). This guidance, issued in the very early part of the twenty–first century, is demonstrative of the slow progress made by the victims' movement which, as outlined above, had emerged some thirty years earlier. Such a 'lag' was seen in equal measure in the Criminal Justice System, with reviews published as late as 2011 highlighting the inadequacy of a system which '… adds to the pain of traumatic bereavement' (Casey, 2011: 32).

In addition to Luce's review and report, a report entitled 'Reform of the coroners' system and death certification' carried out by the House of Commons Constitutional Affairs Committee in 2006 (18 July 2006, HC902–1), detailed a number of written submissions it had received referring to cases in which the bereaved had received poor treatment and service. It also set out views from other interested parties, including survivor group INQUEST, Dame Janet Smith in her capacity as chair of the Shipman Inquiry, and Tom Luce as Chair of the Luce Review. The report accepted the Luce committee's recommendation for a charter for bereaved people –

which later materialised in the form of the current 'Guide to Coroner Services' – with the following caveat:

> We welcome the Government's draft Charter for Bereaved People. However, we note that the raised expectations of the bereaved may lead to severe disappointment in circumstances where serious under–resourcing and, therefore, variable standards in service are likely to persist as a result of inadequate funding for reform of the coronial system. (House of Commons Constitutional Affairs Committee, 2006: 53)

In addition, the report went on to make a number of recommendations which centred around the adoption of a National Coroners' Service, and while it acknowledged that this would substantially increase the cost associated with the service, it was warned that '… the failure to introduce one will mean that the current inequalities of resource will continue' (House of Commons Constitutional Affairs Committee, 2006: 63).

Many of the recommendations put forward in the Luce report were adopted within the legislation that informs current day practice and procedure, namely the Coroners Act 2009 (and Coroners Rules 2013) which provides renewed and updated statute previously contained within the Coroners Act 1988 and Coroners Rules 1984.

Specifically, significant changes included the appointment of the first Chief Coroner of England and Wales, whose role was created to implement the new Act and provide leadership to coroners across coroner areas, as well as terminological changes ('verdicts' become 'conclusions' for example). Another of the Act's provisions was the continued alteration of the boundaries of coroner areas to enable fewer, larger, jurisdictions to come into effect. Thus, in the period between the passing of the 2009 Act and its implementation in July 2013, the number of coroner areas reduced from 110 to 88, with the Chief Coroner laying out the advantages of these mergers: 'Not only does it lead to areas of similar size throughout England & Wales, but it helps in achieving greater consistency of approach to issues' (Ministry of Justice, 2018a: 9).

As a consequence, and according to the Ministry of Justice, the purpose of the 2009 Act was threefold:

> The primary aims of these reforms are to put the needs of bereaved people at the heart of the coroner system, for coroner services to continue to be delivered locally but within a new national framework of standards and with national leadership, and for a more efficient system of investigations and inquests. (Ministry of Justice, 2013b: 4)

On the face of it, then, the new Act brought with it an acknowledgement of, and implementation around, citizens' rights within the coronial system which saw it emancipating itself from its long, Crown–based history. However, use of the word 'efficient' by the Ministry of Justice here is interesting. For some commentators the arrival of the 2009 Act did indeed represent '… an end to the frustration of many who worked within the Coronial system that much–needed reform had been advised but never implemented' (Cooper, 2011: 10). For others, however, the new legislation continues to inadequately fulfil its intended and much–awaited role.

One reform that did not go ahead, for example – and despite initially being identified as one of a number of radical new proposals by the then–Home Secretary Blunkett in 2004 – was the nationalisation of the coronial service. Thus, rather than – as had been suggested – being centrally financed and managed both in terms of funding and appointments, the coronial system would remain under local control not only geographically but in every sense. As described in section 4.4, for Luce (2010: 173), the motivation behind this was financial:

> The last Government did not say much about why it abandoned the Blunkett concept of a new integrated coroner and death certification agency, but the reasons are not difficult to guess. The centralization of responsibility for financing an inquisitorial system with large deficiencies and inequalities in standards of accommodation and staffing, and few reliable boundaries to the scale of its future work, would excite hostility in any Whitehall Finance Director.

Moreover, dissatisfaction with this continued localisation of the coronial system remains amongst those who are working within the system, as articulated by the Chief Coroner in his

most recent annual report to the Lord Chancellor. In calling for a national service to combat 'inevitable inconsistencies', the Chief Coroner was explicit in stating that:

> There is much to be gained from such a move in terms of standardisation, consistency and implementation of reform. The operational infrastructure provided by a national service would address, over time, many of the issues about inconsistency of experience by bereaved families; that experience can occur in many situations outside the formality of the court room – for example in the interaction with the processes that follow immediately after a death is reported to the coroner. (Ministry of Justice, 2018a: 7–8)

Others concur with this view. For example, at the same time as recognising improvements to the system, and with reference to the appointment of the Chief Coroner as head of the new system, Hutton (2015) asserts that:

> It is a common mis–conception that he has day–to day direct line–management control of individual coroners… The role and the influence of the Office are clearly still developing but the direction of travel is unambiguously towards standardisation and modernisation of the coronial service. It must not be forgotten, however, that individual coroners retain a degree of autonomy in their work, especially in the exercise of their judicial discretion which can only be challenged in the High Court… Whilst the large majority of coroners are following his lead and recognizing his authority, there is some definite and considerable anecdotal hearsay evidence that for a small number this is not necessarily the case. (Hutton, 2015: 71–77)

Criticism by other commentators has included the lack of independent inspection of the operation of coroners' courts (INQUEST, 2013) and the denunciation of the 'Guide to Coroners Services' publication introduced as an appendage to the Act as a 'missed opportunity' in the support of bereaved families given that they were not consulted on its conception (RoadPeace, 2014).

In summary, a number of reports and pieces of statute have undoubtedly had a substantial and influential impact on the development of the coronial system in more recent times, leading Dorries (2014: 2) to suggest that '… the work of the coroner has changed out of all recognition

over the last 150 years… ' . This in part results from attempts by policymakers to bring it in line with the *Criminal* Justice System in terms of its attendance to victims' needs. Indeed, as Rock (1990: 49) has suggested, the move from the 'Golden Age of the Victim' of crime in medieval times – so–called because victims themselves supervised resolution of their own problems with the support of family and friends – to the usurping of the victim's place by the State, has created a 'history which fired people who sought to promote the victim's cause'. In the context of the coronial system this history is, it can be argued, complicated, as while the development of the system has been shaped by the progressive acknowledgement of the bereaved as a group who – like victims of crime – should be, but often are not, recognised as its central beneficiaries, this has been moderated by the place of the system and its appendages within a heavily influential socio–legal framework anchored in a long and arguably somewhat convoluted history.

What can be seen is that major social changes have led to notable alterations to the coronial system over time, including: a reduction of the coroner's remit to deal only with sudden and non–culpable death; the tightening of the qualifications required of coroners; the publication of statutory guidance for the bereaved; the emplacement of the Chief Coroner to oversee and provide leadership to the service; and moves towards a more centralised national service.

However, despite these changes and policymakers' attempts at reform, the impact of the historicism of the system continues to be prevalent in the system of inquest that we see today. The next section looks at the contemporary system of inquest, which exists as an inquisitorial, investigative forum for categorising death.

4.5 The inquest today

> The form and procedures of inquests have been analysed to reveal a litany of deficiencies that ultimately compromise the inquest's value as a truth–seeking exercise, leaving researchers underwhelmed, the truth degraded, and the bereaved denied justice. (Scott Bray and Martin, 2016b: 104)

An inquest today is a public inquiry overseen by a judge in the form of a coroner, in a coroner's court, the purpose of which is to discover who, where, when and how a person died. A death must be investigated by a coroner if: the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in prison, police custody or otherwise in State detention such as an immigration centre or while detailed under the Mental Health Act 1983.

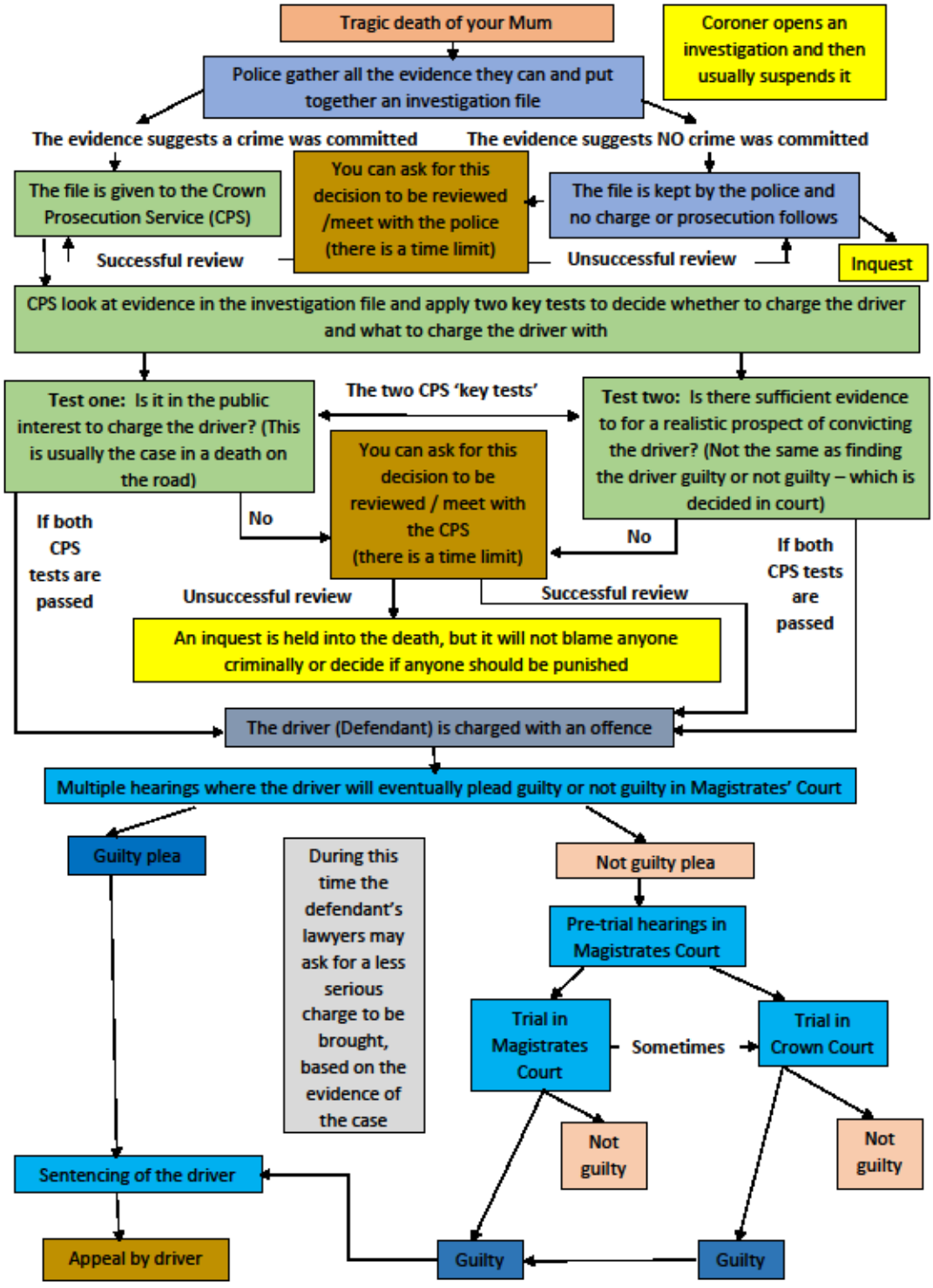
4.5.1 As part of the Justice System

As was the case historically and as detailed above, the coronial system, as an 'inquisitorial court of record' (Thomas, et al., 2014: 15), continues to sit apart from the unified court system in England and Wales, being funded and resourced by local authorities. New coroner appointments are also undertaken by local authorities, although these are overseen, and must be approved by, both the Chief Coroner and the Lord Chancellor. In terms of coroners themselves, The Coroners and Justice Act 2009 set out new requirements regarding the qualifications of newly appointed coroners, who must now be legally qualified (as opposed to legally *or* medically qualified as previously) for a minimum of five years post–qualification.

Figure 9 shows an infographic which is provided to families by Brake (2016), illustrating how the contemporary coronial investigation process sits alongside the Criminal Justice System, to help them understand and navigate the process. It is important to note the complexity of this diagram, which has been developed by those who work for Brake and is indicative of how perplexing and difficult to navigate the system can be for families.

Meanwhile, the 'Guide to Coroner Services' publication which is aimed at bereaved families is designed to explain and advise the bereaved with regards to the coronial system, answering such questions as 'what do coroners do?', 'what is a post–mortem examination?' and 'will I need to speak at an inquest?' amongst many others. However, a note on the very first page of the guide, which was made available to families in 2014, reads very much like a disclaimer, in immediately explaining – presumably for the benefit of the bereaved who might dislike the word – that 'unique' does not equate to 'ordinary':

Figure 9. Overview of the coronial investigation process as part of the Justice System in England and Wales



(Brake, 2016)

> Please be aware that in most legal situations a person who has died is referred to as the deceased. This convention has been used in this booklet. Coroners and their staff understand that the person who has died was a unique individual. (Ministry of Justice, 2014)

In addition to this document, and aside from the numerous 'Guidance notes' published by the Chief Coroner's office, the Ministry of Justice publishes two main annual reports associated with the work of the coronial system. The first, 'Coroners Statistics', includes information on the number of deaths reported to coroners, how many *post–mortem* examinations have been conducted, the number of inquests held during the year, and a breakdown of short–form conclusions – or official 'death categories' – reported. The statistical tables which accompany this report are numerous and detailed and contain a vast amount of information. The second document, the 'Coroners Statistics Guide' for the relevant year, is designed to be read in conjunction with the report. It provides a more detailed overview of the functions of coroners and the Chief Coroner, policy background and changes, statistical revision policies, and data sources and quality.

Furthermore, the Courts and Tribunals Judiciary website provides extensive information on 'The Justice System', including a section on coroners. It also carries a link to the Coroners' Society of England and Wales. Complaints on a coroner's behaviour, language or conduct are dealt with by the Judicial Conduct Investigations Office (something which is discussed in more detail in section 7.2).

As part of a coronial investigation, a coroner decides whether a post–mortem is necessary and orders such an examination to take place. Following this, and if a person is deemed to have, in fact, died from 'natural causes', a coroner will rule as such and the family may register the death. However, if a death is found to be due to unnatural causes, or the cause of death cannot be determined, a coroner must go forward and hold an inquest, and depending on the circumstances surrounding it, a jury may be involved. The Coroners and Justice Act 2009 sets out that a death must be held with a jury if the senior coroner has reason to suspect that:

> (a) that the deceased died while in custody or otherwise in State detention, and that either—
>
> (i) the death was a violent or unnatural one, or
>
> (ii) the cause of death is unknown,
>
> (b) that the death resulted from an act or omission of—
>
> (i) a police officer, or
>
> (ii) a member of a service police force, in the purported execution of the officer's or member's duty as such, or
>
> (c) that the death was caused by a notifiable accident, poisoning or disease.
>
> (Coroners and Justice Act, 2009: 4)

In 2018, only 1 per cent of inquests were conducted with a jury (Ministry of Justice, 2018b).

An inquest must be formally opened as soon as possible after a death has been reported and good practice states that the main inquest should be held within six months (or as soon as is practicable) after the reporting of the death to the coroner (Coroners (Inquests) Rules 2013). Importantly and, in preparing for the inquest, coroners must adhere to the Coroners (Inquests) Rules 2013 by fully disclosing information pertinent to the investigation to all 'Interested Persons'. An 'Interested Person' as laid down in section 47 of the Coroners and Justice Act 2009, is essentially a person who has a right to active participation in inquest proceedings, either by virtue of their relationship to the deceased, because they were somehow involved in the circumstances of the death, or because the coroner deems them to have 'sufficient interest'. Bereaved families *should* therefore fall under this heading, although as the proceeding chapters illustrate, this is not always the case – a finding considered further in section 5.3. In this way bereaved families *and* drivers can be 'Interested Persons' from the perspective of the State.

Interested Persons are entitled to the disclosure of material held by the coroner where the coroner feels it is relevant to the investigation, and this includes post–mortem reports, recordings of any or all inquest hearings, and any other report or document that has been provided to the coroner during the course of the investigation (Coroners (Inquests) Rules 2013).

As part of this requirement other parties who form part of the investigation, such as the police and other bodies including the prison service, are compelled to provide germane detail to the coroner.

At the end of an inquest hearing, a coroner completes a 'Record of Inquest Form' (see Appendix 3), which many coroners refer to at the start of the hearing, explaining that the form is a legal requirement which sets out: the name of the deceased; the medical cause of death; how, when, where and in what circumstances the person died; the coroner's conclusion; and further administrative particulars such as address and birth details.

4.5.2 A 'hybrid' system of law

It is important to reiterate here that the contemporary inquest is completely removed from either the criminal or the civil courts in terms of decisions on guilt or liability. As a non–adversarial, inquisitorial system, the inquest is structured more in the form of an inquiry, without the presence of the prosecuting and defending parties seen in the adversarial system. The evolution of both systems as borne more out of tradition than any kind of systematic review of the effectiveness of one system over another makes their comparison difficult. Indeed it has been suggested that any attempt at doing so is akin to 'comparing apples and pears' (Nijboer, 1997: 84; Ryan, 2003). In an inquisitorial system, the judge takes a more active, guiding role in terms of requesting evidence that the court requires in order to establish the 'facts' of the case (Parisi, 2002). The system is built on the premise that the 'truth' must be sought, whereas in the adversarial system, the philosophy is that the 'facts' and hence justice will emerge if the scope is limited to the ability of the prosecution to *prove* the accusation it has made, having heard the evidence set out by both parties (Cooper, 2011; Ryan, 2003).

The commentary on what designates truth in the courtroom is complex. Scholars disagree on the nature of truth within the adversarial system alone, quite apart from the very different truths that it is suggested exist in the inquisitorial system. King (2001) discusses the issue at length, suggesting that there is an acceptance of a more pragmatic, compromised truth in the adversarial

court room. This does not suggest an apathy towards finding out what really occurred, he maintains, but a description of the events is accompanied by the subordination of telling the complete story. As such, it is accepted that within the adversarial system:

> … clear evidence of the defendant's guilt should be suppressed if illegally obtained… a premium is placed on individual rights and deterring the police from interfering with them… society must accept that the truth of some matters will be obscured in the name of other competing values. (King, 2001: 189).

The inquisitorial system, on the other hand, in seeking to find what King (2001) calls the 'absolute Truth', resolves to fully account for the event in question. In so doing, the State is not only trusted to fulfil its duty adequately but also argues that it *should* be trusted to do so. Given that trustworthiness is the basis for the social contract that exists between the State and the people in terms of its powers, limitations and obligations (Locke, 1967; Rousseau, 1993), this situation:

> … helps fuel a cycle whereby the State is trusted because it makes itself look trustworthy… it stands to reason that police, judges, and other investigators must be more trusted in inquisitorial systems simply because there is no grand scheme to deter them from malfeasance. (King, 2001: 233–4)

However, in reality and as far as the operation of the coronial court is concerned, it has been noted that the inquest is *de facto* a 'hybrid' system, '… not purely inquisitorial or purely adversarial' (Regina v. Her Majesty's Coroner for the Western District of Somerset (Respondent) and another (Appellant) ex parte Middleton (FC) (Respondent) [2004], paragraph 26) with a variety of rules of process pulling it in either a 'more–adversarial' (the examination of witnesses, potentially by an authorised advocate, who give evidence under oath) or a 'more–inquisitorial' (the coroner calls and examines all witnesses first, on matters bearing no charge or complaint, drawing conclusions in answer to statutory questions) direction. For some, it is precisely this contradistinction which calls into question the efficacy of the system, with Scraton (2016: 98) labelling it 'an adversarial wolf in inquisitorial sheep's clothing'. Far from the

trustworthy body politic to which King (2001) refers, it is suggested we are left with a scenario whereby:

> Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval – rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one. (INQUEST, 2002: 2)

4.5.3 Disputing the 'truth'

In the inquest, the burden of proof that the coroner uses to make a judgement on 'how' a person came by their death, stands as 'on the balance of probabilities' rather than on the standard of 'beyond reasonable doubt' that is required in a criminal court of justice. Furthermore, and given that the inquest is based on a fact–finding premise rather than an attempt to determine liability, it would seem reasonable to assume that representation by legal counsel at such a hearing would be unnecessary. However, even though a coroner is unable to determine or rule on liability for a death, the evidence that is put forward at an inquest *can* be used as part of a criminal or civil proceedings which may come later. For this reason, a coroner may, where he or she feels it appropriate or necessary, warn a witness that they are not obliged to answer any question which might incriminate them (Fairbairn, 2019). Thus, where an inquest involves the death of a person in the care of a State institution such as the police, the National Health Service, or the prison service for example, a barrister advocating for that institution will usually be present. For this reason and because of their skills in dealing with court hearings generally, the most appropriate solicitor to instruct will usually be a criminal defence lawyer.

Although it is the case that a bereaved family is also at liberty to be represented by an advocate at an inquest, the monetary cost of appointing a barrister means this proves very difficult for most individuals. A recent House of Commons briefing paper sets out the 'extremely limited' circumstances under which bereaved families might be entitled to legal representation at an inquest (Lipscombe and McGuinness, 2019). It makes a distinction between 'Legal Help' –

that is, legal assistance which can be sought by bereaved families who qualify financially to assist them in the *run–up* to an inquest through the provision of funds for legal advice and preparation – and 'Legal Representation' by a lawyer at an inquest itself. Exceptions to this are outlined in the 'Lord Chancellor's Exceptional Funding Guidance (Inquests)' and occur in one of only two exceptional circumstances:

> - Where representation is necessary for an effective investigation into the death, as required by Article 2 of the European Convention on Human Rights; or
> - Where the Director of Legal Aid Casework has made a 'wider public interest' determination that the provision of advocacy for the bereaved family at the inquest is likely to produce significant benefits for a wider class of people.
>
> (Lipscombe and McGuinness, 2019)

It is more unusual, given the rarity of the involvement of a State institution in a road death, that barristers are present in inquests which deal with road collisions. However, it does happen where families feel either that the State is working *against* as opposed to for them, whereby they have developed a mistrust towards the parties – such as the police – who have been involved in the investigation, or where they feel either unable or unwilling to speak for themselves at a hearing. In circumstances such as these and regardless of whether the concerns of the bereaved have foundation, their access to justice given both the statue detailed above and the – often preclusive – monetary cost of appointing legal counsel, is reduced, and these are issues which are further considered in section 7.3.

4.5.4 Human Rights

The applicability of Human Rights issues to the coronial system arose out of incorporation of aspects of the European Convention on Human Rights ('ECHR') into UK domestic law via the Human Rights Act 1988. Human Rights law is detailed and, at times, arduous, and the intention here is not to provide an intricate explanation of the relevant statute – which can be found elsewhere (http://www.legislation.gov.uk/ukpga/1998/42/contents). However, it is important

to attend to the salient points given the significant impact that such ruling has had on some inquest proceedings[17].

For example, where there is evidence that the State is responsible for a death – because it occurred in State detention for example – Article 2 of the ECHR imposed a widening of procedural scope to ensure that a perspicuous and independent investigation, which protects not only bereaved families' but societal interests, is carried out. This is often referred to as a 'Middleton' inquest after the case which gave rise to the distinction (Regina v HM Coroner West Somerset and another ex parte Middleton [2004]), and has a number of minimum requirements associated with it including that the inquiry must be independent, effective, reasonably prompt, must involve a jury and must involve the next of kin to an appropriate extent (Thomas, et al., 2014).

An additional coronial function that has Human Rights implications, is the duty on coroners to actively seek to prevent further deaths. As identified in section 4.2, very soon after the inception of the General Register Office in 1837, William Farr as Registrar–General emphasised the importance of the inquest as an opportunity for highlighting any risk to public health or safety. During this period, the inquest arguably sat somewhere between the guises of politically populist forum for openness on the one hand, and mechanism for the progression of medical scientific pathology on the other. Thus, for Burney (2000: 52):

> At the same time that the inquest was being recast as a traditional bulwark of popular liberties, it was being infused with the self–consciously forward–looking ideology of science in the service of a modern social order. A new compound vision of the inquest – as a medically driven tribunal guarding the interest of the people – emerged out of an intense reformist activity during the first half of the nineteenth century…

Despite this early identification of the public safety aspect of the inquest, there would be no formal recognition of, or attempt to systematise, this function, until it was formalised and

[17] It is notable that the current UK Government has advised its intention to repeal UK Human Rights' legislation after the its departure from the European Union.

enshrined within the new Coroners and Justice Act in 2009. At this point, the 'Prevention of similar fatalities' or 'Rule 43' clause in the Coroners Rules 1984 which was a discretionary coronial power, was elevated to primary legislation within the 2009 Act through the adoption of the Prevent Future Deaths (or 'PFD') report. Here, where an investigation is deemed to have revealed a situation where the risk of future deaths – without remedial action – is high, the coroner has a power and a duty to use a PFD report to communicate the matter to a person, organisation, local authority, or government department or agency whom they believe should take such remedial action, and demand a response. All ensuing reports are published by the Chief Coroner on the judiciary website and 'Through this route the reports are made public and accessible to all who may have an interest in them' (Ministry of Justice, 2018a: 18).

Although PFDs were not a direct consequence of Human Rights Legislation, it can be argued that they stemmed from a desire to tick Human Rights boxes. In an explicit display of Foucauldian reasoning, Article 2 of the European Convention on Human Rights requires that not only does the State have a (positive) duty to refrain from *taking* life, but it also has a (negative) duty to *protect* it. While this increased importance in the function of the inquest investigation in preventing future deaths has been welcomed by commentators such as Thomas, et al. (2014) as '… something to be applauded' because 'It gives an inquest, among legal proceedings, a uniquely constructive aspect' (p. 369), it raises an exigent question not only about the issues these PFD reports are raising, but also how the case of road death fits in. Considering the hegemony of the car alluded to in the introduction, how far is – or indeed should – road death be prevented by the State?

This is something of a moot point since, unfortunately, Government records make it impossible to calculate the proportion of total PFDs which relate to road death. However, what is known is that the number of PFDs related to road death is low when compared to other short–form conclusion categories, and this was acknowledged by the Chief Coroner in our interview:

> … I suspect if you span back if you were able to, over a period of… there's quite a lot of learning that's come out of road deaths, into road safety, road markings, erm driver

> instruction, age at which we let people driver, erm circumstances in which we light our roads, er all of those sorts of things which may be contributory factors. Erm safety design of tyres. You know all of that. So there may be, a limited amount that a coroner feels, could be, erm, directed to changing any of that. I mean if a death has come about through an accident, and it's no more than a human failing or some other, issue then you may say well actually what, regulation 28 report—what possible, thing could there be to prevent future death? (Chief Coroner)

Attempting to prevent future deaths by raising issues with the likes of prison heads, care home managers, and those involved in the provision of mental health service services for example, is surely necessary and judicious. If lessons can be learned and changes made to help ensure that people do not succumb to the failings of such organisations, they should be. However, when it comes to death on the roads when such a death is deemed to be 'accidental', especially where the cause of the fatal event is deemed to be due to human error or oversight, this does not fit easily within the realms of the inquest and this aspect of its Human Rights function, nor with our Lockean contracts with the State.

An additional reason why the Human Rights function of coroners is important here, is due to the invocation of another of its articles, that of 'the right to respect for private and family life' (Article 8). This article provides that there shall be 'no interference by a public authority within the exercise of this right' (Council of Europe, 1950). Some commentators note simply that the inquest represents State intrusion into what should be a private family matter, and as such, is entirely at odds with Article 8 on the basis that it conflicts with this right to privacy. Since grief falls within a most 'intimate part of an individual's private life', there logically should be an exceptional case for interference by the State in a family's experience (Pounder, 1999; Thomas, et al., 2014). Yet the practice is continued – albeit with the incorporation of *ad hoc* reform as detailed above. This is because the need to establish a cause of death for *all* deaths, appears to override this. Indeed, as suggested by Palmer (2012), the cause of death in many other countries throughout the world troubles few, since heat dictates that burial of a body may take place on

the same day as death, and there will often be no post–mortem and little, if any, forensic investigation. Whereas for centuries:

> … England has wanted a say in the means by which you come by your death. 'They' (officialdom) want to know what you died of and to list and categorize it, for a variety of purposes. They require a pathological cause of death, not just a mode of dying. (Palmer, 2012: 67)

Furthermore, when these two aspects of Human Rights law in the context of the coronial system – low numbers of PFDs and 'no interference by a public authority…' – are combined, the dichotomy around dealing with non–culpable road death through the inquest is further highlighted. The State involves itself in the death, possibly to the detriment of those bereaved by it, investigating *how* it happened, but not *why*. Implicit in this is the acceptance that nothing can – or should? – be done to avoid such deaths in the future, particularly given the knowledge that 'Around two–thirds of crashes in which people are killed or injured occur on roads with a speed limit of 30 mph or less' (Royal Society for the Prevention of Accidents, 2018: 1). It is a dichotomy which is fundamental to our understanding of how the inquest system impacts those that encounter it and whether it – justifiably, or not – impinges upon the emotions of those caught up in it.

4.6 Conclusion: the hybridisation of justice

> … it is taken as given that members of the highest group have the right to define the way things are (Becker, 1967: 241)

The coronial system investigates without apportioning blame, setting itself up to establish the 'truth' of how a person died in order to categorise, commit to record and ultimately register a sudden death. However, as a medico–legal procedure which originated in medieval times and for a long time saw the coroner as an arbiter of *criminal* justice to some degree as well as State accountant, it has been suggested that the inquest of the past was regularly a frustrating process for the bereaved, who suffered from the State need to legitimise a death (Dorries, 2014).

Various attempts at reform have sought to improve this situation. Indeed, a 1910 Select Committee and, the first appointed to publicly examine coronial issues since the 1887 Act – but one of several which failed to engender much in the way of reform (Palmer, 2012) – commented that coronial law was not only antiquated but largely obsolete and expressed astonishment at the amount of 'good work' that had been done by coroners in spite of it. Despite being over a century old, it has been suggested that this comment is as relevant today as when it was made (Palmer, 2012), and critics continue to speak of the significant deficiencies which remain within the system such as the purported lack of consistency across coroner areas, inequalities due to coroners' personal interpretation of – and independence within – the office, and the diminished access to justice that is at odds with 'putting the bereaved at the heart of the system'. Indeed, even though the implementation of the role of Chief Coroner has been welcomed by many (Hutton, 2015) it is recognised by an equal number that there remains a great deal of work to be done.

In addition, findings from analysis of the data show that problems result from the fact that the bereaved see the two concepts of truth and justice as linked in the context of the coroner's court. Given that the inquest exists as part of the *Justice System* within England and Wales, the bereaved – in expectation of some sort of moral response to their loss – bring the weight of their expectation to bear in the lead up to, and at, the hearing itself. In addition, the 'no blame' convention of the coroner's court is a practice which commentators have suggested can cause great difficulty for bereaved families (Calthorpe and Choong, 2004: 148) who do not understand or accept the fact that their loss was 'unavoidable'.

These difficulties with the function and process of the coronial system, and its potential impact on the emotions of bereaved families, are at the forefront of this research. Through analysis of the opinion, sentiment and views of those who experience it first–hand, as well as those who administer the coronial process, the question of whether, in the case of fatal road collision, the contemporary coronial system serves as a 'political technology' by the State, is examined. In other words, does the State legitimise non–culpable road death by using the inquest to

investigate, categorise and register such a death without addressing the question of whether the death is socially tolerable, particularly given the small numbers of Prevent Future Deaths reports which are issued with regards to road collisions? By making such a loss ancillary to the usefulness and social desirability of high–speed transport, not only does the State serve to protect its own interests, but concurrently it requires the bereaved to forego their sense of expectation and entitlement to recognition and moral recompense. Furthermore, while the most recent legislation concerning coroners has sought to make reforms to the coronial *system*, what the 2009 Coroners Act does not look to do is set out in statute what the demeanour and manner of a coroner should be. Often, the language, tone and general comportment of a coroner and his staff are equally, if not more important than the actual words spoken in an inquest hearing (Biddle, 2003), and this is something considered in more detail in chapters 6 and 7.

The following chapter is the first of three analytical chapters which draws out the findings with regards to these questions. Dealing first with traumatic loss, chapter 5 looks at the journey taken by the bereaved immediately following receipt of the death news through the following weeks and months. In so doing the reactions of the bereaved families studied are detailed, with contemplation given to how they sought to make sense of, and find reasons for, the death. There is also a consideration of their initial dealings with the coronial system, with links made between these interactions and their emotional state, particularly given the non–culpable nature of their loss.

5. Traumatic loss and road traffic 'accidents'

As demonstrated in chapter 2, the literature on death is vast. 'Complicated' or 'pathological' grief – so called not only due to its impact on the sufferer but, often, in reference to the type of traumatic event which has caused it – sits as a recognised mental health disorder within current diagnostic texts[18] (American Psychological Association, 2013; World Health Organisation, 2018) and is widely discussed, in particular with reference to those bereaved by violent death such as homicide and suicide (Armour, 2007; Burke and Neimeyer, 2013; Neimeyer and Burke, 2011; Tal, et al., 2017). This chapter looks at how and why families are more likely to experience such 'complicated' grief (Boelen and Prigerson, 2007; Currier, et al., 2006; Stroebe, et al., 2007) when they have lost a family member in a road collision. In so doing, families' journeys from immediate receipt of the death news through the following weeks are considered, highlighting their reactions, asking how the bereaved seek to make sense of, and find reasons for the death, and finally – given the pronouncement of the non–culpable nature of their loss – making explicit connections between their emotional state and their initial dealings with the coronial system.

The findings indicate that in line with the broader literature on bereavement, an unexpected and traumatic loss can have overwhelmingly negative and far–reaching emotional, behavioural, cognitive, social, physiological and financial implications (National Bereavement Alliance, 2017; Tehrani, 2004). From the initial shock of receiving the news, the reaction to the death of a family member in the event of a road collision has consequences that come to bear on people's own mental and physical health as well as their romantic and wider social and familial ties. However, although there was evidence of the familial breakdown referred to in chapter 2 (Cameron and Parkes, 1983; Gilbert, 1997; Guy and Holloway, 2007; Moos, 1995; Riches, 1998), some families' relationships had actually become closer . Much of the reason for such

[18] The Diagnostic and Statistical Manual of Mental Disorders–5 (American Psychiatric Association, 2013) includes diagnostic criteria pertaining to prolonged grief problems – termed Persistent Complex Bereavement Disorder (PCBD) – in the section of the manual devoted to conditions needing further study.
The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD–10), (World Health Organisation, 2016) includes complicated grief within section F43.2 Adjustment disorders.

pervasive aftereffects were the violence involved in the death event itself. The imaginings of the bereaved around the suffering of their family member, together with associated feelings of fear and dismay when seeing the – potentially very damaged and sometimes unrecognisable – body, amplified and intensified their distress. In addition, and contrary to what has been put forward by authors such Shanfield, et al. (1986) and Sanders (1980), while distress was profound in families who lost a child in this circumstance, a person's (older) age at the time of their death did not make the death easier to accept for the bereaved in the data sample.

In moving on from the immediate aftermath of the death, a huge part of the 'grief work' (Freud, 2001; Lindemann, 1994; Stroebe, et al., 2005) undertaken by families centred on frenetic reason–seeking and attempts at meaning–making (Currier, et al., 2006). This included the use of 'tools' in the form of mental explanations which the bereaved created and then articulated, to help them explain the death to themselves and assimilate it into their lives. For example, many declared that the death was better than a continued life left suffering from injury, or that somehow the death was 'meant' to happen. As part of this, the bereaved were seen to spend a great deal of time searching for information about the event – in an attempt at finding the 'truth' about what happened (Parkes, 1986; Rock, 1998; Thiel, 2013) – as well as by undertaking 'internal conversations' (Archer, 2003; Walter, 1996) within their own minds. These conversations saw the bereaved seeking to allocate responsibility to someone or even something for the death, which often included the deceased themselves, in an attempt at somehow repairing the problem of their traumatic loss, and this is borne out in the literature: 'If the injustice seems unlikely to be resolved in reality, however, people restore justice cognitively by re–evaluating the situation in line with their belief in a just world' (Dalbert and Donat, 2015: 489).

Furthermore, throughout the weeks and months following a road death, 'emotion management' (Goffman, 1969; Hochschild, 1979) played no small part in the way that the bereaved presented themselves. Here, expressions of emotion, whether honestly felt or dishonestly portrayed, were a social performance. Indeed, the requirement to control and manage emotion is borne – according to Elias (1983) – of the mechanisms of power and social relationships found

historically in Medieval court society, and which gave some people an advantage over others. This has persisted into contemporary social life, meaning that:

> … affective outbursts are difficult to control and calculate. They reveal the true feelings of the person concerned to a degree that, because not calculated, can be damaging; they hand over trump cards to rivals for favour and prestige. Above all, they are a sign of weakness; and that is the position the court person fears most of all. In this way the competition of court life enforces a curbing of the affects in favour of calculating and finally shaded behaviour in dealing with people. (Elias, 1983: 111)

This observation is highly relevant to the bereaved entering the coronial system who, quite aside from being a group which has suffered traumatic loss and is asked to accept the assault on its collective sentiments as 'unfortunate', is expected to adhere to social 'rules' regarding the handling of its emotion. What was interesting amongst interviewees in the sample, was that despite such times of profound grief and suffering on their part, most of the families interviewed described 'putting a face on' (Valerie, bereaved mother) for the sake of adhering to feelings' convention at some point during the process.

The following sections look in more detail at how and why a death by road collision leads to complicated forms of grief for families. It commences with the initial aftermath of the death, touching on the reason–seeking and grief work undertaken by the bereaved, before looking at how families felt compelled to undertake 'emotion' management – despite their internal emotional worlds having been severely ruptured by the death. Finally, the chapter analyses the decision–making that goes on around the criminality of the collision and the effects on the families at the point at which they met the coronial system.

5.1 Complicated grief

During interviews with families, they described the horror of receiving the news that there had been a road collision and that their family member had died. Bereaved mother Vivien, whose son Anthony was killed when his van entered the opposite carriageway of a minor road into oncoming traffic, described the shock of hearing he was dead as feeling like '… a physical

blow' and this is borne out in the literature (Mastrocinque, et al., 2015; Riches and Dawson, 1996; Sanders, 1980). Despite such initial shock – which was shared by other interviewees – both Janet and Nadia explained how they felt almost discomfited by the calmness they not only displayed but also felt, when the news of the collision was delivered:

> And she said erm, she said 'dad's had an accident' [starts to break down]. And then she couldn't, get, the next word out, and I [starts to cry] she said erm 'and he's died', but she couldn't, she kept saying 'and he's—' [voice is full of emotion and horror] and she couldn't—and I can't, stop thinking of that, and at that point [sniffs], Deborah came along [swallows and sniffs] and I just put my arms around both of them and I—oh God I was so calm! [sounds incredulous], they were just, in bits and, I was just, fine I was, holding it all together. (Janet, bereaved wife)

> … they dropped us at the hospital and there was a, a guy there to meet me, at the door… and erm, took me into a side room and he said 'a consultant will come and speak to you in a minute'… he said [pauses] er '[Jeremy's] had a massive bleed on the brain, it's inoperable and his injuries are unsustainable'. So I knew, he said 'he won't live'… and I just said 'ok can I see him then' and he said 'yeah'. (Nadia, bereaved partner)

This initial composure – seemingly borne out of shock and an inability to acknowledge what had happened – was however a temporary state which, in all cases, gave way to an acute grief that participants found debilitating:

> For 12 month I didn't leave the house. Did not leave the house. Just, wallowing, didn't wanna—didn't wanna do anything. (Gary, bereaved father)

> … dad last time it—he was, trying to, pray at the table and then he just… choked up. And you know he can't even cry because it's so painful… (Naomi, bereaved sister–in–law)

The impact of the loss was pervasive, affecting families not just emotionally, but also taking an enormous and protracted toll physically, mentally, practically and financially (National Bereavement Alliance, 2017; Tehrani, 2004). For Gary and Tania for example, the death of their 12–year–old son Edward when the bicycle he was riding was hit by a car, saw Gary unable to work. They separated as a couple – which caused difficulties for Tania who also had two

older disabled children to care for as well as another son – and they lost their home when the bank repossessed it after fourteen years of mortgage repayments. Gary described a 'living hell' whereby he constantly ruminated on the event and had nightmares about the collision.

Naomi, another interviewee, reported having a run of infections after the loss of her brother–in–law Richard when his Heavy Goods Vehicle drove into the back of another lorry. She complained of constant aching in her back and legs, and blood tests showed her iron levels to be very low, and her husband Phil was prescribed anti–depressants to help him cope with the fact that 'I don't think I go an hour without thinking about it to be honest'. Moreover, Janet, whose husband David lost his life in a head–on–collision when a car travelling in the opposite direction entered his side of the carriageway, explained that her daughter struggled to even get into a car after the loss of her father. Janet explained that because her life was inextricably linked with David's, it would therefore be changed immeasurably by his death:

> … I actually haven't, got any other life. I might do in two years' time… but, I met him at sixteen and that's, that's our life.

This point raises the question of whether and how the age of a person at the time of their sudden and violent death has a bearing on the grief of those who mourn them. Certainly authors suggest that the stage in the lifecycle that has been reached by the deceased is relevant to how the bereaved are able to accept the death ((Dyregrov, et al., 2003; Murphy, et al., 1999; Murphy, et al., 2003; Shanfield and Swain, 1984). This was certainly true for Gary, whose complicated grief (Boelen and Prigerson, 2007; Burke, et al., 2010; Worden, 2018) continued months down the line from his son, Edward's, death:

> … it's an unexpected thing ain't it when, a child dies. We weren't prepared for that, d'you know what I mean? And, I know kids that die like of leukaemia and cancer and what not, I think you've got a little bit of preparance, [sic] you—you're prepared, and an illness is completely different to what happened to Edward. He weren't ill, he had his whole life ahead of him and, for him to be took in such a cruel way…

However, Gary's feeling that Edward's death was somehow 'crueller' because – given his youth – it was untimely, was contradicted by the statements of other participants. For example, Janet explained to me that even though her husband was approaching his seventieth birthday when he died – the same age, coincidentally that her father had passed away – she felt it was 'far too soon', a fact that she felt was ironic given a conversation they had had not long before his death:

> … David had said erm, oh I don't know February time he said 'God I don't wanna be seventy' he said 'but d'you know what' he said 'I'll be quite happy to get there' he said 'all these people keep dying at sixty nine', and you think 'oh God'…

Belinda, the Director of an independent support group for the bereaved, was able to explain why she felt that age at the time of death was irrelevant to the emotional impact on the bereaved:

> … those are the ones that get me actually when people are quite old, quite a lot older, because I think, that person has had such a long life that they, you know that ripple effect in the water they must have touched so many people's lives, and come into contact with so many people, that that will affect a lot of people… you know when most of us—'oh well they had a good long life', well actually that doesn't necessarily make it easier, for somebody. You know if you've been with a partner for 50 or 60 years, how, gut–wrenching is that gonna feel? You know that's you, you've died along with that person… So you know you might be, 70, 80, 90 years old when you die, and yet that's not gonna be any easier really, it's just gonna be different isn't it. And that—for me that's what I've learnt. You know I would've always said 'oh well you know they've had a good life, a good innings' you know we say 'they've had a good innings' you know 'they've had a really long life' er oh that poor 21–year–old absolutely, it's tragic! But it's also tragic for that 80 or 90 year–old, because they've lived that long.

Phil and Naomi said that the magnitude of their grief was so great that they had contemplated ending their own lives after Richard's death, although Phil laughed and appeared embarrassed when Naomi voiced this. According to Keltner and Bonanno (1997), such laughter belies people's attempts to reduce negative emotion, dissociate themselves from distress and elicit a positive response from the social world around them. Phil later explained that their religious

beliefs disallow suicide but there was also a sense that he felt suicide would almost be an overreaction which he should therefore deny:

> Naomi:
>
> … the last four weeks at least I've been, trying to hunt down to get some, counsel—'cause I've realised that—I thought, 'I don't believe I'm still feeling like this' and...we've even thought about ending our lives and stuff haven't we? [completely breaks down]
>
> Phil:
>
> Not that we would [chuckles]
>
> Naomi:
>
> No I know but, it's been, pretty bad.

5.1.1 Changing relationships

Furthermore, several of the bereaved families interviewed described how difficult relations with their families had become when feelings of hostility and anger took the fore. For Nadia, whose partner of five years was killed when his bicycle collided with a bus, her relationship with his family began to break down soon after his death, to the point that when his extended family came to scatter his ashes she was excluded from taking part and. As outlined in the literature review, discord such as this within families has been acknowledged in the literature (Cameron and Parkes, 1983; Guy and Holloway, 2007; Moos, 1995; Riches, 1998). However, there was also evidence in the data of a complete contrast to this pattern of breakdown, which again came from an interview with Naomi and Phil. Early in the process, Phil said that his brother's death – rather than pushing them apart as a family – had actually brought him closer together with his sister, not only through the sharing of grief but also through the creation of stronger bonds borne from a desire to enhance relationships and make the most of 'the time we have left'. He explained that it had made the two of them re–evaluate their assumptions about their own lives and the other people in them:

> She's [Phil's sister] lovely. Tells me she loves me more, these days… I suppose we all are, realising that you know sometimes you take each other for granted… as a family… we're

> kind of appreciating the time we're spending together...We had a song at his funeral 'Tomorrow never comes' and that's what's coming to mind and, we're living, for the moment because tomorrow might never come… there're plans that we have thought of, but we're kind of bringing em forward 'cause we've realised life's short and, you know.

This form of 'bonding' within families is far less recognised in the literature, which has tended to concentrate on the grief reaction of a single surviving family member. Certainly, in the case of Phil and Naomi, the fact that they were able to take solace in the continued relationship with Phil's other sibling, at the same time as adopting a 'life's too short' mentality, enabled them to forge a more positive relationship with her and her partner.

In terms of *why* such an array of emotional responses might arise from an unexpected death, some interviewees were of the view that it was precisely the suddenness of the death that created problems. For example, Family Liaison Officer Nancy suggested that '… they don't know where they've got to start from so, especially if they haven't had a will sometimes that's a bit of a nightmare for some families…'. Similarly, bereaved wife Janet explained that the sudden nature of her husband's death caused practical problems for her. Despite having spoken with each other about their end–of–life wishes, no definitive decisions had been made and as such she was forced to rely on past conversations to give her a lead. For example, deciding whether David should be buried or cremated was difficult because:

> … he [David] said 'whoever has to deal with the situation first, we'll go along with whatever they decide'. And I thought, 'oh yeah that's, yeah that's quite a good idea'. Yeah. But when it came to it, it was still quite hard…

It can be seen that the intense reactions invoked by an unexpected *and* violent or traumatic death are very different, and this has been confirmed by authors including Currier, et al. (2006) and Rando (1996), who suggest that such an event causes us to question our understanding of the world and place within it. The resultant loss of self–identity and control over one's life (Giddens, 1991; Parkes, 1986; Riches and Dawson, 1997) introduces a complex network of emotions that was confirmed by the interviewees in this data sample:

> Oh God I hate this!! [crying, sniffs]. Because it's like, you're out of control, and I'm not used to being out of control. And, I'm fine and I'm fine and I'm fine and then it's just as though, somebody comes up behind you and hits you on the back of the head and you didn't even know they were there and it's—it's like you know it's what people say isn't it it's like a wave dumped over your head [sniffs]. And I hate it. (Janet, bereaved wife)

Even though the fact that a death is unexpected can explain difficulties with such practical issues, it does not explicate the evidentially *less* intense reactions to a death such as that from an acute illness for example. Rather, the reason for the increased level of emotional complexity with road death stems from three main issues described below.

5.1.2 The imaginings of the bereaved

First, with an unexpected and violent death such as that of a person in a road collision, one of the 'complications' for the bereaved in dealing with their grief comes with their imaginings of the suffering that the deceased 'might' have experienced (Goenjian, et al., 1994; Harrington and Sprowl, 2011; Riches, 1998; Scraton, 2016). For instance, it was notable during one inquest observation when a mother who had lost her son in a collision and who had otherwise appeared relatively 'collected' until that point, completely broke down when the position in which his body was found in the car was described. Throughout the interviews, the thought of what the deceased experienced in the final moments before their death loomed large in people's minds:

> … it plays on your mind a bit how bad the accident was. You know and you just—you try not to feel that he suffered but you know that he did… he was trapped in the cab with his legs broke, and they had to cut the cab away to get him out. And then they said because, the cab was actually holding the pressure in his body, once they released it, his blood pressure went down and he, passed out. (Phil, bereaved brother)

Despite the difficulty of their imaginings, the bereaved felt compelled to know as much as they could about what happened to their family member, even though it was often detrimental to them. As Rock (1998: 97) suggests with reference to homicide survivors, there appears to be a

search for comfort through the furtherance of knowledge: 'It was as it matters would become clear if only more were known'.

This provides one explanation as to why studies comparing the grief experienced after an acute versus a chronic illness (Gerber, et al., 1975) find little difference between the two. Although sudden illness–related death disallows anticipatory grief, there is also less room for the imaginings of the bereaved around the suffering of the deceased. This was a key issue for the bereaved who lost family members in the Hillsborough disaster when, after being told at the first inquest that death would have occurred by 3.15pm, rejected and appealed against this information. Thus findings by the Hillsborough Independent Panel (2012: 313) noted that:

> … the restrictions placed by the Coroner on the examination of the evidence presented to the mini–inquests and the presentation of the pathologists' medical opinion as incontrovertible, the imposition of the 3.15pm cut–off severely limited examination of the rescue, evacuation and treatment of those who died.

Certainly, for bereaved brother Phil, the desire to know about his brother's last moments meant that he:

> … didn't do myself no favours the other day you know I was trying to find out information on his wagon. But one of their wagons pulled alongside me in a lorry park. So I asked him, erm what weight he was. He said he's 18 ton. And I said 'how—how much does that weigh unladened?' and he turned to the side and he went, '11 and a half ton'. That's what it weighs with nothing in. Plus the trailer weight and [inaudible 11:34], on top of [name] in seconds and I just—I thought aww.

Janet also explained that when it came to seeing documents and photographs pertaining to the collision scene, and despite knowing they would be distressing, she feared later regret at not seeing them more than any potential consequent distress:

> … I said 'yes' to everything, because I didn't want to, get three/four months down the line and think 'ooh do you know I should've done that, should've had that, should've seen that', so whatever they sa—'d'you want the things out of the car?', 'yes', 'do you want to see the

> photos?', 'yes', 'd'you—?' you know I said, 'yes' to everything because, not that I particularly wanted to see everything, but I wanted to make sure that I hadn't left anything unturned.

Such statements highlight the second complexity associated with the deceased suffering such a violent and traumatic death: the condition of the body.

5.1.3 A damaged body

By its very nature, death by road collision can cause severe physical injury and often horrific damage to a person. Although the State does not exactly 'own' a body after someone has died – in fact a 'no property' principle established by English law dictates that no person is able to claim ownership of a dead body in a proprietary way (Hardcastle, 2009; McEvoy and Conway, 2004) – certain people, such as those who have a duty to bury a deceased person, or hospital staff where the deceased has died within a hospital, may be said to be in lawful possession of it. This stands true where a body is under the jurisdiction of a coroner and furnishes the coroner with the legal *right* to be in possession of a body following a person's death. Thus other people become instrumental in what is actually happening to the deceased after the death event:

> Modern law cannot allow a death not to be rationalised… In post–mortems, scientific examination of the body (often necessitating considerable mutilation) takes precedence over the personal sensibilities of survivors… Those who argue that you can only regain control of dying by doing it at home, or of the funeral by disposing of the body yourself, are near the mark. (Walter, 1994: 11)

In consequence, not only has this loss of control over the body been put forward as potentially re–traumatising for families (Chapple and Ziebland, 2010; Mowll, 2007; Scraton, 2016) but when a *post–mortem* is to take place following a collision – and before any decisions around culpability have been made – those administering the process are often cautious about allowing the bereaved to view the deceased for fear that 'evidence' may be disturbed. However, because it is a legality that someone must identify a person's body, a viewing is necessary from a juridical perspective, creating something of an impasse for those in authority. For example,

Family Liaison Officer Nancy described the condition of a body that a bereaved family would be viewing later that same day as '… not very good', and went onto say that despite explaining that staff at the mortuary could not '… clean him up… ', the family were nonetheless:

> … still happy to go and do it, but I do go in and have a look and if he's particularly bad maybe I might take a picture and say 'well, this is what he's looking like' you know 'and this is the picture, it's up to you if you want to still go in', but someone has to I.D. them…

As alluded to here by Nancy, and as explained in the introductory chapter with reference to my friend being guided towards seeing only a photograph of her partner's hands, recommendations that the bereaved do not themselves view the body of the family member are sometimes heeded (Chapple and Ziebland, 2010; Wertheimer, 2013). However, seeing the body after death for those who felt able was often talked about by interviewees as a necessary experience that yielded no regrets, and this is very much borne out in the literature (Chapple and Ziebland, 2010; Harrington and Sprowl, 2011; Hodgkinson, et al., 1993; Mowll, 2007). For example, Janet described how her visit to see her husband David was a positive one, even though she and her family were aware of his – hidden – injuries:

> … he, looked, perfect, he really did, he still had his [company name] fleece on and, I mean you know the cover was up to here so you didn't see anything else but, erm, I then, you know went back out and said to Deborah, you know 'it's up to you but, he—he looks fine he just looks like he's asleep so, you know you—if you want to come in, but you don't have to', anyway she made the decision to come in and she did say 'oh, I'm quite pleased I went in'.

Furthermore, both Vivien and Janet explained that there was, in part, a more cognitive purpose behind them going to see the bodies of their family members that was distinct from any emotional desire to be close to them. Despite the *knowledge* that they were dead, they needed to see them to confirm the 'certainty of death' (Hodgkinson, et al., 1993: 200) in order that they could begin to admit the reality of the death and move on from the 'denial' stage of grief (Kübler–Ross, 1973):

> … I had to go and see that that was my boy and that he was ok… You have to s—face the reality, yeah, yeah. I think if I hadn't gone I don't think I'd feel right. I really don't think I would have felt right I don't think I could forgive myself for not, giving him that respect it is a kind of respect, it doesn't matter what, has happened to you, I need to be there and to see that you're ok, even though you're not there. (Vivien, bereaved mother)

> … my mum, had this thing that you had to go and see the person you know in the Chapel of Rest, you had to—she said 'you have to make sure it's them', and so from, probably the age of eleven, I went to see my Grandad, and my Nannie, and, then my dad, and then my mum, and she's kind of instilled this in—in me… So, I had to go and see him. (Janet, bereaved wife)

This idea that the bereaved feel they have to verify their family member's death themselves, both in terms of ensuring it actually *is* them and confirming that they *are* dead is not new. Moreover, authors have found various other reasons for the bereaved wanting to view the body of the deceased including confirmation that there had been no mistake (Chapple and Ziebland, 2010; Finlay and Dallimore, 1991; Wertheimer, 2013); a feeling of wanting to care for them (Chapple and Ziebland, 2010; Finlay and Dallimore, 1991; Harrington and Sprowl, 2011); and the fact that their imaginings might be worse than the reality (Singh and Raphael, 1981; Wertheimer, 2013).

In this way the bereaved appear somehow cognisant of the fact that there is almost a 'blockage' in terms of their grief work (Freud, 2001; Lindemann, 1994; Stroebe, et al., 2005), such that their 'mourning rituals' (Neimeyer, et al., 2002; Walter, 1994) are delayed both practically and emotionally until the State has processed the death. Once they have ratified that the person has actually passed away – as opposed to being told as much by another, even if that other is a person in authority – they can get on with the business of despairing, and this tactic is very much approved of by Worden (2018: 190):

> I have found this to be a salutary experience on many occasions and advocate allowing people to see the body tastefully displayed, even in the case of death by automobile or other violent accidents.

Viewing the body may thus be an essential part of contemporary grief work, and the fact that so many religions publicly display the body of the deceased suggests that for many, there is social and psychological value in institutionalising this process. Certainly, viewing the body was something of a demarcation for families, who were then able to start 'analysing' the death, commensurate with attempts to understand it.

5.1.4 An avoidable death

Analysis of the circumstances of the death by families was embroiled with 'what ifs': if only the deceased had been in a different place or, had been at the collision site either earlier or later, the event might not have happened. Janet described how she undertook exactly this kind of analysis about the event, which she felt was unhelpful:

> I think that, he shouldn't have been on that bit of road at six o'clock, because he always left at five, always. He always phoned me at five to say 'I'm, leaving now', but because we were meeting in [town name] he said 'it's not worth coming home'. He's going on holiday he said 'I've got loads to do I'll just stay at work'. I mean he shouldn't ever have been on that bit of road… Well why was he on—?' you know. 'Shouldn't have been there'. But, he was there, and it did happen, and—you know, y—you just gotta stop that because that's not, healthy.

In this way death by road collision is very different to that from a disease such as cancer for example, or even a sudden death resulting from an acute illness, since it is cognitively less complicated to reconcile oneself to a death on which a change in circumstances can often have had no bearing. In this way road death is more similar to death by, for example, homicide, in that the perceived preventability of the death tempts the bereaved towards believing that the event was avoidable (Kristensen, et al., 2012). The constant rumination accompanying such a violent death is borne out of an ongoing internal dialogue – what Hochschild (1979) would call 'private mumblings' – and evidenced by the bereaved in this research sample. Thus, despite Janet's ability to recognise that the 'what–ifs' were very destructive, potentially causing her to '… go round the bend', she felt unable to do anything to stop them. This is in line with findings

by Lehman, et al. (1987: 218) that in such circumstances the bereaved 'appeared to be unable to accept, resolve, or find any meaning in the loss'.

It can be seen that, in the aftermath of a road death, ferocity to families' grief was common, particularly early on in the process when the bereaved had very recently received the news of the death and had either not seen, or were soon to see, the body, and this was often fuelled by their imaginings around whether the deceased had suffered and the state of their body in death.

However, in addition to this, their grief work was also driven by a sense that they were unable to find a reason for such a violent and sudden death in their own minds. This need to find explanations and to repair the sense of moral discomfit that they felt, led the bereaved to use strategies which provided them not only with the comfort that the event was outside of their, or the deceased's, control, but also assisted with the repair to the moral upset that the death had engendered (Rock, 1998; Thiel, 2013).

5.2 Seeking explanations for traumatic loss

It was clear from all the interviews with the bereaved that finding a reason for the death of their family member and being able to explain why the death had occurred, was highly important and exigent. Arguably a central tenet as far as the human psyche is concerned, the belief that we get what we deserve, and ultimately, deserve what we get (Bulman and Wortman, 1977; Lerner, 1980) saw families undertaking frenetic searches to find some meaning in the event. This is borne out in the wider literature which asserts that meaning–construction helps the bereaved to regain a sense of control, as well as promoting healing (Currier, et al., 2006; Davis, et al., 2000; Matthews and Marwit, 2004; Riches, 1998) and, in so doing, pushes them towards ascribing the event to something they *can* grasp hold of, even metaphorically–speaking.

In this way the data saw some individuals using 'tools' to assist them with explanations, including attributing the death to fate, imagining that the death of their family member was preferable to a subsequent life led suffering, or suggesting that the deceased's place in an afterlife gave their death meaning. Interestingly, some families were able to understand at some

level, that they were indeed grasping for some rationale for the event. For Janet, commentary about the 'reason' for her husband David's death was multifarious:

> … I would've hated, to nurse him through some dreadful illness, I really would, and he could have survived this accident and been a cabbage, he could've been carted off to hospital, we could've visited him for six months and then had to switch off the machine and had all those dis—you know I wouldn't have wanted any of—and nor would he. But, the fact is, it was so, sudden, and you haven't had any, time, to, prepare for something like this… I mean he shouldn't ever have been on that bit of road, and it's—it's kind of like fate isn't it?

This feeling that death was a more favourable alternative to the multifarious other negative possibilities was also voiced by Vivien:

> Anthony had developed this stare that my uncle had, and I was thinking 'are you just tired or what?'… and… maybe… this accident happened so he didn't go down that route because, believe me dementia's horrendous… and—I dunno, I suppose that's my way of rationalising it – perhaps something worse was waiting for him down the line.

Nadia also held a fatalistic view about the 'reason' for her partner's collision with a bus while on his bicycle, asserting that '… everything had come together that day because it was his time', and Gary had seen saw 'orbs' in photographs of his son, taken in the days before his death and which signalled, he felt, a spiritual precursor to Edward's death. Families even found themselves directing their feelings towards inanimate objects, as Phil described:

> I had to find out which wagon it was, because I was just hating every wagon… Now I know which one to hate [laughs].

All families engaged in this kind of reason finding in an attempt to make meaning and sense out of the event. Within this, however, was the tendency for the bereaved to attribute responsibility for the death event either to the deceased or themselves.

5.2.1 Allocating responsibility

As a form of reason–seeking by the bereaved, victim–blaming and self–blame are much–discussed phenomena amongst commentators (Bulman and Wortman, 1977; Shaver, 2012; Shaver and Drown, 1986) and very much had their places amongst the interviews in this research. Walster (1966: 74) long ago asserted that lack of control with specific regards to an accident would generate the desire to see it as someone else's fault:

> If a serious accident is seen as the consequence of an unpredictable set of circumstances, beyond *anyone's* control or anticipation, a person is forced to concede the catastrophe could happen to him. If, however, he decides that the event was a predictable, controllable one, if he decides that *someone* is responsible for the unpleasant event, he should feel somewhat more able to avert such a disaster.

The inclination by families themselves to question the responsibility of their family member is well–illustrated by something Janet said:

> … I was worried about, you know had it been his fault, well there's nothing I can do about it but oh my God I didn't want it to be his fault, erm because, I didn't—I knew he, wouldn't have any alcohol in his system he liked a drink, and he always went out for lunch on a Tuesday… but I knew that they never had wine. I mean the guy that comes in always had a cup of tea, in the pub [laughs] but, you know… I think 'God. Did he have a glass of wine that day?' I mean, you know, but, no he didn't because, there was… he wouldn't he was driving he wouldn't, have had anything to drink, but you still, all these things are going round because you're thinking, 'God'...

Other times the search for a reason for the death led the bereaved to look inwards at themselves. People were apt to consider the responsibility of their family member for the event, almost to then be able to dispel it and continue the search elsewhere, often turning towards themselves as blameworthy. During the interviews, more than one person described how self–blame – and the fear that others would blame them – led to them struggling to deal with the consequent guilt that they felt. For example, Gary – whose son was killed when riding his bicycle – said:

> We didn't leave the house for a year, do you know what I mean we felt so ashamed… because, we knew that road. It's a fast road, it is a very very fast road and people down there do not, give a, flying thingy. But he… went on the Sunday, but didn't tell us, as boys do.

Similarly, Janet regretted not having kept David on the telephone for longer prior to him setting off in his car. She felt that had she done so, the timing leading up to the collision would had been altered:

> … if I'd kept him on the phone and—Anya [daughter]… found this amazing, poem and… when she read it to me oh I mean it… was the right one 'cause it was 'if I only had five minutes' and it had a line in it about, if only I'd known I'd have kept you on the phone and I mean it was so like [gasps] apt and, because she was on the phone to him...

Janet also blamed herself for the fact her son saw his dead father immediately after the collision:

> Damian [my son] especially having, gone to the scene that night I mean, you know yeah, not—. I mean he, he, he collapsed twice. He just—his legs gave way, you know his—I think 'oh, why did I let him go, from the restaurant? Why did I—?'. But you know you don't even think, you don't think, you don't believe it's gonna—. No, and I couldn't believe I'd—'oh God why did I let him go?' you know. But he did [pauses] and I mean, at the age of twenty–seven, oh God, it's never gonna leave you is it?

According to support group Director Belinda, this desire to allocate responsibility as part of a search for meaning is typical:

> So, to me it makes complete natural sense that people would want to—it's almost like you have to hang it on a hook and say 'well that's—I can, I can understand now that's exactly why it happened, er so if we don't ever do that again that means that it won't happen again' you know.

Even though self–blaming and victim–blaming might make 'complete natural sense' – despite such a situation being the anathema of 'natural' – it was something that the bereaved felt they, but not others, were entitled to do. When undertaken by wider society the desire for families to

protect their loved one's reputation was very strong, since people did not want to feel that the memory, or moral character, of the deceased had been 'spoiled' (Riches, 1998) in any way.

5.2.2 Protecting reputations

As an oft–raised theme in the interviews – reputation–protection – was and is an important issue for those bereaved by non–culpable road death. Some families experienced the presumption of fault on the part of the deceased, often by those who were not even involved in the system. Families found this very hard to accept, believing that it spoiled the moral character of the deceased and that people were speaking out of turn not only in laying blame but also in articulating those beliefs in the first place:

> … the most disconcerting thing for me was—and I—I know the person concerned, it was on—it was a female, student nurse, who, came upon the scene she must have been shocked out of her life, and was there and then she went and told her partner who she was living with and then the partner told my daughter–in–law, that it was Simon's fault. (Vivien, bereaved mother)

A situation at the inquest into Nadia's partner Jeremy exemplified families' desire to protect the moral character of the deceased. She described that the toxicology report performed as part of the *post–mortem* was read out at the inquest and showed traces of cannabis use in Jeremy's blood. Jeremy's father made a point of responding to this at the inquest in an attempt at keeping his son's name clear, and Nadia explained that she felt he needed to do this publicly to try and mitigate any damage that was caused:

> His dad made me laugh when he had to say about the erm, the cannabis. I mean, it was no surprise everyone knew [laughs] you know, it was never gonna be a surprise that we—he was smoking it 'cause he was. I'm sure that was part of his paranoia, as well. So erm, but when he said 'we've been clearing his house and haven't found any'. [laughs]. So what?.. Probably to cle—to make, you know it's his son's name, here so he wanted to—but it was almost laughable that I found it almost funny.

Such a desire to publicly acclaim the deceased is bound up with families' need for the circumstances of the death to be promulgated, and not misrepresented. For example, Janet felt that the media coverage of David's death would have cast doubt in the public's mind as to who was at fault. She worried that the assumption in a wider society would be that it was due to error on David's part with him being much older than the other driver:

> … this huge, huge layout story a—all about the poor young lad, that died two days before his twenty first birthday and, you know teachers are interviewed and lecturers are interviewed and friends are interviewed and, and then at the very bottom it said, 'oh and a sixty nine–year–old man was also involved', and everybody reading it would think 'oh d'you know what it was the old guy's fault wasn't it, sixty–nine, yeah'.

Similarly Sophie, whose mother was killed when crossing the road, felt that not only were the facts of her mother's injuries not taken into account at the inquest, but that the media embroidered what actually happened by suggesting that her mother was at fault:

> ..the surgeon who erm operated on my mother's, er, aorta erm… came to the inquest… he told them that this, injury does not happen—it's 40 mile an hour, plus. Yes. You only ever see this on motorways and mostly on motorcycles, it's very rare, that this happens – most people die immediately. And they wouldn't, take it on... The, coroner didn't take, the surgeon's, word. [pauses]… the main heading, after the inquest was, 'lady who walked out into traffic, could've been suffering from dizziness'.

Sophie felt adamant that her mother would not have been experiencing dizziness – despite not being with her at the time of the collision – and the impact of this was that Sophie felt those living in the same town as the family would be misled as to what really happened when her mother was hit. It was important to her that people knew what she felt was 'the truth' – in other words her own version of events – but she felt very strongly that this would remain unvoiced:

> … because we live in the same town it's, you know people think 'oh well she was suffering from dizziness now' you know that's what we've gotta live with. For us it would be just so nice to, be able to say 'well hang on no that was not right' you know? Not so much get a conviction but actually get something back. You know?

As has been put forward, as a court of no blame, the inquest does not identify or attribute the responsibility for a death to any person or persons. This means that there is no pronouncement of guiltlessness either, and the notion of blame in a coroner's court is something which is further considered in chapters 6 and 7. Here, and while families stated that they were generally aware of the fact that the coroner's court lays no blame, they also described feeling let down that there was no form of recognition of the 'innocence' of their family member by the State. Finding reasons for a death in families' own minds, was not the same thing as making a public declaration of the same.

The consequences of this ambiguity around guilt and innocence for bereaved families are twofold: first, the innocence of the deceased is not expounded, and, as such, their families stand rather in a twilight area as far as their status as victims is concerned, something considered further in chapter 7. Second, there exists an emotional quandary for the bereaved in asking them to accept an explanation provided by the State for the death, and at the same time not attributing responsibility for the event or even at times providing answers that they are happy with. This is illustrated by a quotation from Janet which describes how she agitated between feeling that she ought not to be laying blame, but equally was desperate to hold someone to account, even if that was her husband David himself. Janet explained how she and her family would have found the circumstance of her husband David's death more acceptable if the person who had collided with him and, who she believed to be responsible for David's death, had swerved to avoid an animal on the road rather than, as she saw it, driving dangerously and thus being entirely at fault 'for no good reason':

> … that first week that's all we kept saying. Well you know, per—perhaps a deer ran across the road or a, you know a fox or a, w—well anything, a cat! I mean, you—you could swerve I know you're not meant to, you're not meant t—you know you're meant to just hit it don't, don't have an accident because of an animal but, everybody swerves, because it's a natural reaction, hmmm. So you know up until, up until then, you just think, 'well yeah maybe that's why he was on—why was he on the wrong side of the road?'. And for so long, that's the thing that's—that's the thing that I can't, get over.

Similarly, and in the early days after his death in his Heavy Goods Vehicle, Richard's family were ready to accept the police's explanation for the sequence of events that led to his death. The collision had occurred as a result of a car driver losing control of his car on a patch of slush on the motorway, causing another Heavy Goods Vehicle to brake in front of Richard's lorry which he then failed to avoid. In the early stages of the investigation, bereaved brother and sister–in–law Phil and Naomi, felt satisfied that the explanation from the police was accurate:

> There was patches but, erm where Richard and the other lorry driver were, it was absolutely clear. It was a cold night, but it was absolutely clear, it's just, unfortunate that, the [car make] … hit, a patch of slush and he—he just lost control of the car. Erm, yeah we did question that… you know we've spoken to, the police last night and, they said they've got books so thick from the council, erm, and in fact, another wagon on the other side of the road, they got his cameras and analysed them, and they said something—they could see grit on his side of the road and a gritter on their side, Richard's side, had been gritted, so it was all above board. (Naomi, bereaved sister–in–law)

Yet as time went on the couple felt that the questions they were raising to consolidate their understanding were going unanswered. Naomi, in particular, could not comprehend how a driver who in her mind had 'caused' an accident, even though he was ultimately indirectly involved, was not being recognised as at fault in some way:

> How come he wasn't, charged? You know even just lose some points and go on a course or something you know what I mean just, I don't know I—we definitely believe he wasn't cautious on the road was he?...Like you know we're not a family just 'yeah let's do him for murder or anything like that' you know what I mean we're—you know we're a Christian family that, you know we care about people… [sniffs and is upset]. We're not out to, do harm or anything… we just want justice in the system… I mean the highway police, and I agree with them, you know, legally they don't have to put signs up on the motorway, because they want—that drivers and as you take your test, you ought to be careful on the road the way you drive! And he wasn't you know. Oh dear [sniffs].

Despite the belief from some of those working within the system that such responsibility placing is entirely natural, others thought very differently. Very Senior Police Officer Tamsin, suggested that people should be more understanding of the fact that mistakes happen, and consequently be less quick to blame:

> Everybody makes mistakes, I've known catalogues of mistakes happen, and nobody can be dispassionate when they, somebody that they care about that much that they've had taken from them and it could've been prevented and that sense of injustice is very real and we all had it at some point about something, but I don't think anybody can fix that, so—should the Coroner's Court fix it? I don't think it's the right place for it to happen, if it was even possible… because if you had the Coroner's Court set up so that, people had an option and a voice and they could, you know, give vent to their concerns in order to describe it, there'd be something else. It would go somewhere else, that distress and frustration. Like 'oh well wasn't the coroner marvellous?! The grief counsellor however—'.

This tendency for some of those in authority to have little empathy towards the bereaved – which is considered in more detail in chapter 7 – augments the difficulties associated with the social victim–blaming that takes place in the absence of any clear–cut explanation for a death. The bereaved find themselves in a very difficult situation in having to then face a system which is predicated on no–blame whilst at the same time – as can be seen in many of the above interview quotes - commonly looking to blame someone or something, as well as holding strong desires to try to speak up to do something 'for the deceased'. In subsequent attempts at navigating their way through social and bureaucratic systems which display a rhetoric of concern for families but often appear not to be 'on their side', they were forced to manage their emotions and often, keep quiet when their emotions were at their most intense, and this is considered in the following section.

5.3 Emotion management after road death

There is a broad social incapacity to effectively deal with death and grief. This stems in part, from a wider society unable to process its own feelings of incredulity at an event – and

embarrassment at its difficulty in interacting with those most affected by it – and in part, and simply, from the nature of bureaucratic systems. The latter is something familiar both sociologically – in terms of the 'iron cage' of bureaucracy identified by Weber – and within populist fiction, a fact to which readers of Kafka's 'Trial' (Kafka, 2001) and Kesey's 'One Flew Over the Cuckoo's Nest' (Kesey, 1979) will attest. However, the threat that death poses to 'ontological security' (Giddens, 1990; Giddens, 1991; Laing, 1990; Richmond and Valtonen, 1994), as well as a lack of comprehension and appreciation with regards to the depth of suffering being experienced goes someway to account for the anaesthetised responses of those bound up in organisations. For example, two participant families had experienced unexpected responses to the death of their family member from organisations who were external to the death process. In Janet's case, having to deal with all her husband's accounts and administrative affairs, illustrated, to her, how ill–prepared for death various organisations are:

> … I got an email back from them saying erm, that 'we are dealing with your very unusual request', and you're thinking, 'but people must die!'. Couples… must die… the main card, charge holder, and the same thing happened with the television licence… so then it goes through and it's like, so we need written permission from the account holder. Well he's dead. So then there's… a little square that you write in your own little thing so I just wrote in you know that he's died. And then I had an email back from them like 'oh thank you' you know 'we are dealing with your request. We are dealing with your very unusual request' [laughs] and you're thinking 'it's a television licence how can it be that unusual?' you know, and they've got like forty things that it could be this it could be this, but there's not one, that's a death. Well you'd think that would be one of the major things.

Vivien had a similar experience not long after her son's collision when she was contacted by her local council who were seeking recompense for damage to the road on which Anthony's collision occurred:

> … we had a bill arrive [laughs] for repair to the damage in the road [laughs]… from… [name of Council] Highways… I phoned them up I said 'just thought I better let you know he died' [laughs]. [Gasps] He was mortified!

The effect of such denial and incomprehension by a wider society, and something that was evident in this research, was that many bereaved families concealed their emotions, often out of concern for the feelings of others, as they explained:

> … people keep saying to me 'oh you're amazing' and I think 'no I'm actually not amazing 'cause you don't see me when I, do deal with my grief'. But I keep my grief away from other people because… I know the damage that giving your grief to someone else can do… (Vivien, bereaved mother)

> … she, asked me a question then I, I thought 'here we go I've gotta say it then'. And erm, it was really hard, to get it out and I thought… 'don't say it then, just don't say anything'. But because she's nice and she was, you know… anyway, I did tell her and… you know and it is shocking to hear it isn't it? I kind of felt sorry for her 'cause she then had to deal with, with hearing that from me, you know what do you do what do you say, to someone that that's happened to... (Nadia, bereaved partner)

> … even my best friend now she—she told me a week ago that, she just doesn't know what to say now. 'Cause, I don't think she thought it was gonna go on like this... (Naomi, bereaved sister–in–law)

Indeed, when discussing the Hillsborough disaster which was highly reported (albeit often in stigmatised and inaccurate ways) Scraton (2016: 378) describes how the social response to the grief suffered by the bereaved families had a limit. Early support and sympathy from friends waned as time went on, with one bereaved father described as saying: 'They just dropped away. They couldn't cope with our sadness even though we tried not to talk too much about him [their son] or the case'.

If we turn to Goffman, such stigmatisation and the emotion management that goes with it sees individuals trying to correct what they see as the basis for their 'failing'. They must work hard in order to portray themselves in a way that they, and others, deem to be acceptable: '… what often results is not the acquisition of fully normal status, but a transformation of self from someone with a particular blemish into someone with a record of having corrected a particular blemish. (Goffman, 1990: 19–20)

In other words, bereaved families’ attempts to manage their emotions for the benefit of others and make themselves ‘normal’ for a wider society are futile, since they will always be the ‘person that lost someone in a road collision’, with all the contention and controversy around whose ‘fault’ it might be, that goes with it.

For Janet, for example, two instances where individuals deliberately avoided interaction which required them to refer to the death of her husband, accord very much with Goffman’s narrative around the reduced social acceptance of the bereaved and thus their victimisation:

> … people are funny, and they just don’t know how to deal with it. I’ve got this little odd job guy out here… he kind of does everybody’s garden… And [Jim], hasn’t once mentioned [Steve]. He can’t. I think he just doesn’t know what to say… .I think he doesn’t know, how to do it, and there are people like that, who won’t, erm one of [Amanda]’s friends who actually we met and [Steve] met and she was really nice, [Amanda] said to us ‘she won’t say anything don’t get upset she won’t say anything she doesn’t—she doesn’t know what to say so she’s not going to say anything’.

Each of these instances left interviewees feeling unimportant and that others had not understood the brevity of their loss. Moreover, in response to these feelings of not wanting to overburden others, families sometimes turned to people who were there specifically for that purpose. These were either professional or volunteer counsellors who the interviewees in the research sample visited to help them when they felt overwhelmed with their grief. However, for bereaved father Gary, there was a sense that they could not provide this aid, because they were not ‘specialist’ enough for such traumatic loss, as he explained:

> I went to it once… The bloke was just a normal bloke. Like, I’m going down the pub and… I’m just sitting—so you just felt like, it was nothing. Because he didn’t know what to do… it was just like going to my neighbour and speaking to him, who knows nothing about it.

This point is confirmed by Walter (1994: 26) who, in describing others' reactions to a bereaved mother whose 17–year–old son was killed in a road collision, explained that even those who were there to provide professional support, found her grief difficult:

> Instead of her grief being accepted as part of life, she described being shunted off to a special counsellor who shunted her off to a special group of bereaved people who met once a fortnight. She found people telling her that it was ok to cry, but they were not happy about her crying with them—do it by yourself, or with a special group, they said. In such cases, counselling and self–help groups collude with the private modern way of death, keeping grief conveniently out of the everyday way so that life can go on as though death did not exist.

Furthermore, despite the increased emotional pressure at a time when the bereaved would surely be forgiven for thinking only of themselves, they still felt the need to shun any conspicuous demonstrations that they were behaving in an overly sombre way. For example, both Janet and Vivien found themselves feeling anxious about, and adhering to, socially accepted norms such as putting others before themselves on the day of the funerals by ensuring people had enough food to eat, or that things were not too 'gloomy' for the children present. Janet felt the need to greet as many attendees at her husband's funeral as possible, likening being outside the crematorium to a 'wedding party'. She was also acutely aware that David's funeral was just one of many at the same venue:

> … there were so many people and, and obviously they've gotta move you on eventually 'cause they've got another funeral you know that'll come out there soon …

In this context of socially accepted practices, the seeking of permission from others to conduct themselves in a particular way was a topic that came up more than once. For example, Janet felt the need to explain to me that 'I'm not morbid' with regards to wanting to go and see her husband's body. In addition, she explained that she felt the need to seek permission from those conducting the funeral service to go and see David for a final time at the end of his funeral, as if his body was the property of someone else, even if only symbolically:

> … as the curtains pulled round, I just said to him 'can I just go inside the curtains just, for a moment?' you know, 'is it like allowed?'. And he was like 'yeah, you can do whatever you want'.

This statement serves to illustrate the emotion work undertaken by Janet at David's funeral. Even at a time of such heightened emotion, social concerns were able to override those of the individual (Goffman, 1969), something which Parkes (1988) suggests goes against the best interests of the bereaved from a mental health perspective. Indeed, for some, this was felt so deeply that it was a case of 'getting through' the funeral or getting it 'over with'. This was illustrated by Vivien who spoke about her son's funeral in rather a conflicted way. She explained that prior to the funeral she worried greatly about her grandchildren's presence at the service, while at the same time speaking animatedly about the 'picture coffin' which was decorated with photographs and pictures of things that David had loved such as hills, tents and chickens. The coffin appeared to symbolise David's funeral for her and be central to the service. Vivien felt that it was 'beautiful' and, unlike the circumstances that led to his death, 'I just felt he was quite safe in there', demonstrating again the attempt to 'repair' some of the harm done.

For Parkes (1986), this is explained by the fact that a funeral is an important as a way of 'mitigating' traumatic images in the minds of the bereaved after a violent death, in addition to the emotional and symbolic needs served by the 'preparation' of the body for burial (Kastenbaum, 2007). This was illustrated by something one of Parkes' interviewees said:

> I keep seeing his mutilated face as if someone puts a slide on,' said one woman after the death of her brother in a car smash. But this memory was somewhat mitigated by the memory of the funeral, which was 'awfully pretty'. She carried photographs of the cortège in her handbag, which she showed to others as if to demonstrate how she had tried to repair the damage. (Parkes, 1986: 175–176)

The problem for the bereaved in the case of non–culpable road death is, however, that the funeral is not the end of the process of death. Regardless of the amount of 'repair work' families may have done, the deceased's family must continue down the road post–funeral and pre–

inquest, existing – as explained in section 4.5 – as an 'Interested Person' in the coronial investigation, and little else. Furthermore, for some individuals, such as Nadia, the fact that she and her partner Jeremy did not live together meant that she was not even designated as an 'Interested Person'. Despite being in a relationship with him for five years and being the first person to be telephoned by the police about Jeremy's collision, she was not categorised as an 'Interested Person' – presumably because their relationship had not been 'formalised' in any way – and she was therefore not entitled to receive any documentation or kept officially informed with regards to the investigation. Guidance by the Chief Coroner addresses such a situation to some degree:

> 61. It is not intended that the coroner has to contact all family members listed in section 47(2)(a). In practice the coroner needs one point of contact with the family (or occasionally more than one when the family is divided) and any other interested persons that have made themselves known to the coroner.
>
> (Ministry of Justice, 2013a: 9)

The social requirement for the bereaved to socially respond to a traumatic death in a certain way, forces them to manage the most profound of emotions and dictates, to an extent, how people *should* react to death. Yet that reaction is drawn out in the case of non–culpable road death, as families are drawn into the inquest process where the State takes control of the body and information pertaining to the story of the circumstances, further disrupting grieving processes and families' quest for knowledge about the event.

The following section looks in more detail at how, given this emotion management and families need to allocate responsibility for the death, the bereaved interact with the initial stages of the coronial system. As a State mechanism dealing with sudden and non–culpable death, the route to inquest is borne from a decision by the police that a death should not, or cannot, be prosecuted. In this way the State implicitly tells the bereaved how they should view the death of their family member, putting forward a powerful and highly symbolic version of the truth about the death which the bereaved are expected to accept. In dictating that under such

circumstances 'justice' is simply not necessary, the implication is that no injustice has occurred. This is very much at odds with families' belief that, given different circumstances, the death *could* have been prevented, an issue that many families found very difficult to digest.

5.4 The bereaved meet the coronial system

Within a Coroner's Office, Coroner's Officers (theoretically the main point for public contact), administrative staff, and the Coroner him or herself engage with, and make decisions which impact upon, bereaved families. At times, a consequence of these dealings for families was a feeling of dislocation from the system – quite aside from their frustrations around the outcome of the process. There was often a 'them and us' mentality, either in the relationship between the Coroner's Office and the bereaved, or – as was more often the case – between the bereaved and the police. As shall be demonstrated, this was in part due to the disparity that sometimes existed around whether the death was deemed to be culpable or not by the State. However, it was also due to perceived problems on the part of the bereaved as regards the manner, behaviour or general capability of those involved in the coronial system. As touched on in section 3.5, Coroner's Officers are sometimes funded through the relevant Local Authority, although they can also be employed directly by the police. Often, Coroner's Officers act in an administrative capacity only, seeing families only towards the end of the inquest process or at the hearing itself, and leaving the great majority of dealings with families to the police investigators and FLOs. Indeed, one FLO interviewed also acted as the Coroner's Officer for the same case on the day of the inquest hearing. This raised a question mark for some about the independence of these officers who were perceived, in their capacity as 'coronial conduits', to be acting in the best interests of the police rather than the families themselves. This is important given that problems with the 'official' version of the truth and justice start, not in the inquest, but much earlier in the process during families' initial interactions with the police. Even though the inquest may not be about justice from a retributive perspective – something considered further in chapter 6 – police decisions around the criminality of a road collision are. This situation has persisted since one of the first references to road death by the Wright Committee of 1936 who suggested

that '… the coroner's court is ill adapted for inquiries into criminal responsibility in cases of this kind, where the law is often difficult and a correct appreciation of it is necessary. The police are the in the best position of investigate the facts' (Wright, 1936: 322). This lack of separation of powers has been raised as a 'crucial' issue by commentators, with Scraton and Chadwick (1987: 19), for example, explaining that:

> … while coroners claim their autonomy and independence from other State institutions, the thoroughness and efficiency of their investigations depend on a close working relationship with the police. As the police have the authority and expertise available for conducting such investigations it is inevitable that something of a special relationship develops between the coroner and the local police.

Thus, and while it may be the case that the police are in the 'best position' to investigate the event, analysis of the data showed that relationships between the police and the bereaved during the investigation of the death were difficult on a number of occasions, often muddying the whole inquest process in the eyes of some families

5.4.1 The death investigators

The police 'Authorised Professional Practice' guidance on fatal road collisions is clear in stating that: 'It is essential that the RP [Roads Policing] lead investigator liaises with the Crown Prosecution Service (CPS) at the earliest opportunity where the evidence supports the likelihood of criminal proceedings' (College of Policing, 2019), and this is very similar to the situation with regards to any other offence category. However, and as suggested by MacConville (2010: 89):

> Once an initial account of an incident has been rendered, the police exercise close control over its meaning and status by the way in which they assess the account and give it value. This is most clear in terms of their evaluation of facts or incidents, an evaluation that may be determinative of the way the case is disposed or at least will be influential in any later decisions (such as those by the CPS) that have to be made.

Indeed, a conversation with a solicitor through a Brake referral, saw him alluding to the fact that the police very much have autonomy with regards to the process of making an initial decision about potential liability after a road collision. Thus, he suggested, other more practical and political factors would play a part in such a decision:

> In fact, I would be interested to know what percentage of cases are reviewed by the police and are not passed to the CPS. I suspect that the number would be high. I suspect that in many cases resources, staffing and funding come to bear when making these decisions (as well as the crucial decision as to whether a prosecution is in the public interest and can be sustained). If every case went to the CPS, I suspect that the organisation would crumble! (Solicitor, personal communication, 12 June 2017)

The central influence of the police about which path a case takes has led commentators such as McConville, et al. (1991) to make reference to their involvement as some sort of 'secret trial', less 'reconstructing' the event as actually 'constructing' it (Howarth, 1997). An interview with bereaved father Gary highlighted how the associated police rhetoric impacted how the Family Liaison Officer assigned to their case behaved towards them Gary thought that the police were blaming their son for his own death before any investigation had taken place:

> It was just the first day, when we walked back into the house, it was about three hours later, he just went '90 per cent Edward's own fault', and that was his exact words.

This fault–finding by the police sets the scene for how the death is dealt with going forwards. Conclusions made in the early part of the investigation about who was to blame for a road collision lead towards a prosecution, or not, if the police so judge, and this decision must then be acceded to:

> The police have been allowed to run their own show, make their own definitions and operate behind a rhetoric of their own choosing. Whatever they decide to do becomes, by definition, in the interest of 'law and order' and therefore of 'society' too. Whoever opposes them is equally by definition, 'anti–police' and thus hostile to 'law and order' and therefore hostile to 'society' (Kettle, 1979: 59)

Indeed, use of the term 'accident' – as a short form conclusion or 'death category' at the inquest – by those in authority, prior to the investigation even taking place appears in itself prejudicial, as suggested by Howarth (1997: 149):

> To refer to a sudden death using the terminology of a verdict which has yet to be established is indeed curious and indubitably has implications for the management and treatment of road death.

Amongst the interviews, once the police had made an initial decision around culpability, for the bereaved to be told there would be no prosecution for the death of their family member, it sometimes felt like the other driver had been given licence to 'walk free'. This was the case with a number of respondents including: Sophie, whose mother was killed by a car driver when she was crossing the road as a pedestrian; Phil, whose brother was killed when his Heavy Goods Vehicle collided with the back of another lorry; and with Janet, whose husband was killed when another driver entered his side of the carriageway. In all three cases the families felt that the police and the CPS had made an erroneous decision in either not charging or, in Janet's case where both her husband and the other driver had died – in not recognising the fault of the person whom families deemed to be 'responsible' for their loss.

Furthermore, the problem with families' consequential feelings of grievance – quite apart from their clear frustration – was that they also felt somewhat adrift. By its very nature, an investigation into an event that caused such a sudden, violent and inexplicably meaningless death could never answer all their questions. When this was compounded by families' perception that the process was not transparent or was being poorly administered, families quickly developed a mistrust of the authorities. This was sometimes fuelled by the fact that those informing the investigation – namely the police – not only met with the coroner prior to the hearing, thus again calling into question their independence in the eyes of the bereaved, but were also often called as witnesses to give evidence (Cooper, 2011; Sward, 1988).

During this time, and in common with families experiencing a criminal death that goes through the criminal courts, a strong desire for information and knowledge about the event (Parkes,

1986; Parkes, 1988; Scraton, 2016) culminated in frustration and anger when families felt they were not getting the answers they wanted. The administration of the system, in terms of the process and procedure of the coronial system and its impact on families' emotions, is considered further in chapter 7. Here, and in terms of the police decision–making that forces the bereaved down the route to inquest – or not – a comment by a Coroner's Officer that people *have* to trust the propriety of what the police are saying and doing highlights the point. Families are forced not only to entrust the investigation of what happened to their family member to the authorities, but also to believe what they are subsequently being told about the circumstance of the death. In short, the system – and the State – takes over and dominates the moral narrative about the death. Thus, the reason–seeking and meaning–making described in section 5.2 which families had worked so hard at, was made more difficult because, regardless of families' initial thoughts about the event, the State was telling them that no–one was to blame but not providing any viable alternative explanation. The consequence of this was a twofold sense of rejection for the bereaved: not only were the explanations for the death which they had developed in their minds rejected by the State in the absence of no–one in authority declaring the innocence of their deceased family member, but in addition, families felt that they – and by implication their severe grief – were also rejected or, at the very least, downplayed by those in moral authority.

5.4.2 Searching for answers

Regardless, families tended to continue with their search for answers, and when this question answering did not happen as they expected in the lead up to the inquest, their sense of mistrust of the authorities, particularly the police in their capacity as frontline investigators of the collision, was further increased. In some cases, families felt that the questions they needed answers to were not even being asked. Sophie, whose mother was hit and killed by a car as a pedestrian, felt deeply distressed by what she believed to be, a 'cover–up' in the investigation of the incident:

> … my mum lasted 2 weeks in the hospital and… within, the first week the guy had gone, and had his car repaired totally. So by the time my mother passed away the car was all

> done, so. Covered up, gone… They didn't look, or take photographs of the parked cars or the area or anything just took that guy's word… And he was allowed to drive away. He took him in the car, erm he asked him a few questions, breathalysed him so he says, but in the inquest he said he can't remember whether he did or whether he didn't. He didn't write it in his handbook… And, people at the scene were saying 'what are you doing how can you leave him drive a car in that state?' you know there was a—the windscreen was smashed whatever, so, you know how can—'what're you doing?' like, you know? And they couldn't believe the state of my mother and, they were, you know believing 10 and 20 mile an hour! It was crazy… it feels, did the policeman even know him or something, you know it feels so, wrong. Totally, totally wrong.

Similarly, Naomi voiced her incertitude, which left both her and Phil feeling unwell and struggling to maintain any sense of daily normality or routine:

> We just don't feel that we can trust the police now… As much as I've been agonising about a date, these questions need to be looked into, because it's someone's life… I just feel like, just why haven't we had information like the report… when we had the meeting with Nicholas and James [police officers], you know they said then they were gonna email to Phil and they haven't. You know they haven't kept to their word… And, it's like well, are they hiding something is that why they're delaying stuff?

This idea of wanting answers was raised not just by families but by coroners themselves. Coroner James explained that, in his opinion, one function of the inquest was exactly that of providing families with the answers they were searching for:

> … I think it's for the family to leave, having, had answered any questions that they may, want and answers, arising out of the death. That's quite broad… but, that's how I treat it. Have you got all the information you want or expected, if not—you know so, ask—ask questions… and I think that what we do which I suspect is what a lot of other areas do is, you know they say to the family 'well' beforehand you know 'have you any questions?'… 'Send 'em in and the coroner will attempt to deal with them'… or you know I'd say 'well I'm sorry but I don't think this particular question's relevant'… 'but we'll d—' in certain circum—'we'll deal with it anyway'… so that's how I consider the role of

> it to be, outside of the statutory obligation. So the family leave the room, thinking 'well—', insofar as it's possible to do so—I mean some people are never satisfied.

Ultimately, and as explained again by a Coroner's Officer, if a family felt that they were not getting the answers they wanted in the lead up to the inquest, they would need to pay a lawyer to represent them at the hearing, something discussed further in chapter 7. Furthermore, if a bereaved family was unhappy with the outcome of an inquest, there was none of the recourse that would be available in a criminal prosecution. In the case of the inquest – *ergo* for the State – once the hearing is finished, that is the end of the matter, as 'There is no right of appeal as such from an inquest' (Fairbairn, 2017: 3)[19]. This was something of a moot point for some of those in authority however. For Very Senior Police Officer Tamsin, the fact that the bereaved might feel side–lined by unanswered questions or unhappy with the decision made around culpability, was irrelevant in an inherently legal system:

> … coronial law isn't designed to make feel better about what's gone on… it's a legal process and—and a coroner sits, above a high court judge in terms of—so the process has never been designed, to give people—'this'll make you feel better'… It's not—it's not set up for that it's not the purpose of it. The coroner is there to decide, 'how did this person die? And, 'should anything happen further from that?'

This is an interesting statement and reiterates the tension that exists between the coroner as espoused to the State while at the same time attempting to realise the requirement to support the bereaved. If Tamsin's view of the coronial system as a solely legal process is correct, the question is raised of whether reform aimed at 'putting the bereaved at the heart of the system' could actually make things worse; in placing the bereaved more centrally – even if only symbolically – in a process which can be nothing but bureaucratic, families' increased perceptions of themselves as the main beneficiaries of that system would doubtless raise their

[19] According to this House of Commons briefing paper, it is possible to challenge a coroner's decision or the outcome of an inquest except in exceptional and very specific circumstances, but this is discretionary, highly unusual, and has an imposed time limit. For a discussion on complaints around the *conduct* of a coroner, see chapter 7.

expectations as a group who both deserve, and will receive, what they believe themselves to be entitled to.

Indeed, Tamsin went onto explicitly suggest a – very Durkheimian – feeling of entitlement by the bereaved. When they do not get what they believe they have a right to, she said, the ensuing sense of injustice almost gives them something to hold on to during the grieving process:

> I think there is a weight of expectation, as in, I live in a civilised society therefore, I want this, and then I want that and then what I want, and these things should be provided to me 'cause I pay my taxes so I want that… why do you want that?! 'I—I wanted this!' Well, because that's gonna bring him back? Because that's going to make me feel better? Because I know of at least as many cases where somebody's had a, you know Unlawful Killing and they walked out of the court going, 'Yeah that's what we wanted'. Did they look less grief–stricken? And in a way, that 'ahh that's not fair!', that, helps people I think, with the grief process, if you're that sort of person. 'Well, I just feel such a sort of injustice, if there was somewhere else I could fight this…' … rather than absorbing that weight of distress because it's all too much, 'that's not fair, and I will hang onto that 'til my dying day'.

In conflating rights and grief work in this way, Tamsin once again draws attention to the dichotomy of the inquest as a *State*–emplaced mechanism for dealing with death by road collision which, at the same time as existing – in part – to protect life, will not renege on the State perspective of a road collision as an 'accident'.

5.5 Conclusion: from the death news to the death system

The traumatic grief experienced by those bereaved by road collision is undoubtedly complicated by the unexpectedness of the loss, the perceived avoidability of the death, the images of suffering that the bereaved must live with, and a damaged body. Despite finding evidence of family breakdown that concurs with the literature, there was also confirmation of familial relationships being enhanced. In addition, and while those who had lost a child through road

collision suffered profound distress, the loss of someone later in the lifecycle at the time of their death did not always make it easier to accept for the bereaved in the sample for this research.

At the same time, a social expectation that their grief is somehow too acute, together with the necessity that they must deal with 'unfeeling' bureaucratic machinery (Morrison, 1995; Zacka, 2017) led the bereaved to have to deal with emotions that overwhelmed and frustrated them. In feeling that they must control these emotions (Elias, 2000; Elias, 2001; Goffman, 1969; Hochschild, 1983), 'emotion management' allowed the bereaved to continue with their lives, albeit differently to that which they experienced before their loss.

Furthermore, families' initial interactions with the police were often clouded by a 'them and us' mentality. This was in part because much of families' emotional expenditure, particularly during the early stages of the grief cycle, was taken up with seeking reasons for, and attempts at making sense of, the loss. In using mental 'tools' and strategies to help them 'wrap up your own brain' (Nadia, bereaved partner), the bereaved had a tendency to want to allocate responsibility to someone or something for the death, whether that be themselves, others or the deceased.

For the police however, decisions around the criminality of a road collision were the main priority. This led to difficult relationships between the bereaved and the police, particularly in the lead up to the inquest, when it was felt that decisions made around culpability were flawed, based on a sense that the death was not important to the police and they were not 'getting to the bottom' of what happened. This was fuelled by the perceptions of the bereaved around the conduct or general capability of the police, something considered in more detail in chapter 7.

This discussion around traumatic loss, emotion management and decisions made around the criminality of a road collision is important, since families' encounters with police and other professionals mark the start of their journey through the coronial system. At the same time as families embark on a process of reason–seeking to help them find meaning in what has happened, the State sets itself up to provide answers to families as part of a system of 'justice'.

Moreover, after hearing that there was no perceived criminality in the death event, and then defining its coronial system as a vehicle for discovering who, when, where and *how* a person has died, expectations on the part of the bereaved are high. Although many families attending the inquest claim they are cognisant of the fact that it is a ‘no blame’ forum, the absence of any clear–cut reason for the event in the aftermath of the death, together with a strong desire to undertake repair work, means families find themselves dealing with a system which they believe will provide them with the ‘truth’ they seek but instead find a system of investigation and categorisation – a fundamentally State–serving and legal process – built on the premise of the non–attribution of blame. Thus, not only do families feel let down when they perceive the answers they receive as part of the coronial investigation to be unsatisfactory, but they often feel *conspired* against by a process they believe has made things worse by not providing the ‘justice’ – whatever that may mean for them – for the death of their family member.

With this, and the history and process of the coronial system – as laid out in chapter 4 – in mind, the next chapter looks at the forum of the inquest itself in attempting to deduce whether a dichotomy exists between what the inquest does and what it seeks to do.

6. The inquest: a problem of legal–historical architecture

> Ostensibly, then, coronial investigations are not reducible to mere fact–finding; they perform a much broader meaning–making task around death, and their justice work is complicated. (Scott Bray and Martin, 2016b: 105)

As a system that sits within the realms of the 'Justice System', it would be reasonable to assume that one of the roles of the inquest is just that: justice. When setting out to write this thesis, and at that point as someone with very little knowledge of the place of the coroner's court within our legal system, the fact that the word 'criminal' was not tagged on to the front of the label was purely semantic. After all, when used in relation to the courts, the word 'justice' connotes adherence to the *Oxford English Dictionary* definition of the word as:

> To punish or reward appropriately, to treat justly (obsolete rare); (b) spec. to try in a court of law; to bring to trial; to punish judicially. (Oxford University Press, 2018).

However, after spending time within the coronial arena, and speaking with coroners, barristers and other involved parties, it became clear just *how* erroneous this (mis)understanding was, for two reasons.

First, there exists a general misconception amongst those in society who are not involved with or, who have not been touched by, the coronial system, regarding the function of the coroner and his or her court, as part of the legal process. Misunderstanding the coroner's role has implications for those families who then find themselves caught up in the coronial system when they suffer a sudden loss through a road collision. Not only do they know little about the purpose and process of the inquest, but – and more importantly here – their notions around what constitutes justice, and, therefore, their motives, often stand in direct opposition to those of the coroner as a representative of the State. Indeed, as Scraton (2016: 430) suggests with reference to the views on 'justice' held by the families bereaved by the Hillsborough disaster:

> For some it is solely about disclosure, culpability, acknowledgement and apology. For others it is about liability, punishment and restitution. These are not extremes but parallels.

> For the State, however, 'justice' concerns the due process of the law, dependent on further investigations to establish possible cases for criminal prosecution and review police actions in the aftermath of the disaster – the very processes that previously failed the bereaved and survivors.

Second, this expectation of some form of 'justice' – or moral response to their loss – can cause great difficulty for the bereaved when their 'unavoidable' loss is not recognised as such or, worse, is not found to be the 'fault' of someone else.

This chapter considers what the bereaved perceive themselves to be entitled to after a death on the road, given their proclivity towards meaning–making and responsibility allocation, and the fact that, as shall be shown, the general public know little – and understand less – about the form and function of the coronial system. This is followed by consideration of what 'justice' means to families who are forced to come face–to–face with the inquest, *vis–à–vis* those 'professionals' who are directly involved in administering it. In so doing, the question of whether the coronial system – as the State's mechanism for accounting for death as part of the 'Justice System' in England and Wales – correlates, or is at odds with, the expectations of the bereaved, is elucidated. The implications of this for bereaved families are then considered.

6.1 Accounting for death

> In everything pertaining to coping with trauma in general, and loss more particularly, the individual is ''trapped'' within a political psychology that enforces the habitus and expectations of institutional dominance on the ostensibly intimate and private response. (Lebel, 2011: 351)

In 2015, a 'Review of Forensic Pathology in England and Wales' overseen by NHS Consultant and Honorary Professor Peter Hutton, set out to review the forensic pathology service following concerns raised within the Home Office about its functioning and fitness for purpose going forwards, particularly given considerable statutory and organisational change. One of the – arguably rhetorical – questions raised is to be found at paragraph 4.7.3 within the report, in the form of: 'Does the cause of death matter to society?' In answer, the report sets out '… a number

of important reasons why the cause of death should be accurately recorded' (Hutton, 2015: 65), which are highlighted as the detection, recording and tracking of public health data. However, the report goes on to recognise that:

> Superimposed on all these 'medical reasons', there is a general trend in society demanding transparency and accountability in public services combined with a 'decline in deference' to authoritarian organisations. (Hutton, 2015: 65)

While contemporary society does indeed demand greater openness from the State, the assertion of a 'decline in deference' from those who are forced to encounter the coronial system would be erroneous. In fact, as shall be shown, it is precisely the coronial system's 'long and dignified history' which Hutton (2015: 78) identifies later in his report, coupled with the public's lack of understanding of the purpose and process of the system, that keeps this deference afloat.

6.1.1 The rhetoric of the coronial system

In order to look at this further, one must consider the most recent legislation that deals with coroners and the inquest system, the Coroners and Justice Act 2009. Within this, clause 10(2) states that in making his or her ruling with regards to who the deceased was, and how, when and where they came by their death, a coroner's determination '… may not be framed in such a way as to appear to determine any question of—(a) criminal liability on the part of a named person, or (b) civil liability' (2009). To the lay person, the removal of any type of liability proclamation in a forum for justice would equate to the removal of a judgement about moral responsibility which would surely seem antithetical.

In adding to the confusion, another State publication, the 'Guide to Coroner Services' is a booklet aimed at the bereaved, which sets out the coronial process and its workings. It is published by the Ministry of Justice as part of its drive to 'put the bereaved at the heart of the system' (Ministry of Justice, 2013b), and uses the word 'blame' seven times within its thirty–eight pages. This use of language is interesting, given the lengths that are gone to within the Coroners and Justice Act 2009 to clarify the position with regards to 'liability', and suggests an

acknowledgement by the State that the issue is exactly that: a potential controversy for the bereaved that requires dealing with in a pre–emptive manner. In fact, it is felt necessary within the document to point out to families that: 'When asking questions you must remember that the purpose of the inquest is to establish the relevant facts of the death and not to apportion blame. You should not ask questions that appear to blame someone for the death' (2009: 19). Furthermore, as illustrated at figure 10 which provides an excerpt from an inquest observation (see Appendix 4 for a fuller transcript), and, as detailed in section 5.4.1, the question of liability is something which coroners deal with specifically, at the same time looking towards the legality of the inquest to provide an explanation to the bereaved as to why the hearing must be conducted.

Figure 10. First excerpt from inquest 2 – October 2016 (see Appendix 4)

Coroner:

Erm, the reason why we're here is, we haven't got any option. Erm, I'm afraid that the law tells me I've got to have an inquest if we have a death that looks as though it, wasn't due to natural causes. And you cannot register your son's death until we've had an inquest. Ok? Erm, now, this document here is called the record of inquest, and you'll hear me read through it formally at the end of the hearing, but it's basically my attempt to deal with the questions that an inquest is expected to cover. And, there's four of them really. Three of them are usually straightforward: who the person was, when he passed away and where he passed away. Erm, usually, fairly straightforward those three. And then the final one is how the death came about. And that is, usually the reason for taking statements and listening to live evidence etcetera. Erm, I've got to fill this document in in a way that remembers that an inquest is really a fact–finding process, it's not about apportioning blame in any particular direction. So I can't fill it in in a way that, determines what we call 'criminal responsibility' on the part of a named person, and I can't use civil litigation type phrases such as 'there's been a breach of duty of care' or 'there's been negligence' or, phrases like that.

Despite this qualifying statement, the coroner later went on to deal with precisely the issue of criminal liability that the court so shuns by warning the driver that he should protect himself during his evidence–giving. This is shown in figure 11.

Figure 11. Second excerpt from inquest 2 – October 2016 (see Appendix 4)

Coroner calls driver to the stand. Driver is sworn to oath and provides full name to the Coroner.

Coroner:

I'm just going to turn briefly to [bereaved family member name] because I want to explain something to him. [Bereaved family member name] just to explain this briefly to you, when I started the inquest I mentioned this document here. Erm I explained that… I cannot name a person and I cannot determine, criminal responsibility on the part of a named person, and I can't use any civil, litigate phrases like 'there's been a breach of duty care' or 'negligence' or anything like that. Ok? Now, when we're dealing with inquiries of this nature, obviously the evidence of the erm, the driver, erm needs to be considered… what I've also got to remember is that er, a witness in these circumstances, erm isn't expected for the purposes of our inquiry, to give evidence that might what we call 'incriminate' them, or leave them open to any sort of prosecution. So I mention that now.

Erm, and I'm just going to explain that to you [turns to the driver]. If any of the questions that I ask you, you feel might tend to incriminate you and leave you open to some sort of criminal prosecution, you're not obliged to answer them. Ok?

Interestingly, several coroners asserted that in those cases where a collision involved more than one driver but there was only one deceased person, they were in the habit of recognising the 'restoration' that can come from involving the driver in the hearing, as the following interview excerpts show:

> So the family have heard the Collision Investigator and it wasn't his fault, then call the driver, that is deliberate. Then I've got… his interview… and so I go through that, giving the chance to comment on it if he does… I don't think it's really appropriate for him not to

> be here, in a case where he's been in a fatal collision with an 18–year–old, I think he needs to be here, personally. (Andrew, coroner)

> … my personal view is that, you know because he's the driver, he should give an account but not be held to account does that make sense? Er he's not allowed to answer questions which could incriminate him but I think he—there is still a useful exercise for him to comment and, and he has the right to be there because he… you know he is a Properly Interested Person, and it may be that if somebody has said something which is, totally wrong he should have the opportunity to comment on that but, it is difficult because I mean, they're vulnerable to criticism from relatives... (Daniel, coroner)

One coroner went even further, suggesting that where no–one was at fault, the driver is as much a victim as the family:

> I've dealt with road traffic cases where, in a number of them the driver of the vehicle that caused a death, wasn't at fault. I consider h—in those circumstances him or her to be as much a victim as the, as the bereaved family. Erm, because, it's something they live with, for the rest of their lives and erm [pauses] I don't think you ever, shake it off you're always asking the question, 'what if?' (James, coroner)

This disunion between what is dictated by those who administer the system and what is demonstrated by them has been discussed on numerous occasions over the decades by scholars (Scraton and Chadwick, 1987) and in investigatory reports and statute. The 1936 Wright Committee, the 1971 Broderick Committee and, more recently, the Luce Review (2003) all discussed and attempted to clarify the position with regards to the coroner's working position on liability in terms of what it is and what it should be. In recommending changes to the system based on its findings, many of which were incorporated into the 2009 Act, the Luce Committee asserted – see chapter 4 for concurrence with this point – that the dilemma is, at least in part, a historical one. A by–product of the past use of the inquest as a mechanism for determining whether a death was criminal or not, the report tells us, is that '… the vocabulary associated with the old function has lingered on' (Luce, 2003: 87). It went on to further elucidate the problem with specific regards to road collision, referring to distinct short–form conclusions –

previously ‘verdicts’ – that it believed both confounded and compounded the situation. While this is certainly the case, it is not only the vocabulary used by coroners that weds them to the legalistic and technical language that they use in their roles, but the very nature of the inquest’s relation to the State. The following statement is again taken from the Luce Report (Luce, 2003: 88) and once again demonstrates the blurring of lines in the eyes of the general public:

> In response to our consultation paper the families and support groups concerned about the handling of traffic and workplace deaths reemphasised their objection to the ‘accident’ and ‘misadventure’ categories. Some gave support to retaining ‘unlawful killing’, mainly on the grounds that prosecutions for manslaughter – whether corporate or personal – in these fields are rarer than they think desirable, and in the traffic death field that prosecutions for causing death by dangerous driving or manslaughter are also less frequently brought or persisted with than they would like to see.

The suggestion here is that precisely because, in the opinion of families and support groups, there are not enough traffic death prosecutions, the ‘unlawful killing’ conclusion – as outlined in chapter one – should be kept to enable a death to be so classified in the coroner’s court. This further indicates what many families expect and want from the inquest – a statement on the immorality of the act – and the report was explicit in recognising this. In acknowledging the ‘uncomfortable’ (Luce, 2003: 89) hybridisation of the inquisitorial and adversarial processes in the coronial system, the Luce Review made recommendations which dealt with the need ‘to put a greater emphasis on what the coroner’s inquest can achieve but the other processes cannot’ (Luce, 2003: 89). This included: putting more emphasis on the inquest’s narrative and fact–finding role as well as its role in highlighting failures which might have led to the death; discouraging the use of conclusions and language which explicitly or by implication appeared to determine civil or criminal liability or its absence; and developing short descriptions which enabled statisticians to more accurately categorise death and which communicated simply the circumstances of the death without determining liability (Luce, 2003).

Furthermore, and as suggested by Thomas, et al. (2014: 199) much of the difficulty with the system is a result of differing agendas:

> … there will be no final determination that clarifies who is to blame for the death… However, there is a paradox here, because while inquest proceedings are ostensibly non–adversarial, the other involved parties may well come to the inquest with a range of adversarial agendas. For representatives of State institutions, there will often be a two–fold strategy. First, to limit the range of the inquiry, especially in so much as issues of criminal and/or civil liability might arise. Second, to legitimise the functioning of penal, police or medical power in spite of the death.

Thus, disparities exist not just between what the bereaved and the State want but, in the intentions of those *within* the court room itself, adding to the perceptions of the public of the coroner's court is a place for accusations and blame.

6.1.2 Public perceptions

Despite regulations laid down by lawmakers and administrators edicting that liability is not to be determined in an inquest, for those who find themselves caught up in the process this constraint is often not appreciated. Belinda, the Director of an independent road death voluntary support organisation, said that even when explanations about the purpose of the system have been forthcoming, those attending the hearing do not always understand them:

> … it's not a court of blame, but… some people hear the word 'court', and just, automatically think 'oh gosh' you know 'I'm in trouble, because I've been called as a witness and, therefore—' you know, I, have vivid er memories of a guy—it was a road traffic collision, absolutely not his fault – the police investigated it, thoroughly and erm, it was just unfortunate that a guy pulled out in front… he was oncoming to this other person who, who pulled out right in his line he didn't have any time to, avoid the collision and the other person died. But do you know he came to court with his overnight bag, 'cause he thought he was going to get sent to prison. And even if the Coroner's Officer had told him and the police had told him that… there's no blame, you're not gonna be found guilty or not guilty we've investigated it there's no, blame at all, he obviously hadn't heard that

> [pauses]… I had to say to him, you know 'it is being investigated but the police are not taking it any further this is not a court of blame nobody's gonna get found guilty', you know and he almost, collapsed with relief.

Given assertions outlined in the thesis introduction regarding embellished media representations of criminal courts (Cooper, 2016; Johnson, 2017; Pandiani, 1978) together with suggestions that victims and witnesses in the Criminal Justice System find a process which not only falls short of their expectations but exists as some sort of 'game' (Shapland, et al., 1985), it is perhaps unsurprising that this lack of knowledge also prevails with the coroner's court. Indeed, Belinda explained that she felt that in comparison to the general public's understanding of the criminal court '… nobody understands the coroners court'. However, not everyone agreed with that; when asked whether he felt that those who have never had cause to be involved with the inquest system misunderstood its purpose, coroner Colin said:

> I would've agreed up until about 20 years ago but the advent of the internet means that if they spend 10 or 15 minutes on the internet, they can get more information than they need. (Colin, coroner)

Putting aside for one moment those who are old, those who are not technologically proficient, those who do not have access to the internet and those who are in such a state of turmoil that they are unable to function properly – no doubt already a significant percentage of those who encounter the coronial system – an internet search using the question 'What is an inquest?' returned a proliferation of results. Within these were different websites which are dedicated to the inquest and its procedures, including local authority websites, encyclopaedic websites, pages written by legal companies and guidance provided through official government websites and documents. An example of the latter and a document described in section 6.1.1, the Ministry of Justice 'Guide to Coroner Services' devotes seven of its thirty–eight pages to the question, 'What is an inquest?', although critics of the document have asserted that it is '… not aimed at bereaved families. It's so dry and technical' (Anthea, survivors' group representative).

In addition, the police are tasked with providing recently bereaved families with a copy of literature produced by Brake which sets out what they should expect in the forthcoming weeks and months, including an explanation of the inquest process. However, as we saw with the system flow chart provided by Brake at figure 9, the complexity not only of the process but of the material designed to explain it, can be daunting for families.

It would seem, then, that despite there being a vast amount of information available to those who may need it, and putting aside any questionable quality and correctness, there is a question mark over when the bereaved – or anyone else – are able to absorb and understand this information. In addition, knowing cognitively what one is facing at the inquest is not the same as having a full appreciation of the proceedings, as again suggested by Director Belinda:

> … some people's expectations are [pauses]—because they don't know what the coronial service does, so their expectation is sort of way off beam, and so nothing that you do from thereon in is, ever gonna meet that expectation. 'Cause I know when I've spoken to people I think 'I'm sure the Coroner's Officer would have told you this', but, they just haven't taken it on board, at all, and you can understand that can't you, you're in shock aren't you and, you get everything bombarded at you, all this information and, you don't know what's going on.

The ability to digest or forget information when in shock is dealt with in the literature (Mastrocinque, et al., 2015; Riches and Dawson, 1996; Sanders, 1980) and further illustrates why there might be a chasm between what the bereaved understand, and the State purports, the purpose of the inquest to be. As a judicial process, this leaves it in danger of not fulfilling a role that some – including the Ministry of Justice given attempts at recent reform – deem to be crucial:

> Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval – rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one. (INQUEST, 2002)

It follows that the bereaved, in a state of shock and turmoil following a traumatic death, are faced with a confusing and ambiguous bureaucratic system that is activated, not by themselves but by the State, in the event of the death. Not only this, but their expectations around what the inquest *will* provide them tend to be coloured by what they perceive themselves to be entitled to, and this is considered in the following section.

6.2 Perceived entitlement

Many families who attend an inquest *are* informed, at least to some degree, as to what they might expect from the system. Certainly, amongst the interviewees, there were those who were able to tell me prior to the inquest taking place that: the inquest is a 'no blame' forum; details of the death event would be aired; and the coroner would decide 'how' the deceased had died. However, taking this cognition at face value is missing the fact that even though families are able to make reference to these coronial attributes, this does not mean that – given their complicated grief – they comprehend what it actually means for *them*. Furthermore, simply because they know on some level what they are to face at the inquest, this does not mean they do not wish for a different outcome.

When families' experience of the coronial system and inquest does not equate to their expectations, there is a mismatch, and we can look towards Durkheim's view of the reasons for, and emotions surrounding, the *Criminal* Justice System to aid our understanding of why this is the case.

For Durkheim, as discussed in the introduction, one of the characteristics of societal development in the context of crime and punishment was the shared aggrievement which accompanied the violation of social norms, something he called 'collective sentiments'. In acknowledging that felonious cases are no longer dealt with by an 'assembled society' as they were in primitive times – and as exemplified by the practice of community accountability seen in the medieval period – Durkheim explains that they are now passed down to intermediaries to oversee. This may simply be a matter of practicality given an increasing number of cases

requiring to be dealt with, or it may be due '… to the extreme importance assumed by certain personages or classes in society, which authorizes them to be the interpreters of its collective sentiments' (Durkheim, 2013: 62).

Although it may, or may not, be the case – in the arenas of penal law and the punishment of criminals – that the population feel their collective sentiments are being correctly interpreted and effectively managed, to draw the same conclusion in the case of the inquest into non–culpable road death would be erroneous. First, there is little in the way of collective sentiment from a society which readily accepts the – sometimes fatal – consequences of high–speed transport. Second, Durkheim's explanation with regards to the definition of crime would assault the sensibilities of any bereaved family:

> … an injury done to collective sentiments, since some of these may be wounded without any crime having been committed… Thus the collective sentiments to which a crime corresponds must be distinguished from other sentiments by some striking characteristic: they must be of a certain average intensity. Not only are they written upon the consciousness of everyone, but they are deeply written. They are in no way mere halting, superficial caprices of the will, but emotions and dispositions strongly rooted within us. (Durkheim, 2013: 62)

Moreover, applying a Durkheimian framework to non–culpable road collision and the inquest leads to a conceptual mismatch. Emotions are as 'highly intense' (Fisher and Chon, 1989) amongst the bereaved as those seen in the social outrage engendered by transgressions which are tackled through the invocation of penal law. The inquest, by implication, says that nothing immoral has happened. The symbolism around morality and culpability that would usually form part of a system of justice is – by virtue of the fact that no *in*justice has purportedly taken place – powerful, but difficult for families for whom the loss is not expected, and feels undeserved and unfair.

For example, the lead up to the inquest for Vivien was accompanied by a certain amount of anticipation. When asked directly what she was hoping to get from the inquest into her son's

death, she explained that aside from 'drawing a line under everything', the inquest was not just for her, but was a means of disseminating information – and thus enabling the 'truth' to be known – about the event. Thus:

> I'm hoping… that we can come away from there, and get on with, the rest of our lives if you like and… just be dealing with the memories and not all the questions… once we've had the inquest, we'll know exactly, or more exactly what happened or other people will, they'll all be informed…

This expectation from Vivien that the inquest would not only give rise to 'what happened' but would make others aware, illustrates not just a desire for information about the event on her part, but shows the importance that she placed on there being an authoritative 'moral' outcome to the proceedings.

Furthermore, although interviewees could not always articulate *what* they wanted from the inquest, there was a strong sense that they were expecting *something*. This was the case, for example, during an interview with Janet:

> … I don't know what I was expecting from it and I think, that, for the three months from the accident that, kind of probably, kept us going?...you know we had the… funeral and… the release of the body and, arranging that and everything and then, you've got the inquest and, looking at this and reading that and, talking about that. And, I mean we weren't gonna get… anything from it because, well you're not are you? It's happened. But I didn't expect it to be, I mean it really threw all of us…

The idea of 'natural' rights is pertinent here. As discussed by Hudson (2003) in looking to the early ideas of Locke (1967) – discussed in the introductory chapter – he explains that people associate in societies in order to enjoy the freedoms that one would hope for as part of a 'just' society. Thus in entering into this type of mutual and reciprocal agreement – reminiscent of Durkheim's 'collective sentiments' – whereby the life, liberty and property of others is respected, one anticipates that the same freedom is enjoyed by all. However, and in the same way that Durkheim's idea of the State as acting on behalf of society can be applied to the

criminal justice arena, what of the application of Hudson and Locke's theorising to the coronial system? Given that the bereaved are forced to hear and accept the State's explanation of, and ruling on, the death event, with little hope of the 'justice' – whatever this may mean for them – that they seek, justice as 'mutual recompense' in the coroner's court, while specious, is flawed, and this is further discussed in section 6.3.

This acknowledgement of competing agendas between the State and the bereaved was confirmed by Scraton (2016: 197), who condemns the inquest system for the very fact that these differing motives exist. The bereaved assume that such an inquisitive process, particularly one which falls within legal realms, is implicit in working for rather than against them, but this is not always the case:

> If bereaved families feel short–changed by the criminal or civil investigations, the inquest is their last resort. It inspires a belief that it is 'their' inquest into the death of their loved one: 'their' time, 'their' right… Yet immediately, behind the sympathetic words and sensitive acknowledgements, hangs the denial of their agenda; a spectre over the proceedings. 'How' – the circumstances of death – can be pursued; it can be discussed; it should be established. But it is 'how' without liability, 'how' without blame. It does not take a sophisticated analysis to appreciate the contradiction. One eminent barrister likened the job of cross–examining at an inquest to working with 'both hands tied behind your back'.

As a consequence, the bereaved, often already beleaguered after having been told that there will be no prosecution for the death, encounter a system which does not provide the answers they seek, which they do not understand, and which many subsequently come to mistrust. It has been shown that, in part, this tension is to do with a mismatch between families' expectations and what the State provides in the case of non–culpable road death. In addition, however, families' beliefs around the inquest as a forum for justice also play a fundamental role in their experience of the coronial system. The question of what constitutes coronial justice is complex and is impacted not only by what justice means to the bereaved but, in addition, stems from the

tension that exists between the State an overseer of the 'death dictate', and its coroners' existence as empathetic adjudicators.

6.3 Justice? Well don't come here love…

A discussion around what comprises 'coronial justice' is crucial when seeking to understand any disparity between what the State provides and what the bereaved expect after a sudden death, although the term is used somewhat loquaciously by commentators writing about the coronial system (King, 2009; Scott Bray and Martin, 2016b; Trabsky, 2016), with little clarity provided as to what it actually means in this context.

Published on the Courts and Tribunals Judiciary website, a section entitled 'The Justice System' invites readers to 'Find out about 900 years of legal evolution – and how it works today' (Judicial Conduct Office, 2018). Amongst descriptions of 'The Supreme Court', 'The legal year and term dates' and 'Structure of the courts & tribunal system', sits a section on 'Coroners', with the first sentence stating:

> Although the post they hold is judicial, and legal qualifications and experience are often required, coroners are not considered to be members of the courts judiciary. (Judicial Conduct Office, 2018)

This already appears somewhat bifurcate. Coroners are judicial office holders who conduct a legal process but are not recognised as part of the judiciary. In compounding this anomaly further, and, if one looks at the official publications of direct relevance to the coronial system in England and Wales – namely the annual 'Coroners' Statistics' document and the 'Guide to Coroner Services' – it is apparent that these are published by the Ministry of *Justice* [my emphasis]. Moreover, once inside the coroner's court, the language and narrative that surrounds the system is arguably that which the general public associates with the *Criminal* Justice System. 'Witnesses' are called to give 'evidence', they must then 'swear under oath' to tell the 'truth', they are entitled to legal representation and, in the case of certain types of cases, a 'jury' is present during the proceedings.

In discussions with coroners about the place of the inquest within the Justice System, responses suggested that views with regards to the meaning of the word 'justice' in the context of the coroner's court were mixed. For example, when directly asked whether there was a place for 'justice' in the coroner's court, coroner Carl replied:

> … I hate that word. I hate that word. I had a family recently write into me saying, erm 'we want justice for our Auntie Jenny' or whatever. Do you, really? Well don't come here love. Don't come here.

Even though bereaved families are not compelled to attend the inquest – this is very much a choice on their part – the fact that as one Family Liaison Officer said, 'In all my years doing inquests I've never had a family not attend an inquest', suggests that most of them do. Furthermore, and as detailed by my findings in section 6.2, the views of those scholars who explain that an all–consuming search for information about a death event is one of the major characteristics following sudden and unnatural death (Littlewood, 1992; Rock, 1998; Thiel, 2013) leads to the suggestion that the family of 'Auntie Jenny' as referenced by coroner Carl would potentially feel that they have little choice but to 'come here' in the absence of any other avenue open to them. Carl went on to clarify his statement about what justice in the context of the coroner's court means:

> If by justice we mean a fair process, yes of course she should get that. If by justice do we mean retribution no, no…

In short, according to Carl, whether the coroner's court can provide users with justice, depends upon what definition of the term is used. Furthermore, this statement raises the paradoxical question – at least in the minds of the bereaved – as why there is a need for a 'fair' process when the State is proclaiming that no–one has done anything 'wrong'. James, another coroner, elucidated the problem:

> I never really know what justice means actually, in these circumstances. I suspect it means different things to different people… you know somebody's been snatched—a loved one has been snatched away, at very short notice, through no fault of his own. And she

> doesn't… I suppose what she doesn't feel she doesn't get justice is because there's—there's no sort of punishment. I think that's probably it. Er but, as I say I think justice means different things to different people in different circumstances.

One barrister interviewed, Colin, raised more complex and philosophical questions regarding the meaning of justice in the coroner's court where death by road collision is being dealt with:

> … there are other settings for justice, there are the criminal courts. For road traffic accidents… is justice required for somebody who has … a momentary flash of inattention and causes a death? Erm, is justice required there in a criminal setting, are they to be castigated for a moment's inattention, compared to somebody who had five pints of beer, done some drugs, only 16… Well, they ain't gonna get it in the coroner's court.

It can be seen that all three of the previous quotations, from those working at the 'frontline' of the coronial system, conflate the criminal justice terms – 'retribution' and 'punishment' – in their narrative around justice in the coroner's court. The problem with such views is that in speaking of retributive justice, the assumption from those in authority is that the bereaved are seeking to punish those who are 'responsible' for their loss. However, quite aside from the fact that as has been shown, the inquest does not exist to provide this, it is arguably not what bereaved families actually wanted. Instead, the findings show that the desired outcomes for these families, from a State–led process which professes to exist to protect their interests – at least in part given drives to put them at the system's 'heart' – is two overarching concepts: 'truth' and acknowledgement.

It is also important to note here that in not seeking retribution, families also did not blame either the car or speed itself. Given the discussion around the hegemony of the car in the introductory chapter, this perhaps serves to illustrate that even those bereaved by road death view high–speed transport as something of a 'necessary evil' in contemporary society.

6.3.1 Justice as truth

The importance of the identification of a 'true' account of what happened was an important theme amongst the interviewees, and it is illustrated by the following quotations:

> We're not looking to blame anybody but we want the truth. (Naomi, bereaved sister–in–law)
>
> … even if, it was down to my mother! The truth. Everything… all they've given me is speculation nothing, no hard evidence whatsoever all, against us. (Sophie, bereaved daughter)

However, the subjectivity surrounding the term 'truth' generated a number of paradoxes. For example, for coroner Carl, the truth is inexorable: 'I don't do justice. I do truth. I don't do justice… I kind of groan when people say, 'justice''.

As a further illustration of this paradox, during the inquest of Gary and Tania's son, the coroner's words during his summing up highlighted not only how illusory, but abstract, the term 'truth' can be. Speaking about the police reconstruction video which was played to the court during the inquest hearing and which showed the events leading up to the collision that killed Edward, the coroner did concede that different versions of the truth are available: 'There are variations that could affect the truth or otherwise of the reconstruction video… ' (Coroner at the inquest into the death of Edward). Again, the idea of there being different 'versions' of the same truth was suggested by barrister Colin: '… it's only when you go to the coroner's court, erm that the truth or, a version of the truth comes out'.

Furthermore, the 'truth' is affected by divergent claims between parties about what happened during the event that caused the death. Figure 12 provides an excerpt from field notes made during an inquest observation in December 2016. The Heavy Goods Vehicle driver (identified both as 'witness' and 'Mr M' in the snapshot below) who had hit and killed the deceased was appearing as a witness at the proceedings and was being challenged about his version of events during the collision.

Figure 12. Snapshot of field notes from inquest proceedings taken December 2016.

Coroner:

'This is not a trial and you are not on trial'. 'You are not obliged to give evidence that could incriminate you in a criminal court'.

Witness says some of his statement is wrong. He saw [the deceased] with his arms up looking surprised at something down the side of the trailer.

Coroner:

'Is there anything else that you want to say?'

Witness:

'I don't know really'.

Family advocate asks questions.

Witness:

Says he wishes camera had been working ''cause I want answers too'.

Advocate starts to give him a bit of a hard time. They start to disagree about when [witness] first saw the truck and how many truck lengths it was.

Coroner:

'I don't think you should argue with the counsel Mr M—. Just confine yourself to answering questions'.

Mr M says that what two witnesses said in their statements was wrong. He also says that what was is in his police statement was wrong.

Advocate:

'There's a danger that what you're saying now is recovered memory'.

Witness chooses not to answer a question on the basis of self–incrimination. He does this a few times and is getting angry/irritated. Coroner has to step in.

Mr M to advocate:

'You weren't there'.

Coroner:

'You don't have to comment Mr M—'.

Advocate is determined to say that he wasn't paying attention and he wasn't looking. When he suggests this Mr M says: 'I find that offensive'.

In such a scenario, as with all of the inquest hearings observed during the fieldwork, the 'truth' is only ever a version of events, and it is a far cry from the 'Absolute truth' that King (2001) tell us characterises the inquisitorial system. For Thiel (2016: 212), and with regards to those bereaved by homicide, the truth that families seek is a form of 'moral truth', based on an attempt at restoring 'some moral order to their anomic lives'. Furthermore, as Berger and Luckmann (1971) posit, the truth is simply a social agreement between parties; there is no absolute truth, just what we agree it to be. Since courts are arenas for social agreement, they thus 'make' truth, rather than 'find' it.

6.3.2 Justice as recognition

The second outcome that the bereaved hoped for from the inquest was a form of acknowledgement, and this took several forms. For some, it was explicit: the family wanted it made clear publicly that a particular person – *videlicet* not their family member – was at fault. For others, recognition of their status as victims from such as the police, the coroner or the media for example, was what they felt would help 'repair' the damage done. Still others wanted an almost simpler form of acknowledgement: their family member – who was morally upright and undeserving of such a death – had been alive, and now was not. Not only did they want to talk to others about them, but they wanted to protect them from any hint of public aspersion by having the 'innocence' of the deceased explicitly recognised.

Furthermore, and similarly to those bereaved by homicide where the perpetrator has been acquitted of a crime (Thiel, 2013) – the notion that people wanted justice *for* the deceased rather than themselves became clear. In not securing this 'justice' for them, regardless of the fact that they were facing an arena which does not serve to provide it, the bereaved families felt that they had somehow let the deceased down. It was as if their family member might as well have been murdered and the perpetrator had never been prosecuted:

> I don't even think you've been able to have time to grieve because you've been so much trying to get the justice for Edward, that, I don't think you've even had time to even, get round to it… (Tania, bereaved mother)

> … he had a 44 minute interview, and that was Edward's justice… Why shouldn't we kick up a fuss about it? If you don't, and you just leave it at that, but you feel like—me and Tania feel like we've failed. (Gary, bereaved father)

> It's just for the, sake of Richard really because like… he can't tell us what happened only he knows what happened in that cab, but, we wanna, support and speak on behalf of Richard don't we you know we want to, stand up for him you know… (Naomi, bereaved sister–in–law)

These sentiments were also supported by Janet who said that despite having at least a cognitive understanding of the purpose of the coroner's court, she felt strongly that due to the no blame convention of the system, the impact of her husband David's death on her and her family was not being recognised. Her sense of justice was being denied by a State which rules that there had been no crime and, by implication, that there was no victim.

> I feel I've got absolutely no justice for David… It's given me no justice, and no peace and no, closure, no justice for David… I feel really, sad to think that, I hope he doesn't think I haven't tried because [starts to cry], I would have done anything…

Janet decided to write a letter outlining her feelings to the coroner, in the hope that by setting out how David's death had affected them as a family, the 'injustice' of the situation would be demonstrated and recognised. When Janet communicated her intention to Clare, the Coroner's Officer in the case, Clare's reaction was one of consternation – not an unusual response from those who sit between the families and the coroner, and something considered further in chapter 7. As Janet enunciated:

> … they *rammed* it down my throat, more than, I don't know three or four times… 'hold on the… inquest is just for finding facts, it's not to find blame it's not to, s—', you know, 'ok ok ok'… at that point I had said to Clare, 'right… I'd like to write a letter to the coroner', and she said 'ooh really? That's unusual!'. Erm, I said 'because, I'd like to… in a very simple—I'm not gonna ramble on like, you know, I'm gonna just put it in very simple terms, my facts, and, these are the facts of me and my family, and the fact is that, my life has changed 100 per cent, my children have lost their father, my grandchildren have lost

> their grandfather, and David through no fault of his own has lost his life, and they are facts, they're my facts, they might not be forensic facts they might not be—but they—they are the facts of my family'.

Janet's statement once again serves to illustrate that while the purpose and process of the inquest is, as far as the State is concerned a 'fact–finding' exercise, the 'truth' that it seeks to reveal is often at odds with the truth – in Janet's case the truth of their suffering – of what it means to the bereaved family. For instance, at the inquest into David's death, the coroner referred to the tragic nature of the case and the fact that two lives were lost, but Janet felt that this was not enough:

> But I do think that there should be something… that gives you a little bit of justice because this guy [her husband], had his life taken away, through no fault of his own… I feel like he's been murdered although I know he hasn't, because I know that young lad didn't set out, at all to kill anybody let alone himself, and also, you know it's a life for a life, you know… he did have his life taken away and it—it was, like manslaughter really wasn't it?

The fact remains that prosecution of the 'other' driver – given that he too had died – was impossible, but what Janet and her family found so difficult was that there was no formal recognition by those in authority that David had been an 'innocent' victim. Indeed, the only short–form conclusion options open to a coroner in the case of a death by road traffic collision are: 'Road traffic collision' or 'Accident', with the coroner in David's casing ruling it as the former. For David's wife Janet, this had a massive impact on them as a family. A lack of any public acknowledgement that, not only was David in no way responsible for the crash, but someone else was entirely at fault meant that there was no 'justice' in going through the coroner's court:

> Erm, regarding the actual, actual inquest, I feel it's a total and utter waste of time and money. I really do. Er the verdict, Road Traffic Collision. Well, do you know what I could have told you that that night. I really could, and I feel I've got absolutely no justice for David, who was driving along, h—happy which was—how nice is that he's coming to meet us all at the restaurant, he was—we were two days, before we were going away on

> holiday, he would have been seventy in two weeks' time. [Breaks down, swallows a lot, very quiet. Whispers] Sorry… (Janet, bereaved wife)

Interestingly Nancy, the Family Liaison Officer who was assigned to Janet's case, explained that the lack of recognition of the seriousness of a death can also be disheartening from the police's perspective. Speaking about the conclusion of 'Road traffic collision' ('RTC') made by the coroner, Nancy said that such a conclusion:

> … frustrates us sometimes cause we're kind of like 'well actually that is, that is an RTC, that is an unlawful killing'. Say for example, the young lad coming on the wrong side of the road – that is an unlawful killing. He's unlawfully killed that man hasn't he? That's not an RTC is it? He hasn't just—it's not a mechanical fault or, er, a case of the road's slippery or some, you know, some other, some other force has come into that. He has, if he was being prosecuted he'd have been found guilty…

This is another demonstration of the dichotomy that exists between the categorising undertaken by the State – which sees it reluctant to demarcate the death as the responsibility of another – and the moral ambit of those who work within the system.

6.3.3 Justice as apology

Marshall (2001) asserts that our feelings are incisive when someone causes us to suffer a wrongful loss. People naturally feel they should be compensated for that loss by them, as they are at fault. This compensation, she says, may be in the form of an apology, which would be *expected* under some circumstances, to a greater or lesser extent, depending on how serious the wrong or loss is believed to be. Indeed, an apology could still be forthcoming in an 'accidental' event and is symbolic of an attempt at reconstructing the 'moral equilibrium'. As revealed in the previous section, this is something vital for families who strongly desire some re–ordering of morality after an unexpected death, and thus would be highly valued by the bereaved.

This situation was illustrated by a conversation which took place between bereaved parents Gary and Tania, with Tania feeling that despite the severe hostility that both she and Gary felt

towards the driver who had killed their son, Edward, there would have been some benefit to them from hearing some remorse from him:

> Tania:
>
> In the beginning there was no—no apology...
>
> Gary:
>
> [Turns to Tania and speaks in a low voice] Even if he apologised, he knew that Edward were there! Do you know what I mean? So an apology isn't—you know… He disregarded it he… didn't give a crap about other road users, so, an apology…
>
> Tania:
>
> Yeah no… But he still, he could've still, apologised.

Phil also felt that an apology from the driver whose accident had led to the death of his brother, would have made a difference:

> … it must be very difficult for em to cope with, knowing that somebody died, through what happened to em but—and they couldn't say beforehand they couldn't come up and say 'look I'm sorry about your brother', because that's almost admitting guilt. But, they never said anything after either you know…

Throughout the inquest observations – where it was beneficial to linger for a time after the proceedings had closed – and absent any formal procedure for redress in a coronial setting, not once was it observed that a driver attempted to apologise to a bereaved family in any informal sense. No doubt this is in part due to the formal commitment to avoid pointing towards civil or criminal liability enshrined in coronial law, but it is also a result of the fact that no framework is built into the hearing which allows interchange between the driver and the bereaved – instead the State and its inquest stand between the parties preventing interaction between them. Nonetheless, even if such a stage was provided for parties to come together and thus possibly elicit apology, attempting to apply the *compulsion* to apologise to the act itself places a question mark over its veracity (Marshall, 2001). While Goffman (1969: 117–118) would agree that there is the potential for insincerity in such a scripted situation, he would also say this is

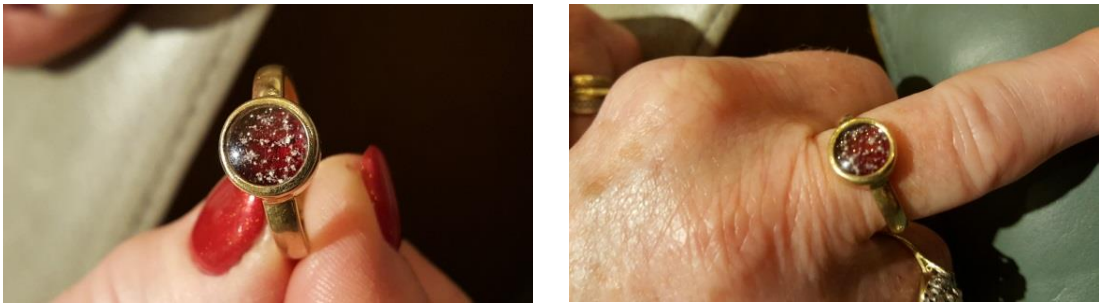
something of a moot point, since 'while the original infraction may be quite substantive in its consequence, the remedial work, however vociferous, is in these cases still largely expressive'.

Unfortunately for the bereaved in the context of the coroner's court, there is little opportunity for communication between parties, whether formally or informally. In a similar way to the judge in a criminal court, proceedings at an inquest are controlled by the coroner, who seek to maintain order through their 'judgecraft' – see section 7.2.5. In so doing, part of the formality of the hearing is designed to discourage the parties from communicating and thus reducing the risk of any disorder. However, the fact that families felt they had no space to express their truth in the form of a coronial equivalent to the Victim Impact Statement meant that they were unable make themselves heard, either by the driver, the State or a wider society, and this had tangible outcomes on their bereavement and sense of 'justice'.

6.3.4 Justice as memorialisation

On this note, and regardless of the way the bereaved sought to manage their feelings of grief, one commonality between all the families interviewed was the fervency by which they sought not only to recall and protect the deceased, but also to paint a picture of them for me. Indeed, as well as talking about their sons, mothers, husbands, partners and brothers, the bereaved were eager to *show* them to me. This came in the form of photographs of the deceased in happier times, death certificates legally recognising their death, memorial service leaflets and even photographs of their coffins. These attempts to keep the memory of their family member alive were often carried out in descriptive, vivid and above all notably proud ways, very much in line with scholarly descriptions of the 'strong moral images' (Thiel, 2013: 30) that the bereaved evoke of the deceased (Parkes, 1986; Rock, 1998). For example, Janet had some of her husband's ashes set in a ring which she was wearing during her interview (see figure 13).

Figure 13. Janet's ring containing some of her husband David's ashes.



It has been suggested that in line with this need to talk about the deceased, there is value in the bereaved being given the opportunity to convey the extent of their loss in a public way. Indeed, in some high–profile instances within the Justice System, the need of the bereaved to publicly recognise the dead has not only been sanctioned, but also facilitated, by those in authority. For example, at the start of the second (two–year) inquest into the Hillsborough disaster, the coroner requested that personal portraits of each of the ninety–six people who died be submitted into evidence, whereby '… bereaved families presented moving tributes to their loved ones' (Scraton, 2016: 454). More recently, the 2018 independent public inquiry into the Grenfell fire saw the friends and families of the deceased being encouraged to:

> … memorialise their loved ones in any way they think best, whether as a presentation or as an audio recording or a short video film, or in any other way… They will be remembered through the words and pictures chosen by the people who knew them best and loved them most – their families and friends… During the coming days there will be much sorrow… But that sorrow will I hope be tempered by memories of past happiness of time spent together and of former joys. (Moore–Bick, 2018)

Opportunities for the bereaved to make the deceased the focal point have been formalised to some extent in statute within the Criminal Justice System, whereby a 'Victim Personal Statement' – affording crime victims, including 'bereaved close relatives', the opportunity to explain how they have been affected by the crime – has been built into the 'Code of Practice for Victims of Crime' (Ministry of Justice, 2015). Yet this is not the case with the coronial system, which relies on the discretion of the coroner to make reference to the life, or indeed the impact

of the death, on family members. However, support group Director Belinda's experience suggested that an inquest is in fact highly important as a setting for people to want to talk about the deceased, particularly once the formal hearing has ended:

> … they don't want you to know just how about that person's death, they don't want you to learn just about a dead body, they want you to know about how that person lived. And that's understandable but of course, the court staff don't have time for that, whereas our volunteers do. You know so they might get the photographs out, show the photographs and things like that and, and I think that's it, quite helpful and I think, to the families to be leaving that sort of, environment, when they have been able to talk about the life of somebody as opposed to just purely talking about their death.

However, there are those who argue quite the opposite. For Rosenblum (2009), encouraging survivors to publicly recount a trauma can be as damaging as denying them that right. Despite this and in the context of the coroner's court, the opportunity for the bereaved to draw attention to the person that the deceased was, rather than simply the event which hastened their death, is important. Not only have the bereaved lost control of their lives through the loss but, as 'users' of an administrative system which bureaucratises death, they are unable to publicly announce the importance of their loss or the impact it has had on them in any formal way. Indeed, Scraton (2007: 235), in his commentary around cases such as the Hillsborough football stadium disaster in 1989 and the Dunblane primary school killings in 1996, explains how:

> As the bereaved, survivors and campaigners were silenced through their pathologisation, and alternative accounts were disqualified through vilification, State institutions and their employees profoundly refused to acknowledge responsibly. Such persistent denial of a broader, moral culpability undermines legitimacy and weakens authority. It prevents the bereaved and survivors from coming to terms with the pain of their loss, exacerbates the suffering of 'not knowing'.

While the cases of which he speaks are high profile, controversial cases which have included an element of criminal, as well as coronial, justice, in the context of non–culpable road death, the acceptance of some degree of moral culpability for the death by the State, is something

which the bereaved would appreciate. However, as has been demonstrated in the case of road collision, the use of the inquest by the State, is to deny its own culpability in this context.

6.4 Conclusion: entitlement, justice and mismatched agendas

As the State's method of orchestrating the aftermath of, and accounting for, a sudden and traumatic death in a road collision in England and Wales, the coronial system has a somewhat convoluted historical development. One of the consequences of this, as demonstrated in this chapter, is a continued rhetoric by those involved in the system which tends towards the retributive, despite the fervour with which the notion of blame in the coroner's court is explicitly denied. Coroners proclaim that the 'no blame' dictate of the coroner's court is absolute, and yet their narrative – both personal and through the use of strategy in the inquest – is often contrary to this. Such tacit repudiation belies a moral dichotomy for coroners who at the same time as being obliged to carry out their socio–legal duties, also display the very human traits of sympathy and empathy towards those who come before them.

It has been demonstrated that there is a general misconception around the form and function of the coronial system. This, together with the inclination by the bereaved to continually search for knowledge about, and meaning in, the event, as well as the contention that they hold 'natural' – *videlicet* 'moral' – rights after the occurrence of such a death, leads to the suggestion that the bereaved enter the coronial system with certain expectations around what they are entitled to. With this in mind, in attempting to define what families *do* expect and want from the coronial system, the word 'justice' in the context of the coroner's court becomes highly important, and is often something very different to the retributive, punitive term that we associate with the law and which those involved in the system often believe families are looking for. Indeed, those who administer the inquest system hold a different interpretation of 'justice' *vis–à–vis* those who find themselves caught up in it.

From the perspective of the bereaved, 'justice' following a non–culpable road death can mean many things. For some, a feeling of getting to a 'truth' that they are happy with, is enough.

Others require a more explicit recognition that they – and the deceased – are 'innocent' victims who deserve a more formal acknowledgement that they have been wronged. For some, an 'apology' for their loss, or the opportunity to be able to memorialise the dead in a formal capacity, would be their justice. Ultimately, though, and regardless of what justice means to them, there was a sense amongst families that the inquest would somehow repair some of the moral harm that they had suffered by an event that was not 'supposed' to happen.

The problem here is that, with regards to the question of the form and function of justice in the context of a coroner's court, and from the perspective of the State, the appropriateness of the inquest – a legal inquiry – as a forum for therapeutic jurisprudence is in doubt. While commentators speak of therapeutic jurisprudence as '… humanising the law and concerning itself with the human, emotional, psychological side of law and the legal process' (Wexler, 2000: 125), the expectation that inquest proceedings will, or indeed should, provide an element of restoration – something which can be called 'mutual recompense' – for families and drivers in the case of road death, is questionable. Certainly, for some of those working within it, the inquest is a wholly legal system which exists to categorise, and learn lessons from, death, and nothing more.

Furthermore, although families profess to appreciate the fact that inherent in the case progressing to inquest is that no blame will be apportioned, the realisation that justice is therefore 'unnecessary' can leave them feeling frustrated and let down, particularly when there is no framework for memorialisation built into the hearing. Being then denied the opportunity not only to formally recognise someone as at fault but to pronounce their family member as innocent, required great effort and further emotion management on the part of the bereaved. As far as the State was concerned, there had been no abrogation of justice and no crime, *ergo* there had been no victims. Yet, for the bereaved, the positioning of the deceased and themselves as victims, was never in doubt.

In finding that families do feel a need to allocate responsibility for the death event, look for meaning in the loss and anticipate 'justice' from the system that it is not set up to provide, it is

apparent that expectations are not met. What remains to be seen, however, is how the *process* of the inquest plays out, in order to assess whether, even in a situation where the bereaved are disappointed in the 'what', the 'how' can be some recompense. Thus, the following chapter – the last of three analytical chapters – looks at families' lived experience of the coronial system once the decision not to prosecute anyone for the collision had been made. From families' initial communications with the police and other professionals, through to their final attendance at the inquest hearing, chapter 7 explicates the thoughts, feelings and encounters had by both the bereaved and those with whom they come into contact. In addition, the issue of access to justice in the context of the historically–bound inquest, given policymakers' more contemporary recognition of putting the bereaved at 'at the heart' of the system, is re–considered and expand upon.

7. The Inquest: process and procedure

With a question mark over the contemporary functionality and integrity of a legal system embedded in the pre–modern, and given the suggestion that the general public has a lack of awareness of coronial procedures (Biddle, 2003; Gregory, 2014), this chapter looks more closely at how the process of the coronial system in terms of the physical environment and atmosphere of the court buildings themselves, together with families' interactions with the various involved agencies, impacted their emotions following unexpected and traumatic road death. In so doing, data gathered during inquest observations, together with direct experiences of the thoughts, feelings and behaviours of families and those with whom they engaged, both in the lead up to and on the day of the hearing, inform the primary focus of this chapter that asks whether bereaved families can be said to be 'secondary victims', of the coronial system, as well as being 'co–victims' of the death.

A 2015 Criminal Justice Joint Inspection report, in considering the 'Investigation and Prosecution of Fatal Road Traffic Accidents', judged the overall standard of communication between the Crown Prosecution Service and bereaved families as poor in 75 per cent of cases (Criminal Justice Joint Inspection, 2015). However, despite such a situation being exactly what has led commentators to point towards the bereaved as 'secondary victims' in the context of the Criminal Justice System (Casey, 2011; Parsons and Bergin, 2010; Rock, 1993; Sanders and Jones, 2011; Shapland, et al., 1985; Thiel, 2013), the situation with regards to non–culpable road death is less clear.

As suggested in chapter 2, for Guy and Holloway (2007), the State provides a 'cloak of care' for those bereaved by road collision, emanating from the socially recognised 'blameless' nature of the death. Certainly, when conducting fieldwork, there were demonstrable cases where the 'cloak of care' appeared well–spread. However, it is also true to say that without exception, the bereaved families sample felt that at least one of the factions they were in communication with fell short – in terms of the behaviour, the manner or the general capability that was demonstrated – in the administration of the coronial system. This was in the context of the inquest often

taking place in formal, court environments, which added to the bureaucratic nature and formality of the hearings, impacting the emotions of the bereaved even before proceedings were underway.

As outlined in the introduction at chapter 1, analysis of the data showed that families' lived experience of the inquest process – from initial interactions with the police, the allocation of a Family Liaison Officer, administrative interplay with the coroner's court and finally attending the inquest hearing – can leave the bereaved with a powerful negative or positive 'ending' to the death of their family member. Families' engagement with the agencies involved at a time of emotional trauma is not a choice and, as will be demonstrated, sometimes aggravates the whole experience for them.

In addition, the bereaved often encounter difficulties in terms of navigating the process and accessing the 'justice' that the inquest provides, whether this is for financial or logistical reasons or simply because they lack the wherewithal to ask the questions that they perceive to be important. Although policymakers have recognised that the bereaved should be 'at the heart' of the system, at the same time, the State makes proclamations around what those bereaved by non–culpable road death are entitled to, or not, restricting their access to justice and leaving them feeling that the playing field is not, and never was, level.

7.1 'Processing' the bereaved

The throng of people who orchestrate the 'death system' once a road fatality has taken place, from: paramedics and hospital staff at the outset; to specialist Road Collision Investigators and Family Liaison Officers ('FLOs') during the police investigation; to administrative staff at the relevant coroner's court; and finally to coroners themselves, would be expected in such circumstances be adept at conducting themselves with tact, diplomacy and sensitivity, having regard to families' plight. After all, many of these people are professionally trained, skilled and experienced in dealing with the bereaved.

Indeed, amongst this myriad of organisations and individuals, arguably the largest professional group that the bereaved encounter – the police – publish explicit guidelines as part of their 'Authorised Professional Practice' online content (College of Policing, 2019). Here, in devoting a section to 'Road policing', a subsection entitled 'Investigation of fatal and serious injury road collisions' sees the College of Policing listing the core and other policing roles that may be deployed for a road death investigation (see table 5):

Table 5. College of Policing Road Death Investigation Team

Core roles	**Other roles**
Forensic Collision Investigator(s)	Police Traffic Management Officer
Vehicle Examiner(s)	Investigators from other disciplines
Family Liaison Officer(s)	Intelligence Officer/Analyst
Investigating Officer (s)	Media/Communications Officer
Exhibits Officer	Scenes of Crime Officer(s)
Disclosure Officer	Interview Adviser
Scene Manager	Toxicologist
Coroner's Officer	Forensic Specialist
Review Officer	Senior Identification Manager
	Disaster Victim Identification Officers
	External specialists, e.g, emergency service personnel, the Driver and Vehicle Standards Agency and the Health and Safety Executive
	Partner agencies, which may provide additional support throughout the investigation, case assessment and judicial inquiry

The same website outlines what is expected of police officers and police staff generally in discharging their responsibilities. In explicitly recognising that road death devastates not only families but individuals and communities, who may never recover fully from such a loss, it contends that:

> The police service must recognise the scale of this impact and loss, and provide an investigative response and level of support that searches for the truth while supporting those affected in a compassionate way. (College of Policing, 2019)

With specific reference to the 'Professional Profile' of FLOs, the guidance sets out the purpose of the role, together with the key accountabilities and behaviours which would be expected of a police officer in this function, including: the provision of support and information 'in a sensitive and compassionate manner'; keeping families updated 'in a timely manner, with all relevant information regarding a police investigation'; and having 'Good communication skills with the ability to listen, empathise, provide support and adapt language, form, and message to meet the needs of different people/audiences' (College of Policing, 2019).

7.1.1 Uncompassionate investigators…

For some of the bereaved, these guidelines translated into a positive experience. For example, Vivien, whose son Anthony was killed in a head–on collision, explained that the police Forensic Collision Investigator in her case showed great empathy in his dealings with her and was '… very, very good, very informative and very, very thoughtful about the whole thing'. Equally, discussions with FLOs in the field established them as often sensitive and sentient to families' feelings.

However, and despite the clarity of the guidelines, the somewhat cavalier attitude of some FLOs and investigating officers towards families – what families themselves termed a 'lack of compassion' – was evident on several occasions. For example, bereaved brother Phil felt that the FLO in their case, John, showed a lack of compassion from the outset:

> … when he first came he sat on the settee and he told us like this like that like this, that and the other [mimes someone giving abrupt factual information]. You know like that and we're like—we're all there mourning and sad and—and upset, and he's giving it to us like—. Yeah. Really he just upset us all, and then he left… saying things like, erm 'and the only person who really… knows you know, he just isn't here to ask'. And we're like, hang on, you're talking about me brother and I'm grieving about him…

Other complaints about the police related directly to mis–recording the deceased's time of death, poor communication – both in terms of frequency and content – and being generally insensitive to bereaved families' feelings. For some of the participants, such as Nadia, the simple act by the police of not providing the service that they had indicated they would, was a frustration:

> … and he gave me two names and two numbers… and said you know 'if you've got any— anything you wanna ask this is the number' erm, and as I say whenever I've rung it, nobody answers and, and they never return a call… And then you know, in a way [laughs] you, you almost expect that these days, don't you, because that becomes the norm.

In other cases, such behaviour served not only to frustrate families but to exacerbate their misery. For example, Janet described how the FLO on her husband's case was a source of great anguish to her family when they met at the garage where both cars that were involved in the collision that killed Janet's husband were being kept. As she explained:

> … my eldest daughter said 'mum you won't see the car will you?' and I said 'oh Good Lord no' you know 'I won't see the car no, I'm just gonna pick up the stuff'… we got to this, place breaker's place which, you know [stumbles over words] awful cars all over the place wrecks all over the place… met Nancy she, opened the door of the office… and at that point I knew… and I turned round and said to Damian 'Damian we are gonna see the car'. And at that point Nancy heard me and she turned round and she said 'oh, that is alright isn't it?'…

Despite police guidelines' explicit requirement to 'support those affected in a compassionate way', it was clear that for those working in the system, policy did not always translate into practice. Further evidence of this was seen in interviews with police officers themselves. For example, Very Senior Police Officer Tamsin, described how police relationships with families can be affected by the emotive tendencies of the bereaved in the wake of such a death and, in so doing, exemplified the emotionally impervious and cynical attitudes characterising the 'cop culture' referred to by commentators (Graef, 1989; Reiner, 2002):

> If you ring somebody, and for quite understandable reasons you get an earful of, 'well that's not very good' and 'I want to see her at the thing' and 'I want you to go over there and I want doing and that didn't happen and the hospital did whatever' you just go, 'you know what, I'm gonna give that one a week'. And you'll move onto the next one, because, who wants that every day… this is just a horrible, lack of empathy that I've developed over having done this so long. Life's not fair. Breaking news gosh! Isn't it awful when people die? Yeah. Isn't it dreadful when it's somebody else's fault? Yes. I'd feel so much better if the person could be punished, but they're already dead so I can't punish them to make myself feel better. Well, you're kind of gonna have to get over it one way or the other anyway… God!! What do you want he's dead!!! 'We'd like him to be puni—' well you'll have to just dig him up!! (Tamsin, senior police officer)

There is a very real contradiction here. The bereaved held an expectation that the agencies with whom they deal, not only morally but given that they are being paid to handle them and their resultant emotions, conduct themselves in a faultlessly empathetic and sympathetic manner. The police however, in dealing with families who are possibly at their lowest – and most angry – ebb, may respond by distancing themselves, which has the effect of erecting barriers between the two parties. Such 'compassion fatigue' (Andersen and Papazoglou, 2015; Figley, 1995; Tehrani, 2009) in the police follows from continual exposure to the anguish and irascibility of the bereaved – in this instance – and leads to changes in professionals' feelings, attitudes and belief systems, affecting both the way they view the world and subsequently behave.

7.1.2 … or conflicted 'performers'?

Another way to equate Tamsin's arguably insensitive rhetoric with the empathetic narrative put out by the institutions overseeing policing provision, is by turning to explanations by other commentators such as Goffman (1969) and Lerner and Clayton (2011), who suggest that behaviour by the police which is less than desirable is inevitable. In an institutional context, behaviour is automatic and preconscious, and individuals respond to each other depending on what they believe to be expected of them. As such, 'People respond to highly scripted cues, including commonly understood obligations and entitlements, that define how they will behave'

(Lerner and Clayton, 2011: 126). When moving from acting as an individual to acting as part of a team, each 'performer' is involved in the co–operative projection of a particular stance, meaning that '… the performance serves mainly to express the characteristics of the task that is performed and not the characteristics of the performer' (Goffman, 1969: 67). Given that their role is therefore based on a 'performance' which sees them managing their emotions, people fall foul of those situations which cause them to react in an – arguably more 'human' – way which is contrary to this 'show'. As such '… discrepant sentiments are almost always found' (Goffman, 1969: 149). The resultant misalignment between families' expectations and provision on the part of the professionals, left families feeling exposed, vulnerable, angry and confused.

It is not only bereaved families' dealings with the police which provides evidence of a mismatch of interests between families and the death system. From the death event itself, to the time after the inquest, bereaved families felt mistreated not only by those most closely allied to the inquest but also by other parties, including hospital staff, local councils and the media. Tania, for example, felt that she and Gary were denied the opportunity to spend the last minutes of their son Edward's life with him by paramedics and hospital staff, which '… they can't ever give you back'. Similarly, Nadia explained how a specialist organ donor nurse had made what she considered to be intrusive and unnecessary inquiries around her partner Jeremy's sexual health. Finally, Vivien described a phone call that she had received the day after her son Anthony's death from a firm of 'no win, no fee' solicitors asking her about her son's recent collision.

7.1.3 Speak to the coroner?!

It is important to note here that families have very little, if any, communication with the coroner him or herself prior to the inquest taking place. Their interactions are limited to police, and the Coroner's Officers and administrative staff at the relevant coroner's court, and this can be a source of huge strain for families who are unable to ally the disassociation of the coroner with the administrative – albeit legalistic – role that they are told he or she fulfils. For instance, Janet

said how angry she felt following a conversation that took place between herself and the Coroner's Officer:

> … I said '… is there any way I could actually speak to the coroner?'. 'Oh my goodness, what—what—!!!' [gasps] … and, to be fair, she probably wouldn't wanna, be speaking to everybody anyway but, I've only asked a question, and it's like, 'good gracious the coroner's up here!! You don't get to speak to the c—'. You know 'who do you think you are?', it was that attitude, and it was just, overly over the top, and I just didn't like it.

It is usual in a criminal court setting for the public to be on unfamiliar terms with the judge, and in an inquest investigating a prison or other death where the State has an involvement, similar disengagement might be understandable. However, in the case of non–culpable road death it is undoubtedly conceivable that the bereaved might feel affronted.

Although families in such cases are told in no uncertain terms that the inquest is an administrative and no blame forum, they are at the same time dislocated not only from the investigation but in their dealings with the coroner, where there is an inaccessibility akin to that seen in the Criminal Justice System. Thus many families feel aggrieved that at the same time as they are being required to stand on ceremony and behave deferentially towards the coroner as a judge – something looked at further in the next section – the converse is true in the way that the death of their family member has been 'informalised' for the sake of the State. As 'innocent' parties in a system where innocence is neither recognised nor proclaimed, their status and standing are somehow reduced to the echelons of court 'users' rather than 'co–victims'. This goes a further way to highlighting why bereaved families might feel – in an arena where no crime has, after all, been committed – that recognition of their status as 'innocent' parties is lacking.

As a consequence, at the end of what often feels like a long and often traumatic road for bereaved families, they find themselves in attendance at the inquest hearing itself, face–to–face with the coroner with whom they are unlikely to have had any previous contact. The following

section looks more closely at the manner and behaviour of the coroner in court, and the impact that this has on bereaved families.

7.2 The coroner and his office: between legality and empathy

The coroner's office represents the mechanism – in terms of both people and processes – which exists to administrate and bureaucratise social reaction to sudden death. As described in chapter 4, the historically idiosyncratic development of the coronial system, together with the attempts at reform which make it what it is today, – the State's mechanism for accounting for death in England and Wales – which is often at odds with the expectations of the bereaved.

Contained within the coroner's office, the coroner's court is the physical structure which not only accommodates the coroner and his staff but houses the court room – often as one of two or three courts within an 'office' – which provides the setting for the inquest hearing itself. While there is a dearth of academic literature which looks at the impact of the physical nature of the court buildings and environment – both outside and inside – on the bereaved families who find themselves there. Biddle's (2003) research is conspicuous in drawing attention to how the setting in the coroner's court can affect the bereaved, highlighting the distress that the atmosphere and ceremony caused for most of her interviewees.

7.2.1 The environment of the coroner's court

In attending coroner's courts to carry out observations, a number were found to have been purpose–built, or newly refurbished – including one which used to be a primary school – and were often located on business parks. These were modern buildings where the facilities had been carefully planned to include waiting areas, private meeting rooms, small conference–style rooms, and larger court rooms. Indeed, as bereaved mother Vivien said when speaking about the court shown at figure 14 – part of a 'suite' of buildings which also hosted the town mortuary: 'I thought it was a lovely court room'.

Figure 14. Midtown coroner's court – external view

Despite this being the case for many of the coroner's courts attended, there were just as many which, although being – as referred to in the fieldnotes and illustrated at figure 15 – a 'lovely old building', offered a very different setting, and in consequence a very different environment, for families.

Figure 15. Westtown coroner's court – external views

The photographs at figure 15 – of a coroner's court that dates from the end of the nineteenth century – illustrate just how judicial the external appearance of these older courts can be, and this was confirmed by coroner Andrew with reference to coroners' offices in general when he said: 'I think our setting could be less formal. I think sometimes people are a bit intimidated by it'.

Indeed, similar contrasts could be found *inside* coroner court buildings. Figure 16 provides examples of a coroner's courtroom within a large 'medico–legal' centre.

Figure 16. Downtown coroner's court – internal views

This court room was modern, well–lit and, in the words of Andrew, less 'intimidating' than those where the judiciousness of the setting could create an acutely formal and often formidable atmosphere for families. Examples of such a court are provided at figure 17:

Figure 17. Easttown coroner's court – internal views

Furthermore, even though the court shown in figure 15 is some one–hundred–and–twenty–five years old, it was built as a coroner's court. This was in contrast to some newer coroner's courts which were contained within other civic buildings, including courts serving the *criminal* side of the justice system. This was evident during a visit to one coroner's court which was housed in the same building as the Magistrates' Court for the town, as shown in figure 18 below. The coroner there raised this issue with me during our interview – which he declined to have recorded – describing his discomfort with the fact that bereaved families attending inquests must necessarily 'walk past defendants' on their way to the coroner's court.

Figure 18. Uptown coroner's court – external view

Similar difficulties were voiced by others. Both coroner Andrew and support service Director Belinda spoke about situations where the emotions of the bereaved have been directly impacted by the way the courts were organised:

> … I've spoken to another coroner before where, he had erm, a lady who came into an inquest, burst into tears and said 'we got married in this room'. (Andrew, coroner)

> … you've got other buildings where, there's a wedding taking place at the same time as the inquest, because it's a dual–purpose building… it's very difficult, you know because on the one hand you want people to be able to celebrate their wedding, and on the other hand you've got people who are quite upset and emotional and you've got that wedding party walking past them… it's not ideal for both… (Belinda, support group Director)

Coroner Colin suggested that the difficulties of this situation had been aggravated by civic attempts at rationalisation, which is presumably a function of reduced resources and funding. He was explicit in telling me that with regards to civil, rather than criminal, court buildings:

> … generally they're all ropey… last year the government… closed an awful lot of county courts, and they've started to suggest that erm, they will start he—having court hearings in less conventional places. And they did suggest pubs at one stage… it's a thin end of the wedge isn't it?

This is interesting as the application of such an intention, rather than being a step towards improving the accessibility of the coronial service for families, would potentially see the inquest

returning to its medieval roots in terms of hearings being 'often convened in public houses' (Sim and Ward, 1994: 246). Support group Director Belinda confirmed her experience of the inadequacy of many court facilities:

> I think it puts the coroner's service on the map where, they are, which is the poor relation in terms of the Justice System, because they're not treated with the same [pauses] respect, or gravitas as the erm, the criminal court. You know you wouldn't dream of a, a trial being heard in, I don't know a room like this for instance, but that's what coroners have to do. Some of them have to hold them in hotels!

The outcome is that, in arriving at the inquest, families are met with a level of formality and bureaucratic rubric which surprises them and adds to their already heightened emotions. This, together with their desire to find reasons for the death, and their attempts at managing their emotions, caused chaos in the minds of the bereaved which was augmented by the necessity for them to then interact directly with a system which purports not to allocate responsibility or lay blame, but – as shall be demonstrated below, and which was alluded to in the last chapter – often does exactly that.

7.2.2 The blame game

Symbolically, families' attempts to venerate the deceased is very different to an explicit recognition by the State that a person 'innocent'. Appendix 4 details excerpts from two separate inquest observations into road collision deaths, at different coroner's courts. An analysis of these, together with interviews and observations from other inquest proceedings, and discussions with families, led to the conclusion that coroners' personal views on liability in the context of the inquest are often very different to the 'party line', which – as judges – they necessarily espouse. Furthermore, these views colour their approach to inquest hearings, where they often behave in a way that makes clear where they believe responsibility for the death lay.

Each one of the eight coroners interviewed as part of data collection was keen to stress that an inquest is not a forum for the apportionment of blame. Indeed, during observations at nineteen inquests, all coroners, without fail, addressed the issue of 'blame' as a central precept in open

court. For the most part, this happened at the outset of the proceedings, with coroners laying down the purpose of the inquest – who, where, when and how – followed by an elucidation of the 'no blame' culture of the system. The language used to put this across varied, with coroners stating that:

> This is not a fault–finding inquiry. (Catherine, coroner)
>
> This court does not deal with blame. (Alex, coroner)
>
> Coroners' courts are not in the blame game. (Michael, coroner)

Some coroners were wholly of the opinion that families *do* seek to place responsibility on another person or persons for a death, to the point where this is almost expected, and it leads coroners to themselves adopt the role of 'emotion managers' on occasion. This emotion management by those in authority entails the use of 'strategies' by coroners, either by implying at the inquest that they recognise a particular party as being at fault for the collision or – as was apparent in one inquest observation where two drivers as well as passengers had been killed – making explicit the announcement that one of the deceased would have been prosecuted for dangerous driving had he lived. In this way, while not being 'allowed' to point the finger of blame, coroners' feelings of sympathy for families was apparent in deliberate moves to make it clear to the bereaved that they had a view of where responsibility lay. For example, coroners Carl and Andrew both alluded to their efforts to tacitly lay blame:

> I actually do nearly say that sometimes… I mean you know when you start talking about there've been failures of this failures of that, erm, which you're allowed to do, erm that's pretty much saying 'huh, their fault!'. But you just can't say it's their fault. (Carl, coroner)
>
> … it's tricky because it's a fact–finding process you can't apportion blame, erm, but I'd have gone as far as I could, in making it blindingly obvious to, the reader of the record of inquest that, that other car, was right over on the other side of the road. I'd have probably incorporated the argument between him and her in that as well, without saying, that—you know that it was his fault or, but it would have been obvious. Driver A was, perfectly on

> his side of the road, the other car was over on this side, and insofar as I can without saying 'this is an Unlawful Killing or—, it was all, down to him'. (Andrew, coroner)

Moreover, coroner Carl, when asked whether he believed families were disappointed when they were not able to publicly declare someone responsible for a death, went on to explain that: 'Not if you handle their expectations properly. But would they like me to say at the end 'and it's his fault!'. Yeah course they would, course they would…'.

Other coroners, however, claimed this to be a misconception, explaining that in their view what the bereaved wanted was to understand what had happened, rather than hold someone accountable. Indeed, one coroner expounded her belief that once the bereaved can find a reason for a collision, not only are they more accepting of the death, but they are also more able to acquiesce to the idea that their family member might themselves be at fault:

> … I remember a particular case where, it was a very very young, deceased er person, and it was contrary to what the family believed, but the evidence was everything, that would lead, to actually it was the fault of, their loved one, that's caused it, and it wasn't the fault of the other person. And I walked in, knowing, that the family won't be happy. But I had to reach that conclusion, and I said to them I said, at the end I said 'I know you're not happy with it but I've got to look at the evidence and the evidence is' and I went through all the evidence as to why, and one of them surprised me completely shocked me, and it was actually in this room… walked forward… and, shook my hand and said 'thank you'. Which I was absolutely astounded by. (Asha, coroner)

The assumption by some coroners that the bereaved are looking to blame someone for the death of their family member leads them towards pre–emptive management of the inquest hearing. Despite their vehemence that the inquest does not exist for the apportionment of blame, their narrative illustrates a dichotomy between the coroner's role as a death judge and their own personal and human moral constitution; they thus sit 'between legality and empathy', something that was considered in chapter 7. This is a central observation because it assumes that a desire to blame is the main focus for the bereaved at the inquest, a notion that has been identified as something of a misnomer.

Although every inquest is inherently different because it deals with the individual circumstances of a death, similarities were evident between all of those attended as a consequence of the legality of the hearings. The questions of who, when, where and how a person died must legally be answered at every inquest, and the 'Record of Inquest' form – shown at Appendix 3 – would dictate the inquest as a 'tick box exercise' were it not for the fact that there is powerful symbolism in the bureaucracy of the box ticking.

If a family chooses not to attend the final inquest hearing, however, a layer of formality in terms of what is read out by the coroner is discarded. Even though a recording of the inquiry is still taken, there is, for example, no need to explain the purpose of the inquest, and the proceedings are much quicker – illustrating that the presence of the bereaved does have a bearing on how the hearing is conducted. However, as discussed in section 6.3, the absence of a family at inquest observations was rare, as the great majority were present for the inquests of their family members. On these occasions, observations highlighted that despite the legal and bureaucratic similarities of inquests, each coroner approached the proceedings in a slightly different way in terms of the narrative that they used, their manner and their behaviour towards the court.

7.2.3 Coronial conduct

Writing about coroners in the Victorian period, Anderson (1987: 16–17) describes how they:

> … were removable for misbehaviour only by the Lord Chancellor or after conviction before a court of law. They settled their own procedure and could exclude the press and public from their courts if they wished; and neither the Home Secretary, the Lord Chancellor, nor anyone else had more than the most limited control over them… Coroners… were thus as much entitled to pride themselves on their independence as were their critics to deplore their arbitrary powers.

Even though the press and public can no longer be excluded from an inquest, coroners continue to hold a somewhat reverential position within the Justice System. Much of the official guidance published by the Ministry of Justice and House of Commons regarding the function and process of the coronial system in England and Wales, describes the legislative role of the

coroner but they remain silent on the way in which that role should be conducted. For example, the Chief Coroner's Guide to the Coroners and Justice Act 2009 (Ministry of Justice, 2013a) deals with: coroner appointments; coroner terms and conditions; coroner availability; and disclosure of information during the inquest process. It does not touch in any way on the personal attributes or comportment of a coroner, something of a paradox given the quite detailed FLO guidelines described in section 7.1.

What the Chief Coroner's Guide *does* do is devote clauses 40–42 to 'Coroner disciplinary arrangements', which include the following declaration:

> The Lord Chancellor, with the agreement of the Lord Chief Justice, has the power to remove a senior coroner, area coroner or assistant coroner from office if that coroner is incapable of performing his or her functions or for misbehaviour. (Ministry of Justice, 2013a: 6)

However, 'misbehaviour' is not defined. For clarification, one must turn to the body which is responsible for dealing with complaints about the personal conduct of a coroner – the Judicial Conduct Investigations Office ('JCO') – to deduce what this conduct should or, should not, be. Thus, under the heading 'What can I complain about?', the JCO website states that:

> We can only deal with complaints about the personal conduct of judicial officer holders. This means that we cannot accept complaints about a judge's decision or the way a judge has managed a case. (Judicial Conduct Office, 2018)

This reads as at once ambiguous and becomes even more so when one sees the following listed amongst the points that the JCO will not investigate: 'A judge's body language, facial expressions or how a judge has looked at a party'. Yet, as will be described below, and, as articulated by barrister Colin, a coroner's demeanour can sometimes appear lacking, which can become an important issue for families who are on the receiving end:

> And lots of judges when they get a little taste of power go all doolally… once they're sitting on a full–time job it's actually very hard to get rid of them… and occasionally I think it goes to some of their heads. There are excellent ones, and there are appalling ones. You

> will get the diligent ones, who understand something about life, and death, and are wise. And you get some who are, just very crass and don't know anything about life. But you see that in the crown court, you see that in the civil courts. It—there's no way I think to erm, screen them out.

7.2.4 Empathetic adjudicators

Despite Colin's reservations, coroners themselves were, generally speaking, very conscious of the emotional difficulty encountered by bereaved families when attending an inquest, and they were sensitive to the fact that evidence would be heard, and documentation would be read, which families find very difficult, even with prior knowledge of the facts. For example, and unlike the oft–seen wholesale disparagement of a witness that occurs in a criminal trial (Rock, 1993), coroners can and – as noted during inquest observations – often do, use their discretion to balance families' needs with legal requirements, making a considered choice as to whether to read out particular pieces of evidence such as suicide notes or text messages that may cause undue embarrassment and sensationalist news stories (Gregory, 2014). Further evidence of coroners' appreciation of the ordeal being suffered by the bereaved was seen not only in the observations of coroners in court, but also by what they said, as the following examples illustrate:

> … I explain to people, that the worst has already happened. If there's a long time between the death and the inquest, there will be bereavement. Bereavement is healing. So you've got healing and then you come to the inquest, and the legal process then rips off the scab off the wound so it starts bleeding again. You can end up with an ulcer and you can never recover. So, I often explain to people, that the point in the inquest is actually to give them knowledge and that's why we hear inquests as quickly as we can… (Alex, senior coroner)

> Hopefully what I read out there wasn't going to upset anyone. They know they've seen that report they've read it. I'm not going to go into 'and his pancreas weighed so much and he was, split across from ear to ear'. It's just nonsense. (Carl, senior coroner)

> I have a very relaxed style in court because I take the view that relatives haven't done anything wrong you know, it's because they've got tragedy in their life. Unlike a criminal

> court you know where they're there… because they deserve to be. Whereas I think here that's not—so I try never to be, too—too difficult and, and overbearing you know and let the families, you know really, relax and feel that they can, you know that they can participate in approach. (Daniel, senior coroner)

Such utterances illustrate that there stands a complex interplay between legality and empathy, which sees coroners compelled to conduct an inquest because the State dictates that it must be so, at the same time having doubts themselves about the veracity of the proceedings for bereaved families. This observation was aptly illustrated by coroner Andrew:

> … with the best will in the world sometimes, you sit there and, you're doing an inquest and, I'm genuinely sat there thinking 'I'm making this family go through this for no reason'. You know, I'd rather write them a letter. Erm, and so, I do like telling them, 'look, I'm not making you go through this for no—you know just for the good of my health it's—you know this is why this has to be here'.

Furthermore, support group Director Belinda summarised how she thought that the differences in coroners' conduct comes down to their interpretation not only of the law but how they, as judges, feel it should be delivered:

> You know so you might get some, very compassionate coroners, and then others who just go by the letter of the law and are very rigid in that letter of the law, er and see it as a very, very formal process, erm, and that can be—and sometimes that's useful because if there are, tensions within the people who are attending that can often make people, you know behave themselves. But, in other circumstances it can be very off putting, for families and—and they feel [pauses] you know, very tense, the whole thing is very tense, er and it's not always necessary for it to be, so formal and so—so tense because I think it's a difficult enough time as it is for people attending.

This fits with the assertion made in chapter 7 that coroners face something of a 'moral maze' in carrying out their roles, which sees them necessarily behaving decorously in line with what their status as judges dictates, while at the same time recognising the difficulties for families in having to encounter the reality of the system.

7.2.5 Getting the balance wrong

The reduced level of formality alluded to here by Belinda allies it more to the inquisitorial – less formal – system of law than the, more decorous, adversarial system seen in the criminal court and described in chapter 4. Further demonstration of this informality is found in the prerogative of the 'Interested Person' to question witnesses, should they wish to do so, as set out in the following clauses within the Coroners (Inquests) Rules 2013:

> Entitlement to examine witnesses
>
> 19 (1) A coroner must allow any interested person who so requests, to examine any witness either in person or by the interested person's representative
>
> (2) A coroner must disallow any question put to the witness which the coroner considers irrelevant

(Coroner (Inquests) Rules, 2013)

This practice is contrary to procedure in the adversarial Crown Court which, in allowing defendants to 'question the evidence' as part of Human Rights statute, frequently leads to an 'us' (the professionals) and 'them' (the lay court users) scenario with '… the marginalised outsider position shared by victim, witness and defendant' (Jacobson, et al., 2015: 3). For Freckelton (2007), this practice – in allowing the bereaved participation rights and thus enabling them to feel involved in the process – should be seen positively. In reality, however, Gregory (2014) found that this was a matter of equilibrium, with coroners attempting to balance the needs of families with the 'dignity' of the court by 'managing' the questioning – and arguably the emotions – of witnesses: ''I don't want a free for all' said one coroner I interviewed'. (Gregory, 2014: 242)

Certainly, during one inquest observation, the coroner appeared to very much get the balance 'wrong' when, in lambasting the parents of the deceased's girlfriend when they tried to ask a question, the coroner raised her voice to request that they 'go through the family'. The courtroom was small, 'the family' were sat one row ahead and people appeared embarrassed; the formality she was requiring appeared not only excessive but inconsistent with the lack of

instructions that had been given to the court at the commencement of the proceedings on how the process would work. Even though the immediate family – the 'Interested Persons' – would most likely have been told about the procedure regarding questioning, it is far less likely that the wider audience would.

Striving to get the 'right' balance in court was something referred to by several of the coroners with whom I spoke. For senior coroner Alex, it comes down to something he referred to as 'judgecraft':

> Sometimes you would want a greater degree of formality, and then you keep control but you, keep control through your judgecraft. And judgecraft doesn't mean pomposity, judgecraft is about how you, control court… If people behave, and they're respectful, and orderly, anything goes. If on the other hand it's chaos, erm it's the coroner's or judge's job to bring order to the chaos.

7.2.6 Maintaining control

Although rare during fieldwork, on occasion it was clear that the use of 'judgecraft' to 'control' the court was necessary. Courtroom tension saw coroners using 'strategies' to ensure that matters proceeded in way that was calm and, above all, judicious. For example, during one observation, emotions amongst the audience in the court had exceeded the gamut of their moral barometers, such that they had become 'non–compliant' in terms of the capitulation that Goffman's (1969) 'social norms' – and the State – would demand in a courtroom setting. This particular inquest was an inquiry into the deaths of three individuals who had lost their lives in one road collision. Dominic, who was driving while drink and drug–impaired, died in a head–on collision which also killed two of the three occupants – who for the purposes of anonymity has been called Philip and Stuart– of another car travelling in the opposite direction. The case had gone to inquest because there was no–one to prosecute but, unusually – and arguably for the benefit of the bereaved family in the court – it was explicitly stated that had Dominic lived, he would have been prosecuted for Death by Dangerous Driving, amongst other offences. The first witness to be called to the stand was the passenger in the car Dominic had been driving,

and fieldwork notes at figure 19 clearly illustrate the agitation that the proceedings caused for some.

Figure 19. Snapshot of field notes from inquest proceedings taken January 2016

[Passenger name] (in car with Dominic) called as witness.

- She Describes 'getting wrecked'
- 'I could walk and I could talk, I wasn't like, paraplegic on the floor'.

She was in not fit state to drive in the early morning. Lots of swearing from her – 'c' word used a number of times.
She's speaking very quickly and coroner keeps slowing her down. [Passenger name] apologises. Tears at one point.

Coroner: 'Slow down and listen to me' – reprimand like a school ma'am [my observation].

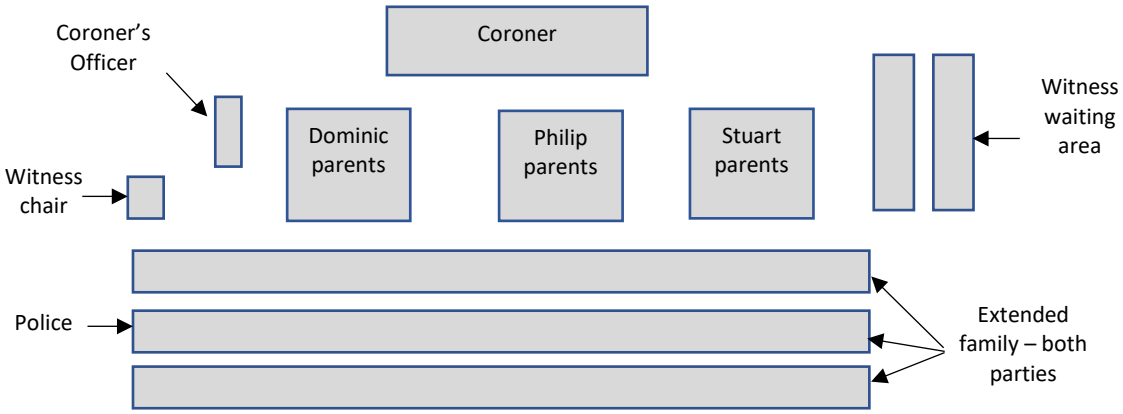
[Witness name] says she doesn't remember the collision.

Coroner asks if there is anything else she wants to say. Her friends are in front of me (including boyfriend and brother) – shake their heads as if willing her not to say anything [my obs].
[Witness name]: 'I understand they [referring to family] want someone to blame'. Tears – says it wasn't her fault.
Then some friction – Philip's sister asked how come driver's door was open? [Witness name]'s boyfriend' said 'It was already open' [he shouted out in her defence].
Coroner keen to keep control.
Now questions from [witness name]'s insurance company.
Started fighting – Dominic's partner kicking off at witness boyfriend who made comment which I couldn't hear. She said 'You haven't lost anyone have you?!'.
Police get involved. Coroner rises court and leaves.
Police – speaking to and about everyone to calm it down. Tells them to:
Be respectful of people who have lost people
Be respectful of fact it's a court
Meanwhile witness has stormed out: 'You can all answer your own fucking questions!!'
Families of deceased at front conducting themselves with dignity. Witness 'representatives' agitated.

While the coroner's attempts to keep control in the court and avoid conflict should be noted, throughout the hearing, the parents of all three of the deceased – including the parents of

Dominic – sat feet away from each other, with all other family members seated in the rows behind, as shown in the diagram at figure 20 that was drawn at the time:

Figure 20. Courtroom layout penned during inquest observation January 2016



This arrangement is very different to the layout found in a criminal court setting, where affected – but uninvolved – parties like victims' families are now segregated both practically and symbolically during the proceedings. This in itself is a recent development in the Criminal Justice arena – families were previously required to sit with the defendant's family in the public gallery – demonstrating how the State 'takes over' the proceedings in an attempt to prevent dialogue and potential conflict. Since such a separation of parties is deemed not to be necessary at an inquest by virtue of the blameless nature of the death, it is left to the coroner – and potentially the police who are usually present albeit in their capacity as witnesses – to use their authority to control the proceedings and prevent any friction.

7.2.7 Declining deference?

On this note, throughout the period of fieldwork observations, it was notable that families, while occupying the same, highly emotive space as 'adversaries' in a coroner's court, were able to manage their emotions effectively enough to behave in a dignified and reserved manner. Even when the system forced them to conform to a situation which they found intractable, families generally accepted it and adhered to the social norms required of them in an area highly regulated by the State, and Janet's case was indicative of such an inquest.

In being expected to attend the inquest with the family of the 'other' driver who had died in the collision, she and her family felt worried, as she explained:

> I was aware of how Damian felt about it and he still really didn't—he was still a bit like this 'oh God I don't really w—' I don't know why, in his mind, he was—you know he just kept saying 'well you know you don't know they might be a really funny family and they might be one of these aggressive families that kind of blame you even though it's not your f—' yeah I—I don't know, he'd got something in his mind that he, was really worried about.

Janet and her family had requested that the inquests into the two drivers be held separately, but the coroner had dismissed this, as appears to be the normal course of events at an inquest where more than one person has died. On enquiry, this was assigned to – bureaucratic rather than emotional – constraints around budgets and practicalities, since more than one inquest using the same evidence and calling the same witnesses would be costly both in terms of time and money.

Nancy, the FLO in David's case, felt that Janet's aversion to seeing the other driver's family was misguided, implicitly making a judgement about how Janet and her family *should* have felt:

> … the coroner has said 'no it'll all be done on the same day'… I think their concerns as a family was that they weren't sure about who this family were and I think in their minds 'oh a young 21–year–old he might be a bit scroty, a bit—', you know, in actual fact he's just a nice lad that unfortunately has had row with his girlfriend probably no different to their own son...

This raises an interesting issue about the inquest hearing itself in that, as there is no blame, there is an implied notion that there are no – or will not be – feelings of conflict between the parties who attend. This is, of course, quite different to what happens in a criminal court when there is often an expectation of hostility between factions and is particularly the case with road death where it is felt that one party 'caused' the death of another. Indeed, the findings show that feelings of hostility between families can and do lead to conflict being brought into the road death inquest, and this was confirmed by more than one coroner:

> They start fighting occasionally. (Carl, coroner)
>
> … sometimes you know we'll get, people who actually shout out and heckle and, you know saying 'nonsense'' and storm out you get a lot of emotion, pouring out there… (Daniel, coroner)
>
> You will see it kick off. You will occasionally see fisticuffs. (Colin, coroner)

Furthermore, conflict *within* families – a common thing in those who have suffered a sudden and traumatic bereavement as outlined chapter 5 – also sometimes plays itself out in the inquest. Coroner Andrew described how one of his 'tactics' in the courtroom if it is felt beforehand that there is a danger of conflict, was to 'almost bore people into submission' by going over the legally–required aspects of the hearing. Thus he would:

> … talk about the forum, talk about the questions that we need to address, talk about, you know, it's a fact–finding exercise etc etc, erm, and by the time you've done that for 10 minutes, things have usually sort of relatively calmed down… .If as very rarely happens the volunteers came to me and said 'hmm bit or a problem with this one, families aren't talking it's an estranged family etc, erm, one's shouting at the other', I'll say, deliberately, erm 'get everybody into court', I'll come into court, erm, we'll start it, and then if I need to come out then I will do… and then, I can do my, spiel for 10 minutes and that tends to diffuse things, and then I can say 'look, if you've still issues to discuss I'm going to step out of court or are you happy for us to get on with it?' and 9 times out of 10 they'll say 'I'm happy to get on with it'.

Andrew suggests that situations of conflict are 'rare', but he is speaking with reference to his experience in *all* inquests into sudden death of all kinds. It would be interesting to know – although extremely difficult to discover – what proportion of those hearings where conflict emerges are inquests into road death. It is likely that – unlike with inquests into suicide where no–one else is involved for example – coroner Daniel's view that '… one of the manifestations of grief is to blame someone… ', added to the meaning–making, reason–seeking and tendency to want to attribute responsibility that were demonstrated in section 5.2, means that the road death inquest is more likely to prompt discord. Certainly, and at least with regards to road

collision, it has a stance which is rooted in its desire to deny the 'need' for dissonance given the fact that there is no explicit recognition of guilt, but often this does not chime with the beliefs of the bereaved.

However, in Janet's case, and despite feeling discomfit because of her feelings of antagonism towards the family of the 'other' driver, she described how she and her family behaved in a demonstrably complaisant fashion in the lead up to and throughout the inquest. For the most part, and regardless of whether a coroner was successful in achieving a balance between appeasing the audience and accounting for the State, or whether he or she was deemed to be preserving the requisite level of compassion, the majority of families observed showed great deference to the coroner, the court and the law in the inquest setting. While families said they were dissatisfied with the system, particularly in the lead up to it, on the day of the inquest they were wholly acquiescent in terms of their conduct, contrary to the 'decline in deference' alluded to by Hutton (2015) and which was discussed in section 7.2.

Tyler has shown that such deferential behaviour is typical of those who find themselves in a court setting which, in turn, stems from views of the legal system as 'legitimate' (Tyler, 1990; Tyler, 1994; Tyler and Huo, 2002):

> Legitimacy is a value in the sense that it is a feeling of obligation or responsibility that leads to self–regulatory behaviour – that is, voluntarily bringing one's behaviour into line with the directives of those authorities one feels ought to be obeyed. Individuals with strong beliefs in the legitimacy of the police and the courts are more inclined to self–regulation; they take personal responsibility for following laws, accept the decisions of legal authorities, and are more like to defer voluntarily to individual police officers and judges. (Tyler and Huo, 2002: xiv)

Such legitimacy leads to the co–operation on which legal authority depends, and '… includes willing acceptance of legal authority, deference to the decisions made by judges and police officers, everyday rule adherence, and willingness to aid the police…' (Tyler and Jackson, 2014: 3). Tyler (1990) tells us that in perceiving a legal system to be moral and just, people feel a

'normative commitment' to it. Their evaluation of such a system is less related to outcome and their own self–interest, and more related to whether they feel they have been heard, and whether they have been treated with dignity and respect along the way.

In the context of the road death inquest, Tyler (1990) is right. Both the coroners and the bereaved that interviewed described feelings of hostility within families and towards others which found their way into the inquest hearing itself. Yet for the most part, the bereaved – at the same time as decrying the behaviour of conduct of those with whom they had contact – acquiesced to both the coroner and the system as a 'legitimate' legal procedure. Where the coroner was felt to be empathetic towards a families' plight, this was appreciated: ', even amongst those who had found others involved in the process lacking: '… I thought she [the coroner] was, brilliant. I thought she was great' (Nadia, bereaved partner); 'I thought she was very efficient, and erm succinct and… I thought she actually worded her words quite kindly' (Vivien, bereaved mother); 'I mean the Coroner was fantastic…' (Tania, bereaved mother). However, when the procedure in general, or the manner or behaviour of those within it had been perceived as poor, the legitimacy of the system was called into question. Again, Tyler (1992: 442) has an explanation for this:

> Why do those who experience judicial hearings react to issues of participation, dignity, and trustworthiness? The answer lies in recognising the important role that legal and political authorities play in defining people' feelings of self–esteem, self–worth, and their sense of personal security.

As we know, a 'sense of personal security' is something that those bereaved under sudden and violent circumstances lack profoundly. Yet coroners' attempts to adapt to the increased status of the bereaved as 'consumers' within the inquest system is something some of them have been more successful at than others. They are locked into the Justice System and the formality that a system bound by statute brings, at the same time as the lack of clear and uniform guidance provided by the State on coroners' demeanour and comportment, sees them operating idiosyncratically within their roles. In addition, although some coroners' moral rectitude when

dealing with those suffering such profound and complicated grief is pronounced, for others the view of their role is wholly juridical, and, for most, their view is to attempt to straddle both sides of the coin but that is set against each side of it constraining the other. Needing to bestraddle their role as State representatives in the administration of death and the demands of new victimhood is challenging, leading to a lack of uniformity across courts and confusion amongst the families who encounter them.

7.3 The coronial bereaved: secondary victims or dissenting service–users?

Following on from this, an important question, and a main aim of this research, is to draw a conclusion about the victim status of those bereaved by non–culpable road death by assessing what effect the inquest has on their worlds. Should they be labelled 'secondary victims' in a way that is akin to the label applied when families suffer at the hands of the Criminal Justice System (Casey, 2011; Parsons and Bergin, 2010; Rock, 1993; Rock, 1998; Sanders and Jones, 2011; Shapland, et al., 1985; Thiel, 2013), particularly given continued attempts by survivors' groups such as RoadPeace and Brake to campaign for and raise awareness of them *as* victims?

7.3.1 Victim agency

Those bereaved by road death have lost a central person in their lives; they feel aggrieved, not only by the death of their family member, but often by their treatment in the preface to the inquest. When their immediate and traumatic grief is followed by what they see as poor treatment from the State and its agencies, they can feel dislocated from, and frustrated by, the system. This, according to Scraton (2016: 465), is almost an inevitability:

> Whatever reassurances are given by judges and lawyers that courts and their processes belong to 'the people', the law's traditions and reverential conduct are constant reminders to the contrary.

Such contentions concur with assertions put forward by the likes of RoadPeace, Brake and the World Health Organisation who see the consequences of road death as trivialised by the State. However, the fact that families often feel let down and frustrated by the system does not

necessarily mean that they are victimised *by* it. After all, in Kenney's (2004: 225) definition of a secondary victim as '… the interplay between victims' social and institutional interactions, on the one hand, and their agency to cope on the other', 'agency' is important. Support worker Belinda's explanation of the interplay between the event of the collision and people's ability to cope with it is succinct:

> When people are facing adversity they, pull things out of the bag that, that even they didn't know they had. It's the very adversity that makes them stronger, and it is really interesting and yet, other people are just left, completely, you know, mentally unstable… I think a lot of it is to do with the death and the circumstances of the death, and it is always going to be complicated… But, I think some people manage that process better than others.

To exclude the agency of the bereaved would be to deny the 'resilience' – in the context of victimisation (Green and Pemberton, 2017) – that results from them 'taking part' in their grief as an 'active process' (Attig, 1996). The fact that those bereaved by road death have the capacity for resilience in the fact of traumatic loss was seen amongst interviewees in the sample, as the following example shows:

> It's funny… since he's not been here and obviously it was dreadful and, you know and, I think you suffer and everything else… and then now I think, 'well, here we are sort of 8 months on and, and I'm still here. You know we've all lived, we've all done our thing for the last 8 months and, and I'm ok, really, you know. (Nadia, bereaved partner)

In this way, and despite all the interviewees being adversely affected by some part of the coronial system, this was mitigated to a degree by their agency, which enabled them to move forward emotionally; as suggested by support worker Darren, '… you don't recover you adapt'.

For others, however, their ability to adapt was much more difficult and, as outlined in chapter 5, bereaved families do not just feel grievance as a result of poor treatment at the hands of those administrating the coronial system. Given that the coroner's court, in investigating non–culpable road death is an arena where conflicts of interest abound, the bereaved also suffer as a result of the disparity between what they expect from the inquest and what it becomes evident

that they are going to get. In this way, the impact of their social world on their agency is important (Bandura, 1989; Bandura, 2006) since '… in many spheres of functioning, people do not have direct control over social conditions and institutional practices that affect their everyday lives' (Bandura, 2018: 131).

Furthermore, this lack of direct control can be compounded by the fact that despite the State requiring the involvement of the bereaved in the coronial system in the first place, their ability to access the 'justice' it provides is not uniformly attainable, something which is considered in the next section.

7.3.2 Access to justice

Once the bereaved are told that the death of their family member is non–culpable, their engagement with the coronial service is not discretionary. Even if they decide not to attend the inquest hearing itself – which, as was outlined in section 6.3 is rare in the case of road death – they will receive documentation and communication pertaining to the death from the relevant coroner's office. This situation makes it something of a paradox that families' access to justice in this context is then seen to be undermined, whether this was financial or for more socio–economic reasons.

Certainly financially, it was often the case that families were unable to afford legal representation at an inquest, where – as outlined in section 4.5 – no legal aid is available. Concerns of this nature were voiced in an interview with Phil who felt that he and his wife Naomi were not getting the answers they wanted from the police about his brother's death while driving a Heavy Goods Vehicle: '… we're left in a kind of—who do we turn to to get this really sorted out you know. We're not rich people we can't really afford a solicitor. It's erm, all a bit awkward in that—for us'.

It is important to understand here, given that a coroner's court is not one of liability, why bereaved families should need representation at all. Colin, a barrister, explained that there are a number of reasons why families might benefit from the services of an advocate at an inquest.

The first is that families do not always have confidence in the version of events that is being put forward by the police or the Crown Prosecution Service, he said. As discussed in section 6.2, there is very little opportunity for recourse in the coronial system, where decisions made with regards to culpability by the State are not open to challenge and there is thus no right of appeal for bereaved families. As one Coroner's Officer explained , people have to believe that what the police are saying, and doing, during their investigation, is as it should be, and that their decision not to prosecute is a wise one informed by evidence. She acknowledged that this does, though, require complete trust in the police. When asked what families should do if they feel they are not receiving the answers they would like, she said that they would need to pay a lawyer to represent them. Sometimes they could 'go through the coroner' who might reopen an investigation but that was unusual, she said. Thus, as Colin explained:

> … the main reason a family might want to get a barrister involved is er, questions. So for instance they don't agree with what the police may have written, they don't agree with what some of the witnesses may have said, because even though, a literal interpretation of what the coroner's got to do is this person was in a car, and they died, they actually do delve and try and find out a little bit about the narrative and what went on.

Even where a legal representative is appointed at an inquest, this does not mean that the outcome for families will be any different. For instance, bereaved daughter Sophie felt that both during the investigation and at the inquest into her mother's death 'things have been covered up so much' but:

> I've spoken to my solicitor about it you know he was there, and he said he felt—it was the first time he's ever felt like walking out of court himself… I said 'do you think we need to put a complaint in about this coroner before it's too late?' and he said 'the coroner is untouchable…'

The second reason why an advocate might be used at an inquest highlights another of the situations where access to justice was diminished. Where a family lack the confidence – or simply do not have the wherewithal – to ask the 'right' questions themselves, paying a solicitor

to act on their behalf means a greater level of assurance that their interests are being represented. Again, the interview with Phil demonstrated that this was a very real issue for families:

> The only problem is really we could do with some of these a—questions, answering before… you know I'm not a talker I do get very nervous, and I just feel, I could do with somebody legal or something to ask these questions for me… we feel that we'd like someone to, ask for us, 'cause we're not, you know… I get nervous and we're not people of authority. (Phil, bereaved brother)

Another, financial reason, why bereaved families might feel the need for legal representation at an inquest, is that, as barrister Colin again explained, they might want to have the option of a later claim for compensation under the Fatal Accidents Act. In this scenario he said, 'the coroner's court is the first opportunity they have of testing the other witnesses on the other side'. As a non–adversarial process, there is no 'cross–examination' of witnesses during an inquest, where either the family as Interested Persons or their appointed lawyer are invited to ask questions. However, and as Colin explained, this questioning is used as a means of assessing whether those who witnessed a fatal collision will provide the evidence he – as a solicitor – will seek at a later claim. Thus:

> … it's important to gauge as early as possible, are they going to be good witnesses, did the old ladies actually say what they saw, erm, did the police put words into their mouths which, very occasionally happens, or did other people put words into their mouths… lay people like you and me are notoriously unreliable in gauging speed, for instance, of cars. Lots of people say 'oh he was doing sixty or seventy' and it comes out they were only doing twenty or thirty… Erm, road traffic accidents, 70 or 80 per cent of the time you know who's gonna win and you know who's gonna lose. You know, if you get a set of papers that shows your chap's got convictions as long as his arm, six drink driving offences in the six months before the accident and was killed on the day—on a Saturday night at 11 o'clock and was found with excess blood in his alcohol [sic], you're not going to win so, unfortunately in those circumstances the family almost certainly are gonna have to pay for it if they want someone to go along and argue their corner.

It was not only barristers and families that highlighted these issues with regards to families' reduced access to justice. For example, support worker Darren was explicit in suggesting that different socio–economic groups have differing expectations as to what the legal system should provide them with. This 'social capital' (Bourdieu, 1986) is not uniform but rather is more available to those who acquire it through their higher positions of power, status or social networks. In the context of the Justice System and, as explained by Darren, higher–status, higher, socio–economic groups often have the ability to manoeuvre – or manipulate – the Justice System to meet their own needs and give themselves an advantage. They generally know where to go for support, have an ability to ask – and get – and generally interact very differently with the system than people from a lower socio–economic groups. Conversely, those members of less advantageous social economic groups tend to have more of a 'put up and shut up' mentality, 'suffering' the system rather than being in control of it, and this is a situation that coroner Andrew described as the 'inequality of arms'.

This situation – in terms of the coronial system's disallowance of challenge and inconsistencies in families' access to justice – leads some more vulnerable families to flounder in the context of the coroner's court, and this leads to a greater sense of victimisation by the system. When this situation is juxtaposed with: the narrative around the non–attribution of blame used by those in authority both inside and outside the court setting; the mismatch in expectations that the inquest as part of the Justice System brings; and the fact that some families experience the coronial system as something they must 'endure'– their status as secondary or co–victims within the context of the coroner's court is confirmed.

7.4 Conclusion: a victimising process

From the moment the police arrive to inform a family of a death on the road, throughout the investigation and until the time after the inquest hearing, bereaved families were impacted, sometimes positively but often negatively, by those who work most closely with the coronial system. The manner and behaviour of the agents involved, including the police, court and administrative staff at the coroner's court and other parties such as hospital staff, local councils

and the media, often fell short of families' expectations given the traumatic situation that they found themselves in. In addition, issues with access to justice for the bereaved, whether logistical, financial or socio–economic, as well as the disallowance of any type of challenge to coroners and their rulings, meant that some of the bereaved felt disadvantaged throughout the whole process, further impinging on their view of the coronial system as 'fair'.

In asking whether these dynamics led to secondary victimisation amongst those bereaved by non–culpable road death, findings show that not only is it difficult but erroneous to divorce families' experience of the coronial system from their agency, outlook and perspective. However, it has also been demonstrated that the coronial system itself and those that work within it, have a bearing on the weight of the loss and the emotional burden felt by the bereaved. Certainly, the extent to which the bereaved were able to accept not only the death but the explanation that was being put forward for it, was the difference between a more protracted and complicated grief, and a grief borne out of 'normal' mourning. Even for those families who appeared to be 'coping well' with the death, their lived experience of the inquest process – from initial interactions with the police, the allocation of a Family Liaison Officer, administrative interplay with the coroner's court and finally attending the inquest hearing – left the bereaved with a powerful negative or positive 'ending' to the death of their family member. Indeed, when families' experience of the investigation in the lead–up to the inquest felt like something of a lottery in terms of who they were forced to deal with, and how they were treated, their experience as a whole was poor, even when the hearing itself was well–conducted. Conversely, when families went into the inquest feeling prepared and supported, the impact of what they termed a 'poor' outcome was lessened. Ultimately, the very fact that their bereavement was tied intimately, not only to how they coped with their emotions around the actual death, but also how those emotions were affected by the State–bound social system that subsequently ensued, confirms that status not only as co-victims of the death, but as secondary victims of the system that deals with it.

The following, and final, chapter, concludes the thesis, by drawing together all of the findings and reflecting back on the research questions as set out in the introductory chapter at chapter 1. In addition, it considers the answer to the overarching question of whether bereaved families are victimised as a direct result of the contact that they necessarily have with the coronial system.

8. Conclusion: victims of a death *and* a system

It has been shown within the literature review at chapter 2 that for those bereaved by violent crime, dealings with the c*riminal* side of the Justice System can be re–traumatising for families, creating 'secondary victims' whose suffering is compounded by their contact with the courts and those within them. The fundamental consideration of this research was to consider whether the coronial system, integrated within the Justice System in England and Wales, re–victimises those bereaved by non–culpable road death in the same way that the Criminal Justice System has been said to do – given their obligation to interact with it at some level. Certainly, for those facing the criminal court, there is a tendency to make certain assumptions about, and often misunderstand, how the system operates, resulting in part from inaccurate and misleading media representations. Yet It has been demonstrated that not only does this same situation exist, but that it is further pronounced with the coronial system, which is less often encountered and even more misunderstood.

Medieval in origin, the coroner's role developed from that of an early State accountant with an involvement in *criminal* justice, to overseer of the Foucauldian State's 'political–technology' used to investigate, categorise and register sudden death. Recent attempts at reforming the coronial system have gone some way towards its remodelling, particularly in light of the recognition of victims and a wider victims' movement. However, critics continue to speak of significant deficiencies within the system such as the purported lack of consistency across coroner areas, inequalities due to coroners' personal interpretations of – and independence within – the office, and diminished opportunities to access the 'justice' that the system provides, all of which are at odds with moves by the Chief Coroner – a newly created role – towards 'putting the bereaved at the heart of the system'. This research aimed to corroborate this having regard to the experience of those bereaved by a specific kind of sudden death: road death.

For those who experience the loss of a family member in a road collision, and while the deceased stand as the primary victims, the bereaved can be said to be 'co–victimised' by it. The traumatic grief they experience is 'complicated' by the suddenness of the death, the imagined suffering

of the deceased, a damaged body, and the perception that the death was somehow avoidable and 'unnecessary'. This is borne out in the literature, as is families' consequent desperate search for knowledge about the event, in seeking to provide some significance to their loss. Moreover, in the face of such a loss and as also described in the literature, there was evidence of family breakdown amongst participants. However, enhanced familial relationships were also apparent, borne from a sense that people should 'make the most of' the time they had left'. Moreover, in contradiction to much of the literature, the loss of an older person in a road collision was not easier for the bereaved to accept.

Commencing with the death collision, leading through to the coronial investigation, and continuing into the inquest hearing itself, when the police and Crown Prosecution Service deem there to be no culpability for the collision, families find themselves facing a system which sets itself up to establish the 'truth' of how a person has died in order to categorise, commit to record and ultimately register a sudden death, while at the same time investigating without apportioning blame. It has been argued within this thesis that, in the case of road death, this amounts not only to an acceptance by the State of such a death, but moreover as a justification *for* it, with the inquest standing as a vehicle for the State to assert that the death 'could not be helped'.

In order to draw a conclusion as to the overall research question – whether those bereaved by non–culpable road death are secondarily victimised by the coronial system – three sub–questions were posited and addressed. Namely: whether judgements are made by those inside *and* outside the inquest system regarding who is 'to blame' for the death leading families to feel stigmatised and isolated; whether there stands a discrepancy between what the bereaved seek from the State in response to the death of their family member, and what the coronial system not only sets itself up to – but also exists – to provide; and finally whether there exists an incongruity between what families – given their traumatic grief – perceive themselves to be entitled to in terms of their treatment by those in authority, and how those involved in the 'death system' operate. The findings from these inquiries (considered in detail in chapters 5, 6, and 7)

are summarised in sections 8.1 to 8.3 below, followed by a response to the overall research question in section 8.4. Section 8.5 then goes on to explain the importance of this research as a unique and necessary contribution to knowledge within the socio–legal arena.

8.1 Stigmatisation following a sudden and traumatic loss

The first research sub–question confronted the stigma which, as outlined in the literature review chapter, attaches itself to the family of someone who has, for example, died in the case of homicide or through a drugs overdose. In asking whether similar judgements are made in the case of death by road collision it is important to acknowledge that appraisal and assessment of the bereaved comes from two corners.

Firstly, for the bereaved themselves and those *outside* the inquest system, road death is not only unexpected and traumatic, but also violent and horrific to imagine. In the early stages of the death process, families felt a deep–seated need for knowledge about the event that led to the death, concurrently seeking reasons and using mental strategies to 'explain' the loss to themselves. As part of this they had a tendency towards responsibility allocation for the event, expecting a moral response to their plight from a society which had 'allowed' the death to happen. Wider society in turn, in seeking to shun such explicit reminders of its own mortality, had difficulty not only relating to, but communicating with, the bereaved, who endeavoured to 'manage' their emotions for fear of their grief being seen as something of a pestilence.

The second group who were found to be guilty of adjudging the deceased – and by implication the bereaved – were those inside the system who make decisions, and assumptions, about the circumstances surrounding the death. In seeking to allocate responsibility for the death and finding a system which not only does not lay blame but which actively shuns the laying of liability, commentators have asserted that families feel frustrated and let down, believing that they have been conspired against by a system for whom the death is unimportant. This was confirmed by the data, with the bereaved finding themselves confronting the paradox that, not only is no–one responsible for the death, but their family member is therefore not recognised as

completely ‘innocent’. The ensuing sense of malfeasance is compounded by the dichotomous narrative of those on the ‘frontline’ with regards to culpability, and it led to families’ interactions with the police being clouded by a ‘them and us’ mentality. Indeed, it was often felt that flawed decision–making and a sense of police investigators wanting to ‘move on’ meant that brevity was favoured over the articulation of an accurate representation of the collision event. Moreover, inquest proceedings themselves were often affected by coroners’ personally–held notions around liability and the (non)attribution of blame.

8.2 Mismatched expectations

The second research question considered whether there stands a discrepancy between what the bereaved seek from the State in response to the death of their family member, and what the coronial system not only sets itself up as – but also exists – to provide. More specifically, given that the public are generally unaware or misinformed about the role of the coroner as a ‘death judge’, and that the bereaved necessarily encounter the system when they are in a highly emotional state, is the bureaucratic nature and outcome of the inquest divergent to their expectations?

In terms of the inquest hearing itself, families’ erroneous expectation was that, even if the police had not managed – or sometimes not even tried – to get to the ‘truth’, the coroner, and the inquest – as part of the *Justice* System in England and Wales – would not only seek, but find, both the truth *and* justice. It soon became clear, however, that this expectation was at odds with the primary function of the inquest as an essentially legal process, and despite the State setting itself up to provide families with answers – through the definition of the system as a forum for discovering who, when, where and *how* a person has died – families’ expectations were high.

On arrival at the coroner’s court, families often encountered a highly formal setting or an inadequate one. Procedure was eminently ordered, ceremonial and bureaucratic, and greatly affected by the presentational style of the individual coroner and their personally–held notions

around liability. In part, families' experience of the inquest hearing itself was a consequence of the historically perpetuated and archaic nature of the coronial system, which displayed a continued rhetoric – and often tacit behaviour on the part of the coroner – towards the retributive. This was despite coroners' proclamations regarding the 'no blame' *dictum* of the coroner's court which demonstrates a moral dichotomy for coroners between the obligation to carry out their socio–legal duties, and their more humane sympathies towards the bereaved.

This retributive, punitive narrative was something that carried over into coroners' definition of the word 'justice' in the context of the coroner's court, where there was a different interpretation of 'justice' *vis–à–vis* the bereaved, from whose perspective it meant many – other – things. For some, it was about getting to the 'truth', while for others what was needed was an explicit recognition that they – and the deceased – were 'innocent' victims. For still others, some form of – often symbolic – 'apology', such as the opportunity to memorialise the deceased in a formal capacity, would have been their 'justice'. Regardless of the means, reparation of the moral harm that had been suffered was coveted by the bereaved but seen as extraneous by some of those working within the system. Indeed, as far as the State was concerned, no crime meant there was no necessity for justice, *ergo*, there were no 'victims'.

8.3 Lack of empathy

The third research sub–question inquired as to whether there exists an incongruity between what families – given their traumatic grief – perceive themselves to be entitled to in terms of their treatment by those in authority, and how those involved in the 'death system' operate. This was achieved through a consideration of bereaved families' dealings with the police, the relevant Coroner's Office and the coroner him or herself – in terms of these officials' conduct, demeanour or general capability in administering the coronial system.

The manner and behaviour of the agencies involved, including the police, court and administrative staff at the coroner's court and other parties such as hospital staff, local councils and the media, often fell short of families' expectations given the traumatic situation that they

found themselves in. However, despite this perspective, some coroners were successful in maintaining a balance between legality and empathy, although this was not always perceived to be so by the bereaved, particularly those who were having difficulty accepting the death. Consequently, families felt not only let down by a system that was not providing them with the answers, the truth or the justice they needed, but *conspired* against by a process they believed had made things worse. Moreover, there was little or no opportunity for recourse for those families who felt that they were mistreated in some way, or experienced access to justice imbalances, in a system which obligates the bereaved to engage with it, meant that the *opportunity* for the bereaved to feel that they had achieved justice 'for' their family member – whatever form this took – was denied them. Despite these difficulties, it was by far the norm for families to demonstrate deferential behaviour, particularly towards the coroner and in the inquest setting.

8.4 Confirmation of secondary victimisation

These mismatches led to an overall imbalance in the experience of those bereaved by non–culpable road death. Added to this was the fact that for the bereaved studied, those who were able to accept the explanation they were being given for their loss early–on in the process, appeared to be more 'philosophical' about the death and less likely to succumb to poor treatment by those in authority. Conversely, those who 'fought' not only the death but the system with which they then had to deal, and who were unable to moderate their expectations as it became evident that these would remain unfulfilled, were impacted more profoundly. Despite the existence of an interplay between bereaved families' lived experience of the inquest process, and their agency and outlook in dealing with the – often arduous – interactions necessitated by the system, their encounters with the coronial system left them with a powerful negative or positive 'ending' to the death of their family member.

In this way, and despite policymakers' reforms and coroners' attempts to balance the needs of both the bereaved and the State, bereaved families' emotions, and their grief, was intimately tied not only to the actual death but to the State–bound social system that followed it. In raising

the expectations of the bereaved towards recompense – whether moral or symbolic – and then just as assiduously dashing them, the coronial system led the families of those killed in a non-culpable road collision towards a status as both co–victims *and* secondary victims of that system. Despite the rise of the victims' movement and the State rhetorically conceding some of those rights, the coronial system of England and Wales remains somewhat wedded to its medieval past. Moreover, the coroner's role is revealed as something of a predicament, caught between a legalistic and antediluvian State apparatus on the one h333and, and, on the other, the desire – both politically and morally – to put the bereaved 'at the heart of the system' (Ministry of Justice, 2013b). In continuing to fulfil their role as accountants for death, coroners are unable to fully adapt to the needs and desires of those survivors left behind by road deaths. Thus, the coronial investigation and inquest remains a system that is primarily working for the State, rather than the individuals and families affected by the death.

In summary, for some bereaved families, the inquest as the culmination of often months of investigation, signified 'the end' to the death process, enabling them to draw a symbolic line under the more practical and certainly social part of their loss. However, the discrepancies that exist between what those bereaved by road death seek – given their need for recognition of the non–culpable nature of the event – and what the coronial system exists to provide, are several. First, the 'expectation gap' that I have outlined left families feeling let down, isolated and unheard. Second, inadequate interactions and communications with the system and its agencies, including the police, coroners, hospital and court and administrative staff, were not only distressing but often retrogressive for the bereaved. Finally, there was opportunity for little or no recourse when the bereaved felt the need to formalise their dissatisfaction, despite being deemed to be 'at the heart' of the system. Thus, whilst the ceremony of the inquest stands as the end of the State – and social – channel for non–culpable death, this is not true of the *personal* part of the death process. Indeed, for all of the participants their grieving continued long after the announcement of the coroner's 'conclusion' on the death at the end of the hearing, and this was particularly the case where families felt that the 'truth' and 'justice' had evaded them.

Thus, the micro–culture of the inquest, in the context of a system which shuns attribution and at the same time claims to 'put the bereaved at the heart of the system', does little to provide the reaction and 'closure' that families often expect. It is the combination of these issues which puts the bereaved firmly in the camp of secondary victims, in part due to the raised expectations of the bereaved who, despite social changes around the rights of victims, are not central to a system which continues to be drawn by its origins an archaic biopower death system, a system which can only draw victims into its arms rather than its heart when it comes to non–culpable road death. This leaves a situation where, at best, we have a system which provides a chronological ending for families who feel the need to 'move on'; at worst, there are families who are secondarily victimised by a system that does not meet their expectations, or their needs.

8.5 Contribution to knowledge

As outlined in chapters 1 and 2, road death has been identified as a public health issue of global proportions, together with the recognition that there exists an acceptance of the – often fatal – risks associated with the 'hegemony' of high–speed transport. In the UK, 'survivors' groups' have condemned a tendency to trivialise road death, pointing towards a lack of victims' rights, and failings in a system of justice which they believe increases the suffering of the bereaved. However, such commentary has tended to focus on the *Criminal* Justice System and its treatment of the bereaved, with the emotional impact of that part of the Justice System which comes into play when a loss is deemed to be non–culpable – the coronial system – remaining largely unexplored.

This thesis sought to redress this imbalance, with findings regarding – in the context of non-culpable road death – complicated grief, emotion management, and the dichotomous expectations between the bereaved and a system of 'justice' cloaked in historical ontogeny, leading to the conclusion that the bereaved are secondary victims of the coronial system. This determination suggests that the families and friends of people who have lost their lives either as drivers, passengers or pedestrians in a road collision, are *not* served by the coronial system as the State's mechanism for administrating sudden, non–culpable death. Rather, it provides

confirmation that the inquest stands as a bureaucratic machinery which merely helps to frame the emotional landscape in which bereaved families find themselves. This fills an important gap in the knowledge about the interactions between the current State administrative systems for dealing with sudden death and those that use them, and in particular exists as the first step in eliciting increased socio–legal understanding of the emotional impact of the coronial system on those bereaved by non-culpable road death. Further research is required to identify whether similar findings regarding the emotional impact of the coronial system can be adhered to other bereaved groups.

Appendices

Appendix 1. Participant Information Sheet and Certificate of Consent

This Informed Consent Form has two parts:
Part 1: Information Sheet
Part 2: Certificate of Consent

You will be given a copy of the full Informed Consent Form.

Name of researcher: Melanie Pearson, PhD Research Student
Name of organization: University of Essex (Funded by the Arts and Humanities Research Council)

Part I: Information Sheet

What is the project about?

The purpose of this research is to consider the adequacy of the UK inquest as a part of the Criminal Justice System, with specific regard to those bereaved by road death. To date, much research on the Criminal Justice System and its impact on the bereaved has been concerned with the criminal court, and the coroner's court has largely been ignored. Those studies that have considered the inquest, have concentrated largely on suicide (Gregory, 2014; Biddle, 2003), with mixed results in terms of whether the bereaved suffer at the hands of the process. I will be asking bereaved families and coroners for their views on the inquest and asking whether their experience is divided or whether there is a harmony in their perspective which could be used to inform and strengthen procedures going forward.

What will it involve?

This research will involve your participation in an interview that will take about one hour. I would like to talk to you about your experiences of the inquest process because I feel that your personal experience can contribute much to our understanding and knowledge of the impact of the societal processes involved in dealing with road deaths. Please do take time to reflect on whether you would like to participate or not; your participation in this research is entirely voluntary. I am asking you to share with me some very personal, emotionally difficult and confidential information, and I understand that you may find this difficult. You do not have to answer any question that you do not wish to and may ask to stop the interview at any time.

What will happen with the results?

The information recorded is confidential, and no one else except my research supervisor at The University of Essex will have access to the information documented during your interview. I would prefer to tape–record the interview, but no–one will be identified by name on the tape. The tape will be kept as an electronic file and will be coded and secured using password protection. I will take notes of the interview if you would prefer not to be tape–recorded.

Any information recorded is confidential, and real names or addresses will not be used in any project reports, or given out to any members of the public. I will give you an opportunity to review your remarks at the end of the interview, and you can ask to modify or remove portions of those if you do not agree with my notes or if I did not understand you correctly. I am happy to return transcripts of tapes for comment to ensure they accurately reflect our conversation. .No–one except me will have access to the information and any tapes will be destroyed when the research project is completed. The content of the interview may be used as part of my thesis or in academic published papers.

Who to Contact

If you have any questions, please contact my supervisor Dr Darren Thiel by email at djthiel@essex.ac.uk or by phone on 01206 872638. This proposal has been written in line with British Sociological Association guidelines and has been reviewed and approved by the University of Essex ethics committee.

Part 2: Certificate of Consent
(This section is mandatory)

Name of participant:

Title of the project: The impact on, and adequacy of, the inquest process with specific regard to people bereaved by road death

Main investigator and contact details:
Melanie Pearson
University of Essex
Wivenhoe Park
Colchester CO4 3SQ
Email: mjpear@essex.ac.uk

Members of the research team:
Dr Darren Thiel, University of Essex

1. I agree to take part in the above research. I have read the participant information sheet, which is attached to this form. I understand what my part will be in this research, and all my questions have so far been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I have been provided with a copy of this form and the participant information sheet.

Data Protection Act 1998: I agree to the researcher processing personal data that I have supplied. I agree the processing of such data for any purposes connected with the research project as outlined to me. I further agree to the researcher processing personal data about me described as sensitive data within the meaning of the Data Protection Act 1998

Name of participant:

…… ……. ……. ……

Print Signed Date

Appendix 2. Transcribed interviews

Section of transcribed interview from participant grouping 1: Bereaved families

Name: Sophie
Date: 08/04/17

Researcher:
Erm, are you able to tell me, what happened?

Sophie:
[Sighs] Erm well, we—we don't know [laughs]. We—we you know the inquest, we thought that we would get answers out of it, everything was, speculation. Erm, and on our part we've come away, erm, really disappointed really disappointed. Erm, I think—because the police really, didn't do what they should've done on the night, erm that's where it all stems from. Erm, I think because of that, they've just wanted to brush it under the carpet.

Researcher:
Right.

Sophie:
Erm, I mean my—my mum was delivering birthday cards to, her brother. Er she was parked in the er, street coming off, the road my uncle lives. And erm [gasps] there was a, b—what they said on the night was that she walked out between two cars.

Researcher:
In order to cross the road?

Sophie:
Yes. In order to cross the road to get to the other street. Erm, there was an eye witness there, apparently, who said that she just, came from nowhere erm, between two parked cars. Er the driver of the vehicle said that he pulled into a gap and hit something he didn't know what he had hit. Erm, she'd gone into the windscreen, erm and she was on the road. Erm, my uncle ran outside and, there were lots of other people around he rung my dad my dad went there as well. Erm, well the injuries were just, horrendous. Erm, you know her legs were just—well from a bumper impact you can imagine they were just, well she had a degloving injury on, on her right leg I believe, totally open, er fracture. Erm broken nose, jaw, erm, both legs, ruptured er trans—complete transection of the aorta, and erm injuries to her head as well.

Researcher:
But that sounds like she was hit at some speed then doesn't it?

Sophie:
Yeah yeah. Erm, but the eye witness said that she came from between parked cars erm, at the inquest they did, I—well I—I, have spoken to, people who arrived after it had happened, and they said that there was a massive gap, erm, you know they couldn't understand where she had come from, because there was a huge gap there there were parked cars, but where she would have parked er where she would have crossed, was, [inaudible 3:43]

Researcher:
There was nothing.

Sophie:

No. So they really couldn't understand. Erm they did say in the inquest that there was a gap of 11 metres that they had erm got that information from the CCTV. Erm but we do believe that it was bigger than that because there was a—another car to come out of that I think, the car that they can see on the CCTV, was somebody who'd come later. So, believe that it's bigger than 11 metres again. But, the coroner didn't go and look into that gap or ask the police to look further investigate into that you know, it was just totally…

Researcher:
It was just accepted.

Sophie:
Yeah yeah. Yeah. The police collision expert said, the damage to the car was minimal, so he put a figure, of 25–30 mile an hour. Er the eye witness said that he was travelling between 10 and 20 mile an hour, and [pauses] well, I belie—you know I feel the coroner did—really didn't do enough for us in court.

Researcher:
Didn't ask the questions.

Sophie:
Oh he did—you know I—I feel, well I think anyb—if anybody read, the case of my mother, they would say "hang on", you know "this just doesn't add up. Let's look further" you know? But, you know I thought that would be the job of the coroner to, want to find more answers but, she—she didn't do, a thing.

Researcher:
Were they—was the Coroner's Office, in touch with you directly, or did everything go through the police?

Sophie:
Erm, he, spoke—no he didn't speak it was all emails erm, from the coroner to, my solicitor mainly.

Researcher:
Right, so you had a solicitor involved?

Sophie:
We did yes. Because we felt we—we [sighs] we just weren't getting anywhere with the police. You know and erm I needed somebody really to take over I couldn't erm, you know I just couldn't get anywhere with them. Really couldn't you cou—you could tell a million miles away they would just, brush it under the carpet you know "let's just get this over and done with" because, they didn't take any measurements on the night they didn't take, the driver's phone, er, no they took, one photograph of a car, that—not the driver that hit my mum it was the car that my mum fell onto after she was hit which was dented. They took a photograph of that only because witnesses called the policeman just before he left they—they noticed marks on a parked vehicle and said, "you'd better come and see this" and he took two photographs of that car. He let the driver, of the car with the smashed windscreen and the headlight and god knows what was wrong with it, drive away from the scene.

Continues…

ENDS 55:22

Section from transcribed interview from participant grouping 2: Coroners

Name: Alex
Date: 14/11/2016

Researcher:
Ok, thank you very much. So, initially can I just ask about you, in terms of how you've ended up being a coroner?

Alex:
I wanted to be a coroner since the age of 14. I was at medical school doing Physiology at Newcastle. I graduated in 79. And I then, went to the College of Law at [town name]. Qualified as a solicitor specialised in Mental Health Law, and child protection, and erm, in 1994, 93 94—93 I was appointed Coroner for [area name]. 99, I applied for the [town name] job and I was appointed the full time coroner in [town name], and 2 years ago we merged with the [area name] area so I'm now the coro—Senior Coroner for [area name]. So for—that's 22 years, I've been a coroner and I've been able to do what I wanted to do.

Researcher:
So a lifelong ambition to be a coroner.

Alex:
Since about the age of 14. I spent time in the path labs watching er various things and playing with microtomes and, I've got a family background of law of medicine and, things of that nature and, it's something I wanted to do.

Researcher:
So do you think it was about the mix of things do you think the law and the medicine combined?

Alex:
No it's about social care, support, humanity, and it's about religion. 'Happy are those who mourn they shall be comforted', and what better place can you be, in being a coroner, than to support people in difficulty and need. Erm judges are, we're not special we, are judges among peers and basically, we—we serve, the public. And basically, everyone that gets into erm, contact or complace, with the law, erm they're a reflection of our old humanity, we're all flawed and we–we are people, and basically, it would be wrong to be too judgemental because, given different circumstances given different genes given, lots of different things, anyone of us could have been in that predicament.

Researcher:
Yes. Who knows where we all might be.

Alex:
Absolutely. And, innocent people, do end up in prison and it's wrong to look at [inaudible 2:35] offences because nobody knows how they would behave, given that plot in life.

Researcher:
Yes yeah. You do things in quite a different way than I've seen all the other coroners that I've seen, and I've seen a few now, do things. In that, you're the first one who hasn't had people standing up and sitting down and…

Alex:
It's distracting. It's distracting for the jury, it's intimidating for the witnesses and it's distracting for the advocates.

Researcher:
Right. And do you always do that?

Alex:
It depends. Sometimes you would want a greater degree of formality, and then you keep control but you, keep control through your judgecraft. And judgecraft doesn't mean pomposity, judgecraft is about how you, control court. When you're driving a car, when you first start as a leaner, you're very mechanical aren't you? You're not sure about the pedals, not sure if things are in the right place, you are very mechanical. As you become more experienced, you are still as careful, but you are changing gear in your head before you actually change gear, you are braking before you've realised you've braked, and when you're a judged, if you're good at it, you do things automatically. The more you do, the better you get was it Gary Player, that said, that erm, "the more I practice, the better I get". Pure coincidence isn't it?

Researcher:
Right, and so what you're saying is, you get to the stage where you naturally are able to keep control.

Alex:
I have held inquests over the last 22 years, up until last year I was holding the best part of 5 or 600 inquests a year. Go back over 20 years and work out 5 to 600 inquests a year, erm it's probably a considerable amount more sittings than any judge in any other jurisdiction. Because I work very very long hours, coroners should be available 24/7. I do it at weekends and at night, I take deaths in the middle of the night and, basically it's what I do.

Researcher:
Yes. But are the family at the forefront of your mind, always with an inquest?

Alex:
Hopefully that's evident. Hopefully that's evident.

Researcher:
Well it is it's—I have to say having seen quite a number this is the first jury inquest I've seen, and it's less evident with a jury inquest, and because of the advocates.

Alex:
Right. It is 'cause the jury [inaudible 5:11] the advocates get in the way. But, erm I didn't want to call, his partner, because that's personal. I was hoping, that his stepfather would be able to tell me what I needed but he didn't know. And I had to call his brother reluctantly, because someone wanted to make an issue of something that wasn't there. Erm but yes the family are at the centre and erm—they're only at the centre, in that, this is their loved one and, this is part of their bereavement journey. Equally Miss F—, G— B—, all the witnesses that come to give evidence, they're bereaved as well, they've lost somebody, they will be suffering, they'll have been through anguish they'll have had sleepless nights last night, and they need to be looked after. But, when there's an issue that needs to be dealt with, you've got to deal with it.

Continues…

ENDS 22:32

Section from transcribed interview from participant grouping 3: Other

Name: Tamsin
Date: 19/05/2017

Researcher:
Right. It does seem quite mixed, very much in terms of whether the Coroner's Officers come from the police or are employed by the Local Authority. It's just—I think they're local authority in [area name]. Do you think the funding has any bearing on the role at all?

Tamsin:
It does in as much as, I don't think we should pay for it at all, if the Government and the Corporation who are the equivalent of our local council [inaudible 7:21] if they think that they can reduce the amount of money that they, give to us in order to support, emergency services, then why we have to pay for that at all, is a complete mystery to me. Why would we? There's no benefit to me, or to the [area name] Police, not that police services work on the basis of reciprocal arrangement we have to provide a service, to the public, but there's no benefit to us to having a police officer, in the Coroner's Office. It doesn't help the individual, because their support structure is completely removed from them, so the line management is over here they're in a different office they're by themselves, and a Coroner's Office is, basically, just dead dead dead dead dead dead before you get there before you've answered your first phone call before you've started your process, whatever it is that you're gonna do in your day, it is just dead people and upset people, about the fact that somebody that they loved is now dead. So having them, remote from an infrastructure, of people who are part of their team, isn't great. But trying to—so my next negotiation with the Coroner is, I want them, to work over here, and, our Coroner is not keen on that idea at all because, her point is "oh that there's issues of confidentiality these are public re—these are personal private records of individuals" and you know "coronial authority far exceeds that of the police" and I can't—it's a police force we are kind of used to dealing with, secret and top secret information and, it—we've got 2 tons of methamphetamine next door we've got some quite decent locks on the door, and we are able to control, who can go in there and who can't, so having some of your paperwork in an officer, doesn't really strike me as a massive risk to the running of your, coronial functions but, you know. But it is—the question about the money is, I want—if I have to pay for it at all, I want to reduce the spend I, spend on it because, we've gotta reduce the spend, on everything. So if I've got three quarters of the amount of money that I think it costs to run all of my departments that means the next time somebody goes out and stops a car that has 4 suspects in it, we've got enough money to take, a DNA sample from 3 of them and take a photograph of 3 of them to take fingerprints from 3 of them, does somebody want to pick who goes free, or who gets a 'it's your lucky day sunny'. If we go to a crime scene, that has, 4 knives, strewn around and they all seem to have blood on and they're all got evidential value, I'll just do the 3 then shall I? And what—or if, obviously as people will say to me, "well you can't do that", I know I can't do that, but I've run out of money at the end of quarter 3, I don't have enough money to take these through to the end of March, so, whilst all of those concerns are hanging over you, spending quite a lot of money on a police officer, 'cause a police officer comes with other, costs associated so, a civilian officer provided you phrase their contract appropriately you can have them—these are my usual office hours plus I would like you to work on call but not out of the office and you'd share that with other people but, you know, here's your retainer of £30 a day to be inconvenienced and sober, is effectively all that's required. You need to be on the end of a phone and not plastered if somebody rings you. But apart from that you can be wherever you like. Cinema and theatre is difficult but I've done it, just sit on the end and then, you know, get—text me don't ring me, ok [inaudible 11:03]. If you have a—you can have a police officer on an on call rota but, essentially if you ring them, then you're recalling them to [inaudible

11:11] duty, which incurs a 4 hour statutory, payment, even if it's just "hello", it's just a police regulation so that's, 4 hours pay at double time for a phone call makes them expensive to use. And then over the course of a weekend if it's a religious significance death so we try to process Muslim and Jewish deaths more quickly, or if it has something that involves erm, organ donation for example, they can be on the phone all day, as in—and on a Saturday or a Sunday and then that's definitely double time so—. Which they can have as money or they can have it as, I'd like that time off so they work for one day they get two days off which means 2 days abstraction from the office which means you'd have to pay somebody else overtime to cover it and it just, it starts to escalate out of control. But they can easily be on the phone all day, even if it was a—a working day in the office it just means all their other work backs up whilst they're saying, "right, the tissue match for the organ from the liver which is over there that can be biked across too" I mean they—they're negotiating and liaising with the hospital 'cause their, function is to be the spokesperson for the coroner who says,"yes that liver can leave my jurisdiction" for example so it's quite admin heavy, for obviously time critical.

Researcher:
Hmm. Do they make a lot of the decisions the Coroner's Officers or your Coroner's Officer? So, on a day–to–day basis would they refer to the Coroner for everything really or no, they make a lot of their decisions and then, pass it all to the coroner as a file.

Tamsin:
No. Yes. Yeah. Yes. Erm, because the coroner isn't available 24/7 so if you've got somebody making a decision about can this—can this body be released for the purposes of organ transplant can this, body be processed with a non–invasive post mortem, in order that the body can be buried before sunrise tomorrow—before sunset tomorrow, then those are decision that they have to make because otherwise—yeah, if I leave it until 8 o'clock when I hope the coroner will be having their breakfast, it'll be too late to get any of those things, in place. And they—I mean they obviously know, where the boundaries of their, l—jurisdiction would stop where the—where there's a level of responsibility that they ought not to take on, but they can do—they know how an inquest works, so therefore they know the right questions to ask in order to say, "that's gonna be fine". It's just that, the person was moved from that hospital to that hospital they haven't been in that hospital for 24 hours so that doctor won't write a death certificate but that doesn't mean, that you need an inquest into that person's death, unless the family think that they were intubated incorrectly but if there's no suggestion, anything bad happened, it's just going to be, finding out who the last consulting surgeon was on that person from whatever hospital they came to, and that information package will satisfy the coroner than, well what does he say he probably died of because you've just got a mismatch. Somebody arrives in my hospital and you know "well I don't know we'll open up their chest and like—oh god it's all gone horribly wrong and they've died. I don't know why that happened because I've only just seen them" whereas if you get the medical history some time later, put that together as a package, fine that's why they died they were never going to make it, and it's ok. If there's some suggestion that, they were anaesthetised wrongly, or that there could've been some culpability in the surgical action or that the other hospital should never have sent them there, that kind of thing, perhaps there will be an inquest, that the coroner will need to rule on, in which case that body's not gonna be released, for anything, until this goes before the coroner and she will decide, "actually I'm pretty cool with that" or, "no we'll open an inquest Monday" which will be automatically deferred to 6 months from now because they take forever, erm but yeah they—so they make some decisions based on sound information within their comfort zone, but they know where to stop, to leave that for a decision for the coroner to make.

Continues…

ENDS 55:31

Appendix 3. Record of Inquest form

Record of Inquest

Following an Investigation commenced on the
And Inquest opened on the ,
And an inquest hearing at on the heard before in the coroner's area for E[redacted]

The following is the record of the inquest (including the statutory determination and, where required, findings).

1. Name of Deceased (if known)

2. Medical cause of death

   1a

   b

   c

   II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

4. Conclusion of the Coroner as to the death

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth	
(b) Name and Surname of deceased	
(c) Sex	(d) Maiden surname of woman who has married
(e) Date and place of death	
(f) Occupation and usual address	

Signature of

Appendix 4. Extracts from two inquest observations

Inquest 1 – September 2016

Coroner: And this is the inquest touching the death of [deceased name] and also [deceased name]. I understand that we've got er [name of family member] and also [name of family member], is that right? Good morning.

Just to explain that an inquest is a fact–finding exercise on behalf of the State to answer four questions: who the deceased was, when the death occurred, where is happened and how the deceased came about their death.

Now, everyone who dies has an individual inquest. But because, the circumstances of the fact that these two people were in the same car, what I—the way I'm going to do it in court—what we would normally do is open the inquest, for one person, hear all the evidence, and then I would make a conclusion for that one person. But, all of the evidence in relation to the circumstances of, the er road traffic incident is the same evidence because it involves the one car. So, what I'm going to do with your permission is I'm going to, open both inquests at the same time. I'm going to deal with the separate, medical causes of death because obviously, unfortunately the passenger was—passed away at the scene whereas [deceased name] passed away about a month later in hospital so I'm going to deal with that.

And then I'm going to ask the officer, to take us through, the actual incident involving the car, which will be, the same evidence in relation to both people.

And then, there'll be a short adjournment and then I will bring, the Conclusion for each one. Is that ok? So I've explained what I intend to do, with them.

Now, I'm going to start with [long pause] erm—and just also to explain that, in this court there are two ways in which I can accept evidence, the traditional way where, I swear a witness into the box and we can ask questions. And as members of the family you may also ask questions. This morning, erm we will only have erm evidence from PC [police officer name] who will go through the police investigation, but as members of the family you can ask questions of the officer. The second way in which I can accept evidence in court is under rule 23, which means that I can refer to any document or report. And the reports I'm going to refer to today, all deal with the—the injuries and the—the medical cause of death.

[Coroner goes onto read brief details of what took place at the collision event, confirm the name, date of birth and address of each of the deceased, and a summary of the medical cause of death in each case. The only witness is the police Collision Investigation who is called to give evidence. Towards the end of his evidence the inquest continues as follows]

Coroner: So in essence officer there's no, physical default with either car or carriageway which would explain why the vehicle left the carriageway and collided with a tree.

Police Officer: No there's no mechanical defects that would be likely to cause or contribute on the vehicle, the vehicle is fine.

Coroner: What we have is—although it's December in which you would expect cold, probably bad weather, it seems to be—it was particularly bad for those few weeks and on that evening it was raining as well. So the carriageway would have been wet.

[Evidence continues]

Coroner: And you said, that, there may be an element of inexperience of the driver. Erm, do you look at the driving history?

Police Officer: Ma'am my colleague has, followed all that my role is—is purely technical erm, I'm told—I'm told the driver had a provisional driving licence, erm [pauses] yeah and was not being supervised, at the time of driving. There were no 'L' plates displayed on the vehicle, erm nothing to suggest that it was, under instruction.

[Evidence continues until Collision Investigator finishes his evidence]

Coroner: In fairness what we've done with the inquest is, ruled out the obvious reasons for, these sort of incidents. Mobile phone use, alcohol, drugs, and—there's no evidence of speeding is there?

Police Officer: No I don't believe this to be a, particularly high speed impact. What we've got to bear in mind with this collision is that, the sides of the vehicle are generally the weakest structural areas. And in this case the weakest structural area of the car, has hit a substantial tree. That's gonna cause intrusion and we've got significant intrusion into the front passenger cell which, because the tree's missed the rear passenger cell the children have next to no injuries. All the injuries are sustained by the two people in the front where the main area of impact has taken place.

Coroner: Thank you officer. Erm, family members do you have any questions of the officer?

[Family members shake heads and mumble 'no'].

Coroner [addressing family members]: You understand everything he said it's, erm a case of, importantly ruling out, things because it's—in this court it's as important to rule out the obvious things that people may suspect, but on the balance on probabilities which is what this court works with we do feel it's a combination of, possibly a—an inexperienced driver when faced with particularly poor erm, weather conditions.

[Continues]

Coroner: Thank you. [Addressing family members] So there's no questions of the officer?

Family members shake heads.

Coroner: Erm, family members you've heard all the evidence, is there anything further that you know that you think is important I should be aware of before I conclude?

Family members shake heads.

Coroner: I just wanted to make sure that you felt that we—I just want to take fifteen minutes just to think about things because I've got to just formulate some documents and write on it so if we could, be back at erm, five past I'll not keep you longer than I need to but if you could just give me fifteen minutes to just consider the evidence again thank you.

[Coroner rises and leaves]

Usher: All rise [Coroner re–enters the court room]

Coroner: Thank you, thank you.

Well as I've explained the inquest is to answer those four questions: who the deceased was, when the death occurred, when it happened and how the deceased came about their death. The decisions I make today and are on the balance of probabilities, not the criminal court where you have to be sure of everything. Now I'm going to deal with, erm, in the same order I did this morning so if I deal with [deceased name] first.

Er, so [family member name] when you explained that the information was correct in relation to your mum well, I'm sure you've worked out that answers three out of the four questions so I will accept that document as evidence of identification and also, date and place of her death. I will accept the er, medical findings of Dr [pathologist's name] and also the autopsy scan so the cause of death will be recorded as 1A Multiple injuries. And for my conclusion here today, the conclusion is that she's died as a result of a Road Traffic Collision. On the documentation I have to write something in box 3 and, I won't propose to read it again for your father because it's the same and what I've simply put is that, she's died as a result of injuries as a received on [date], as a passenger in a car which left the carriageway of the [road name and location] and collided with a tree. The most likely cause of the collision was, driving inexperience and poor weather conditions.

So, in relation to er [deceased name] that dals with that. Just the formalities for [deceased name]. Again, you confirmed that we had your father's details correct. I will accept that as evidence of identification and also, the date and place of your father's death. Similarly for medical cause of death I'm grateful for the report from the hospital, and that will be, in accordance with the detailed report that I read out. And I've written the same explanation that your father died as a result of a Road Traffic Collision, the only difference is that obviously, I've put that he died as a result of injuries he received, er when the vehicle which he was driving er left the carriageway and collided with a tree. Again the most likely cause of the incident was driving inexperience and poor weather conditions.

We'll now deal with all the formal documentation, these will go to the Registrar today, and so there's nothing you need to do as family members. If you want copies of anything please speak to [Usher's name] when I've left court. Just to say thank you for coming it must, be terrible to come in these, circumstances. Er but thank you for doing so because we like you to be here because a) you get to hear the evidence, you can always ask questions of the officer if you had any I appreciate you hadn't but you had the opportunity. And just on behalf of myself and [Usher name] and everybody who works here please, accept our sincere condolences for your loss and particularly for those, er of your, er remaining family who are not here. [Usher name] and I have just been saying that, our heart goes out to the, children that were in the car at the time and, er so in due course please, express our sincere condolences to everyone. A pleasure to meet with you, I'm sorry we meet under these conditions but thank you.

Usher: Court rise. [Coroner leaves court]

Inquest 2 – October 2016

Coroner: Good morning this is the resumption of an inquiry into the death of a [deceased name]. It is a matter that was reported to our court back at the beginning of, [month] of this year, and in due course, the decision was taken that, this investigation required an inquest hearing erm, and that's why we're here. I've been provided with a list that confirms that everyone who's been asked to attend is present, erm and what I'm going to do initially is just to, erm, speak briefly to, erm [family member].

[Coroner addresses family member] Good morning. [name] erm, clearly you have erm, someone with you this morning. Erm, I'm just going to briefly just tell you, what we're planning on doing, before we hear any evidence.

Erm, the reason why we're hear is, we haven't got any option. Erm, I'm afraid that the law tells me I've got to have an inquest if we have a death that looks as though it, wasn't due to natural causes. And you cannot register your son's death until we've had an inquest. Ok? Erm, now, this document here is called the record of inquest, and you'll hear me read through it formally at the end of the hearing, but its basically my attempt to deal with the questions that an inquest is expected to cover. And, there's four of them really. Three of them are usually straight forward: who the person was, when he passed away and where he passed away. Erm, usually, fairly straightforward those three. And then the final one is how the death came about. And that is, usually the reason or taking statements and listening to live evidence etcetera. Erm, I've got to fill this document in in a way that remembers that an inquest is really a fact–finding process it's not about, apportioning blame in any particular direction. So I can't fill it in in a way that, determines what we call 'criminal responsibility' on the part of a named person, and I can't use, civil litigation type phrases such as 'there's been a breach of duty of care' or 'there's been negligence' or, phrases like that. But you'll hear me read through it at the end.

Now, I've got to be sure that, I've got the personal details right in relation to your son. Was your son know as [deceased's Christian name]?

Family member: Yes, yeah.

[Coroner goes on to check spelling of name, date of birth and where deceased lived]

Coroner: So, as I said the people who have been asked to attend are here. I'm just going to erm—could I just confirm [car driver insurance company representative name] is here?

Car driver insurance company representative: Yes.

Coroner: Good morning. Erm, just to explain to, erm [family member name]. [Family member name], occasionally we'll have representatives from either legal companies or insurance companies attended. [Car driver insurance company representative name] is one of them and I think you're here on behalf of the insurance company who insured, the driver involved in this incident who we're going to hear some evidence from. Erm, and I think you're here in a, what we call a 'noting brief' capacity if you like, but erm, you've been provided I think before I came into court with a copy of the Collision Investigator's report and also, a transcription of erm, the driver's police interview is that right?

Car driver insurance company representative: That's correct.

Coroner: I know you're strictly here in a noting capacity. I'm relatively relaxed about that [Car driver insurance company representative name], if there comes a point where you do genuinely want to raise an issue then, please raise it with me and we'll, proceed from there.

Erm, what I'm going to do initially is just remind the court what the information was that we were told during the early stages of the investigation and [family member name] it doesn't necessarily follow that this will prove to be correct, I'm just explaining what we were told at the beginning and, when we've heard all the evidence, I'll determine whether it was right or not.

[Coroner goes on to read the details of what took place at the collision event]

Coroner: That's the background information. [Addresses the family member] Now, one thing I do want to mention to you, is this. Clearly, in our court we hear lots of upsetting evidence from time to time. If we get to the point where you want to step out sir, by all means just go and, you don't need to ask for permission from me, and one of the staff will come out and check, if and when you feel able to come back in. Ok?

I'm going to—I know you've been sent the evidence that I'm going to touch upon today, by a Coroner's Officer. Erm, because of that, erm what I'm not going to do is I'm not going to go through all of the detail of all of the statements, and particularly in relation to the *post–mortem* report I'm sure you've had it…

Family member: I've read it. Yes.

Coroner: …you've had the opportunity to read it and I can't see any particular reason to go through in any great detail today. But I'm just going to deal with that initially…

[Coroner goes on to summarise the *post–mortem* report and medical cause of death. Witnesses are then called, including an eye witness to the collision, the police Collision Investigator and the driver of the vehicle who hit the deceased]

Coroner calls driver to the stand. Driver is sworn to oath and provides full name to the Coroner.

Coroner: I'm just going to turn briefly to [family member name] because I want to explain something to him. [Family member name] just to explain this briefly to you, when I started the inquest I mentioned this document here. Erm I explained that when I fill it in I've got to fill it in in a way that, erm remembers that I—I cannot name a person and I cannot determine, criminal responsibility on the part of a named person, and I can't use any civil, litigate phrases like 'there's been a breach of duty care' or 'negligence' or anything like that. Ok? Now, when we're dealing with inquiries of this nature, obviously the evidence of

the erm, the driver, erm needs to be considered. And, what I've considered so far is a, verbatim—a word–for–word transcript of, interviews that, erm I think were undertaken on [date] of this year and [looks towards driver] I think you had a solicitor present with you [solicitor name]? Yeah. And, I've obviously noted and taken consideration all of that evidence. Ok? Erm, now, what I've also got to remember is that er, a witness in these circumstances, erm isn't expected for the purposes of our inquiry, to give evidence that might what we call 'incriminate' them, or leave them open to any sort of prosecution. So I mention that now.

Erm, and I'm just going to explain that to you [turns to the driver]. If any of the questions that I ask you, you feel might tend to incriminate you and leave you open to some sort of criminal prosecution, you're not obliged to answer them. Ok? Erm, but what I'm going to do is, I'm going to approach your evidence in this way. Having indicated that, I've read all of your interview transcript erm, there's a s—I'm going to just summarise your interview erm and your account and just ask you if this remains your position.

[Coroner goes on to summarise driver's interview]

Coroner: So I don't propose to go through any further evidence, but I'm just going to ask [family member name] if he's any questions. So have you any questions for the driver at all?

Family member: No, no.

[Driver is asked to step down and police Collision Investigation Office comes to the stand and is sworn to oath]

Coroner: Senior investigating officer for the purposes of this inquiry so we have a, erm a young man 18 years of age being, erm according to Dr [name] fatally struck during the course of this collision. Erm, I mentioned earlier to [family member name] that the beginning of the inquiry will have, the police inquiry and the coroner's inquiry running in tandem. Erm, you undertake your examinations er and you speak to witnesses etcetera. You reach a point where, so far as I understand it you've, explored all the circumstances and have reached a decision that, no criminal prosecution is going to follow in relation to the driver. Is that right?

Police Officer: That is correct.

Coroner: During the course of the inquest and while you've been in court throughout the morning, erm that position remains the same presumably?

Police Officer: It does, yes.

[Hearing continues]

Coroner: Your inquiry didn't lead to any evidence that we've not heard about in relation to whether they were playing chicken or daring each other or anyth—there's no other evidence about that?

Police Officer: No there was no evidence to say there was any larking around or messing er with each other. As I said the evidence just pointed to—they were rushing to get back er, and as the evidence has said to confirm that they wanted to stay overnight. But there was no evidence to say that they were actually messing about no.

Coroner: [family member name] have you any questions at all?

Family member: No.

[Police Collision Investigator stands down]

Coroner: [Family member name] what I'm going to do just for a few moments is—that's the evidence that we're going to hear. I know there were a couple of extra police witness statements that have been sent, to you. Erm, I can't see any reason for me to go through those. So what I'm going to do is I'm—I'm just going to step out of court for a few minutes. If anybody wants to leave the building and come back in by all means do. Erm, at the moment it's just before 11 I'll be back in court erm, say at about quarter past 11 to conclude the inquest, I'm happy that we're able to conclude. So if you want to step out and come back in, then by all means do.

[Coroner leaves court and re–enters 11.15am]

Coroner: I've been dealing with an inquest exploring the sad circumstances surrounding the death of [deceased name], and I'm content that we're in a position to conclude the inquest today. In terms of the medical evidence the medical cause of death I'm content to record 1A Severe Head Injuries for reasons explained earlier and set out in Dr [pathologist's name] Home Office pathology report. [Deceased name] was not suffering from any natural disease at the time of this incident. In terms of, who the deceased person was, I accept as confirmed earlier by his father that it's [deceased name] and where and when he passed away set out in Dr [name] report erm, it's the [hospital name and address], and that was the following day at approximately [time and date].

So in terms of how the death has come about. Erm, just a few findings er based upon the evidence that we've heard. I accept that at the time of this incident the traffic lights were showing green for the driver [driver name]. Erm, I accept erm in stating that the evidence also of the Collision Investigator erm, and erm, what he said about how many seconds it would take between the er pedestrian signal changing and erm, people then being prevented from erm erm lawfully crossing over the road to the other side of the pavement. I cannot accept therefore [name of deceased's friend]'s evidence in relation to the crossing but I acknowledge that his accounts follow what must have been an extremely stressful and upsetting incident for him and I take that into account. Erm I accept that the evidence that we've heard in relation to alcohol both in relation to [deceased name] and [driver name] erm, I don't feel that alcohol's played a significant contributory part in the decisions er made by erm [deceased name] on this particular occasion, and ultimately erm this appears to have been a tragic misjudgement erm, on [deceased name]'s part, in terms of feeling as though he had enough time to make his way across the road across the path of the oncoming traffic. And I commend also the people who remained on the scene including the first witness we heard from today to provide assistance.

The standard of proof that I need to apply on these occasions is really, on the balance of probabilities and I'm content that the following is probably correct.

[Coroner goes on to summarise the name of the deceased, the medical cause of death, the time, date, place and circumstance of the death]

Coroner: A conclusion of the coroner must be one of Accidental Death, and the registered particulars will be as confirmed by his father earlier, but the date and place of death being [confirms details].

[Family member name] I'm going to conclude our erm inquest at that stage. Can I pass on the condolences of everyone here at the court to you and your family in relation to [deceased name] passing away. I'm grateful for your attendance and for your assistance with the investigation. That's the conclusion of the inquest and what happens now is I give—hand a typed version of this document to the Registrar, so that the—[deceased name] death can then be registered. Erm, the staff will assist you with anything you need to know about that but the Registrar will deal with that and we'll provide a copy of the record of inquest in due course.

[Coroner addresses person from insurance company]

Coroner leaves court.

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