Looking for justice: the family and the inquest

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Abstract

This thesis critically examines the claim that 'family' is at the heart of the contemporary inquest system, analysing the impact of this putative change on the construction of kinship, death and the legal. Adopting an interdisciplinary approach, it engages with socio-legal and cultural analyses of death; family and kinship scholarship; and critical legal scholarship on death and the state. In doing so it reveals the richness of the inquest as an area of law which has hitherto attracted relatively little attention but which merits extended exploration. Drawing on historical and jurisprudential materials in the first section, it provides an analysis of the changing historical form of the inquest, and argues that legislative and judicial reconfiguration of the inquest process since 2003 has fundamentally changed the nature of the system, most importantly in relation to the engagement of family prior to a final hearing. It argues that this engagement of the family affects the jurisdiction and form of an individual inquest, and developing this analysis, it explores a series of interviews undertaken with Coroners and officers in England. This empirical work deepens the earlier analysis, drawing insights from reflections on a set of vignettes which trouble the edges of ideas of family; emphasising the ways in which images of family and kinship are conceptualised and materialised through the unfolding of an individual inquest.

The central argument is that 'family' is a negotiated and constitutive feature of the inquest system; charged with overseeing dignity in a bureaucratic process, making substantive and transparent that which may be otherwise impenetrable and formal, and simultaneously determining the edges of the private and intimate. The thesis contends that an emphasis on meaningful connections to the deceased leads to a fluid construction of kinship, and a reimagination of the politics of both death and family. It argues that the inquest system, without narratives of kinship and connection, risks existing in a solely technocratic form in which 'disinterested decision-makers using objective, rationalist and universalised forms of knowledge justify decisions that are communicated in an expert language' (Morgan 2006, 246), and the family bring a 'tacit expertise that underpins shared experiences, values, symbols, identities and understandings, [providing] the tenor or texture of debate [that] transmits and generates a community because of its capacity to defy routinisation and the explicit codes of expert knowledge' (Morgan 2006, 259). Working through the inquest process and unpicking these contrasting forms of expertise, this thesis reveals the way in which an individual inquest is constructed through an endeavour to combine contrasting tensions; to blend a contingent, contextual, participative and meaningful process with the ceremony of a mini state funeral (Davis et al 2002), the collection of statistical information, and the setting of standards to prevent future deaths.

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Common abbreviations

HRA = Human Rights Act 1998

CJA = Coroners and Justice Act 2009

ECHR = European Convention on Human Rights and Fundamental Freedoms

2013 Rules = Coroners (Inquests) Rules 2013, SI 2013/1616

2013 Regulations = Coroners (Investigations) Regulations 2013, SI 1629/2013

1953 Rules = Coroners Rules 1953, SI 1953/205

1984 Rules = Coroners Rules 1984, SI 1984/552

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1. An Act abolishing the Deodand 1846 9&10 Vict. c.62	42
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Chapter One: Introduction

> First, the public, especially the bereaved, family and friends, need to know what happened, how the deceased came by his death. … The public need to know. They have a right to know. It is natural justice, public justice and justice to be done in public, openly and transparently, for all to see, particularly the family. The family has now become, quite rightly, the focus for this public process, to give them answers, where that is possible. They are at the heart of the process as the Charter for Coroner Services makes clear. (Thornton, 2012a).

I formally began this research in September 2012. The focus, driven by my experience in practice, was on the deployment of human rights strategies by families. I was keen to examine the ambivalence, progressive possibilities and paradox generated by families speaking for the dead, the incapacitated or the missing. However, in late October 2012 the Chief Coroner for England and Wales gave the speech quoted above, with legislative change following the next summer. The shift prompted a new and provocative line of investigation. The critical socio-legal question of the meaning and impact of the family in law remained central to my research, but the change promised new possibilities for the family; not simply rights to engage, but a place at the heart of the inquest in a fundamental reconstitution of an eight hundred year old legal jurisdiction.[1] Acutely aware of the range of ways in which the putative change could be resisted or dismissed – as politically convenient window dressing, as governance-through-therapy, as a neoliberal retreat of the State, as incompatible with public health objectives, as impossible because of resourcing – I resolved to take the claim of the now-central family seriously and to seek to understand its implications. My objective in this thesis is to do this: to provide a critical analysis of the family in the inquest as part of a wider discussion of the inquest and its constituent parts in liberal (post) modernity, focusing on understanding what the centrality of the family might do for inquest law, and the ways in which the family and the bereaved are constructed in the inquest system.

My approach to this research is interdisciplinary, employing a range of different academic tools and approaches to examine my central questions: What does it mean for the inquest to describe family as being at the heart of the process? How did the inquest get to this contemporary formulation? Who does the system perceive to be family and the bereaved, and how does their construction and engagement in the process interact with conceptions of law? Underlying these questions is a concern with exploring justice: an interrogation of what justice can be in a particular context by looking at the place of the family in the inquest. I approach this question of justice through a broad

[1] The office of Coroner was founded in 1194, see Hunnisett (1958), and one of the earliest responsibilities was to hold inquests into death, see Hunnisett (1961), chapter 2.

concept of accountability in an endeavour to open up justice, and return to questions of 'open ended justice' (Pavlich 2007) in my conclusion, but it is central to my thesis that this search for justice is my task and is not necessarily why a family is involved in an inquest. It is also critical to my argument that I am not seeking to posit a fixed conception of family or to solidify a label of family, but instead seek to explore how conceptions of family emerge and are deployed in the contexts of the inquest system.

I set out some of the areas of scholarship I engage with below, but my key audience is the legal academy and the conceptually interested practitioner, particularly those with an interest in interrogating the interface between the practice and the theory of law. I see my work as situated in that scholarship, drawing on insights from different theoretical traditions where I found their reflections useful to illuminate or unpack my concerns.

My central argument is that putting the family at the centre of the inquest reveals the way in which the inquest system and the law of the inquest jurisdiction seek to combine contrasting tensions, in an endeavour to enable the blending of a contingent, contextual, participative and meaningful process, with the ceremony of a 'mini state funeral' (Davis et al 2002), the collection of statistical information and the setting of standards to prevent future deaths. My contention is that the inquest is an unfairly overlooked site in doctrinal, critical and socio-empirical legal scholarship,[2] and also in the wider academy. As a practitioner and an academic, I have long found this lack of interest in the inquest odd. It is a site and a system which engages with some of the most fundamental questions for critical law and society scholars; from the law/fact divide, the impact of representation, the proper place and limits of discretionary power, and the interplay of legal and medical knowledge, to questions of the creation of legal subjects, the meaning and possibilities of justice and the ways in which we account for life and death. It is both newly formed and ancient, operating across and between different scales and jurisdictions (Valverde, 2011) with narratives of legitimacy and critique flowing from a wide array of sources. And ultimately – most importantly – it is a space irrevocably bound up with lived experiences of grief and bereavement, which both personal and professional experience has taught me must be approached with great care and respect.

This introductory chapter is in four parts: I start with a brief outline of the contemporary inquest jurisdiction, and then set out some details of my methodological approach. In the third part I outline

[2] Other than work referenced in this thesis, there has been little legal scholarly attention on the inquest, perhaps because of the widespread perception that the Coroners court is only about establishing facts; 'we don't do any law here' as I was told by a volunteer at one Coroners court I visited. A notable recent exception is the comparative UK/Australia work being undertaken and published by Carpenter, Tait and associates (see various citations). It is also similarly overlooked in legal practice, and often – driven mainly by funding concerns – solely reduced to an instrument to negate, pre-empt or prepare for other proceedings.

of some of the key areas of scholarship I draw on, and close with a summary of the chapters in the rest of this thesis.

The contemporary inquest system

A Coroner must conduct an investigation when they are made aware that a body is within their area and they have reason to suspect the death was violent or unnatural,[3] from an unknown cause or was while the individual was in detention.[4] Such an investigation will conclude with a public inquest hearing unless it is discontinued.[5] The legislative rules for the conduct of that investigation and the inquest at the conclusion of it are set out in the Coroners and Justice Act 2009 (CJA 2009) and the rules and regulations put in place when the CJA 2009 was brought into effect in 2013.[6] The inquest closes with a declaration of findings of fact, and a conclusion (previously a verdict), which can be either a short form (and there are suggested although not prescribed words) or a narrative account of the circumstances of death.

My focus is on the contemporary jurisdiction, but in order to explore that jurisdiction, my research investigates the family in the historical and modern inquest systems.[7] I use these periods as a shorthand (of my own creation), not in order to make definitive claims about conclusive moments of rupture or a comprehensive uniformity across the inquest system at a particular historical moment, but rather to characterise critical shifts in the form of the inquest. As such, and drawing on Burney (2000), I argue that the period 1846-1926 can be seen as a transition period between the historic and the modern inquest. Furthermore, this modern inquest, characterised by medical and legal expertise and a dearth of community[8] or family participation, transitioned into the contemporary inquest in the period 1998-2013. My account is attentive to the shifting relationships of conceptions of public in the inquest, from a hearing which could be characterised as a public investigation, to an

[3] Unnatural is not defined in legislation and there are differing interpretations of what it means, see discussion in Matthews 2014, 99-101 which highlights that it is a matter for an individual Coroner, subject to review on grounds of irrationality, and see discussion in Prior 1989.
[4] S.1 Coroners and Justice Act 2009. In 2014 there were 223,841 deaths reported to Coroners (Ministry of Justice, Coroners Statistics 2014).
[5] Where, for example, the cause of death was unknown and was established to be natural causes by a post-mortem, and the Coroner does not believe there are reasons to continue the investigation; S.4 Coroners and Justice Act 2009. There were 25,889 inquests opened in 2014, a reduction of 14% on the previous year.
[6] Coroners (Investigations) Regulations 2013 SI 1629/2013; Coroners (Inquests) Rules 2013, SI 2013/1616.
[7] I recognise the extent to which describing the operations of Coroners and inquests as a system is potentially problematic, given some wide geographic varieties including different types of Coroner, and given the interconnectedness of the office of Coroner at different times with other legal and administrative structures, including revenue collection and criminal and medical responses to death, but contend that there are systemic elements, including a bundle of distinct legal responsibilities attributed to Coroners.
[8] The example of the jury's ability to add riders, not abolished until 1980 and discussed in Chapter 3, demonstrates the ways in which these periods are illustrative rather than definitive.

investigation undertaken by experts which concludes in a public hearing, to the contemporary process, in which the investigation prior to the final hearing has been opened up to include the family. I argue it is this role of the family which characterises the contemporary inquest, and my particular interest is on the ways in which the family are engaged in shaping and constructing the inquest. While innumerable ingredients have contributed to this reformulation,[9] two key legal developments bookend the shift and are of particular importance for my account. The first is the development of human rights jurisprudence.

Coming into force in October 2000, the Human Rights Act 1998 provided that the right to life in Article 2 ECHR would be directly enforceable in English law for the first time. A central feature of Article 2 is the requirement for structures for the investigation of all deaths, and for an enhanced, detailed investigation where the State was somehow implicated in that death. It also emphasises the importance of family participation in the investigation. As outlined in Chapter Four in relation to the family, and as discussed in various practitioner texts[10] in relation to other changes, it has had (and continues to have) a dramatic effect on inquest law, beginning with the key House of Lords decisions in *Amin*[11] and *Middleton.*[12]

If there was to be a bright line marking the end of the modern inquest and the foundation of the contemporary inquest, it would fall in 2003, the same year in which *Amin* was decided.[13] In that year two vast official reports were published which imagined a fundamental restructuring of the inquest: the Luce Review (Luce 2003) and the 3rd Shipman report (Smith 2003). The review headed up by Tom Luce had come about as a result of general concerns about the failings in the certification of deaths following a series of scandals. These included the actions of GP Dr Harold Shipman, which also provoked a parliamentary inquiry lead by Janet Smith, producing five separate reports into the systemic failures which had allowed him to murder so many of his patients.

There was a great deal of common ground in the conclusions of the reports (as well as some significant differences) and both rejected the wholesale scrapping of the inquest system, with Janet Smith writing that 'I think that the tradition of the Coroner's inquest is so well rooted in this country

[9] Not least the critical role of campaigning organisations like INQUEST, set up in the 1980s, see Scraton & Chadwick 1987 and also see criticism of the system arising out of mass fatalities like those who died in 1989 at Hillsborough football stadium or on the Marchioness pleasure cruiser, see inter alia Wells 1991, Scraton et al 1995, Scraton 2013.
[10] See, inter alia, Simor (2015), Thomas et al (2014), Matthews (2014), Dorries (2014).
[11] R (Amin) v SSHD [2003] UKHL 51.
[12] R (on the application of Middleton) v West Somerset Coroner [2004] UKHL 10.
[13] The fact that there is no such bright line is demonstrated by the Government's response to the reports in 2004, which makes little reference to the role of the bereaved (see foreward to Home Office position paper 2004).

that most members of the public would regret its loss, even though they are critical of the way it is operated at present.'[14] Both emphasised the ways in which the system was not responding to the needs of families, and the Shipman inquiry in particular framed the family as key participants in oversight of procedures for investigating death. It argued that had family members been involved in certification procedures, it would have been a real deterrent to Shipman, and would have increased the chances of his crimes being detected.[15] The Luce Review was more cautious, emphasising the involvement of family where suitable, and the need for informed participation, in line with other public services,[16] but proposing, in its consultation document, that family should be at the centre of the inquiry.

Neither set of recommendations were implemented in full. Instead, in a stop-start negotiated process,[17] they framed the possibilities for reform, organising and informing the policy debate which resulted in the coming into force of the CJA 2009 and associated secondary legislation in 2013.

Focusing on the family: blending methods

To explore my key questions I combine historical, jurisprudential and empirical approaches. Whilst my chapters are nominally divided into the distinct approaches adopted, my analysis developed along the three linked but distinct paths simultaneously, and insights from each approach provoked continual reassessment of my research materials as my thesis developed. This is important because I do not seek to make claims about 'truth' in the inquest, but rather set out an interpretation of the subjects I research. The three approaches enabled me to reflect on and develop this theoretical engagement, as themes emerged through one mode of analysis which could then be brought to bear on another approach; to challenge and expose assumptions, limitations and commonalities. This included the development of my key themes of the role of risk and the possibility of forms of accountability, but other themes are also evident in my narrative. For example, a critical aspect of my historical analysis is the relationship of law and contingency, and an examination of how a deodand gave form to a particular response to the issues posed by this relationship. These reflections raised questions and initiated my reflections on the relationship between the family and contingency in the contemporary inquest, and the place of law in that relationship.

I open with a historical perspective, which, drawing on Foucaldian scholarship, examines the way in which the inquest has arrived at its contemporary formulation. As Douzinas explains, 'The job of the historian is to examine not the ethereal sources and linear paths but the contingent conditions and

[14] Smith (2003), para 19.11.
[15] Smith (2003), summary, para 51, and see discussion at para 19.39.
[16] Chapter 8, pg 143, para 7-8.
[17] See inter alia Glasgow 2004; Luce 2010; Thornton 2014.

unforeseen circumstances out of which values grow' (Douzinas 2007, 27). As such, it is an anti-Whiggish endeavour, eschewing an emphasis on progress in favour of examining reformulations; arguing that engagement of the family was a critical factor in endeavours to control risk, and that the involvement of the family has revived the possibility of forms of accountability[18] in the contemporary inquest.

In the context of these themes of risk and accountability, I turn to examine accounts of law; to consider how a jurisprudence of the contemporary inquest might engage with the conception of the central family. My account of law is a broad one, and draws on a combination of my experience in practice, my empirical research and phenomenological socio-legal and critical reflections on the need to view law in its 'particular, and thus variable, material and historical manifestations' (Ewick & Silbey 1998, 18).

Thus this thesis does not make any universal claims about the character of law, but characterises the inquest as a site constructed by, engaged with and constructive of law. My account of law encompasses the authoritative announcement of a legislative or judicial figure and also the representation of law, and engages with questions of how law 'becomes' (Pavlich 2011), exploring the shaping and constitutive role of the tacit, procedural and unstated in law. I approach this in two stages; drawing on a jurisprudential engagement with jurisdiction through the work of Dorsett and McVeigh (2012, and see McVeigh et al 2007), and using their insights and a range of other scholarship to undertake an empirically grounded exploration of the contemporary inquest as a system in which themes of risk and accountability are in continual productive interaction. My argument is that what happens before the public hearing of the inquest is not just critical to any understanding of that hearing, but is critical to an understanding of the way in which law is engaged, authorised and represented in the hearing and in the final conclusion of the inquest. My analysis of the contemporary inquest does not draw explicitly on governmentality methodologies (Foucault 1991; Pavlich 2007), but returns to consider the links between conceptions of governance and my approach in the conclusion, while my narrative seeks to draw out the complexity and power of choice, freedom and empowerment, described by Larner as the tenacity of neoliberalism (Larner 2000, 9).

To give context to my approach, I briefly set out an example of the role of disclosure (dealt with in more detail in Chapter 7).

[18] Drawing on Morgan (2006). I discuss my conceptions of accountability below and in Chapter 3.

Family at the centre: situating theory through disclosure

A key change in the CJA 2009 and associated secondary legislation is the introduction of a right to disclosure to an interested person of all relevant materials on request.[19] Different research strategies might be deployed to consider this change. A doctrinal research strategy might analyse the narrowing of the Coroner's discretion and query the lack of duty on the Coroner to tell interested persons what documents they hold.[20] A socio-legal empirical study could examine how many Coroners now provide disclosure who did not do so previously, or how their approach to the range and content of disclosure differs. A critical cultural-focused enquiry could draw on the work of the Hillsborough Independent Panel as a case study in which non-state scrutiny of documentary evidence was key in resisting official narratives. An ethographically oriented approach might examine the meaning of disclosure for family members, how they responded to the documents they received and how they used the information to resist or subvert the official discourses of the inquest.

There is value in all of these approaches, and I draw on aspects of them in my analysis. However, in all of them the family is only one actor amongst others,[21] and none would provide an account in which the family was the centre of the law of the inquest, with most of these approaches envisaging law in positivist terms, with a focus on the legal authority of the Coroner and the family as rights holders making claims against that authority. As such, the central family would be implicitly dismissed by the choice of research method. Drawing on Dorsett & McVeigh (2012), my approach avoids starting from an assumption of the authority of the Coroner and the law, exploring instead how that authority is represented, and how law is inaugurated and authorised in a particular context. To examine this, Dorsett & McVeigh argue that attention should be focused on 'technologies of jurisdiction' – those devices or strategies which are oriented towards establishing legal relationships within a jurisdiction. I argue that the key technologies which establish the jurisdiction of the inquest are those of notification and enabling participation of the family (see Chapter 4), and that disclosure of documents is a critical part of the way in which family are enabled to participate. In this way, disclosure to the family is part of constructing the authority of the inquest jurisdiction and thus the law of the inquest.

I combine this approach with an analysis of naturalistic decision-making, drawing on the insights of Hawkins (2002). He argues against a positivistic account of decision-making which overemphasises

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[19] The rules are contained in R.12-16 Coroners (Inquests) Rules 2013 SI 2013/1616.
[20] See Matthews 2014, 7-25, and see 7-24 to 7-32 for discussion of the disclosure provisions.
[21] Not that the family is a single actor, as all would recognise that families can be split and there can be different interested persons involved.

rational sorting of factors in individual cases. Instead he focuses on the systemic, recognising the role of a series of actors making sequential decisions in a particular context. Drawing on this and on Lukes (1974) enables me to attend to the tacit and contingent shaping processes in the inquest system, including the critical role of materials in resisting accounts of law as external, disembodied and instrumental (Riles 2006; Bennett 2009; Jacob 2012).

Taking these two approaches together – combining jurisprudential reflections on the construction of a space for law and a naturalistic account of systems of decision-making – I explore what those decisions (or lack of decisions) suggest about the meaning of disclosure to the family as a constitutive part of inquest law. Often portrayed as questions of fact, procedure, convenience and common sense, my assertion is that these are decisions of law, not simply when they are challenged or when they are made by a Coroner, but when they are made by officers[22] (Atkinson 1978; Carpenter et al 2015a), administrative staff and crucially, by family themselves. They are specific to a particular context but are linked to a set of broader concerns about the purpose of the inquest process, and they shape subsequent legal actions. Regarding disclosure as a technology of jurisdiction enables a focus on family participation as a lawful relationship, and a systemic understanding of how actors perceive that engagement is critical to exploring how disclosure represents law, engages the family as legal actors and gives authority to inquest law.

Finally, reflecting on these insights from the perspective of my critical historical analysis reveals the ways in which disclosure reformulates conceptions of public in the inquest. This is developed in my analysis below, and includes the ways in which, reminiscent of the deodand, the disclosure materialises and empowers the family and gives authority to the law of the contemporary inquest.

The historical and jurisprudential approaches I adopt are discussed further in Chapters Two to Four, and I turn now to briefly explain my approach to collection of my empirical data.

Empirical research

I interviewed eight senior Coroners and five officers.[23] My focus was on analysing how these actors construct 'family', to explore the meaning that these actors give to the role of this construction in the inquest system, and to explore the relationship between this construction and the themes I explored in my jurisprudential and historical analysis of the inquest.

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[22] For the sake of brevity, I refer to those officers who work for the Coroner (who may be employed by the police or the local authority) as officers throughout.

[23] Of, at the time, 91 Senior Coroners across 97 Coroner areas, together with 450 officers (Chief Coroner 2015, para 52 & 66).

I employed a purposive sample to contact potential interviewees (Bryman 2012, 418), and the Coroners I interviewed acted as gatekeepers to the officers (Bano 2005, Kindle Location 2460-61).[24] I had sent out my CV with the letters to Coroners, and it was clear that the Coroners I interviewed were aware of my background as a solicitor representing family members. Three Coroners made direct reference to my former firm, two positively and the other negatively. Others alluded to my experience, stating that I would of course know the law in relation to a particular point. I believe it is likely that my background made access to Coroners easier, but my presentation was as both an insider, with some insider knowledge and experience, and as an outsider, as an academic and former solicitor for family members who could sometimes provide a challenge to the coronial system (Hage 2006). However, rather than presuming anything in relation to the way in which my interviewees positioned me, I sought to take my cue from the person I was interviewing (Ribbens 1989). As Bano notes, drawing on Anderson (1993), the result of my standpoint is that my interviewees may not have told me things that they would have reported to another interviewer, but perhaps they told me things they would not have told a researcher who was focused, for example, on questions of public health or the law in relation to dependency claims for bereaved individuals.

Influenced by Hawkins (2002) (although with some significant differences in approach as discussed below), my interviews were loosely structured, and 'made to seem as much like natural conversations as possible' (Hawkins 2002, 453). Where possible (in all but two interviews) I closed with a discussion of individual vignettes, which were designed to raise questions of legal and cultural definitions of family. In one interview I did not have time to discuss the vignettes at the end, whilst in another I was told there was little time to conduct the interview and so opened with the vignettes (and the interview in fact went on for an hour and ten minutes). My general approach was to open each interview with scene setting questions about the experience and background of my interviewee, before moving onto a series of semi-structured questions (Bryman 2012, 468-496), ending with the vignettes. My decision to end with the vignettes in this way in the majority of my interviews was to avoid foreclosing areas and channelling responses in particular directions (Barter & Renold, 1999). The vignettes enabled my interviews to engage more deeply in exploring the

[24] As gatekeepers they made it possible for me to interview some officers, but it was not clear to me whether they had encouraged or obliged their officers to be interviewed. It was clear that they did not seek to curtail access to their officers in any way; the interviews were held separately and I assured the officers that their answers would be anonymous with no feedback to their respective Coroner. Conscious of the particular importance of ongoing informed consent where questions of access provided by gatekeepers arises (see Miller & Bell, Chapter 4, Miller et al 2012), I emphasised at the beginning and end of interviews that they were not obliged to take part, giving them time to read the consent form and information, and stating that if they wished, their statements could be withdrawn at any juncture in the future. All my interviewees presented as confident and clear in their views and did not express any concerns about taking part.

meanings my interviewees attributed to particular circumstances (Barter & Renold, 1999). They were a particularly important part of my methodology, and so I set out further details of them here.

Vignettes

Spalding and Phillips note that vignettes have been productively used in social science research since the late 1970s (Spalding & Phillips 2007, 954) and Finch uses vignettes to examine kinship relationships, noting that interviewing using vignettes invites statements about normative beliefs in a contextualised set of social circumstances (Finch 1987, 105). Finch also argues that, rather than depicting extreme situations, the vignette should focus on the mundane, although it can be advantageous to include some unusual features (Finch 1987). They also acted as miniature case studies, allowed the participants to explore holistic issues (Yin, 1994, 12) and encouraged participants to describe their own experiences (Barker & Renold 1999). I was clear that the vignettes were my creations, drawing on caselaw as well as my experience from practice, and as such, contained something of me (Spalding 2007, 958).[25] Therefore, rather than relying on methodological approaches which emphasise the desirability of the controlled experiment and the isolated objective feature (Epstein & Martin 2014, 4-7), I explored the responses of the interviewees and my role in constructing those vignettes, drawing from critical reflections on the dynamic instability of law and society and seeking to explore how that dynamic instability might play out in the forum of the inquest (Pavlich 2011). In my analysis of the answers, rather than testing the responses against each other and against doctrinal law to establish truths, I used the vignettes and my interviews to develop and deepen contextually grounded theoretical insights (Yin 1994, 13).

[25] Keenan (2009) shows how race, class and gender can be reinforced by systems which self-describe as neutral, and in an analysis of the ways in which the inquest process can be revelatory of patriarchy she notes the importance as a researcher of recognising your own standpoint. My identification as a white male with professional qualifications and some experience in representing families in inquests (as a solicitor rather than as an advocate) impacted in particular in relation to the construction of my vignettes. Although I had reflected on some aspects of gender in my work, in particular seeking to ensure that I had a gender mix amongst my interviewees as far as possible, I did not reflect on the gender make-up of the vignettes until after my interviews. I created the vignettes drawing from reported cases and from my own experience, and on further reflection was struck by the gender bias within them, with 3 of 4 deceased being male, and 5 of 7 family members identified as female. My experience in practice was overwhelmingly in situations where the deceased was male and I was instructed by a female. This gendering in the system is borne out to some extent in the literature, with a higher rate of inquests amongst men (accounting for 67% of inquest conclusions in 2013, see Coroners Statistics 2013, 19), with a large amount of scholarship on the higher prevalence of self-inflicted deaths amongst men (see for example Murphy 1998; Scourfield et al 2012) while Maple et al (2014) argue there is overreporting of women's voices in suicide literature (Maple et al 2014). I have thus subsequently reflected on the responsibility of a researcher to avoid reinforcing gendered cultural assumptions about death (see, for example Canetto 1993, in the context of suicide, and the discrepancy between deaths of women reported to a Coroner (46% of references) and inquests held (33% of inquests were into deaths of women)) and would take this into account in the design of any future projects.

One reflection on the vignette as a tool for research is that whilst my research design envisaged that the vignettes would provide more detailed substantive reflections on definitional questions about who constituted family and the opening questions would enable the interview to engage in wider systemic questions, in fact many of the most interesting systemic insights came through consideration of the vignettes. This was perhaps because of a common law-style preference for working from cases to principles, or perhaps was because the vignettes provided some hard cases which potentially challenged some of the broader assertions in the earlier stages of the interviews (and which enabled me at times to return to those broader assertions and to interrogate them in the light of the vignettes). Whatever the explanation, there is some irony in the fact that it was the examples of individual cases which provoked some of the most interesting systemic responses.

Vignette 1: the non-adopted daughter and the missing wife

A tree alongside a public footpath falls onto a pedestrian, killing them. The pedestrian is a 65 year old male. The police attended his address and informed the occupant, who identified herself as his daughter. After initial contact with her, she tells your office that she does not think she was ever formally adopted by him but lived with him as his daughter from the age of five (for the last 35 years). She says she thinks he was married once, and she thinks he would not have got divorced because he was a staunch Catholic.

In follow up questions, I teased out further explanation, for instance whether officers would permit the daughter to be involved, whether they would seek details of the wife and how they would go about seeking those details. With this, as with the other vignettes, I asked Coroners how they would expect their officers to act, how they would decide what to do, and how they would respond if their officers came and discussed this scenario with them.

Vignette 2: the girlfriend

A soldier in a barracks in your district is found shot dead. Internal Army investigations suggest the gun shot was self-inflicted. His girlfriend contacts your office. She had been going out with him for ten months at the time.

Follow up questions included testing how additional information would affect the decision, including details that she is pregnant with his child, they lived together and he was an orphan with no other relatives. I was surprised to discover that for many participants, the fact that it was a soldier with a boyfriend/girlfriend relationship suggested it was either possible or even likely that the deceased was also married, a factor I had not envisaged in the vignette design.

Vignette 3: the mother, biological father and the new partner

The school bus which should have picked up a five year old girl was cancelled at the last minute, but no-one informed her parents, and she walked home from school. On the way she was run over and killed. The police have informed her mother and her partner. The mother informs you that the father is not on her birth certificate and she had an old (now expired) non-molestation order against him after he was violent towards her. He has had no contact with the child, who was born after she left him. She says her new partner has effectively been the father, and she wants him to be treated as such in the inquest.

With this vignette, I sought to raise further questions about the extent to which Coroners and their officers would expect to search for further possible next of kin, once they had identified an obvious next of kin, as well as questions about the way in which decisions were made about interested persons.

Vignette 4: the long lost sister

A man dies in police custody. He was homeless, and police were unable to find any next of kin. After the post-mortem, his sister contacts your office. She says she has had no contact with her brother for 30 years after a family dispute, but wants to be involved.

My attention in this scenario focused on two areas; what evidence, if any, might be needed to support the sister's claim, and whether the length of time she had been out of contact with her brother would make any difference in the way she was approached.

The vignettes produced insights which run through my chapters on the contemporary system (chapters 5-8), and as shorthand I refer to the individuals in these scenarios using the titles of the vignettes as the non-adopted daughter and the missing wife (Vignette 1), the girlfriend (Vignette 2), the mother, biological father and the new partner (Vignette 3) and the long lost sister (Vignette 4).

The lack of information in the vignettes was deliberate; as Finch (1987) notes, ambiguity forces interviewees to invent factors which would help them decide, and in so doing, I hoped they would reveal ways in which they would understand and frame the situation. I selected the ways in which the deaths had occurred from real cases to ensure they would be believable for the participants. In relation to the relationships, these were invented by me as possible scenarios which might arise and which could require an exercise of discretion on the part of the Coroner (i.e., not falling into the automatic categories of family in the legislation) or might raise questions about the differences between close emotional ties and formal kinship links.

Barker & Renold (1999) emphasise the importance of plausibility of vignettes, and as with Spalding & Phillips (2007, 959) I experienced validation of my vignettes in some of my interviews, with interviewees stating they had had a case like this, or asking if these were examples taken from their jurisdiction. However, one officer described the circumstances in Vignette 3 as implausible. As discussed in chapter 7, this officer stated that this set of circumstances would not happen – the new partner would not be treated as the father because the mother was available to be next of kin. Here, the very implausibility of the scenario was itself revealing, as this response revealed the way in which the officer would play a part in tacitly ensuring these circumstances would not arise.

My interviews

Taken together, the interviews provided over 17 hours of discussion.[26] My officer interviewees had been in post for an average of five years, while the Coroners I interviewed had an average of 13 years coronial experience (both full and part time).[27] The Coroners' experience spanned the whole of England (not Wales), from north to south and east to west, and their jurisdictions varied widely, from heavily populated urban districts, to areas incorporating medium sized towns/suburban areas, to far more geographically spread out and less populated rural areas. Their support and place of work varied widely as a result, from full time Coroners with a large staff of officers to part time Coroners with few officers. I conducted interviews in offices based in police stations, in council offices, in offices in a solicitor's practice and in purpose built Coroners courts (a diversity highlighted by Thornton, 2014).[28] Five interviewees were female (3 of 5 officers) and eight male (6 of 8

[26] The interviews with Coroners each lasted 100 minutes on average, while the interviews with officers were an average of 1 hour and 20 minutes.

[27] Although these averages do not include some examples of lengthy relevant experience before becoming a Coroner or officer.

[28] Most of my interviews took place in busy offices surrounded by inquest files. In relation to these individual inquest files, I draw on valuable academic work reflecting on inquest files (Atkinson 1978; Langer, Scourfield & Fincham 2008) and consider that documents can provide and ground theoretical richness (Riles 2006; Jacob 2012), but reluctantly concluded on grounds of time and not to seek access to inquest files as part of this study. In contrast to Langer et al's work on suicide, I considered it would be difficult to identify a category of files to examine which would illuminate my specific questions, and a general review of files might tell me very little about the key questions I sought to examine. In particular, as my interviews demonstrated, many decisions were taken tacitly, and I considered that the average file would be unlikely to reveal the insights that I obtained in the answers to the non-adopted daughter in Vignette 1 for example. This approach is in contrast to Hawkins (2002, 448), who argues that reviewing files was an essential part of establishing whether the accounts his interviewees gave of how they made decisions was reflected in practice, but I was not concerned with comparing the accuracy of my interviewee's account to their actual practice. I did note Hawkins' concern that without engaging with files there is a risk that individuals will spout an official line and will exaggerate the extent to which decisions are thought through. However, my interviews demonstrated the opposite – they illustrated how many decisions were tacit or left to others to decide, and there was also a very broad range of responses differing from official lines about the role of the family, perhaps reflecting the less hierarchical structure of the coronial system as compared to the health and safety system.

Coroners), but drawing on Chilvers (2012) I refer to all interviewees in gender neutral terms in my write up for reasons of anonymity.[29]

Despite this diversity, I did not endeavour to produce a systematic sample of the Coronial areas across England and Wales, and have not sought to produce generalizable results.[30] One critical finding across all of my interviewees was that they considered that the family had achieved greater importance in in the contemporary inquest and had more involvement in it, but as with all my findings, this can only be said to be true for those Coroners and officers who agreed to take part in my research. My methodology draws from ethnographic preference for the thick and rich account over an emphasis on statistical proportions, and as such adopts a qualitative approach, seeking to develop theory rather than purporting to provide an accurate representation of a larger world (drawing on 'theoretically informed ethnography', see Taylor 2002, 5, drawing on Willis & Trondman). I do still make knowledge claims, to the extent that I claim that an individual Coroner or officer made the statements I report, and at the time they stated it, they appeared to mean for me to believe it was true. However, I am not engaged in establishing the truth or falsity of those claims, but rather seeking to explore how those accounts represent the world. What can however be said, drawing on Platts (1988, cited in Roseneil & Budgeon 2004, 153), is that if these practices are possible in the examples I give, then they are possible in other cases and must be taken into account when thinking about general propositions. Importantly, my focus does not seek to compare the statements that Coroners and officers made to the way they act in particular circumstances, by seeking to consider their statements of what happened in particular cases alongside the 'reality', but rather engages with how they understood, represent and give meaning to their actions.[31]

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[29] For reasons of anonymity I have deliberately not identified my interviewees as Coroner A, B, C etc to avoid the possibility of cross-identification through analysis of their answers. Some answers were edited for length and where interviewees have referred to features of specific cases I have changed aspects of those cases to ensure anonymity, whilst seeking to maintain the essence of the account I was given.

[30] I had reflected in advance on a concern that I would emerge with a particular bias towards the family, given the ability of Coroners to refuse to engage and the potential for social desirability bias in the answers I received (Grimm 2010). In the event I was able to secure interviews with Coroners with a broad range of approaches to the role of the family (as I believe my quoted excerpts demonstrate), but additionally while I have endeavoured to reflect the range of answers I received, I do not seek to draw quantitative findings from my research.

[31] This is one reason that I decided not to engage with observations of inquests, but I was also concerned about the possible impact of my presence on the hearing and the ethical issues around the consent of participants to inquests nominally held in public but where the only attendees other than myself are connected to the deceased. Furthermore, as my work progressed I became increasingly interested in the investigation before the inquest hearing, and was concerned that observation of formal hearings would mean my work lost this focus on the role of kin in shaping the hearing, and could instead reinforce the production of reality found in the hearing, ignoring the people and issues which had been excluded, included or remoulded before that stage. In this context, I also decided that observation of officers at work was unlikely to be a productive approach to this research. My interviews (and other research, see Wheatley 2012) confirmed that

As the selected group is not designed to be representative (Finch and Mason 1993, 30), I did not seek to explore how common it is for Coroners and officers to respond in a particular way, and I do not suggest in most scenarios how common a particular approach was (although where it is overwhelming I have made an exception), but rather seek to 'indicate broad patterns and associations' (Hawkins 2002, 453).

As discussed below, I had developed two broad themes from my historical and jurisprudential research; a focus on risk and a concern to engage different forms of accountability, and I was keen to explore how there arose in my interviews. Both themes were evident in all of my interviews, albeit in different ways (as my analysis below shows), and my initial intention was to draw on conceptions of framing drawn from Hawkins (2002), including the surround/field/frame model. This is a methodology which explores the ways in which the wider socio-political context (the surround) and the institutional framework (the field) impact on the way in which decision-makers interpret and classify the circumstances they are faced with. The crucial question is not what items of information (or factors) are part of making a decision, but rather how the decision-maker understands and organises the information they are presented with (the frame). Hawkins argues that the frame, as a structure of 'knowledge, experience, values and meanings' is always contingent and will 'instruct a decision-maker how to understand a case, a problem or a person.'[32]

I found the use of framing as a way of undermining a positivistic reliance on factors helpful (and see my analysis in Chapter 5 on this), but ultimately rejected a reliance on Hawkins' analytical approach for four reasons. Firstly, the analysis of my empirical work does not seek to develop a universal theory of decision-making, but rather examines how my interviews challenge and bring additional nuance to my theoretical insights about the place of family in law. Secondly, I found that the field/frame relationship did not lend itself to my research context; I argue the institutional structure of the inquest is itself radically constituted and reconstituted by the engagement of family, and I seek to open up questions and links rather than conclusively determine relationships. Most fundamentally, my account is one in which frames remain ways of organising a scenario but can be seen to be deployed strategically, rather than instructing a decision-maker how they should respond.

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much of the work of officers is on the telephone or by email, and they are extremely busy. I considered there would be a great deal of complexity in obtaining consent from individuals, particularly bereaved individuals, and it would take considerable time (and would be very difficult) to penetrate and understand their work in these circumstances (Hawkins 2002, 448).

[32] See Hawkins 2002, 53-55. Hawkins' use of framing is drawn from Goffman (1974), and see Manning & Hawkins (1992) for a fuller explanation of the way in which he develops framing. Also see Jameson (1976) and Durham (2001) for some critical reflections on Goffman's use of framing.

I draw here on Kennedy's (2008) work on legal determinacy and his critique of Kelsen and Hart,[33] but draw my account of what constitutes law more broadly than in that work.[34] In my analysis, the frames are drawn from the themes I identified in my historical analysis and link to the ways in which the jurisdiction of the inquest is given authority, and as such are deployed in order to combine forms of accountability or to respond to concerns about risk. Finally, and more prosaically, I found that division of my analysis into a series of chapters discussing distinct frames lost the fluidity I encountered in the inquest system and the ways in which framing of a particular scenario could shift.

In various ways as I engaged with the implications of my research, my experience as a lawyer for the family and entrenched faith in the role of lawyers, legal rights and legal technicalities protecting families was exposed and challenged. One example of this was the response from some Coroners that families without lawyers might have more opportunity to ask questions outside of the scope of the inquest. Another was that, upon reflection on the vignettes, I had envisaged that as potentially complex cases with scope for subsequent civil claims, Coroners might be more cautious in relation to interested person status and might challenge claims that individuals were entitled to engage. As my experience as a lawyer had often been seeking to push Coroners to go further than they might otherwise have wished, with some Coroners apparently keen to narrow the scope of the inquest wherever possible, I had not reflected on the value that the system might put on the engagement of family, and that in more complex cases, they might be more likely to want interested persons to be involved.

The process of transcribing interviews and exploring the insights from those interviews at the same time as engaging in critical historical research and jurisprudential reflections provoked me to continually reimagine my approach to my thesis. Most importantly, it encouraged me to develop a nuanced account of law, encompassing not just rules which structure the space of the inquest, preventing or enabling, excluding or legitimising, but the ways in which each inquest emerges, and the inquest system has emerged, as a contingent process, constructed by and constructing representations of law. It has encouraged me to reflect on law as other than an exercise of

[33] As well as Kennedy 1997.

[34] Kennedy argues that legal work comes into play after the work of investigators and parties in establishing the facts (Kennedy 2008, 158-159), while I seek to draw out the law in the initial procedural interlocutory engagements of the officer, the Coroner, the family and others.

sovereign power; not focusing on questions of authority, and how family might be being given authority, but instead on the integral place of the family in authorising law.

Key literature

In addition to the literature discussed above, there is some specific literature which I draw on and which I discuss in this section, as well as three broad areas of work which I summarise below.

In relation to accountability, I define accountability broadly as the requirement to reveal, explain and justify, and draw on Morgan's (2006) distinction between 'convivial' and 'technocratic' forms of accountability. Convivial accountability emphasises methods of achieving meaningful revelation, explanation and justification to produce a contextual, nuanced and contingent accountability founded in a tacit participating community. It is defined as distinct from technocratic accountability, which may be a judicial, democratic or administrative based approach to accountability, but is based on rule-formation and technicalities, emphasising neutrality, objectivity and expertise.[35] My analysis seeks to explore the appearance and arrangement of these forms of accountability in the inquest. I recognise that the use of 'convivial' as a term in the context of the inquest could be insensitive and inappropriate from the perspective of bereaved individuals, but I use it here in Morgan's terms to maintain theoretical consistency and not to denote geniality or good cheer.

Another area of literature which underlies my analysis is a developing body of literature on the inquest as a site of therapeutic jurisprudence.[36] Advocates of therapeutic approaches to the inquest emphasise the limited nature of this perspective (Freckelton 2008), resisting paternalism and focusing on the need for the inquest to minimise harm to the bereaved, with some success (as consideration of the 2009/2013 reforms in light of the recommendations in Freckelton 2007 demonstrates). A framing of the inquest as site of therapy can result in an emphasis on 'closure' (Tait & Carpenter 2013; Carpenter et al 2015b), with a perception that grief is a process to work through; a perspective Butler characterises as invoking 'the Protestant ethic when it comes to loss' (Butler 2006, 21). To the extent that I have a normative project in this work, I seek to develop a critical analysis which opens up space for kin and of kin. As such, my approach is cautious of the possibility of overclaims of the inquest as a necessary or essential part of a process of grief, but I argue that family and grief is central to the contemporary inquest; where the place of the family is constructed in the tension between narratives of 'a space to grieve' and 'the need to know,' and

[35] There is a great deal of literature which engages with criticism of the inquest system from the doctrinal, medical and public health perspectives, and one central feature of my analysis is on conflating these criticisms as different forms of technocratic concern distinct from questions of the relationship of convivial and technocratic accountabilities.

[36] Which is part of a far wider literature on the therapeutic, see inter alia Foote & Frank 1999; Aubry and Travis 2015.

return in my conclusion to reflect on the questions of therapeutic jurisprudence, bureaucracy and the possibilities of justice.

To contextualise the three broad areas of scholarship I draw on – sociological and cultural responses to death; family and kinship scholarship; and work on death and the State – I give some key examples and explain how I seek to build on them below.

1. Sociological & cultural concern with death

One key area for academic engagement with death and society is attention to the investigation of suicide, and in that context I draw on Atkinson's (1978) insights into the ways in which actors in the inquest system construct suicide, and in particular on the key role of the officer in that account. Other research has included analysis of the role of the inquest in bereavement (Davis et al 2002; Biddle 2003), including establishing 'facts' and a fitting explanation (Hawton & Simkin 2003; Scott Bray 2010; Chapple, Ziebland & Hawton 2015), as well as public health oriented assessments of the effectiveness of the Coroner's court as a site for constructing suicide (Linsley, Schapira & Kelly 2001; Palmer et al 2015) based in part on the influence of the family in that process (Carpenter 2015b).

This scholarship also calls for reflections on the inquest in a wider context of death and grief, and the way in which relationality is revealed and engaged by death in contemporary society. These range from cultural claims of the modern private death, surrounded by family and sequestered away from the community (Aries 1981; Prior 1989) to nuanced empirical analysis of relationships between deceased individuals and their family, kin and the wider community (Seale 1995; Klinenberg 2001, 2015; Owens et al 2008; Kellehear 2009) as well as reflections on kinship, grief, the body of the deceased and systemic responses to sudden death (Dix 1999; Howarth 2000; Partington 2004; Mowll 2007; Chapple & Ziebland 2010). Butler (2006) resists an account of the privatisation of death, arguing that the loss of death is not exclusively composed of the loss of the deceased or the loss felt by the living, but of a relational tie. As such, grief is not privatising but instead 'furnishes a sense of political community of a complex order, and it does this first of all by bringing to the fore the relational ties that have implications for theorising fundamental dependency and ethical responsibility' (Butler 2006, 22). In one example of a piece of work drawing on Butler, Reimers (2011) argues that practices of grieving are kinship practices which can presuppose and reinforce the heteronormative conjugal family, potentially preventing 'other relations and identity positions from being articulated as legitimately in mourning.' (Reimers, 2011, 259); and such articulations have impact beyond the context of grieving (Quinlan et al 2015).

My work draws on all of this scholarship, engaging with the ways in which death raises and reveals questions of community and kinship, and I seek to add further insight on the responses of law and the ways in which law shapes and is shaped by those practices of grieving. In this context I also draw on socio-legal work on succession and inheritance law (Monk 2011 & 2014) engaged in exploring the way law mediates the relationship between death and kinship.

2. Interdisciplinary kinship and family research

My reflections on kinship and family are not solely drawn from work relating to death, but also engage in two broad and in places overlapping fields of scholarship in feminist and Foucault-influenced literature.

From critical feminist engagements with family and kinship I draw insights about the contingent construction of family and kin (Al Haj 1995; Jacob 2009 & 2013) the shifting nature of conceptions of the 'traditional family' (Smart 2007, 11) and a need to attend to practices of family and kinship (Butler 2004; Morgan 2011). I also draw from work theorising an ethics of care (Held 2005; Slote 2007), empirical work engaged with the role of negotiation and obligation in the construction of family (Finch 1989; Finch & Mason 1993; Maclean & Eekelaar, 2004) and calls for critical analysis of a focus on the heteronormative, biological and conjugal in kinship (Weeks et al 2001; Law Commission of Canada 2001; Roseneil & Budgeon 2004; Roseneil et al 2013; Weston 2013). Importantly for my work, feminist scholarship has traced and critiqued legal and administrative reconceptualisations of family and kinship (Smart 2009; Sloan 2011; Cornford, Baines & Wilson 2013) and has called for critical reflection on the theoretical framings in those shifts (Wilson 2007; Pylkannen 2007) including the 'ambivalent gift' of legitimation of relationships (Butler 2002; Barker 2012).

I draw on all this work to challenge the 'obviousness' of family in some accounts of the inquest, and to provide critical nuance to a potential overemphasis on the progressive nature of reforms widening legal definitions of family. I seek to add to this literature by developing an account of the iterative relationship of the law and kinship in the inquest, with an emphasis on both what family do and who family are, and with attention to the role of family and the system in the construction of a meaningful and instrumental form of kinship.

My work also engages with accounts of the politics of conceptions of family (Buss & Herman 2003) in the context of multiple neoliberalisms (Larner 2003, 510). As such, whilst this is not solely a study of governmentalities in the inquest, it engages with Foucauldian scholarship, including O'Malley's (2009) reflections on risk and Pavlich (2007) on restorative justice. In relation to risk however, my conception of risk is not solely drawn from O'Malley, as I also seek to explore the different ways in which risk appears through my materials, including an exploration of the ways in which my

interviewees engage with the risk that an inquest will fail to engage in construction of a 'grieveable death' (Butler 2006).

The historical work draws in particular on the work of Donzelot (1979) on the rise of the family. His work has been criticised by amongst others, Atkinson (2014) who draws on Bourdieu (1996) to argue that this account fails to recognise the ways in which family is reproduced through subjective schema and objective structures. Sidestepping this debate, my reading of Donzelot relies on his emphasis on the essential malleability of family as a tool of policing, to critically expose accounts in which, as Atkinson puts it, despite lacking a universal substance, family 'is treated as if it had a timeless essence and natural basis, an existence sui generis and palpable purpose, with which agents carve up the social universe and organise experience' (Atkinson, 2014, 225).

My use of this scholarship is therefore to engage with the contingent creation of the contemporary inquest. However, my account does not set out with a presupposition of law-as-tactic (Foucault 1991, 95), or with a concern with unaccountable petty sovereigns (Butler 2006, 65), but seeks instead to engage with the formulation of an account of law in a particular context, returning to consider the potential relationships of this account of law with Foucault-inspired engagements with law in the conclusion.

3. Death and the State: critical legal scholarship & campaigning activist literature

The final area of scholarship I draw from is research which engages with the most contested inquests; those which are involved in exposing the potential failings of the State in relation to deaths involving State agents and systems. Developing out of critical criminological attention on the politics of inquests into controversial deaths at the hands of the State, this area of research was first instituted in the 1980s (see Warwick Inquest Group 1985; Scraton & Chadwick 1987; Tweedie & Ward 1989). Since then it has included critical legal reflections (Scott Bray 2012) as well as insights from other disciplines, particularly media/cultural studies (Erfani-Ghettani 2015) and with close links to activist work, in particular the work of INQUEST (Ryan 1996; Coles & Shaw 2006; Shaw & Coles 2007; Speed 2012) but also the Institute for Race Relations (IRR 2015). Particularly focused on deaths relating to policing and in custody (see Beckett 1999; Pemberton 2008; Martin & Scott Bray 2013; Scraton 2013) this scholarship has provided a sustained critique of the workings of the inquest system incorporating the concerns of bereaved individuals and including insights into the way in which the inquest system can reinforce hegemonic power through reproduction of structures of race and class (Scraton 2002; Keenan 2009; Razack 2011a & b, 2015), tropes which do not only arise in the context of deaths involving state agents (Carpenter et al, 2015a). In one example of this

scholarship, Scraton argues that the inquest is a site for aggregating truth, and illustrates the ways in which the system can work to deny truth and thus justice and accountability (Scraton 1998).

I draw on this for critical reflections on the ways in which the inquest system can hide prejudice and deny the humanity of the deceased and lived experience of the bereaved, adding a perspective of the non-controversial inquest and the perspective of the actors within the inquest system.

From a promise to control risk to the inquest hearing: chapter guide

Chapter Two examines the relationship of law, the family and the community in the historic inquest, and the shifts which constituted the foundation of the modern inquest. To explore these shifts, I draw on the deodand – a gift to God of an object or animal which had been associated with death, and which had sometimes been used for financial relief of the bereaved. In my discussion, I argue that the deodand brought contingency, risk and community engagement into the law. Its abolition was a promise to contain that risk, and was matched by the first right for the bereaved family to bring a claim, formalising family and simultaneously limiting law's reach. Its loss was a loss of the uncertainty and contingency of materiality, and a move to rationalise the investigation of death; limiting the unruly community and disempowering the family through regulation. Crucially for my account, before its abolition, the deodand had represented the possibility of convivial forms of accountability in the inquest (drawing on Morgan 2006).

I move in Chapter Three to further explore the interaction between Morgan's (2006) categories of convivial and technocratic accountability in the historic inquest, before analysing the possibilities for convivial accountability in the contemporary inquest. I argue that the inquest has a long history of combining forms of accountability, and that while convivial approaches were diminished in the modern inquest, the contemporary reformulation presents the possibility of a revival. I argue that a fundamental feature of the inquest system is its perceived ancient heritage, with a mixture of aims and a stated emphasis on facts and pragmatism instead of lofty ideals, as well as a pride in local connections. This flexibility and ambiguity, with the possibility of constructing a contextual meaningful account of death in alliance with powerful narratives of therapeutic closure for the bereaved, legal continuity and modern medical knowledge, gives the inquest a unique legitimacy, but also presents a series of risks, challenges and the possibility of creating or reinforcing injustice. To explore and illustrate these possibilities and problems, I develop case studies on what I have termed 'the social welfare inquest' – an inquest which engages with the concerns of social welfare law. Some similar themes run through social welfare law – a concern with scale, particularly local/national; questions over discretion and the administrative/judicial divide; and tensions between paternalism, expertise and participation – and it is also far less well examined than other

areas of the inquest, from the inquests into deaths in custody discussed above, to inquests into medical malpractice and road traffic deaths (see Howarth, 1997). Furthermore, I argue it merits attention as an area in which the inquest is increasingly engaged.

Chapter Four takes up the themes of combining forms of accountability and the central place of the family, and explores how these relate to conceptions of law. Drawing on Dorsett & McVeigh's work on jurisdiction (Dorsett & McVeigh, 2012), I develop a jurisprudential account of the contemporary inquest jurisdiction, which accounts for the central family and draws in the themes of risk and the liability to reveal, explain and justify through both technocratic and convivial modes of engagement. This account of law prioritises the materials of law, and the systemic, the procedural and the technical aspects of law, as well as the way in which the jurisdiction is represented. Importantly for my research, I argue that the law of the inquest is not just an official account of death, and is not just the form of the procedures which govern the conduct of the space. It is also a question of the ways in which lawful relations are constructed in the inquest and in the space and time before the inquest. I argue that paying attention to the practices of jurisdiction, and in particular exploring the key technologies of jurisdiction – those of notification and enabling participation – reveal the emergence of the family in inquest law. Critically for my argument, it is through attention to these jurisdictional devices that the claim of centrality can be understood and joined to an account and a representation of law. Furthermore, in placing the family at the centre, those jurisdictional devices institute a representation of inquest law in which the participative family is constitutive of the law of the inquest itself. This is an account of law authorised by the joining of possibilities of accountabilities, but in this chapter and subsequently I also draw out the ways in which law remains continually bound up with risk. This concern with risk may resisted by a jurisprudence of combined accountability, but as with the abolition of the deodand, the carefully constructed structures of law do not banish risk, but enable it to resurface in different forms; now, crucially, through the possibility of failure of the delicate relationships between structures and formulations which authorise different modes of accountability.

In chapters Five to Eight I take the insights from these historical and jurisprudential chapters and explore my empirical work to deepen, contextualise and challenge the claims in those earlier chapters. In Chapter Five, I consider the first contact that officers and Coroners have with the family, and expand on the ways in which I link my critical and jurisprudential reflections to an analysis of my empirical research. I open by focusing on the next of kin, how the next of kin is determined, and the first contact that they have with the inquest system (and specifically the officers). I argue that this first contact and initial engagement with officers is key to understanding how the next of kin (and the family more generally) are constructed in the law of the inquest. The

chapter focuses on the disconnect between the formal legislative requirement that the next of kin are notified at the opening of the inquest and the lack of definition of next of kin, and the ways in which this formal requirement plays out in the practice of the inquest. Critically, even accounting for the lack of legal clarity, my research shows that a reliance on the text and techniques of law will not properly account for the ways in which the next of kin is discovered and engaged, and demonstrates the need to engage in a naturalistic and systemic analysis. In this discussion, I draw out the ways in which processes of routinisation and typification are particularly crucial aspects of the way in which decisions are made about next of kin, and argue that notification illustrates the role of family in reintroducing contingency and resisting typification. In the final section of this chapter I move to examine first contact with the Coroner in order to draw out the key frames which I use to analyse my interview materials. In this section I explore how the different answers Coroners gave to the question 'how and when do you first have contact with the bereaved' demonstrate the ways in which the same factors can be given different meanings depending on whether the frame adopted was focused on engaging with combined forms of accountability, or was instead concerned to pre-empt risk.

A key early issue for the inquest system in any investigation, and a critical determinant in making decisions about next of kin, is the question of the dignified disposal of the remains of the deceased. In Chapter Six I examine the role of dignity in relation to the way in which inquest law and the inquest system construct the tripartite relationship of the family, the body and the inquest process. Drawing on and developing Dorsett & McVeigh's (2012) distinction between jurisdictions of conscience and jurisdictions of civility, I open by comparing the construction of dignity in canonical and civil courts in relation to the role of families seeking or resisting exhumation of human remains. I argue that the different approaches, with a focus on dignity as humanity versus a conception of dignity as civility/honour, envisage the relationship of the family and the body in fundamentally different ways. I move to explore the place of the family in oversight of the body in the contemporary system, arguing that the family are responsible for the dignified engagement of the inquest with the deceased, and I then move on to explore framings of conscience and civility in relation to post-mortems and the release of the body to the family.

Chapter Seven engages with the traditionally legal concerns of status and rights as procedural questions before and during the public hearing. My attention is directed to exposing the ways in which an attention to rights and status do not fully explain the reflexive and reactive relationship of the family, law and the inquest. I argue that decisions (and non-decisions) in relation to who has the status of 'interested person' and who has the right to receive disclosure can again be seen to be framed through attention to accountability and risk, and I explore the role of extra-legal hierarchies

and the critical importance for the inquest system of having someone there to represent social connection and emotional ties. Central to this analysis is an uncovering of the ways in which decisions are tacit and sequential, and have critical implications for the shaping of the investigation and inquest. However, rather than seeking to deny law's place in these procedures and processes, I argue that law remains central in these interactions, as it is the practice of creating lawful relations – the crafting and representation of a lawful jurisdiction – towards which actions are oriented. Thus the family are called to law by a broad notification, and the law of the inquest is inaugurated in that process, and once called, the family's participation shapes the inquest process. Their participation gives meaning and authority to the law, fusing privacy and kinship with transparency and oversight, but creates the risk that their absence or their refusal to conform to the demands of the system will leave the public hearing as remnant, thin and undignified.

My final substantive chapter turns to engage with that public hearing, and focuses in particular on the complicating and revealing role of other participants, to explore the ways in which they construct a central family. This chapter engages with the place of the public inquest and explores the ways in which technology has a critical role in the construction of a public space. Inquest hearings are held in very different places, from police clubs (with the snooker table covered over), registry offices (where for one widow, the last time she had been in the room was on her wedding day), hotels, town halls, specially built courts and magistrates courts. I argue that the role of the family is key to the public nature of the inquest, and explore the relationship of the family with the media and a jury, as well as the role of legal representation for the family. I also argue that the unrepresented family illustrate the ways in which Coroners endeavour to construct a space for combining accountabilities, and how concerns with risk can disrupt this construction. I close with reflections on the ways in which some of my interviewees engaged with meaningful revelation, closure and the conclusion of the inquest, arguing that an emphasis on understanding can be framed through attention to risk or as part of an attempt to create space for kin to weave their own understandings into law.

My conclusion draws the threads of these chapters together, exploring the possibilities of seeing an open ended justice through the role of the family in the inquest, and highlighting future possible projects to continue to pursue the reflections in this thesis.

Chapter Two: A promise to control risk - the abolition of the deodand and the rise of the family

And nothing may we use in vain;
Even beasts must be with justice slain,
Else men are made their deodands.
Though they should wash their guilty hands
In this warm life-blood which doth part
From thine, and wound me to the heart,
Yet could they not be clean**;** their stain
Is dyed in such a purple grain.
There is not such another in
The world, to offer for their sin

Andrew Marvell, 'The Nymph Complaining for the Death of her Fawn' c.1650

Introduction

For centuries in England and Wales, at the end of in an inquest into a death, the jury could declare an animal or inanimate object to be responsible for the death. Such an object was named deodand, a gift to God,[37] and was forfeit to the Sovereign. Abolished by statute in 1846, the demise of the deodand coincided with Parliament's approval of Lord Campbell's Act of the same year, which permitted relatives of the deceased to claim damages arising out of the death. Prior to this, any possible claim for negligence ended with the death of the injured party.

Recent academic engagement has focused on the deodand as an example of the role non-human actants can play in law, troubling the distinction between human and object/animal (Bennett 2010; Dayan 2011; Lemke 2014) – an endeavour which can be traced back through Marvell's Nymph, and the transformation of 'ungentle men' into deodands through unjust slaying of an animal. This chapter builds on these insights, and focuses on the moment of abolition of the deodand to draw out the subversive possibilities of the deodand and the place of the family in the historic inquest. I explore the ways in which the deodand brought contingency and materiality into the law, and argue that in exchanging the deodand for a claim, the law promised to contain risk, which the deodand had previously demonstrated was everywhere and in everything. However, this promise to replace risk

[37] From the Latin *deo dandus* or *deo dandum.*

with certainty with the imposition of a familial compensation claim – constructed as rational and progressive – brought a new kind of arbitrariness into the law.

I argue that this replacement of the deodand with a familial claim to compensation makes an account of the place of the family a crucial part of any discussion of the deodand, and vice versa. Drawing on Donzelot's (1979) thesis that the family is critical in the emergence of liberal governmentalities, I develop the abolition of the deodand and the institution of the family claim outside the inquest as a case study to examine the contingent emergence of the modern and contemporary inquest and the place of the family and the community in that account. Critically, prior to this moment, the family had no special place in the law, and the legislative swap of the deodand for the claim was a key step in carving out a distinct place for them in the inquest jurisdiction.

The chapter is in four parts. In the first part I briefly discuss the deodand itself and describe the relationship between the deodand and the family in the historic inquest. Thereafter, adopting Donzelot's methodology of exploring history through tracing the lines of transformation which reshape the social surface, I analyse three lines of transformation, starting with the technical legal change from deodand to cause of action by the family. My second line of transformation analyses the shift from community to family; exploring public order and the inquest as a popular court. Finally, I examine mutations in the ritual of the inquest, the promise to control risk, and the decline of materiality.

The deodand – flexible, contingent and anti-modern

In London, in late August in the mid-thirteenth century, a jury gathered on a Monday morning to consider the death of William Bonefaunt. They concluded that

> On the preceding Sunday, at the hour of curfew, the above William, had stood drunk, naked and alone, on the top of a stair in the aforesaid rent for the purpose of relieving nature when by accident he fell head foremost to the ground and forthwith died. The stair appraised at 6d for which William De Brykelworth, one of the Sheriffs, will answer.[38]

The stair from which William fell was a deodand, and the value of it was forfeit. 'Any moveable thing not fixed to the freehold, or instrument inanimate or beast animate' (H.B. 1845) could be a deodand, and William Bonefaunt's step illustrates the deodand in all of its elusive ambiguity.

[38] Sharpe 1913, 194-5, Roll F27. See also a deodand of 12d for a step in the case of William Hamond at 233, Roll G. Other Coroners rolls have instances of deodands, see for example Hunnisett 1961b.

Its defining feature is a lack of definition. The decision to name an object deodand was at the discretion of the jury (although the attitude of the Coroner was inevitably relevant; Pervukhin 2005, 248) and it was for the jury to assign a value to it.[39] Crucially, the deodand was an inherently contingent object; a chattel which through the jury's shaping of the narratives of death became linked to that death. The variability of the deodand's appearance in the law and the historical record mean that few irrefutable assertions can be made about it, and its origins predate legislative attention. The earliest official mention of the deodand is found in the reign of Edward I, in *De Officio Coronatoris* in 1275-76, which includes no definition and which clearly draws on pre-existing common law.[40] The deodand did not appear again in statute until 1833,[41] but was considered judicially and, probably most influentially, in the work of a handful of key jurists, including Fleta, Britton, Coke, Hale and Blackstone.

Unfortunately, in their attempts to set out the law – a task which, speaking about his wider project, Coke describes as 'a worke arduous, and full of such difficultie, as none can either feele or beleeve, but he onely which maketh tryall of it' (Coke 1797) – they only succeeded in creating more mystery and confusion over the meaning and purpose of the deodand.[42] In fact, as Pervukhin (2005, 239) convincingly shows, the creation of deodand law was driven by juries, and many of the rules around deodand were created as jurists and courts sought to make sense of the wide variation in jury decisions on deodand. Few inquest jury decisions were appealed for the courts to develop common law principles, and while jurists sought to impose clear principles on deodand law, there is little evidence to suggest that juries considered themselves bound by these principles.

This is not to suggest that Coroners and juries entirely ignored these rules. For example, courts emphasised the role of movement, and juries often suggested movement[43] was important, as with Elyas Ide, seaman, who fell from a mast and 'immediately' died. The jury 'attribute his death solely to his drunkenness and the rope, and further find that neither the ship nor anything belonging to it was moving or being moved except the rope, which they appraise at 10s' (Sharpe 1913, 177).

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[39] Although this valuation could be, and was, challenged, see for example Hunnisett 1961a, 33.

[40] De Officio Coronatoris states 'Concerning horses, boats, carts (mills) etc., whereby any are slain, that properly are called deodands, they shall be valued and delivered into the Towns, as before is said.' Hunnisett contends that this was not a statute proper, but was rather an excerpt from Bracton, a thirteenth century jurist, which came to be regarded as a statute; Hunnisett 1961a 5.

[41] 1833 3&4 Wm IV c.99 (Fines Act).

[42] Including making errors of law, as noted in Hunnisett 1961a, 5 and H.B. 1845, 191.

[43] The test is generally stated to be omnia quae movent ad mortem, deodanda sunt (a deodand is that which moves to the death).

However, as court decisions acknowledged, movement was only one factor,[44] and other jury considerations in finding and valuing a deodand seem to have included mischief, negligence, retribution, and proximity.[45] Juries manipulated items said to have caused death – and the values of those objects – and 'tailored their findings to each individual case.'[46]

It is otherwise difficult to understand the deodand of a ladder in the case of William le Cupere of Bedford. The jury concluded that on 18 August 1272 he had

> climbed up Cauldwell church … to do his work. He saw two pigeons in the belfry, climbed up inside it to look for them, and by misadventure fell through the middle of an opening (*clera*), breaking his right leg and the whole of his body. (Hunnisett 1961b, 38)

He died the following day, and the ladder he had climbed up to get into the belfry was appraised at 6d and declared deodand. Suggestively, the report also states that the Prior of Cauldwell was fined for taking it without warrant, and although no explicit link is made between the Prior's behaviour in taking the ladder and the declaration of deodand, it is clear that in some way the jury linked William's death to the Prior, perhaps as an informal health and safety punishment. From our perspective, the ladder might be seen as peripheral; having used it to enter the belfry, the inquisition suggests it played no part in his subsequent fall. Declaring the ladder to be deodand, therefore supposedly – by one definition (Wellington 1905, 16) – the immediate cause of his death, serves to highlight the deodand's flexibility.

The abolition of the jury's power to manipulate the deodand in 1846 is part of a wider context in which the institution of the inquest engaged with conceptions of modernity during the 19th century in a productive tension between the professionalised inquest (a site for medical and public health intervention) and the inquest as a public forum for protection of individual liberty (Burney 2000). Abolition was one step within a broader pattern of cultural, political and legal reformulations; including legislative endeavours to rationalise and standardise the office of Coroner, to deal with

[44] See, for example, Elena Gubbe who on November 1, 1324 fell into the Thames while attempting to collect water; the stair of the wharf was a deodand and appraised at 4d, while the earthenware jugs she had filled with water from the river were not (Sharpe 1913, 100).
[45] See, amongst others, Sutton 1999, 14; Pervukhin 2005, 239. Burke similarly states that there is evidence that in some cases, negligence or carelessness might encourage a jury to find a deodand or increase the value of it, see Burke 1929.
[46] Pervukhin 2005, 245. Also see the range of jury decisions, and valuations in Gray 2011.

corruption, the abolition of Coronial election in 1888 and a reconstitution of the office and powers of the Coroner in legislation in 1887.[47]

This modernisation of the Coroner's inquest meant that by the early twentieth century the inquest had been significantly reworked: pulled out of the public house, 'where the majesty of death evaporated with the fumes from the gin of the jury,'[48] and (re)invested with its 'modern [focus of] an investigation into the cause and circumstances of death.'[49]

The deodand as financial relief

One aspect of the flexibility of the deodand is that, although theoretically forfeit to the Sovereign, it was sometimes used as a mechanism to provide financial support to those bereaved by the death. In 1837, Robert Cocking, a stuntman in Vauxhall Gardens, died when his parachute failed to open. Following the inquest, the parachute was declared deodand and was given to the Treasury. A fund to support his widow applied for the parachute, and this was granted (Smith 1967).[50] Similarly, in 1825 in London, deodands of £50 on a coach and horses and £10 on a cask of ginger were granted to the widows of deceased men (Sharpe 1913, XXVI). The coach and horses had run over and killed a hairdresser, while the cask of ginger was being carried by a labourer when he fell down a hole and died.

Primary sources do not generally tell us what happened to the object, and sources differ over whether as a matter of law the owner of the deodand could choose to forfeit the object which would then be sold, or pay the valuation by the jury, or if it was not open to them to choose. Where the object was forfeit itself, it is unclear what role the jury's valuation played, but it is clear that in some instances, as with Robert Cocking's parachute, the object itself was given up. In many sources, there is slippage between deodand as an object and deodand as a sum of money amounting to a valuation of an object, as with the debates in Parliament at the point of abolition, where the Attorney-General referred to the new system as 'making the deodand recoverable by an action at civil law.'[51]

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[47] I reflect further on these shifts in Chapter 3, but see Births and Deaths Registration Act 1836, An Act to provide for the attendance and remuneration of medical witnesses at Coroners Inquests 1836, County Coroners Act 1860, Coroners Act 1887, Local Government Act 1888.

[48] Sprigge 1889/2012, 125 (354 in the original), and see Hurren 2010, 239.

[49] Dorries 2004, 6. The pace of such changes should not be overstated, and as an example, Burney describes the move out of the public house as 'slow and partial', noting that 'pub inquests, especially in rural districts, survived well into the twentieth century.' See Burney 2000, 81.

[50] Smith goes on to note that the Robert Cocking's wife did not collect the parachute, which was eventually sold at auction, probably to the owners of Vauxhall Gardens.

[51] HC Deb August 11 1846, vol 88, col. 626.

The Sheriff, or other local official, is often stated to be responsible for the deodand, and may have been able to collect the value from the local community (Wellington 1905, 17), and there are examples of a deodand being awarded but not subsequently collected from the owner (see inter alia, the cases discussed in Sutton 1997). As with the definition of the deodand, the sources suggest a great deal of variability in practice, and also in valuation, with at least one suggestion that where the Lord of the Manor publicly declared the deodand would be given to the deceased's family, this encouraged higher awards (Gray 2011, 27).

However, it is not easy to establish how often the deodand was used to provide some financial support for the bereaved, as the ultimate destination of the deodand is not generally included in the Coroner's rolls which are the main source of evidence. One support for it as a practice might be found in the rule which states that no deodand will be declared in non-moving cases where the victim was under 14. Pervukin argues that this rule appears to have been inadvertently invented by Staunford based on Coroner's rolls and jury decisions but without firm judicial authority (Pervukin 2005, 253). She contends that it is likely that the rule arose because most children would be killed at home, and it was unlikely that juries would want to punish grieving parents. Another possibly complementary explanation is that if the deodand was regularly granted to the bereaved, there would be little need for a deodand for the death of a child at home, because the parents would both own the deodand already and be the beneficiaries of a declaration of deodand by the jury. While this is speculation, there is substantial support in the secondary materials for the deodand playing a role in providing financial relief for the bereaved (Burke 1929, 16; Havard 1960, 14; Smith 1967, 398; Thurston 1976, 1; McKeogh 1983, 198; Sutton 1999, 16; Gray 2011, 27).

The historical origins of this practice are contested. Links to the deodand have been drawn (and disputed) with Biblical law, Roman and Greek law as well as the Anglo-Saxon concept of the 'bane' whereby family members of those slain would receive payment from the slayer to avert vengeance (see inter alia, Anonymous 1841, 15-17; Wellington 1905, 14-15; Finkelstein 1972, 85; Jurasinski 2014). MacCormack argues that a definite conclusion cannot be reached (MacCormack 1984, 339), while Sutton considers that 'It is quite possible that the deodand was at first a form of compensation which gradually developed into pure forfeiture' (Sutton 1999, 12).

The traditional narrative in relation to deodands is that they peaked in use in the 13th-14th Centuries and gradually disappeared during the 16th, 17th and 18th centuries, before reappearing with the railway age, when some significant deodand awards were made (Wellington 1905, 17; Havard 1960, 14; Sutton 1997, 46). Some near-contemporary sources support this analysis (Anonymous, 1841, 15). However, Sutton has identified 'extensive and valuable deodands' in Holderness in Yorkshire in

the 18th Century, as well as examples in Marlborough and Westminster (Sutton 1997, 48-50), and Pervukin suggests that the deodand might have continued to be levied, but had slipped out of official attention (Pervukin 2005, 248). The presence of the deodand in Marvell's *Nymph* could also be counted as supportive evidence for awareness of, and therefore some possible use of, the deodand in the 17th Century.

From financial relief to cause of action

Crucially, by the time the deodand came to be abolished, its abolition was mirrored by the introduction of a right for the dependent family to claim compensation, reinforcing the link between the bereaved family and the deodand. This technical legal line of transformation, from a discretionary decision by the inquest jury, to a claim outside the inquest, is explored in three short sections; I outline the deodand's role in financial relief for the bereaved, then I discuss the debates in Parliament, and finally I assess the replacement - the family's right to bring a claim.

Discretionary relief

A crucial plank in the argument against the deodand as a compensatory tool was that it was based in the 'defective machinery of a Coroner's court', in the arbitrary exercise of discretion by the inquest jury.[52] From the perspective of the dependent bereaved and the need to replace lost income from the death of a family member, the wide scope granted to the jury in relation to both the award of a deodand and the valuation of the item doubtless carried risk. There was little guarantee that if any relief was awarded it would cover the loss, and there was a risk that the jury would award no deodand at all. Smith argues that juries may have declined to award significant deodands because of the stigma attached to such awards, and inquest juries might have objected to mistreating otherwise responsible citizens by taking away their property or fining them (Smith 1967, 395). In 1845 H.B., albeit in an article seeking to juxtapose the unreasonable use of deodands in the 1840s with previous decisions, describes it as being 'clear from the ancient authorities, that jurors always determined the amount of deodand to be imposed with great moderation, and with due regard to the rights of property and the moral innocence of the party incurring the penalty' (H.B. 1845, 190).

There was also the risk that large deodands could be struck down by the court, leaving families with nothing (Cawthon 1997, 141-4; Kidner 1999, 321). In 1842, a decision of Lord Denman nullifying an £800 deodand was 'an example of the venom which Coroner's courts could excite among high court judges' (Cawthon 1989, 144) and there were a sequence of cases in the early 1840s in which the

[52] According to the Attorney General, Sir John Jervis, first author of the still-authoritative textbook Jervis on Coroners, see HC Deb 11 August 1846, vol 88, col 626.

Queen's Bench deployed a variety of technical arguments to invalidate large deodands[53] (although not all appeals by owners of deodands were successful[54]).

It was not only the jury that exercised a discretion in relation to the deodand. Once declared, the deodand was forfeit to the Crown or to whomsoever the Crown had granted the right – a local landowner or a local institution. Thus, for a bereaved family to receive financial relief, a second hurdle sometimes needed to be crossed; as with friends and relatives of the nine individuals who died in the Sonning railway crash on Christmas Eve 1841. Despite the reluctance of the Coroner, the jury levied a £1000 deodand, attaching 'great blame' to the company for placing passenger coaches (filled with 3rd class passengers) close to the engine, so that the heavy goods which formed most of the train crushed their coaches when the train hit a landslide. Subsequently, *The Times* reported that friends of the nine deceased would get £100 each. It seems that Mr Palmer, the local lord of the manor, received petitions from these friends based on the article in the *Times*, as he then wrote to the paper to state it was questionable whether a deodand would belong to him, and in any case it was too early to say how the money would be distributed. Sutton notes from the accounts of Great Western that there was indeed no apparent subsequent payment to Mr Palmer, but the company did pay out money for hospital bills for those injured.[55]

A possible response to both the risk of having a deodand struck down and the family not receiving compensation, was for a jury to threaten a deodand, and thereby to negotiate a solution with the deodand owner. In one example of this, in 1833, the jury apparently extracted financial support for the widow of John Skinner from the ship-owner Mr Mellish by threatening a deodand (Cawthon 1989, 146-7).

Thus the deodand could be deployed as a tool to give money to the family, either through a direct grant or through indirect means by jury negotiation, but the bereaved could not oblige the Coroner, jury or state to provide them with financial relief. Smith, reviewing these developments, suggests that the deodand was moving towards a system of compensation 'although at a painfully slow rate and in an incredibly haphazard fashion' (Smith 1967, 389).

[53] E.g. *R. v. Great Western Railway Company* 3 A & E, N.S. 333; *R. v. William West*, (1841) 1 QB 826.
[54] *The Queen v. The Grand Junction Union Railway Company* 113 Eng Rep 362 (1839).
[55] Sutton 1997, 46. Also see Matheson 2014, chapter 2, and Gray 2011, 31, which suggests the deodand was in fact £1,100.

Passage of the Bills

In direct contradiction to this, in the Lords debate on abolition, Lord Campbell asserted that under the deodand, relatives could receive no compensation, whatever the degree of negligence.[56] Lord Campbell's critique focused on the incoherence of a law which compensated where injury was short of death, but not where death ensued, as well as the deodand's consequent failure to deter poor practice leading to deaths.[57]

In the other House, Thomas Wakley, prominent radical MP and 'one of the most fearless, capable and sympathetic Coroners who ever served the public' (Cowburn 1929, 397) set out an alternative account of why the deodand 'ought not to remain in its present state.'[58] He cited an example of a fatal accident which was caused by a railway employee previously found to be guilty of very gross offences but nevertheless retained by the company. The jury had imposed a deodand of £2,000. As Coroner, Wakley was concerned that 'if it was tried in a court of law, the inquisition was not very likely to stand.' He therefore consulted the Attorney-General[59] and leading Counsel[60] and was advised that the result would withstand the scrutiny of the Queen's Bench. Having satisfied himself,

> He said to himself 'Well, it is now clear that for their gross misconduct the company will have to pay 2,000*l*.' He was however sadly disappointed by the result. The case was taken by the defendants into the Court of Queen's Bench, where the inquisition was at once declared to be utterly worthless – it was cast aside and treated as almost worse than waste paper. He believed that no inquisition had ever been drawn with so much care and attention as that to which he was referring; and he thought it was quite clear, from the result, that the law ought not to continue in its present state.[61]

For Wakley, the problem with the deodand was the inconsistency of its application, which gave a reactive and conservative Queens Bench the opportunity to defeat just punishments with legal technicality.[62] Wakley was eager to use the position of Coroner to promote public health, and had

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[56] HL Deb 24 April 1846, vol 85, col 967. Lord Campbell's speech echoes a similar statement by H.B. from 1845, and it may be that this was his source for the statement, see H.B. 1845, 193.
[57] See, for example HL Deb 24 April 1846, vol 85, col 967-9, and HC Deb 21 August 1846, vol 88, col 926.
[58] HC Deb 22 July 1846, vol 87, col 1372-3.
[59] It is not clear whether he is referring here to the then Attorney-General, Sir John Jervis, who had been in post for 5 days, or an earlier Attorney-General.
[60] Mr Serjeant Stephen, first author of New Commentaries on the Laws of England.
[61] HC Deb July 22 1846, vol 87, col 1373.
[62] In a later debate, noting differences between the Attorney-General and Mr S. Wortley, he noted that, despite having received an entirely similar education, they had widely differing views on the deodand. Indeed 'if either of these Gentlemen were elevated to the Bench, the law of Coroner would entirely depend on the opinion of which of them happened to be the judge.' HC Deb August 11 1846, vol 88, col 626.

found 'no benefit whatsoever to arise from the present law of deodands'[63] because it failed as an effective tool he could use to force change.[64] Instead of reinforcing a rational investigation dedicated to preventing future deaths, the deodand permitted the jury a wide rein at the end of the hearing; granting them the ability to declare a deodand against a gentleman's horse, when his servant may have been to blame for the death; failing to punish a livery stable keeper who lent a drunken apprentice an unmanageable horse which then killed someone; or unjustly punishing a railway company which had properly examined a train before it left the station.

And this last concern of Wakley's tapped into a deeper concern: that the arbitrary and unpredictable deodand inhibited the increasingly valorised risk-takers in charge of industry (Simon 2004). In contrast, the deodand, representing a tool available to the local community for the collectivised management of risk, clashed with dominant conceptions of risk as either a matter of individual responsibility, dealt with by contract law and thrift, or else something to be spread through rational, predictable and institutional mechanisms (O'Malley 2000 & 2002).

Support for the principle behind the conjoined Bills was overwhelming; they were approved by large majorities in both Houses of Parliament and were supported 'by the Lord Chancellor, the Lord Chief Justice, by all the law Lords, and by the Judges of England.'[65] The only unease expressed about abolition was raised by Mr S. Wortley MP, who argued that despite its problems, the deodand provided 'a cheap and ready compensation [for] the poor'[66] avoiding expensive and risky legal proceedings. Additionally, he argued that the Bill would not enable claims against a company, but only against a servant 'who was in most cases a man of straw, and could pay nothing.'[67] His concerns, immediately dismissed by the Attorney General, would prove prescient.

Claim for the dependents

On August 18, 1846, Queen Victoria assented to the abolition of deodands.[68] Eight days later, Lord Campbell's Act came into effect,[69] the rule in Baker v. Bolton[70] was bypassed and claims for bereaved relatives were instituted.

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[63] According to Lord Campbell, HL Deb July 22 1846, vol 87, col 968.
[64] See further discussion about Wakley's campaigning efforts in Chapter 3.
[65] HC Deb May 7, 1846, vol 86, col 173.
[66] HC Deb 11 August 1846, vol 88, col 625.
[67] HC Deb 11 August 1846, vol 88, col 625.
[68] 1846 9&10 Vict. c.62.
[69] 1846 9&10 Vict. c.93.
[70] Baker v. Bolton (1808) 1 Camp. 493, 170 ER 1033.

The mechanism purportedly gave agency to bereaved families, but was in fact extremely limited from their perspective (Cawthon 1986, 201), with workers – legally deemed to have voluntarily taken on risk by signing an employment contract – particularly poorly served (Kidner 1999, 331; Stein 2008). Judges compensated bereaved families 'rarely and begrudgingly' (Cawthon 1989, 147)[71] and while there was an increase in claims, particularly for railway passengers (Kostal 1994; Oliphant 2014), legal, social and cultural barriers prevented many claims from getting as far as a courtroom (Bartrip & Burman 1983; Bartrip 1987, 7; Kidner 1999, 321; Stein 2008, 956-7). S.2 of the Act required action by the estate of the deceased, which was impractical for those too poor to proceed to probate; and the courts restrictively interpreted the Act to require pecuniary loss, thus replacing the uncertainty of the deodand (Sutton 1997, 50; Pervukin 2005, 245) with the vagaries of establishing negligence and financial loss. According to the Mines Inspector in 1853, 'However gross may have been the neglect which caused the husband's death, all interests are arrayed against the survivors.'[72]

Thus compensation, based on an increasingly structured assessment of loss, itself shaped by documentary evidence generated in a civil action to a specific standard of proof, replaced discretionary and flexible financial relief. At the same time, juries in civil claims were warned not to take the opportunity to punish railway companies with large awards against them (Kidner 1999, 328) and were instead to focus on the law. Dependents better able to establish family connections or pecuniary loss – those with formally sanctioned relations recognised by the law[73] and with licit, certain and evidenced financial affairs – were in a far stronger position than those with less formally recognised intimate relationships or financial affairs (Stein 2008, 957). The question of financial relief shifted from the inquest arena to the civil courts; from a local space, a hearing held in a public house attended by neighbours, into an 'extended, expensive process' in a formal court room (Cawthon 1997, 144). The dependent family became a key actor; plaintiff and later claimant, moving from the periphery of the law into law's direct gaze, and the jury, potentially capricious in the inquest, was shackled in the civil jurisdiction by legal technicalities, expertise and evidence.

In this process, despite being re-engineered as the vehicle of justice, the family revealed flaws when opened to the scrutiny of the law. In particular, legislators expressed concerns about leaving the family to manage finances. A widow, left to herself, as Viscount Sandon observed in the House of

[71] Although railway companies complained that in their cases, juries awarding compensation were overly generous, see Kidner 1999, 333.
[72] H Mackworth, quoted in Bartrip 1987, 7. Also see Smith 1967, 401-3.
[73] Categories of potential claimants were set out in ss. 2 & 5 of the Act, and relationships falling outside these formal categories could not form the basis of a claim.

Commons, might marry another man and 'the money might all be expended the day after the verdict in a drunken frolic.'[74] Such families had to be controlled; meaning widows, cast either as domestic angels to be protected or fallen women to be anxiously managed (Ward 2014), had to be restrained and the money secured to the children.[75]

In the post-deodand world, the risks for business were made more predictable,[76] as new technology drove the development of tort law (Oliphant 2013, 837-8). However, financial relief for the family may not have appeared any less arbitrary, and was certainly less immediate. The family were given rights, but with little ability to enforce such rights for all but the richest families, and the informal, negotiated and uncertain gave way to the impenetrable, constrained and putatively certain.

From an unruly community to governing through the family

As well as a tool for financial relief for the family, the flexibility of the deodand enabled financial relief for others – if there was no family, or the family was not formally constituted. Alternatively, monies could be put to community benefit – fixing bridges or providing financial relief to those with leprosy (Sutton 1999, 16; Burke 1929, 18) – or as a negotiation tool to effect health and safety improvements (Smith 1967, 397; Cawthon 1989, 147). Abolition of the deodand was a way of managing the unruly juries who sought to use the deodand in this way, whether with the support of a local Coroner, or without, as Thomas Wakley discussed with such chagrin in the House of Commons. At the same time, the creation of a right to sue for the bereaved dependents was part of a process of formalising the family, and framing them as properly and primarily responsible for leading reaction to death. The abolition of the deodand and the implementation of the Fatal Accidents Act were thus central to strategies to manage the unpredictability of the community following death. The next section looks at each in turn.

Subduing an unruly community

Prior to abolition, the deodand was available as a tool of resistance for the community, most famously in relation to the industrialisation of Britain and the railways. As discussed above, abolition was closely linked to the protection of risk-takers driving the burgeoning rail network. As Wellington dryly notes, 'the date of this statute (1846) may suggest the great inconvenience which the law, if it had remained in operation, would have caused ... to railway and other enterprises in which loss of life is a frequent occurrence.' (Wellington 1905, 18; contrast Kidner 1999, 323).

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[74] HC Deb 22 July 1846, vol 87, col 1369.
[75] See Lord Campbell, HL Deb 21 August, vol 88, col 926; also see s.2 9&10 Vict. c.93; and discussion in Kidner 1999, 325.
[76] Although some companies railed at the awards given by juries; Kidner 1999, 333.

The railways expanded dramatically in the first half of the nineteenth century,[77] 'a mindless juggernaut, grinding private rights into the ground in the blind quest for profit.'[78] As deaths at the hands of the juggernaut became a frequent occurrence, some inquest juries reacted to defend the private rights of those killed by the railways. The Mechanic's Magazine of 1842 cast the railways as 'The Modern Mechanical Moloc' and severely censured 'the railroads for the numerous accidents that had occurred, attributing them to a general lack of precaution and scarcity of safety measures.' As a result 'Deodand after deodand has been imposed by honest and indignant juries – deodands in amount surpassing any previously known in our criminal history' (Burke 1929, 28). Case reports bear this activity out, and in a number of cases in the late 1830s and early 1840s, juries found trains and carriages to be deodands, and valued them at significant amounts.[79] The Monthly Law Magazine in 1841 stated that 'in 1840 we have seen [deodands] rapidly ascend to £500, £800, and at length, £2,000.'[80] Railway companies took such inquests very seriously, 'almost always sending legal counsel and at least one director' (Cawthon 1989, 145) and successfully challenged many deodands which were awarded.[81] Railway deaths provided the backdrop to the debates in Parliament,[82] and Cawthon highlights the 'behind the scenes' intervention of the 'railway interest' – 'A combination of outraged lawyers, employers and judges [who] got in the ear of Parliament in the matter' (Cawthon 1989, 147).

Before this lobby succeeded in abolishing the deodand, Smith suggests that the law left juries little choice but to declare trains and carriages as high value deodand, as an ancient rule that the deodand moved to the death bound them to recognise them as such and it was 'hard to pretend they were low value' (Smith 1967, 395). This version of events implicitly undermines the place of active

[77] See for example, the statement by Mr Williams MP in 1846 that in the previous 2 sessions of Parliament, Bills for railways requiring private funding of £210,000,000 (over £100bn at 2014 prices) had been passed, which had 'caused great apprehension in the money market, that the monetary affairs of the country would be deranged, and its commerce considerably retarded, by the application of so much capital to railway undertakings.' See HC Deb 11 August 1846, vol 88, col 623.
[78] J Kellett, quoted in C Wolmar, *The Subterranean Railway* (London, Atlantic Books, 2005) 19.
[79] See Cawthon 1989 for a detailed discussion of this development, and also see a deodand of £1,400 awarded against the Stockton & Darlington railway, discussed in Fellows 1930.
[80] Anonymous 1841, 15-16 – which may well have been the deodand which Thomas Wakley discussed in the House of Commons in 1846.
[81] See, for example *R. v. William West* 1 A & E 826, *Leeds and Selby Railway, R. v. Midland Railway Company* 8 QB 587 (1844), *R. v. Great Western Railway Company* 3 A & E, N.S. 333.
[82] See for example the 'mildly humorous exchange' (Smith 1967, 399) between Lords Campbell and Lyndhurst, in HL Deb 7 May 1846, vol 86, col 174-5, and the pointed remark by Lord Campbell in which he stated that he trusted that the 'great many' House of Commons members who were also railway proprietors 'would forget that they were directors, and consider only that they were citizens and subjects' (see HL Deb 24 April 1846, vol 85, col 969).

resistance in the deliberations of these juries, who could have decided on a low value,[83] or chosen, as in other deodand cases, to separate part of a moving object from the whole (E.g. Hunnisett 1961a, 33). Instead some Coroners and juries explicitly deployed the deodand as a tool to exact concessions, and while this was not common in the early Victorian inquest, it was a vital and potentially progressive development, curtailed by the abolition of the deodand (Cawthon 1989, 147; Gray 2011, 29-31).

Without the ambiguity available in the deodand, the inquest jury lost this tool, and also lost the possibility of expressing a formal retributive reaction to deaths deemed to be by misadventure. Furthermore, shifting out of the potentially populist Coroner's court meant that arguments over compensation lacked the vital energy which an inquest in close physical proximity to the death could generate. By contrast, after abolition, financial loss was principally a dispassionate question for objective determination by the law, and the potentially insurrectionary voice of the public was radically diminished. The inquest, the 'only court in which working class people could participate as jurors' (Sim & Ward 1994, 263) was shorn of a tool for the community to exact accountability.

Governing through the family

Inquests have long been a site for the maintenance of public order. As part of this, emphasis was laid on the community's role in safety and security. In the 1840s, J. Toulmin Smith argued that inquests were a forum for

> free unofficial men ... to declare for the satisfaction and security of all, whether it appears to their plain common sense that the case is free from suspicion. ... The object is one of such paramount importance to the safety and security to all men in the community, that there has, from the earliest times existed an officer ... whose special function it is to preside at these inquiries. (Toulmin Smith 1852)

The Coroner as presiding officer did not constitute the historic jurisdiction of the inquest, but rather arranged for it to exist. The Coroner 'did not "hear and determine," but *kept* records of all that went on in the county and that in any way concerned the administration of criminal justice' (Wellington 1905, 1).

However, in the period from 1840 to 1926, the development of medical expertise and medically qualified Coroners, the shift from election to appointment of the Coroner, the reduction in cases which had to be heard by juries, and the removal of the body from the inquest forum, reshaped the

[83] As other juries did, e.g. in relation to the first recorded railway deodand, awarded in April 1833, for Jane Hazell, a girl killed by a train of three wagons of sand. A deodand of £2 was levied on one wagon and the sand in it, see Fellows 1930, 73.

place of the community, from agents of that declaration to listeners to the declaration. Public order was increasingly maintained through public information, not necessarily through public involvement in any conclusions. As Burney argues

> At its theoretical core lay the proposition that the public circulation of information concerning potentially disturbing deaths was a tool of social stability. In giving a formal context for the airing of the gossip, rumour, and suspicion generated by such deaths, the inquest diffused a tension that, if left to fester, might pose a threat to the reign of sense and reason. (Burney 1994, 34)

In the maintenance of public order, the emphasis was on the gathering of men, 'the doer, the creator, the discoverer, the defender' rather than women, 'whose intellect is not for invention or creation, but for sweet ordering, arrangement and decision,' excluding, apparently, legal decision-making (Ruskin, quoted in Ward 2014, 8).

However women, including the spectre of the drunken widow, also presented a risk to public order. Whilst her husband was alive, the Victorian wife was 'By her office, and place … protected from all danger and temptation,' (Ruskin, quoted in Ward 2014, 8) but such protection was lost following her husband's death. Thus the hearing had to engage in protection and restraint of such women, and it was in this context that the dependent family was reconstituted as key participants in the inquest; firstly as claimants in a potential civil case, and later with the development of formal rights to engage with the inquiry. Family, rather than community, became the essential component in an effective declaration of the cause of death to allay suspicion; as junior co-author and principal reactants to the declaration. Whilst in 1817 Umfreville, a key pre-Victorian authority, had declared that Coroners should not 'intrude themselves into private families' (quoted in Cawthon 1986, 194), these moves shifted the system directly into that private space.

Donzelot describes this transformation of family into the reorganising principle of society as 'as a positive form of solution to the problems posed by a liberal definition of the state rather than as a negative element of resistance to social change' (Donzelot 1979, 53). He analyses the way that in this period family became the foundation of the liberal state's response to pauperism and indigence, with philanthropy focusing efforts on the family, encouraging family saving and thrift, and making the family 'agents for conveying the norms of the state into the private sphere' (Donzelot 1979, 58). As he argues, the strength of family as a mechanism for policing lies in the relationship between the imposition of these state norms and the complexity of familial configurations; social control is maintained through an interplay between external forces and differences of potential within the concept 'family.'

Thus, according to Donzelot, because the family is malleable and ill-defined, continually recreated by the interplay of external and internal pressures, it becomes the key tool by which social cohesion is maintained. The shift from deodand to compensation claim is an illustration of this; a move from networks of solidarity to claims procedures. The abolition of the deodand marked a severing of a key link between the community and the family in relation to death. At the same time, the establishment of a limited civil claim marks out the separation of family and a claim to justice distinct from any rights the community might have.

Furthermore, the family was developed as a mechanism to import key norms, focusing on the protection of life within and by the family and interdependence of family members to the exclusion of their place and links in the community. The difference of potentials within family, and the flexible engagement with that variability was seen in the tool of compensation; as noted above, with larger awards for lawfully recognised families which managed their finances in formally established ways and could thereby establish dependence on each other, whilst less formally constituted families lost out. Law reinforced the angel in the home, and penalised the fallen woman. Through all these means, narratives around compensation and explaining the unexplained saw the formal family recast as the basic unit of engagement with the state's relation to death, for which investigations take place, from which claims to justice can initiate and must depend, and upon which social control is founded.

From contingent matter to the promise of law

The abolition of the deodand and creation of the right to claim highlights a final line of transformation; that of the place of ritual, symbolism and materiality. I examine this final line in three parts: ritual and the deodand; the abolition of the deodand; and the role of materiality.

Taming Death and the Deodand

Aries describes the medieval taming of death occurring through humankind's strategy of controlling death by detaching it from the blind violence of nature through ritualization. He argues that a crucial part of this ritualization is the imprisonment of death in public ceremony and spectacle (Aries 1981, 604-5). Key to this was a belief in the advance warning of death; in comparison a sudden death was ugly, destroying the natural order of the world (Aries 1981, 10).

Berman (1999) argues that, in such cases, ceremonies were needed to re-establish law. The deodand can be seen as playing a part in this strategy of humankind against nature, a part of the ritual of death and a bulwark which re-tamed death, tying it down with a physical object and opening it out to public exploration and authentication. Berman suggests that the declaration of deodand, like trials of objects and animals on the Continent, must be seen as part of cultural

storytelling, permitting 'the community to heal itself after the breach of a social norm by creating a narrative whereby a symbolic transgressor of the established order was deemed to be "guilty" of a "crime" and cast beyond the boundaries of the society.' (Berman 1999, 5). Thus a declaration that an object is guilty must be taken seriously and its symbolic content must be assessed, rather than being dismissed as superstition or error, because the legal narrative plays a function in constructing reality. A narrative founded in such proceedings identifies transgressors and removes them from the community, through banishment, forfeiture, excommunication, or execution. This symbolic gesture, founded in an essential human need for a managed response to an unexplained event, is a common thread in contemporary academic discussion of the deodand (Sutton 1997, 11; Berman 1999, 25-31).

However, there is a crucial difference between the deodand and trials of animals and guilty objects.[84] Unlike in those trials, the potential deodand, be it animal or object, was not charged and symbolically put in the dock, and the inquest hearing was not primarily charged with deciding its guilt or innocence. A declaration of deodand did not result in the slaughter of an ox that gored, and resulted in a payment by the owner rather than actual forfeiture in some cases.[85] Instead of being the defendant in a criminal process, the object or animal was part of the factual nexus that the jury shaped into a narrative explaining death. It was a flexible process, in which a range of potential conclusions could be reached, and objects which were nearby when the death occurred could be symbolically brought into the forum, declared deodand and valued at the end of the process. Equally, the jury could reach a conclusion on death without finding a deodand.

While the symbolic importance of the deodand – casting out an object to preserve the integrity of the social order – might have similarities to other legal processes involving non-human actants as in the continental animal trials, the distinction between the two is important in analysing the abolition of the deodand and the institution of the family claim.

Ritual and Abolition

Some Victorian and contemporary commentators argue that, with its very basis in superstition (Burke 1929, 16), the deodand could not survive modernity (Finkelstein 1972, 207; Berman 1999, 53). The deodand as an evil object could not be reconciled with reason, 'which is the soul of law' (H.B. 1841, 191). However, this account of the irrational deodand underplays the contingent nature of the deodand and its abolition. MacCormack argues that it is not clear that juries were engaged in declaring an object to be evil (MacCormack 1984, 339), and immediately prior to its abolition, the

[84] See MacCormack 1984, 323, counselling caution in drawing links between the deodand and non-human trials.
[85] See Finkelstein 1972 compared to Jamieson 1988.

primary narratives around the deodand were of prevention of death and compensation of the bereaved. Adaptation of the deodand was not impossible. It could, as Smith has argued was happening, have been remodelled into compensation for the family (Smith 1967, 389). Additionally, adopting the justifications of Hale and others, modification of the deodand could have increasingly focused on the deodand in a narrative of prevention of death (Hale 1800). Such a shift could have maintained and obscured the symbolism of the banishment of the object; allowing the ambiguity of the deodand to continue to reflect different concerns.

Having criticised the irrational deodand, one Victorian commentator proposed exactly such an adaptation in the Monthly Law Magazine of 1841:

> When we consider how often the death of a husband and a father plunges the wife and children in a state of extreme destitution, how frequently a whole family is thus by one blow deprived of the very means of existence, we must surely lament that it is not left to the discretion of the inquest to deduct a certain portion of the deodand for the relief of the sufferers. Thus the same means which have been adopted to instil a horror of inflicting death, might also tend to the support and nourishment of life. (Anonymous, 1841, 24)

This proposal was not acted upon. Crucially, this was not because the deodand as an object which caused death was no longer sustainable. The deodand was never solely such an object, but was instead a flexible community tool which could meet various ends. It was this very freedom and flexibility which could not be tolerated; as a jury could not be relied upon to be objective and rational.

Once the deodand was abolished, the powerful demands of symbolic justice required that the inquest did not lose the aspect of excommunication, and the reworked public health inquest, gradually shorn of its criminal jurisdiction, found this in the responsibility to banish systems, structures or processes which had caused death, in order to prevent future death.[86] Importantly, for reasons of complexity and expertise, these were not questions which could be left to the jury and had to be dealt with by the Coroner.[87] Symbolic justice could therefore be married with reason, at the cost of the exclusion of the irrational jury. The deodand, not necessarily associated with evil before its demise, is now regularly cast as the evil object, because it was abolished in the name of rationality. However, rather than the deodand itself, it was the jury's freedom to name objects

[86] Now contained in Schedule 5 of the Coroners and Justice Act 2009 and Rule 28 of the Coroners (Investigations) Regulations 2013 SI 1629/2013.

[87] The jury's power to add a rider recommending action be taken to avoid future fatalities survived until 1980 when it was abolished after 'this power was abused' (Matthews 2014, 342).

deodand which offended reason, and the deodand was made the blameless victim of the triumph over reason over evil. In this triumph, symbolised in the Coroner's reports to avoid future deaths, one crucial aspect of the previous legal regime was lost: the deodand as physical object.

The loss of materiality

At one level, the deodand was an object made by the jury. It was given substance, independent form and value by their declaration, as wheels were separated from carts, and individual steps from staircases. At another level, it pre-existed the declaration as an object which the deceased was near in the moments before their death; a cask they were carrying, a vat of ale they fell into, a boat they fell out of, a ladder they climbed up. It might have been classed as a thing which moved due to a deliberate act – a horse which bolted – or an object which could not reasonably have any intention attached to it – a pebble on which they tripped.

All of these things act (Latour 2005). They intervene, make a difference, and make things happen. They are actors both because they pre-exist and because they are named as actors by the jury, and these cannot be separated. A deodand cannot be intangible, untouchable, but it also cannot be called into being as a deodand unless the jury names it so. Once called into being, it acts backwards, as a cause, occasion or instrument of death, and forwards, as explanation, punishment, deterrent and relief.

Abolishing the object as an actant can be seen as part of a wider trend in which causation shifted from Aristotelean to Newtonian understandings of the subservient nature of things. Bennett argues that this conception, the 'image of dead or thoroughly instrumentalized matter, feeds human hubris and our earth destroying fantasies of conquest and consumption.' (Bennett 2009, Kindle Loc 40-43). She calls for recognition of the vibrant nature of materials; not by positing a force that can enter and animate a physical body, but rather by exploring the affective nature of non-human bodies. A modern focus on a division of object and actor binds material into 'passive, mechanistic, or divinely infused substance' (Bennett 2009, Kindle Loc 90) while removing this division allows a refocusing on the catalyzing capacity of non-human actants and their affective potential. Lemke, drawing on Barad as well as Braun & Whatmore, argues that this approach is too all-encompassing and fails sufficiently to recognise the importance of a relational perspective, and the conditions in the specific moment in which non-human actants have vitality (Lemke 2014, 13-14).

These insights are demonstrated in the deodand; both in the way the deodand is founded in the specific relative conditions of the moment of its creation, and the affective potential of each deodand. The abolition of the deodand meant that recognition of this affective capacity was lost to inquest law. The deodand had acted to give power to the forum, the community, as explored above,

and this was denied after 1846. Crucially, it also had an affective place for the family. In granting the deodand to the bereaved, the very material of death was being tied into the outcome of the inquest. The family, in receiving the parachute that did not open, was put in immediate proximity to the deceased and the end of their existence. Where a family received the value of the contents of the barrel which had crushed one of their number, that money was directly linked to that cask; it was representative of that cask and maintained the immediacy of the link to death. The material was thereby affective in a way which transcended a formulation of it as an instrument of another human. It also could not be said to be wholly an instrument of the jury, as while they had a broad discretion to attribute value, they were bound by what was available to be a deodand – a house twenty miles away from the death could not be deodand – and if they could compensate without the deodand, such compensation would not intervene in the narrative of death in the same way. The deodand's affective value was therefore axiomatically fused with the conditions of the historically specific moment it was created; stretching from the physical site and moment of death, to the politics of the inquest hearing which shaped the narrative of that death.

Its combined physicality and contingency also permitted it to embody risk. Until its abolition, the deodand marked a world in which peril and possibility lay everywhere and in everything. In binding those risks into physical form, it made them directly available to the community, and provided both demarcation for the generation of a narrative and a vessel to contain the ubiquitous risk. It embodied the local community's response to the danger of death, charging them with a responsibility to engage with the physical world's capacity for unruliness, and materialising the joining of law and that world. Aries describes the medieval resignation to suffering and death, and acceptance of the constant presence of evil, not as submission to nature or biological necessity, but 'as recognition of an evil inseparable from man' (Aries 1981, 605). Similarly, the deodand had acted as recognition of – not submission to – the inseparable place of the uncontrollable physical world in law. It characterised an embracement of the generative nature of law's relationship with the material world, and brought the contingency of the physical world into the heart of law.

Abolition meant the separation of the inseparable, and the abrupt termination of the possibility of the deodand acting beyond human agency whilst being inextricably merged with human agency. This was lost to law; reinforcing a change of perspective towards the natural world as lifeless instrument or unthinking beast; static, pending the call of humanity's will to act and control. The shifting possibilities once held out by Marvell's Nymph were excluded, and the place of matter was refashioned as thoroughly inert, beneath law's gaze and without affective potential.

Separated from contingent matter, law proceeded to make a bold promise: that it could characterise, contain and restrain risk. Appearing to give agency to the bereaved family – the apparent chief beneficiaries and subjects of the Act – law promised to provide certainty, predictability and control. Through Lord Campbell's Act, law identified legitimate risks, and promised to reduce them; not only from the risk of poverty for a bereaved family, but also the risk of arbitrary removal of property and the reduction of risky behaviour, as a claim against careless companies would 'read such companies a proper lesson.'[88] Law's promise was prospective, providing certainty in the face of such risks, through the imposition of apparently objectively justifiable factors; negligence, loss, evidenced family link (O'Malley 2009, 60-61).

Thus while the deodand had dealt with risk through incorporating and materialising it piecemeal, passing possession of it to the community, the law sought to settle risk in advance, sharing it out according to political rationalities. This meant, as far as possible, individuals owning their own risk, determined by contracts of employment or insurance, or else risks being spread by formal institutional means. The effect was that law's promise to the bereaved family was a fallacy, as the individualisation and spreading of risk either thrust risk upon them, or passed determination of fault and need to more centralised and more inaccessible authorities. The reframing of the relationship of risk and law reassembled death and the family as legal subjects constituted by knowable relevant factors, stripping away identity (O'Malley 2009, 66) asserting law's comprehensive reach and denying the authority of anything outside law's purview.

Such a perspective disabled law's ability to embrace potentially undisciplinable material and to respond to the elemental disorder of sudden death. The control on offer was thus illusory for law's subjects, as despite law's promises and efforts to evade, the material and uncontrollable refused to be rationalised away. Where the material of the deodand had sustained networks of solidarity, maintaining affective links between law, the community, the family and the deceased, the loss of the deodand broke those links, separating family off and subjecting them to the disciplinary process of claiming.[89]

Conclusion

The deodand appears at the end of the historical inquest, at the conclusion of a particular inquest and the point where the record ends. The deodand appears at the last, only to disappear, and it is this very liminality which means that an analysis of the deodand is not limited to a discussion of the

[88] Lord Campbell, HL Deb 21 August 1846, vol 87, col 926.
[89] akin to the move from collective to disciplinary processes analysed by O'Malley in relation to insurance, see O'Malley 2002, 99-100.

inquest but can produce an account which drives directly at legal personhood and the foundations of the modern state. Its value to the scholar is in its ambiguity, grounded in the dualism of its thing-ness and its essential lack of clarity. The fact that it can never be pulled away from the contingent moment of its creation highlights the role it played in bringing physicality and contingency to law, and in giving authority to the community. The circumstances of its abolition and the development of a civil claim are similarly illuminating; as law promises to structure and make certain, and family is reshaped as a vital tool of governance; constrained and directed.

Law's role is not limited to restraint and subjection in this account. The deodand holds out an alternative formulation, absorbed in an object made powerful by legal tradition, ancient precedent, and within a particular imaginary of the common law. The deployment of the deodand in an individual case could appear unjust, but the deodand represented a form of justice framed through 'convivial' local accountability (Morgan 2006) founded in the contingent moment and engaging in a productive relationship between law and the material world. Its replacement promised to correct its flaws, but in the futile search for clarity and legitimacy, the law shifted away from the richness and possibilities of contingency and materiality while risk, loosened from captivity in the deodand, reappeared in an itinerant guise, threading through responses by the state and the family to sudden unexplained death.

Chapter Three: Combining accountabilities

Introduction

The abolition of the deodand was not the end of possibilities of seeking an opened ended justice in the inquest. Bracketing the question of the legitimacy and accountability of the inquest until the next chapter, taking a broad approach to the definition of accountability in the inquest, and seeking to explore justice through that broad conception of accountability, I turn in this Chapter to engage with some of the ways in which the historic, modern and contemporary inquest provided forms of accountability. My focus is on case studies from what I have termed the 'social welfare inquest' – an inquest into a death which engages aspects of social welfare law and the responsibilities of the state. I open by considering the historic social welfare inquest, and the transition to a modern conception of the inquest, and then explore case studies in the contemporary jurisdiction in relation to deaths linked to welfare cuts, inquests involving the provision of housing and care homes, and the relationship of Serious Case Reviews and inquests into child deaths. Using these case studies, I argue that the inquest can in some cases offer the prospect of a nuanced and tailored accountability in response to an unexpected death. My contention is that while the contemporary inquest cannot make findings of civil or criminal liability – leading to critique of its possibilities for achieving accountability – it can open a space for accountability through revelation, explanation and justification.

My analysis develops academic discussion of a collapsed distinction between democratic, bureaucratic and judicial modes of accountability. Drawing on Morgan (2006), I characterise these as technocratic forms of accountability, as opposed to community or 'convivial' forms of accountability. I argue that adaptability of the inquest allied with the recent changes in inquest law open a space in which convivial forms of accountability can be achieved in combination with other forms of accountability. However, I also argue that the inquest can be left at risk of being limited through capture by expertise and technical forms of knowledge, undermining the prospect of non-technocratic forms of accountability.

Accountability and the historic social welfare inquest

Accountability connotes revealing, explaining and justifying (Scott, 2000, drawing on Normanton)[90], and is intimately bound up with foundational notions of justice, responsibility, the limitation of

[90] There is a huge literature on accountability, including typologies of accountability (Mashaw 2006), and reflections on accountability norms and regulation (Harlow & Rawlings 2006; Black 2008; Casey & Scott 2011). My focus is not on regulation, but on the possibilities a broad conception of accountability offers for justice, and my focus is on the role of accountability in revelation and explanation, with particular attention on the possibilities of participative, 'convivial' accountability (Morgan 2006).

power, legitimate authority and democracy. Some Victorian Coroners, as the 'magistrate of the poor' (Sim & Ward, 1994), were intimately engaged with seeking accountability for the most vulnerable and marginalised, in cases involving a wide range of circumstances from child welfare to treatment of the impoverished.[91]

In November 1840, a diabetic inmate at Hendon workhouse died after being confined for impertinence in a damp room with only bread and water to sustain him. In the inquest into his death, Reverend Williams, a local magistrate and chairman of the guardians of the workhouse defended the incarceration, arguing that the room was more comfortable than 99 cottages out of every 100 in Hendon. The jury disagreed, finding that this inhumane treatment of an infirm man had caused his death. Thomas Wakley – the radical MP and friend of William Cobbett who had advocated abolition of the deodand – was Coroner in charge of the hearing, and his oversight of the inquest left no question over where his sympathies lay; accounts of the inquest describe Wakley stating that the guardians of the poorhouse had shown as much impertinence to him during the inquest as the deceased had shown to them (Sim & Ward, 1994). Wakley, the 'zealous advocate of the working classes' (Sharp, 2012, 379) was a doctor and medical campaigner and had represented at least one bereaved family in an inquest before being elected Coroner for West Middlesex in 1839 (Hempel 2014). His investigations could be high profile and deeply controversial, with significant public interest in their outcomes. In July 1846, he oversaw an inquest into the death of Fredrick White, a soldier who had received the lash for indiscipline. He sought a medical opinion from Horatio Grosvenor Day, a surgeon, but after examination of the case, Day disputed any causative medical link between the corporal punishment and White's subsequent death. Wakley disregarded his opinion, insisted on the link between the use of the lash and White's death, and the jury agreed with him. Their verdict found that the 150 lashes White received caused his death, and furthermore declared themselves unable to 'refrain from expressing their horror and disgust at the existence of any law … which permits the revolting punishment of flogging to be inflicted upon British soldiers' (Hopkins 1977, 180). The case was credited with stopping corporal punishment in the British Army (Sprigge, 1897; Thurston, 1969; Hopkins, 1977; Sharp, 2012), and meanwhile Day was subjected to a very public backlash for refusing to subject his expert opinion to Wakley's cause (Day, 1849).[92]

[91] And there is evidence of earlier inquests expressing concerns with, and making improvements to, social conditions, see inter alia Angell's (2007) review of Ellwood, which refers to 'a Coroner's inquest that resulted in better living conditions for imprisoned Quakers' in the seventeenth century.

[92] At the same time Wakley was subjected to fierce criticism in the House of Lords for 'rejecting the evidence of four [doctors] because it was not such as he wished' (Lord Redesdale, HL Deb 14 August 1846 vol 88 col 695). In the light of the controversy over the cause of Frederick White's death, particularly the testimony of Day, and the apparent desire of Wakley and others to use his death as a campaigning tool to stop corporal

Wakley's high profile stint as Coroner from 1839 to 1862 was followed by other Coroners similarly engaged in pushing a public health agenda, including Edward Hussey, controversial, empathetic and fractious Coroner for Oxford from 1876 to 1894. Hussey's tenure as Coroner was a natural step for a doctor who had held himself out as a campaigner for the poor from early on in his career, and as Coroner he championed causes relating to deprivation and poverty, including child healthcare, infanticide and neglect (Hurren, 2010, 226).

Coroners like Wakley and Hussey founded the reputation of the Coroner as the magistrate of the poor. The inquests they oversaw, usually in a local pub, were 'held by the free-men of the neighbourhood *before* the Coroner and not *by* him' (Wellington, 1905, 9, emphasis in original). One contemporary drawing of an inquest which appears to have taken place in the boardroom of University College Hospital 'records Wakley's choice of position at the head of the table, the jury seated in equality along each side' (Richardson 2001, 2152) and it was critical that those jury members were entitled to directly question witnesses. A guide on coronial practice from 1888 notes:

> After each witness has been examined, the Coroner should inquire whether the jury wish any further questions to be put. This is essential to the administration of justice; the jury living in the neighbourhood being, most probably, acquainted with the circumstances better than the Coroner. (Melsheimer, 1888, 35)

Unlike the modern disinterested detached jury, the inquest jurors were framed as active and central participants in the hearing. Furthermore, the jury itself was potentially more diverse than juries in other jurisdictions, as the inquest was the only court in which working class men could act as jurors (Sim & Ward, 1994). As Chapter Two argues, in alliance with a campaigning Coroner or in opposition to the Coroner's direction, as in the case of the 'Calthorpe Street' jury who ruled the death in 1833 of a police officer in clashes with protestors a 'justifiable manslaughter' (Scraton & Chadwick 1987, 31), the inquest jury could act to resist powerful factions like the railway lobby or the Government (although such jury decisions were often overturned on appeal).

The wider community was not only involved in the historic inquest through acting as jurors, but also, in the majority of areas, voted to elect the Coroner. These elections could be hard fought and

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punishment in the army, it is perhaps incorrect for Pietz (1997) to state that 'Reformers like Wakely [sic] were revaluing the reasons for death within a scientific framework of purely physical causality for which moral considerations were, quite properly, removed' (1997, 107). For Wakley, in this case and in many others, moral considerations and physical causality were intimately intertwined; after the verdict, he announced that he had made inquiries and White was insane at the time he was punished. Hopkins notes a report from the *Sun* that 'The worthy Coroner seemed much affected' by the lashing to death of an insane man (Hopkins 1977, 182).

expensive affairs, with a potentially broader and more flexible franchise than in Parliamentary elections.[93] It was this link between the central role of the community and the place of the Coroner as expert which produced and defined the modern inquest (Burney, 2000). It is also this combination which enabled the Victorian inquest to potentially provide a bridge between different forms of accountability; both as a place which involved different modes of expert technocratic accountability within its institutional architecture, and as a place in which community or convivial accountability was made possible.

Dowdle (2006, 4-6) argues that an inability to identify 'the people' to whom accountability is held led to accountability being defined through institutional architecture; from the democratic, to the bureaucratic-organisational and judicial-legal. Some Victorian Coroners demonstrate a combination of all of these modes of accountability; an elected local judicial official, embedded in and generating a nascent public-health oriented bureaucracy.

The jury retained a central role, and the wider community was involved through attendance, election of the Coroner and engagement in public discussion of the proceedings. As such, the historic inquest can be seen as a forum in which 'convivial' accountability could be generated (Morgan, 2006). Morgan describes convivial accountability as accountability grounded in social identity and implicit or tacit knowledge and focused on the importance of revealing, explaining and justifying in ways which are meaningful to those involved in the community. Such accountability is local, immediate and contextual, and the flexibility and ambiguity of the Victorian inquest meant it was ideally suited to such forms of accountability. While it was concerned with investigating death, there was little that was fixed, with, for example, few procedural rules and a range of possible recipients of accountability; it could be for one, some, or all of; the deceased, their family, the community, the Coroner in their own right or as representative of the Sovereign, their electorate or a wider public, or some non-identified future possible victim.

At the same time, the Victorian inquest could be a place with an absence of any form of accountability, with many Victorian Coroners subject to fierce criticism and accusations of bias towards vested interests. Scraton & Chadwick (1987, 25-28, drawing on Hall & McLennan) highlight the ways in which the historic Coroner's role reinforced 'local power relationships based on wealth and property', as the inquest into the deaths of 95 miners in an explosion at Haswell Colliery in County Durham in 1844 illustrated. W. P. Roberts, a campaigner for improved mine safety, attended

[93] Glasgow 2007, 80-82. In America at a similar time, as European settlers spread west 'and the number of Coroners grew, there was no accompanying demand that they possess medical or legal credentials. Political, not professional skills were what was demanded of potential Coroners' (Johnson 1994, 269). For discussions of selected coronial elections, see Burney 2000, 16-51; Glasgow 2004a & b, 2007; Hurren 2010.

the inquest, and reported that 'A stranger coming suddenly into the room might without much difficulty have fallen into the error that the Coroner was the attorney for the coal owners' (Roberts, 1844, 70). From the other side, populist Coroners complained of a lack of adequate powers to investigate, with Hussey describing the Coroner's court as 'the place where Ignorance talks to Ignorance and seems wise' (Hurren, 2010, 234).

In the face of such criticism, including widespread criticism of bribery and corruption (see inter alia Hunnisett 1961, 169; Richardson 2001, 2150; Glasgow 2007, 95-6); and driven by narratives of rationalisation and medicalisation, the Victorians engaged their reforming zeal. As discussed in Chapter 2, this included abolition of the deodand, as well as efforts to standardise fees and powers of Coroners; and the holding of inquests in public houses was banned (although continued nonetheless for many years; Burney, 2000, 80). The office of the Coroner was refounded in statute in 1887, and a year later, 600 years of history were wiped out as election for county Coroners were replaced with local authority appointment.[94] In 1926, the role of the jury was further reduced, when the requirement to view the body was removed and inquests without a jury were initiated, and by 2014 99% of inquests were heard by a Coroner sitting without a jury. Furthermore, the coronial role became an expert position, with five years of legal or medical experience required, a development which can be read in the context of Day & Klein's description of a privatisation of accountability, 'in so far as professionals and experts claim that only their peers can judge their conduct and performance' (Day & Klein, 1987, 1).

By this time the inquest's role in criminal investigations was already diminished as Coroners had fought (and ultimately lost) a long battle with the police and Justices of the Peace for primary responsibility for violent crime, and this role was further reduced in the twentieth century.[95] The 1926 Act obliged Coroners to adjourn an inquest when criminal charges were brought in another court, but the inquest still had power to name an individual guilty of homicide and commit them for trial. This power was criticised by the Wright Report (1936, 22-31) and then again by the Broderick Report (1971), and was eventually abolished by the Criminal Law Act 1977 following the high profile controversial decision by an inquest jury to name Lord Lucan as guilty for the murder of his children's nanny. In relation to civil liability, the Wright Committee recommendation that 'Coroners' courts should be prohibited from dealing with questions of civil liability' (Wright Report 1936, 34) was introduced in the 1953 Rules, which determined that the verdict could not be framed in such a way as to appear to determine any question of civil liability.[96] The Coroner's (Amendment) Rules

[94] In the Coroners Act 1887 and the Local Government Act 1888.
[95] Toulmin Smith, 1852; Havard 1960, 32; Dorries, 2014, 6-7.
[96] Rule 33, Coroners Rules 1953, SI 1953/205.

1980 further limited the role of the inquest, removing the power of juries to add 'riders' or recommendations to their verdict. Glasgow, analysing these shifts in the context of endeavours to ensure all Coroners were medically qualified, argues that post-1926 'the campaign for a more expert medicalized inquest gained momentum whilst the campaign for medical Coroners declined' (Glasgow 2007, 228).

Thus the inquest shifted from a legal forum founded in popular participation, to a more technical and professional jurisdiction, with fewer Coroners concentrated in larger districts (from the 1930s onwards there was a reduction in the number of coronial districts, from 309 in 1936 down to 128 in 2003 (Dorries, 2004, 7) and 97 in 2015[97]). Drawing on Morgan (2006), this development, with a greater emphasis on the need for Coroners to act as disinterested and arms-length actors, can be seen as part of a shift which undermined the possibility of convivial accountability through the inquest. Morgan argues that forms of revelation, explanation and justification tending towards the technocratic 'triadic' form – in which an expert and neutral actor provides accountability sitting outside a dispute – seek to mute raw politics and hide discretionary and value-laden decisions. In doing so, they can crowd out community knowledges and meaningful participative explanation.

However, aspects of the inquest remained resistant to this modernising drive, including crucially, the fact that the Coroner remains an office primarily organised on a local rather than national level. A shift to a national service was proposed by Luce (2003, 101) but these proposals were rejected and Coroners continue to be local appointments.[98] One of my interviewees reflected on this, telling me that,

> Parliament in its infinite wisdom, despite the advice of Dame Janet Smith and Tom Luce that it should be a national service, has decided no, it remains a local service, and yet we have got this fudge that it is a local service but with national leadership from the chief Coroner. Well if it is a local service it is going to serve local needs, quite properly in my view, if they really wanted to make it a national service and we all did it the same way then why didn't you make it a national service? Instead we have got a mish-mash which is perhaps the worst of all worlds.[99]

[97] See Chief Coroner 2015, para 52 & 66.
[98] Albeit with consent of the Chief Coroner, who has issued guidance on how appointments should be made.
[99] My interviewees reflected a range of opinion on the 2009/2013 structures, with another describing the CJA 2009 as 'a bit of a compromise and a fudge' while a different Coroner emphasised the need for 'national leadership' and a connection to the local community.

Critically, as other researchers have found (Scraton & Chadwick 1987; Tait & Carpenter 2013), its local foundations remain a central feature of the office of the Coroner, and my interviewees often expressed a strong connection to their area, as one told me

> [This] is a lovely jurisdiction because it is very wide-ranging, a real mixture. … it is quite a nice rural area, we get a lot of people coming out on bikes on Sundays.

Another expressed enthusiasm for the complex urban area they were Coroner for, telling me this wasn't a rural or suburban area, but was a place with 'really complex difficult cases, lots of difficult custody deaths, complex cases where police cover-ups are involved' while another stated that 'this really is a jurisdiction where I have done the death of a homeless person found on the street followed by the death of a member of the aristocracy, it is a place of real extremes, it is a fascinating place to work because of the range of cases.' This fascination turned to local pride in some cases,

> It may be that some areas of the country are different, but on the whole in my jurisdiction anyway, people are not liars.

For another Coroner, this connection was key to doing their job,

> I get to understand [this area], so when you are a judge, circuit judge, you move around a lot of different courts, you are just looking at the defendant and his offending record, with here we are looking at why death is occurring in certain parts of [the area], do we need to put fencing up on a bridge over the dual carriageway because people keep jumping off it, that sort of thing, you get to know the community.

As well as this local connection, another theme which has been noted by other researchers is the emphasis by Coroners on the ancient heritage of the office of the Coroner and the inquest. One of my interviewees saw the strength in a jurisdiction which

> predates the Star Chamber which was the first court in this land, by three hundred years, you have got ancient and very real common law powers. And I think that is a strength of our service, even though I like things to move on, I am not hide bound, but it is our difference that makes us good.

Longstanding legal commentator Joshua Rozenberg sums up this sentiment in his foreword to a textbook on Coronial law: 'No other institution in our legal system has survived unchanged for so long' (Dorries 2004, vii). As Scraton & Chadwick (1987, 22) argue, this emphasis on a static institutional account can disguise the dynamic nature of the inquest system and the sometimes controversial role Coroners have played, losing sight of the contingent ways in which the system has

developed in response to other pressures. However, this sense of history remains critically important as a key way in which the inquest system narrates its legitimacy, an ancient office focused on fact finding aided by modern medical knowledge; flexible, pragmatic and local, and now, with bereaved family at the centre. In 2012 in his 'first major speech' as Chief Coroner, Thornton HHJ made this clear:

> 'Coroner' – that is a good word, with an ancient and fine heritage. I am very proud to have that word in my title … One Coroner impressed me when he said: 'I have a deep affection for the office.' And so you should, rightly so. It is an office of great veneration and continuing importance. But I suspect you would be the first to admit that the Coroner system is not perfect. (Thornton 2012b, 1, 3)

His speech went on set out his ten priorities for the following twelve months, and closed with a reflection that

> When someone once wrote that death was 'The certain end of all pain and of all capacity to suffer pain', they were not thinking of those left behind. The bereaved rightly expect justice from the Coroner system. I shall listen closely to them – and to the organisations for the bereaved – so as to understand better their concerns. They should be at the heart of the process. (Thornton 2012b, 10)

This narration of legitimacy from an ancient and fine heritage emphasises continuity whilst dictating and describing a break with the past and a shift to a process with family at the heart. It is this reformulation that reinvigorates possibilities of a space for convivial forms of accountability, and for convivial and technocratic accountability to be co-constructed in an individual inquest. For participating family members of the deceased, the inquest holds out the possibility that issues will be aired, evidence can be gathered and interrogated, witnesses can be tested, and that systemic flaws and potential failures by individuals can be publicly exposed. As one Coroner told me,

> Families at one point could arguably be ignored, they can't be ignored now, they are very powerful.

Accountability in the contemporary inquest – case studies of the social welfare inquest

For some family members, the opportunity to question witnesses intensively and test detailed evidence can provide a form of accountability, as a place of public revelation in which those who were engaged in the death must explain and justify themselves. For others it provides a basis for further efforts to establish culpability or liability, with the potential for collecting or testing evidence

for public campaigns or civil or criminal claims arising out of the facts which resulted in death. As comments in my interviews demonstrated, it is also a place in which the family play a critical role in revealing and constructing meaningful explanations. One officer told me a story about a death in which a doctor was not sure about certifying the cause of death,

> You need to speak to the next of kin [and] they said, well that is what his father died of, and they thought that it was just a ticking time bomb. [You need to] reassure the family, then seek their opinions with regards to your objectives, and not only are you dealing with their loss, but also gathering from them any information that you think would be supportive of the Coroners decision, and so their needs are satisfied.

This was not a case which went to inquest, as the role of the family was key in constructing the medical cause of death, but when a case did end up as an inquest, the role of the family was critical for this officer,

> (Officer) The family represent moreover more about the person, rather than just the past medical history … so at least they have an opportunity to say, this guy had worked all his life, up until the age of 75, he was a master builder, he had worked in all sorts of environments, he was a lovely caring person … it is representative of the person rather than: Chest infection. Pneumonia. Died.

Unexpected deaths can raise fears of social failure, requiring the construction of counter narratives emphasising connectedness (Klinenberg 2001; Kellehear 2009). As this officer describes, family involvement in an inquest holds out the possibility that the inquest can produce an account of a person rather than their medical history, creating the possibility of a meaningful, contextual story of life and death (Scott Bray 2010), with emphasis on connections and care. Seale (1995) argues that such narratives are key to resisting fears of abandonment and isolation, and are central to strategies to contain death in contemporary society. His argument is in part a response to the Ariesian (1981, 614) contention that the modern invisible death is a solitary affair, separated from the rest of the community and reduced to a medical, institutional event. Aries argues that where the ideal death had been at home, with a community gathered around the death bed, this contemporary institutional death takes place away from the public, and is a private family affair. By contrast, medieval death 'could not be a solitary adventure but had to be a public phenomenon involving the whole community' (Aries 1981, 604), and where community rituals after death had once contained the forces of nature, the modern community, ashamed of death, abdicates its responsibility for death and mourning. Others also contest the Ariesian account, identifying community strategies in, for example, late Victorian England (see Frisby 2015), rejecting a proposed twentieth century

disengagement with death through attention to graves and churchyards (Rugg 2013a) or emphasising the possible agency of elderly individuals who choose to die at home alone (Kellehear 2009), and from an academic perspective, the inquest can potentially provide a space for unpicking the role of family, kin and wider community in these debates. It can do this because it is not a space solely directed at medical expertise and causation (Timmermans 2005) but also seeks to engage in a wider construction of meaning, an accountability through meaningful revelation and representation, engaging with family understandings of 'ticking time bombs' and accounting for a person beyond the perfunctory 'Chest infection. Pneumonia. Died.'

Furthermore, the inquest can produce a form of accountability through formal or informal standard setting and rule compliance, with pressure exerted on the State to act, whether as a result of the evidence which emerges, as a result of the conclusion of the court on the cause of death, or in response to a recommendation by the Coroner to prevent future deaths.

In relation to the conclusion of the inquest, the CJA 2009 retains the rule that the inquest cannot make, or appear to make, findings of criminal liability in respect of a named individual or of civil liability.[100] The inquest is required to try to determine the answers to four statutory questions; who the person was, and how, where and when they died.[101] In cases which engage Article 2 ECHR, 'how' must be interpreted more broadly to include the circumstances in which the individual died[102] and the conclusion should include conclusions on the central issue or issues. The impact, according to Matthews, is that in cases where it is not clear from the outset whether it is possibly a death which engages Article 2, 'a proportion [of cases] increasing exponentially … the Coroner usually plays safe, and casts the net wider rather than narrower' (Matthews 2014, 124).

The CJA 2009 also gave increased priority to the inquest as a site for producing recommendations to avoid risk of future death, and introduced a duty on Coroners to send a Report to Prevent Future Death (PFD Report) where, in their opinion, action should be taken to save life in the future.[103] The

[100] s.10 CJA 2009.
[101] S.5 & 10 CJA 2009, and to also provide the particulars needed for registration of the death.
[102] S. 5(2) CJA 2009. Where the right to life is engaged, the inquest is the usual way in which the obligation to investigate suspected breaches of Article 2 will be discharged, if there is no criminal investigation or public inquiry (*R (on the application of Middleton) v West Somerset Coroner* [2004] UKHL 10 at 20). Such an inquest requires the conclusion to be informative, setting out conclusions on major issues in the evidence, as 'an uninformative jury verdict will be unlikely to meet … the purposes of an Article 2 investigation' that families should have the satisfaction of knowing lessons learned may save the lives of others (*Middleton*, para 18)
[103] Sch.5 CJA 2009. A recipient of a Report to Prevent Future Death (PFD) has an obligation to respond to it within 56 days, explaining what action has been taken or will be taken together with a timetable, or providing an explanation why no action will be taken (R.29(3) & (4) Coroners (Investigations) Regulations). However, if the recipient disagrees with the basis for the Coroner's report, there is nothing further a Coroner can formally do (see for example PFD Report: Jones, 2013).

role of the report in effecting accountability through setting standards is grounded in the expertise of the Coroner in shaping the report,[104] and in the effectiveness of publicity of poor practices.[105] The report is the responsibility of the Coroner, and illustrates the way in which different forms of accountability can be enmeshed in one document. It is founded in a conception of a rationalised professionalised bureaucratic-type accountability focused on systems and public good (Dowdle, 2006, 4) but is also part of a judicial or rule based approach to accountability through setting and testing against standards. Furthermore, while it is not formally part of the conclusion of the inquest, it is part of the narrative of revealing and explaining death. One Coroner emphasised some of these different objectives

> (Coroner) I have always had this tendency to write long reports, but always with good purpose and always to explain why, because unless you tell a story people won't understand why you are making your concerns.
>
> (Ed) Do you think it elicits a better response?
>
> (Coroner) In practice I think it does, because it is also unarguable, if you have got some vague nonsense, you get vague nonsense back, if you have told the story, it also means that the family know when I have taken so much care and time, that (1) the story has been told and (2) if the responses are inadequate then the families can then challenge and say 'you haven't responded, you haven't adequately dealt with it.'

The contrast between telling a meaningful story and writing 'vague nonsense' is clear, and can have the effect of improved enforcement as the family can act on it. Reflecting on all these changes, another Coroner described that the result would be 'longer inquests, more expense, more experts, more litigation' as well as more jury inquests.[106] In this context, I turn to explore accountability in the social welfare inquest through four case studies.

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[104] Rather than engaging with the effectiveness of PFDs in terms of numbers of lives saved, my attention is on the PFD as a possible part of combined accountability, but for other work in this area, see Fletcher 2011; Sutherland 2014; Mok 2014.

[105] Efforts to strengthen the effectiveness of the PFD report mean that now both the report and response must be sent to the Chief Coroner, who has stated that there will be a presumption of publication (Chief Coroner 2013c). Furthermore, in December 2013 the Chief Coroner produced the first Summary of Reports to Prevent Future Deaths. This highlighted a significant increase in reports from 2008 (when the Ministry of Justice began collating reports), and states that it is expected that this trend will continue (Chief Coroner 2013b). He also indicated that he is keen to develop his role in this area, and that it is implicit that he should have a role in taking some reports and responses further, recommending action where appropriate, including potential legislative changes (Chief Coroner 2013c, para. 54).

[106] Because deaths in mental health units now require a jury to be called, and see discussion at para 27, Chief Coroner (2014-15), and Chief Coroner (2014b).

Welfare benefits & the death of Malcolm Burge

Malcolm Burge, a 66 year old former cemetery caretaker from the City of London, died on 28 June 2014 in hospital in Bristol 'having earlier that day set light to himself and his car in a car park in Cheddar Gorge, Somerset.'[107] His inquest was held in February 2015. It heard evidence that he had been overpaid £800.69 in benefits as a result of an administrative backlog at Newham Council, and that the Council had initiated legal proceedings to recover the money. The Coroner's Report to Prevent Future Death (PFD) finds that 'due to a number of factors in particular his age, lack of mental awareness, inability to both understand and use the internet and modern telephone procedures [sic] communicate his problems to the Council, and as a result took the drastic action that brought about his death.' The distressing details of his death were reported by Cahal Milmo in the Independent newspaper under the headline *The appalling death of a man caught up in benefits nightmare*. The report notes that Mr Burge,

> had spent all but four years of his life living in the grounds of the City of London cemetery. The imposing Victorian graveyard in Manor Park, east London, is one of the largest in Europe and his father – Mervin – was head groundsman, raising his family in the grey-stone lodge house … [Mr Burge] followed his father into the gardening trade, working at the cemetery and elsewhere in adjoining Wanstead. But when his mother died in 1992 and his father contracted Parkinson's Disease, Mr Burge gave up the work he loved to become Mervin's full-time carer, moving to a smaller property in the grounds of the cemetery. It was to this house that his family came last year in the immediate days after the harrowing events in Cheddar Gorge. (Milmo 2015)

The PFD states that 'the Court understands that the deceased had never before owed money or been in debt' while Milmo describes it as a 'harsh indignity for a man from a proudly working class background who, according to his family, had a traditional attitude to debt.' The Independent report also records his family stating that when they visited his home he had destroyed other documents but had 'clearly left out his communications with the council … It was clearly of importance to him' and quotes his sister telling the inquest 'He was a very quiet and proud man. We knew nothing about this until after his death' with his niece adding 'His pride kept him away from asking us. We would have helped him.' The report concludes with a final reflection

> For the man who felt he had to travel far from home to end his life, there was at least a return to the place that had provided sanctuary throughout his life. His remains were placed

[107] PFD Report, Burge, 2015

> in the memorial garden of the City of London Cemetery, the place he knew best. (Milmo 2015)

The account is affecting, a media obituary created from the evidence at an inquest. The inquest constructs the 'sad sad sad story'[108] of the death of Malcolm Burge as a victim of bureaucracy, an existence made precarious by digital technology, out of time and place in a world of IPads and the internet; according to the Coroner,

> a tragic tale of a man who had lived all of his life in the city of London being caught up in the changes to the government benefit system. And while it seems clear to me now that he was a man who needed help and was in distress, unfortunately Newham Borough Council were unable to give it to him. (Milmo 2015)

At the hearing, Newham acknowledged failings in their communications with him, and apologised if these failings contributed to his death in any way. Presumably dissatisfied with their response, the Coroner sent a PFD Report which set out action to be taken in relation to communication with individuals in Mr Burge's position, including a direction to see people in person, offer them assistance, or direct them to 'some responsible organisation such as the Citizen's Advice Bureau.'

This case can thus be seen to combine the technocratic and the convivial. The inquest gave space for the family's narrative, resisting the isolation of Malcolm Burge; a man who lived a private life and may have been abandoned by the State, but who nevertheless had a loving family who would have helped him if they had known of his insecurity. The public narrative of the media constructed a return home, while the PFD seeks to correct administrative systems which could conspire to marginalise others, and cause future deaths. However, as with other inquests into deaths linked to cuts in benefits, this case also reveals the limits of the possibilities of accountability through the inquest.

The cuts to welfare benefits instituted by the Government since 2010 have been fiercely contested. As well as academic inquiry (See inter alia, Antonakakis & Collins, 2014; Coope et al, 2014) there has been a great deal of political and media attention on self-inflicted deaths said to be a result of benefits cuts,[109] as well as criticism of that attention (see O'Neill, 2012). One consultant clinical psychologist concluded that 'When the government made cuts to the benefits system in March this

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[108] as Milmo described it on his Twitter account in a tweet promoting his report, 12:00 on 7 February 2015, https://twitter.com/cahalmilmo/status/563970469607784448.

[109] Including a campaign for the Government to release figures of deaths linked to cuts in welfare, which resulted in a statement from the Prime Minister in PMQs on 24 June 2015 that this information would be released.

year we noticed a significant peak in the number of suicides in the borough' (Cowburn, 2013). Coroner's hearings have proved a place for family members and those affected by benefits cuts to raise concerns and provoke media interest. Some Coroners have ruled that benefits cuts contributed to self-inflicted deaths; including the Coroner for South Staffordshire, who ruled that Tim Salter had committed suicide, and a 'major factor' in his death 'was that his benefits had been greatly reduced leaving him almost destitute' (Traynor, 2013). In February 2014, an inquest into the death of Mark Wood in Oxford heard evidence that he had died from malnourishment, and his decline and death were due in part to a decision that he was capable of working. Following the inquest, his sister wrote to Mark's MP, David Cameron, and made statements to the media: 'We worked for years to create a place for him to live safely. But that stopped when his benefits were stopped. He tried so hard to survive' (Gentleman, 2014).

A brief online survey of media reports indicates at least 20 cases reported in the national media between 2011 and 2014 which link benefits cuts to self-inflicted deaths. Furthermore, one linked Report to Prevent Future Death has been published in this period. It states that the assessment by the DWP that Michael O'Sullivan was fit to work triggered his death but was crucially flawed, because it failed to take into account important medical evidence (PFD Report: O'Sullivan, 2014).

The reports arising out of the inquests into the deaths of Michael O'Sullivan and Malcolm Burge both focus on procedural natural justice-style considerations around access and representation, ignoring the substantive political questions of welfare cuts. As such they highlight the potential for official narratives which disassociate and decontextualise death (Scraton, 2002, 16). Razack (2011 & 2015) explores this, finding that inquests into the deaths of Aboriginal people in police custody in Canada persistently medicalise those deaths and attribute them to alcoholism, with First Nation Canadians typically framed as a dying race unable to enter modern life. Razack argues that this framing creates the inevitable consequence that their deaths are thereby disconnected from an ongoing violent colonialism. Similarly, while Coroners have the duty to report where action could be taken to prevent circumstances giving rise to death, no Coroner has submitted a report which states that future deaths might be avoided by reversing policies designed to reduce the welfare bill. Drawing again on Morgan (2006), the inquest system works to mute raw politics to insulate itself as a disinterested actor, but this never quite works as calls for accountability continue in the face of continued injustice. The outcome of the inquest, perhaps a reference in the findings of facts of 'how' the individual died, and at most a conclusion that benefits cuts were a contributing factor, cannot meet the requirements of convivial accountability, because it is necessarily grounded in an individual approach which ignores the wider political decisions central to the death. Thus, in an attempt to be a place of individualised objective law rather than politics, and to establish itself as a

neutral expert actor, the inquest system can undermine the possibility of effective accountability; determining that, ultimately, Malcolm Burge committed suicide.

However, whilst the requirements of the system focus the investigation on the state of mind of the deceased, and a possible conclusion of suicide acts to disconnect the death from wider politics, the potential for a contributory finding in some cases, and the potential that the inquest hearing can provide a public link between the death and benefits withdrawals can work to reconnect the political. Thus, where the Coroner seeks neutral language, describing the cuts as changes which Malcom Burge was caught up in, the Independent report develops this into a wider critique, noting that 'an increasing number of people, ranging from campaigners to Coroners, argue that Britain's increasingly stringent welfare system has at times become inflexible to the needs of the most vulnerable' (Milmo 2015). Unlike the position of First Nations people in Canada, and perhaps other deaths in the UK such as deaths of the homeless (see Carr 2015), the media and social media attention given to these inquests demonstrates that the inquest can provide an important space to engage with the question of what is a grieveable death (Butler 2006). Where deaths are not referred to the Coroner (as with immigration custody deaths in Australia, see Powell, Weber & Pickering 2013) no such possibility even arises, and public discussion is far more limited as a result, whereas in the cases linked to benefits withdrawal, the system is perhaps capable of providing a focal space for public engagement with accountability and possibilities of a form of justice, even if the outcome and attention of some Coroners might be limited and directed solely to technocratic forms of accountability.

Housing & the Lakanal House fire

On 3 July 2009, a fire started in Flat 65 in Lakanal House, a high rise block of flats in Southwark owned by London Borough of Southwark (LB Southwark). In the resulting blaze, six people died, including Catherine Hickman in Flat 79. Ms Hickman was a private rented tenant of the flat, which had been bought from LB Southwark under the Right to Buy (RTB) scheme. Amongst numerous failings identified, the jury found that internal modifications to Flat 79 made more than a minimal contribution to Ms Hickman's death. The modifications had been undertaken by the leaseholder, and had been approved, but with a recommendation that they be checked for fire safety by LB Southwark's Building Design Services. This check did not take place (Inquisition: Hickman, 2013).

As Carr (2011) has argued, the argument that RTB transformed supplicant social tenants to property-owning responsible citizens is problematic. Carr demonstrates the limited autonomy of the RTB leaseholder and argues for recognition of the vulnerable, conditional and marginal nature of their ownership, with a consequent high risk of impoverishment. Carr also emphasises the complex

position of a local authority trapped between public law-type responsibilities towards their social tenants and private law restrictions on their relationship with long leaseholders, and the impact that has on their perception of the place of the RTB leaseholder.

The PFD report at the close of the Lakanal House inquest, and responses to it, demonstrate these themes, and the ways in which the PFD report can operate as a form of technocratic accountability which seeks – and fails – to neutralise the political, potentially leading to a vacuum of accountability. Following the inquest, the Coroner wrote to LB Southwark and the Department for Communities and Local Government (DCLG) under Rule 43 (the predecessor to the PFD Report) setting out a number of concerns, including a lack of inspection of modifications within the flats (Lakanal House, Rule 43 Reports, 2013). LB Southwark responded to state that the lack of a right of access to RTB flats meant they could not check for modifications, with RTB leaseholders framed as a barrier to their public law duty to manage the risk of fire in all their properties (LB Southwark, 2013). They called for a national approach, presumably a request for a statutory power of entry. DCLG's response ignored this request (DCLG, 2013), and reaffirms guidance on fire inspections emphasising the autonomy of RTB lessees (Local Government Association, 2011). These responses re-expose the long-standing conflict between a Conservative-dominated central government in support of RTB, and a Labour-controlled local government opposed to the policy. The focus of the PFD on the procedural questions of guidance and inspection is an endeavour to circumvent politics, but the muting of the political never quite succeeds (Morgan, 2006, 257). The dispute over the essential status of the RTB leaseholder remains bound up in values, context and tacit conceptions of community and cannot be reduced to objective matters capable of disinterested decision. Thus a focus on the technical and a lack of engagement with these convivial issues leaves a gap, undermining the possibility of achieving accountability through either rule setting or through meaningful explanation or justification after the inquest.

Further analysis of the response of LB Southwark demonstrates the way in which the muting of the political and reliance on the overtly technocratic conceals the marginalised and vulnerable RTB leaseholder, and their potentially even more vulnerable and marginalised tenant. The Coroner recommended that in future, LB Southwark demonstrate the safety features of flats for new residents, and consider additional ways of disseminating information, including affixing fire notices inside each flat (Lakanal House, Rule 43 Report, 2013). In response, LB Southwark confirmed they would roll out fire training for all new tenants, and existing residents would receive an information pack. In relation to fire safety notices, they did not propose to do this, taking into account increased information and signage in communal areas, and also 'considering we cannot do so in dwellings sold under the right to buy … without the owner's consent' (LB Southwark, 2013). The leaseholder is

again constructed as presenting an insurmountable obstruction – it is not clear why, for example, leaseholders could not be offered the option of a fire safety notice for the inside of their flat. In addition, the differential treatment of residents and tenants means that new leaseholders or new tenants of leaseholders would not be given training on fire safety, while new public tenants will, including training in relation to safe exit routes. The legal framing of leaseholders as responsible autonomous citizens, promoted by DCLG and grudgingly acceded to by LB Southwark, thus leaves them and their tenants less protected in the event of a serious fire incident. This is even clearer when RTB leaseholders are compared to other leaseholders in relation to modifications. While there is no right of entry to RTB homes, other types of leaseholder commonly have a right of access to check modifications, leaving a RTB leaseholder and all those in a block with them, including other RTB leaseholders or their tenants, less well protected from fire.

As a footnote, drawing again on Carr (2011), the Lakanal House fire also demonstrated the ways in which, rather than being enriched by their purchase of a home, RTB leaseholders may be left potentially impoverished by it. In this case it is because of the cost of paying for fire-proofing work. An impact of the fire at Lakanal House was widespread reassessments of fire protection in communal parts of social housing stock. In one case in the First Tier Tribunal, it was held that despite the fact that a building was scheduled for demolition in the near future, urgent fire prevention works were deemed necessary by the freeholder local authority. As a result, the leaseholder was obliged to pay for them (LB Southwark v. Robinson, 23/6/2014, FTTPC Case Ref: LON/00BE/LSC/OO10).

Ultimately, the outcome of the Lakanal House inquest demonstrates that RTB leaseholders fall between two stools, left potentially more vulnerable than either social tenants or other leaseholders. However, the process of the inquest also demonstrates the possibilities of narrower accountability in the individual cases. While wider community voices were only heard through written submissions – demonstrating that even in the potentially most expansive and community-focused of contemporary inquests, examining the very material foundations of the neighbourhood, the community's role is limited – the scope for a critical outcome and the generation of a meaningful and contextual accountability through revelation and explanation was boosted through engagement of the families of the deceased and the jury's detailed narrative conclusions. There was also extensive media coverage and public discussion of the case. As such, the one-off high profile investigation can be usefully contrasted with inquests into deaths in care homes, which may be no less distressing for those involved but which are far more common.

Care Homes & the death of Walter Powley

Care homes are sites which engage with particularly complex forms of security and safety, with individuals potentially susceptible to a form of precariousness bound up with frailty and isolation as well as an often intricate and opaque structure of provision. As a result they can be places of extreme danger which the inquest is perhaps uniquely able to expose (Mahoney, 1997; Head & Taft, 2007; McGovern & Cusak, 2014), and with which Coroners appear to be increasingly engaged (with encouragement from the courts, see *R (Bicknall) v. HM Coroner for Birmingham* [2007] EWHC 2547 (Admin)). Both inquests and PFD Reports can highlight issues in an area where the victims are particularly vulnerable and there are potentially fewer avenues for the bereaved to seek accountability; including the difficulties of successfully pursuing justice through a civil claim and where concerns have been expressed about other oversight mechanisms, not least the Care Quality Commission, which is primarily responsible for inspections of care homes (Health Select Committee, 2013, 2014).

Between April 2013 and April 2014, 33 reports were made by Coroners relating to care homes, with many of these inquests also ending in a narrative detailed finding of fact.[110] Accountability can thus be engaged through meaningful explanation in answer to the question 'how' someone died, and through a PFD Report, directed both to individual care homes, and at those charged with bureaucratic oversight of the system. Eight of the reports are directed to the Care Quality Commission (CQC). Some of these demonstrate concerns about the CQC itself, and as such expose the role of the inquest in forms of accountability through bureaucratic-type oversight.

One example is the disturbing case of Walter Powley. Mr Powley was an 85 year old who went into a care home in Leicester on 4 May 2012 to receive emergency respite care. On 8 May he was found to have fallen out of bed, onto a scalding radiator pipe. He was taken to hospital, where he died from his injuries just over a week later. At the end of the inquest into his death, his family released a statement: 'We had supported and cared for dad daily and kept him safe in his own home for six years following a stroke. The fact that he died from injuries sustained as a result, in our view, of inadequate care in a place where he was supposedly safer than at home is heartbreaking' (Troughton 2013). The jury[111] concurred, returning a narrative verdict and recording that his death was caused by the severe burns from the pipe and was contributed to by a lack of covering of the

[110] See inter alia PFD Reports: Barton, 2013; Godfrey, 2014; Grey, 2013; Jones, 2013; Morris, 2013; Newton, 2013; Rivers, 2014; Robinson, 2014; Waldron, 2014.

[111] Called because it was a case which involved a death which had to be reported to the Health and Safety Executive.

pipework, inadequate risk assessments and failure to keep proper records.[112] In addition, the Coroner sent a PFD to the CQC and Health and Safety Executive (HSE), noting that despite regular and recent inspections, the danger from this pipework was not identified (PFD: Powley, 2013; Troughton & Owen 2013).

In their responses to the Coroner, the CQC and HSE both accepted a degree of responsibility, but both suggested the other agency was in a better position to inspect for this particular issue (see Care Quality Commission 2013; Health & Safety Executive 2013). From the CQC's perspective, their inspectors did not have sufficient knowledge of health and safety law, while the HSE argued that the CQC was the lead inspector of care homes and so was best placed to proactively lead inspections. The Coroner's efforts in this case reveal a flawed regulatory system, and demonstrate the way the inquest and the PFD Report can be powerful tools to shine a light on systemic inadequacies, providing evidence-based criticism and combining convivial accountability through effective family participation and technocratic accountability through explicit standard setting. However, they also demonstrate the limitations of this accountability in this forum; a liability to reveal, explain and justify can easily be lost in expertise, complexity and institutional boundary watching, which a Coroner has no official power to follow up or challenge.

The question of follow up and expertise also highlights a deeper issue around the relationship between a one-off inquiry by a structurally independent Coroner in a public forum, as opposed to the consolidating, explicitly expert and anonymous Serious Case Review (SCR) into the death of a child. The relationship and potential tensions between these two types of inquiry, ostensibly charged with the same objective of preventing future deaths, is my final subject of discussion, and illustrates some of the complexities between two systems which engage with technocratic formulations of accountability, and the ways in which that interaction can crowd out other possibilities for accountability.

Serious Case Reviews following the death of a child

An SCR must be carried out where a child has died and abuse or neglect of a child is known or suspected.[113] The purpose of an SCR is similar to a PFD, 'to identify improvements which are needed' but is additionally 'to consolidate good practice ... [and to produce] programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to

[112] The case also demonstrates more traditional forms of accountability through criminal prosecution, as in a subsequent HSE prosecution, the care home pleaded guilty to breaches of health and safety and was fined £100,000, see BBC News 2015.

[113] R.5 Local Safeguarding Children Boards Regulations 2006 and Working Together to Safeguard Children, 2013.

children' (Working Together, 2013, 66). An SCR is therefore a solely technocratic-oriented form of accountability founded in expertise and anonymity and directed towards bureaucratic reform.

Coroners are required to notify the Local Safeguarding Children Board (the Board) where they investigate a death of a child, and must disclose all information gathered as part of that investigation.[114] However there is no provision providing for disclosure from a Board to a Coroner. This absence led to the Worcestershire High Court decision in 2013 involving the death of a looked-after child.[115] The Worcestershire Safeguarding Children Board had undertaken an SCR; collecting over 600 pages of evidence, ten Individual Management Reviews, six Information Reports, and producing a draft overview report. The Coroner requested all of this evidence, and, after initially resisting, the Board disclosed the draft overview report but refused any further disclosure. The Coroner obtained a witness summons to force disclosure, and the Board applied to the High Court to set this summons aside on the basis of Public Interest Immunity.

Baker J noted that the chief concern of the Board was that the overriding purpose of a SCR might be undermined, because candour from contributors would be less likely if their confidentiality was not secure. Baker J held that a Coroner has a 'crucial' and 'vital' role which includes investigating deaths of looked-after children, and as such, the public interest in full disclosure to the Coroner firmly outweighed any claim for non-disclosure.[116] The case was heard in May 2013, and in July 2013 the implementation of the CJA 2009 substantially changed the process. Where previously Coroners had to apply to the High Court to order disclosure, they now have the power to order it themselves. Post-July 2013, where a Board seeks to make a PII claim, the Coroner may need to consider the documents, and can insist on seeing them.[117] The presumption must therefore be of much wider disclosure of evidence collected in SCRs to the Coroner – with the Chief Coroner arguing that the decision 'reflects the trend in the courts towards greater disclosure, at least, in this case, for the eyes of the Coroner' (Chief Coroner 2014a, 4).[118] In the context of this new disclosure regime, a growing

[114] R.24 and 28(4)(b) Coroners (Investigations) Regulations 2013/1629.
[115] *Worcestershire County Council and Worcestershire Safeguarding Children's Board v. HM Coroner for Worcestershire* [2013] EWHC 1711 (QB).
[116] At the end of his judgment, Baker J stated that it was relevant that the disputed documents were authored reports, based in part on interviews but without any transcripts. He further indicated doubt that knowledge of onward disclosure to the Coroner would inhibit the individual interviewed in any case; leaving the door open for more intrusive disclosure by Coroners, but with a potential argument for Boards who wish to resist.
[117] Sch.5(1)(4) and 5(2)(2) CJA 2009 and CPR 31.19(6)(a).
[118] This is a significant development, as the literature indicates little consistent nation-wide practice of interaction between the inquest system and safeguarding systems in the past (see inter alia Stanley & Manthorpe, 2004; Brandon et al, 2008; Manthorpe & Martineau, 2009). As the Coroner in the Worcestershire case stated, disclosure was needed in part so that the Coroner could 'understand, in a specialised field such as child protection, how each of the contributing agencies interpreted their own and others' fulfilment of their

emphasis on PFD Reports, and the growth of Article 2 inquests, there will be more interaction between Coroners and SCRs in the future.[119]

Critically, the approach highlights the role of the Coroner considering the evidence separate from the public inquest and from onward disclosure to the family. In an endeavour to resolve a tension between candour-through-anonymity and a meaningful role for the Coroner, the approach emphasises the non-automatic nature of disclosure to the family.[120] Disclosure to the family in these cases is framed as presumptively risky, and while the approach of an individual Coroner holds the potential for shifting that presumption and considering the contexts of a particular case, a risk-framing producing an overemphasis on risk threatens the possibility of an effective participative role for the bereaved family, which itself threatens the possibility that an inquest can combine effective rule-making and a meaningful contextual account of the circumstances.

Conclusion

An individual inquest can hold out the possibility of what I have termed 'combined accountability,' but can also fail to provide any form of accountability for death, particularly in circumstances where uses of direct force by the State are central to the death.[121] It is also a place in which conceptions of accountability can come into direct conflict, and a neat demonstration of this might be the direction of the Chief Coroner that Coroners should employ moderate, neutral, well-tempered language, rather than forcefully expressing themselves to be appalled or disgusted (Chief Coroner, Guidance Note 3, 2013). It would be interesting to know how the apparently (at times) uncivil Thomas Wakley would have responded to a direction to prioritise technocratic moderation over perhaps more meaningful language, with his self-declared penchant for uttering 'unpalatable truths to ears attuned to courteous fictions' (Sharp, 2012).

However, my focus on the role of the inquest as a place for exploring social welfare law also illustrates the ways in which forms of accountability can be shaped and combined, and critically, after decades of heavy emphasis on the narrow and expert, the shift towards wider investigations,

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respective functions to [the child].'Worcestershire County Council and Worcestershire Safeguarding Children Board v. HM Coroner for the County of Worcestershire [2013] EWHC 1711 (QB), 26.

[119] with potentially significant implications for the workload of Coroners (and implications for an inhibition of effective accountability due to information overload, Greiling & Spraul, 2010).

[120] Chief Coroner 2014a, perhaps over-emphasising this, as a strong argument could be advanced in a Middleton-type inquest that documents created as part of an SCR ought to be disclosed to the family members, and a blanket ban on such onward disclosure would be very difficult to justify.

[121] And see the different possibilities highlighted in such cases by MacMahon (2014), contrasted with the critique of Scraton (2002).

narrative conclusions, more reports to Prevent Future Deaths and an increased role for the family, has reinvigorated these possibilities in an individual inquest. As one Coroner told me

> Families are a huge pressure group now, who can in fact be very powerful in, for example, effecting change following death. I did a report which was discussed in Parliament, and the family are very keen to ensure that if changes are brought about they can be.

The inquest here made possible a form of justice for this family, but it is central to my argument that this powerful place of the family is not solely directed toward accountability in the inquest, but is also central to constructing the accountability, authority and legitimacy of the inquest, and it is this that I turn to in the next chapter.

Chapter Four: Accountability, legitimacy, authority and jurisprudence

Introduction

As my first two chapters have argued, the inquest has long been a contested, ambiguous and contingent space. Politically, legally and culturally constructed, it is a jurisdiction in which, historically, narratives of sovereignty, neighbourhood, revenue, justice and pardon worked alongside each other. Starting with the Victorian reforms to the inquest, the modern jurisdiction developed out of a particular productive tension between discourses of public health and those of the liberal state (Burney, 2000). The endeavour was designed to reduce contingency but the increasing emphasis on technocratic accountability in the twentieth century eroded the possibilities of more convivial approaches to achieving revelation, explanation, and justification. My argument is that the contemporary inquest has seen these possibilities revived, and in this chapter I turn to examine how the core of that revival – the central place of the family – can be seen to have reshaped the legitimacy and authority of the inquest.

Whilst themes of heritage, a local link and expertise are key to narratives of the legitimacy of the inquest, my focus in this chapter is on legitimacy as lawfulness, and the ways in which lawful relationships and the authority of the Coroner and the inquest are constructed. My objective is to develop a jurisprudence of the contemporary inquest, which encompasses an account of combined accountability, with family at the centre. It is in two parts: firstly I explore authority in the inquest, and drawing on Dorsett & McVeigh and a historical account of the inquest, I argue that any account of inquest law must engage with a range of sources of authorisation. In the second part I turn to explore the critical place of the family in the law of the inquest, and the ways in which they are engaged in the law of the inquest. My focus here is on establishing the importance of attention to the technical procedural rules which shape the place of the family, and of developing an argument that a conception of a participative family is constitutive of contemporary inquest law.

Rival authorities

A traditional doctrinal account of authority in the inquest focuses on the wide discretion of the Coroner, emphasising the network of legislation, precedent, guidance and best practice which constrains and supports the work of the Coroner, who acts to answer the four questions of who the person was, and how, where and when they died.[122] In 1994, the Master of the Rolls, Thomas Bingham declared that 'an inquest is a fact-finding inquiry conducted by a Coroner, with or without a jury, to establish answers to four important but limited factual questions.'[123] The Coroner is 'the

[122] See, for example, Thurston 1976; Matthews 2014; Dorries 2014, which Riles 2005 would describe as instrumentalist texts.
[123] R v. North Humberside Coroner, ex p. Jamieson [1995] 1 QB 1, 23G.

public official responsible for the conduct of inquests, whether he is sitting with a jury or without' and it is his duty

> to ensure that the relevant facts are fully, fairly and fearlessly investigated... He fails in his duty if his investigation is superficial, slipshod or perfunctory. But the responsibility is his. He must set the bounds of the inquiry. He must rule on the procedure to be followed. His decisions, like those of any other judicial officers, must be respected unless and until they are varied or overturned.[124]

The dual focus is on a narrow but important inquiry, and on the authority of the Coroner to determine that inquiry. The Coroner, unless overturned, speaks the law, arising from an investigation which is not superficial, slipshod or perfunctory but which is otherwise theirs to shape. The central emphasis is therefore put on the Coroner's authority to determine, decide and judge.

There is a huge amount of critical academic reflection on the question of authority, including compelling scholarship which focuses on the inherent violence of the exercise of legal authority.[125] If applied to the inquest, as with a doctrinal account of authority which focuses on the source of legitimate power, such framings place the Coroner as ultimate authority within their jurisdiction. Despite the power of this critique, such an account risks seeing individuals other than the Coroner as lacking any constitutive role in that authority. Taking the claim of the centrality of the family seriously, my attention is instead on the ways in which the authority of the inquest is constructed through law. This approach focuses on the way in which authority is given to law, and the critical role of individuals other than the Coroner in shaping that authority. Importantly for my account, I employ a broad conception of law, and as well as the official outcomes of the inquest, I characterise the operational, interlocutory and procedural rules which establish the system and the parameters of an individual inquest as equally important subjects of legal analysis. Furthermore, as I explain below, and drawing on Dorsett & McVeigh (2012), this broad conception of law includes jurisprudential reflections on the representation of this law.

Authority in the historic inquest

The role for actors other than the Coroner in establishing the law was perhaps clearer in the historic inquest. When the historical Coroner was informed of a suddenly dead body lying within their[126]

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[124] R v. North Humberside Coroner, ex p. Jamieson [1995] 1 QB 1, 26 B-D.
[125] See inter alia, Benjamin 1996; Agamben 2005; Mantell 2014.
[126] While the office of Coroner appears to have always been always staffed by men historically, to maintain consistency with the rest of my thesis I use third person plural to denote a singular Coroner, relying on Chilvers 2012.

jurisdiction, the first step they had to take was to call together the community to carry out an inquest. *De Officio Coronatoris* in 1275 provided that the Coroner was 'to go to the place [where the body was] ... and shall forthwith command four of the next Towns, or five or six to appear before him in such a place' and 'when they come thither' the Coroner is to hold an investigation.[127] Fines were levied on Coroners who did not call the jury, or on community members who did not attend. Earlier statutes ensured that, where an Inquest is held 'for the Death of Man... all being twelve years of age ought to appear unless they have reasonable cause of absence.'[128] These inquests into the death of man were distinguished from other inquiries into robbery and burnings of houses, from which 12 year olds could be excused. Crucially, where a death had occurred, all were obliged to attend, and as noted above, when they attended, the inquest was held by the jury '*before* the Coroner and not *by* him' (Wellington, 1905, 9, emphasis in original).

In one classically liberal formulation, the Coroner was framed as

> an officer at common law, with a thoroughly constitutional and responsible origin and wide jurisdiction ... There is no more important thing needed in our day, than to induce the public to know that the common law, instead of being a mystery which they cannot understand, is the sole guarantee of their liberties; and that every man may understand it, and is bound to understand it. Its entire foundation rests upon the principle ... That freemen are not to have so-called "justice" administered to them by functionaries, but are to adjudge of all matters that concern them for themselves; that every man is to be tried by his peers; that every matter, inquiry into which concerns the welfare or safety of freemen, is to be inquired into by the freemen themselves, and none other; and that the magistrates whom they shall acknowledge as legitimate are those only whom they have themselves, as free men, chosen. (Toulmin Smith 1852)

As with the contemporary doctrinal formulation, this places a strong emphasis on the breadth of the Coroner's discretion. However, lawful authority in this account is dispersed, challenging a thin account of a judicial officer exercising the authority of the sovereign within their jurisdiction, and instead inserting rival constitutive authorities. The Coroner's authority is itself constituted by contrasting sources; a knight (or later) landowner responsible for the revenue to the Crown, but also an elected magistrate with a 'truly popular characteristic' (Toulmin Smith 1852). In addition, their

[127] See De Officio Coronatoris, AD 1275-6, 4 Edward I.
[128] The Statute of Malborough, AD 1267, 52 Henry III, c.24

legal authority in the inquest was founded upon the wider principle that free men were to adjudge the law for themselves, represented by the legal authority of the jury.

Rather than jumping to doctrinal questions of the source and the legitimacy of potentially competing authorities, an alternative approach to analysing the authority of law is advocated in the work of Dorsett & McVeigh (2012). They argue that attention to the ways in which practices of jurisdiction represent or authorise the law can provide accounts of the links between authority and law, and produce an account which links authority to the institutions of law. They argue that jurisdiction should be considered as a practice of creating legal relations: it is the power to speak the law, and calls and binds people to law. Critically, they call for a focus on who authors the law – who speaks, determines, decides, judges – and for law to be seen as more than simply rules, but also as the representation of the authority of law.[129]

Seen from this perspective, while the pre-modern Coroner's legal authority was engaged when they received notification of the slain, the wounded or the suddenly dead, their jurisdiction extended to notification of the community and to calling that community to law. The jurisdiction of the inquest, a public hearing which binds the event of death to law – making the death legal; both public and explicable – was not constituted until the appearance around the body of the neighbours of the fallen. It was this gathering of the community which inaugurated the law of the inquest. Once gathered, their participation together with the Coroner shaped the jurisdiction, linking their legal joint authority; and ultimately speaking the law by pronouncing the verdict. Contested and lost in reforms though this theme eventually was, the quote illustrates the powerful narrative of an inquest in which free citizens, bound with an obligation to understand the way their liberty is upheld, acted in a jurisdiction and through a common law represented as theirs.

Reading the authority of the law of the historical inquest solely through the role of the Coroner creates the risk of missing this complexity, and runs foul of Hannah Arendt's critique of the historian overlooking what actually happened in an endeavour to find objective meaning, 'independent of the aims and awareness of the actors' (Arendt, 1954, 88). Instead of a focus on the incomprehensibility and inefficiency of the historic inquest, from the deodand to the election of the Coroner, attention on the inquest as given authority by the combination of both Coroner and jury can illustrate the ways in which the inquest was constructed by their conjoined or differing aims and awarenesses, as the example of the differing deployments of the deodand demonstrates. The modern and the contemporary inquest developed through, or in resistance to, these narratives of the roles of the

[129] See further, Dorsett & McVeigh 2012, 10-29.

Coroner and the jury, and I turn next to trace these accounts of authority in the contemporary jurisdiction.

The representation of authority in the contemporary inquest

A key moment in the creation of the modern inquest was the Coroners Act 1887.[130] Prior to this, statutes had been declaratory of, supplementary to or restrictive of the coronial jurisdiction developed in common law, but the 1887 Act constrained Coroners to investigations into death.[131] The source of modern and contemporary inquest law is therefore founded in the will of Parliament, with all the potential complexities and interpretative possibilities which flow from that formulation. One Coroner described this to me when I asked who the inquest system was for;

> (Coroner) I don't know, it is a very interesting question isn't it. I think the trouble with Parliament again and again is it does not state its purpose, both under the old law and the new, nowhere does Parliament say 'and the purpose of the inquest is…' – all it says is 'as an inquest you shall answer these four questions.' Yeah, why? What for? What good does it do? No answers.

In this gap, in an office committed to uniting ancient tradition, local association and a modernist demand for efficiency, expertise and therapeutic responsiveness, the question of the basis of legitimate authority in the contemporary inquest remains live. To seek to examine this, rather than focusing on the legal source of their power, I asked my Coroner interviewees who they were responsible to,

> (Coroner) Do you know, it is a question I have never asked myself. I don't know, anyone who has an interest in the deceased, I suppose is the broad answer.

> (Coroner) Well, on one level, I have a statutory responsibility to do my job properly as complying with the statute, I am technically responsible to the Chief Coroner and the Lord Chief Justice, and I have got a wider responsibility to the public, to ensure I think that I am doing my job properly, and that I can identify circumstances that if remedied could prevent future deaths. And so I think I have got three comparative layers of responsibility.

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[130] Sir Thomas Bingham MR (as he then was) described the 1887 Act as moving the office 'into the modern era' see *R. v. North Humberside Coroner, ex p Jamieson* (CA) QB [1995] 1, 11C. Also see Melsheimer 1888, 4, and Impey 1817, 442 which describes an earlier statute as 'being wholly directory, and in affirmance of the common law.'

[131] Except Treasure trove, which remained and remains part of the Coroner's domain despite proposals for reform (including amendments to the role in unintroduced parts of the CJA 2009), see discussion in Matthews 2014, 399-417, and see an interesting historical discussion of law and practice in relation to treasure trove and the Corbridge Lanx in Dawson 2014.

> (Coroner) I suppose the relatives.
>
> (Coroner) I see it as a responsibility to society, to do your duty as best you can, as independently as you can, so public service I think is important, that is what I really try to do, it is an independent judicial position, very much with an emphasis on public service.
>
> (Coroner) I serve the people of [this area], that is my primary responsibility, I have no problem though in saying that I report to the chief Coroner. A lot of people think that being appointed by the local authority and being funded by the local authority, yes it is bizarre, but that it is a real problem. I see myself as a local officer, serving the people of [this area].
>
> (Coroner) Well the joker answer is God and the Queen. You are responsible for doing your job; I am not answerable to the local authority, I am not answerable to anybody really other than the duty to do my job well and if I am not doing it well I can be judicially reviewed, so I am an independent judicial officer with all that that implies.

From the pragmatic unreflective to the technical legal, and from an emphasis on judicial independence to an office embedded in intensely local foundations, these reflections demonstrate the range of ways in which authority is constructed from the perspective of the Coroner. They are important in two ways; firstly because they illustrate the thinness of a narrow, purely doctrinal account of legal authority focused on statute. Secondly, they are a group of reflections on questions of jurisdiction; questions of who belongs to the law of the inquest and who that law is properly addressed to: from relatives, to those with an interest in the deceased, from the local population to a wider public, and ultimately – the joker answer – to God and the Queen. They are about geographical and legal boundaries and the hierarchy in which the inquest exists, and they are bound up with questions of the representation of the law of the inquest. Critically, while there is engagement with questions of illegality – of the oversight of judicial review and the proper relationship with the local authority – they are also focused on lawful relations, described by Dorsett & McVeigh as 'a positive engagement with the offices, roles, and obligations and rights shaped by jurisdiction' (Dorsett & McVeigh, 2012, 55).

This focus on the creation of lawful relations further calls into question an account of the Coroner as solely responsible for the creation of lawful relations – as sole author of the law. The Coroner's role is central, but as the range of their reflections shows, their jurisdiction, and the jurisdiction of the inquest, is malleable and open to hermeneutic concoction. The flexibility of these foundations mean the inquest is perhaps uniquely responsive to the actors and factors which shape, grant or deny legitimacy and authority. Drawing on these insights, and adopting a jurisdictional perspective

focused on the creation and sustaining of lawful relations, the critical question is therefore not: what is the source of the legal authority of the Coroner? It is rather: how are different devices and knowledges combined to shape and represent a jurisdiction which has the authority of law?

Dorsett & McVeigh's key tool for such an analysis of jurisdiction, which endeavours to join the institutional life of law to representations of law's authority, is the concept of the technologies of jurisdiction, which they argue shape lawful relations. Technologies of jurisdiction are the devices or organisational structures which are ordered towards the production or embodiment of a jurisdiction. Those devices or strategies have a role in giving form to the way in which persons, places and events are bound to law and the representation of lawful relations. To identify these technologies requires us to focus our attention on material practices, on the craft of law.[132]

Crucially, this is an attention to what is often perceived as the procedural and the technical; to questions of who or what is within or outside the law, what devices give them authority in the law and how they are bound by law. They are questions of legal doctrine, of statutory construction and of legal technique, what Riles has described as the technical aesthetics of law (Riles, 2005, 976). In both the historic and contemporary inquest, there are two critical means by which the inquest jurisdiction is produced, by which people are bound to its law, and by which lawful relations are represented in the inquest: notification and enabling participation.

As argued above, the historic inquest was a place of law because of the gathering of the community, and it was notification and their participation which bound them to law and gave their pronouncements the representation of law. Their role, questioning witnesses, giving evidence, establishing a verdict or declaring a deodand, confronted, responded to and shaped the law of the inquest and the legal authority of the Coroner. As such, their participation highlights the need to focus not on the ultimate power to decide, but on the way that that power is formed in a specific case and the way that those specific cases are part of an ongoing systemic creation of a legal jurisdiction. As Chapter Three illustrates, this community role gradually diminished in the modern inquest, and as I now turn to argue, drawing further on an analysis from the jurisprudence of jurisdiction, it is the notification and participation of the family which makes the contemporary inquest a place of law.

[132] See further, Dorsett & McVeigh, 54-80.

Family at the centre

The representation of the law of the contemporary inquest emphasises the family's move from peripheral to central. In one example, in an interview on the Today programme on 25 July 2013, the Chief Coroner declared that the purpose of the procedures being introduced was to put the family at the heart of the inquest.[133] Ten months earlier, the then newly appointed Chief Coroner gave a speech in which he set out the two core functions of the inquest system: the 'need to know' and 'preventing future deaths.' In relation to the former, in the quote which I abridged in my introduction, he stated

> First, the public, especially the bereaved, family and friends, need to know what happened, how the deceased came by his death. That applies particularly to deaths in custody or at the hands of an agent of the state, where there is a wider duty to protect citizens from the wayward or mistaken actions of the state and to expose wrongdoing and bad practice. But it applies equally to all deaths where there is a real element of uncertainty. The public need to know. They have a right to know. It is natural justice, public justice and justice to be done in public, openly and transparently, for all to see, particularly the family. The family has now become, quite rightly, the focus for this public process, to give them answers, where that is possible. They are at the heart of the process as the Charter for Coroner Services[134] makes clear. (Thornton 2012a)

The account, when combined with the new procedural rights for the family, is one of enabling the possibility of convivial accountability. The focus is on meaningful revelation, with an emphasis on the importance of participation and connection through community. In contrast, the second core function focuses on an amorphous wider society who will be protected from risk through an emphasis on expert, rule-setting technocratic means. It is thus a philosophy of law for the inquest jurisdiction which sees the inquest as a space for combining the convivial and the technocratic, and the place of the family in that construction is central.

The shift of family from edge to centre of the legal process was gradual, and some discussion of the piecemeal changes to the law are important because they reveal and contextualise the dramatically new place of the family and the foundations of the technologies which bind the family to the law of the contemporary inquest.

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[133] In an interview relating to the introduction of the 2013 Rules and Regulations.

[134] The Charter (part of the Guide to Coroners and inquests and Charter for Coroner services 2012) has now been replaced by the Guide to Coroner Services (2014).

The 1887 Act includes only one mention of the relatives of the deceased, in s.18(6), in which it is provided that a Coroner holding an inquest can authorise a body for burial prior to the verdict, and if he does so he should deliver the burial order to 'the relative or other person to whom the same is required by the Registration Acts to be delivered.'[135] Otherwise statute law was silent as to their involvement in the investigation into death, but that was in the context of very few procedural rules about the way inquests should be managed. In the Coroners (Amendment) Act 1926, provision was put in place to make rules for the running of inquests, but a decade later, the failure to put such rules in place was decried by the Wright Committee, which described Coroners labouring under the 'disadvantage of having no general rules of procedure' (Wright 1936, 51). The Wright report did note that in practice it was common for family to be permitted to be represented, but it was at the discretion of the Coroner (Wright 1936, 55).

Rules were eventually made in 1953[136] which allowed relatives who notified the Coroner to be represented at the post-mortem.[137] In addition, the 1953 Rules provided that an otherwise undefined 'properly interested person' should be entitled to be informed of the hour, date and place of the inquest hearing, and to put 'relevant' and 'proper' questions to witnesses at that hearing.[138] Effectively declaratory of the pre-existing guidance on Coronial practice[139] the proactive family was permitted procedural entry, but their involvement was limited and circumscribed.

In 1980, new Rules were published.[140] Their explanatory notes describe them as amending the 1953 Rules, and note that for Rule 5 defines persons who have a right to examine witnesses at the inquest. The content of Rule 5 was repeated in the 1984 Rules, [141] which, according to their Explanatory Notes, were also chiefly consolidating, and their principal amendment of substance was the creation of a power to draw up an interim death certificate. However, the impact of Rule 5 of the 1980 Rules and its translation into the 1984 Rules was to define who was entitled to be involved

[135] Interestingly, for deceased members of both Church of England and non-Church of England, orders to bury could be delivered to relatives or persons responsible for the funeral, but for non-Church of England funerals only, an order to bury could also be delivered to a friend: compare Burials Act 1874 s.17 and Burials Act 1880 s.11.
[136] The Coroners Rules 1953 SI 1953/205.
[137]1953 Rules, R.4. Such representation had to be by a legally qualified medical practitioner, and the Coroner must notify them of the post-mortem. The rules did not include any right for relatives to request a second post-mortem, but it was subsequently held that the Coroner's power to hold a post-mortem is not exclusive, and they cannot refuse a reasonable request for a second post-mortem from an interested party (discussed further below). *See R v Greater London Coroner, ex parte Ridley* [1986] 1 All ER 37.
[138] 1953 Rules, R.16.
[139] As noted above, see Melsheimer 1888, 35.
[140] Coroners (Amendment) Rules 1980, SI 1980/557.
[141] Coroners Rules 1984 SI 1984/552.

for the first time.[142] The Coroner retained a general discretion to include any other properly interested person, but after 1 July 1984, for the first time, some family members had an automatic right to participate in the inquest hearing, although automatic and discretionary participants alike often continued to be described as properly interested persons. Furthermore, they were entitled to see documentary evidence used in the inquest, during and after the hearing (but not in advance)[143] and they should be notified if criminal charges were preferred in relation to the death. [144] In 2005 the category of automatic entrants was expanded to include civil partners and partners[145] while in the CJA 2009 this right shifted from secondary into primary legislation and the categories of family members were further expanded.[146]

It is this expanded category of family which is represented as at the heart of the contemporary inquest jurisdiction as a legal space focused on combining convivial and technocratic forms of accountability. Crucially, the family can be seen to be brought to law and bound to law by two specific technologies of jurisdiction: notification and the enabling of their participation. These technologies, despite their clear differences to the organising techniques of the historic inquest, have clear parallels with those devices which constructed the place of the community in the pre-modern inquest. The analogy with the place of the historic community is instructive, and I explore the ways in which they are similar or might be distinguished below. Furthermore, as my analysis below shows, these technologies were founded in the procedural requirements before the 2009/2013 reformulation, but they also represent a radical departure from the previous place of the family.

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[142] providing that a properly interested person would include a parent, child, spouse and any personal representative of the deceased; as well as any beneficiary under a policy of insurance issued on the life of the deceased, 1984 Rules, R.20.

[143] 1984 Rules, R.37 & 57 respectively.

[144] 1984 Rules, R.33. The rights in relation to notification of the post-mortem remained identical in the 1984 Rules, and in both Rules, relatives could request a different pathologist if the proposed pathologist worked in the hospital in which the deceased died. The 1984 Rules supplemented these rights with notification rights where material from the body was preserved, or where special examinations for toxicological or other purposes were to be undertaken. This right to be notified included the requirement that the relatives be told what material was being preserved or tested, the period for preservation, and options for disposal after expiry of period of preservation. 1984 Rules, R.9 & 12.

[145] persons of the same or opposite sex who lived together in an enduring family relationship, see Coroners (Amendment) Rules 2005 SI 2005/420

[146] to include brothers, sisters, grandparents, grandchildren, children of a brother or sister, stepfathers and stepmother, and half-brothers or half-sisters, see s.47 CJA 2009. Also the definition of partner was amended so that instead of an enduring family relationship, a partner was someone in an 'enduring relationship' - compare s.47(7) CJA 2009 with the pre-existing provision in the 2005 Rules.

Binding the family to inquest law I: notification

Under the 1953 and 1984 Rules, relatives were not automatically notified of a post-mortem; they were informed that it would be going ahead only if they notified the Coroner that they wished to attend or be represented at the autopsy. Writing before the 2009/2013 changes, Thomas et al (2008, 127) state that despite there being no statutory duty to notify, there were 'an increasing array of reasons why this should be done' citing 2002 Home Office policy, Article 8 ECHR, and case-law which 'has noted it is good practice to seek the views of the family prior to the post-mortem.'[147] The material practices of notification vary, from acting directly, through other family members or other agents of the State, including telephone calls and attendance in person, to written physical or electronic communications. Problems with communication have been a common cause of concerns and complaints raised by family members, including discrepancies in information and methods of notification.[148]

In response to this critique, the 'array of reasons' was superseded by a specific requirement in the 2013 Regulations that the Coroner 'must attempt to identify the deceased's next of kin or personal representative and inform that person, if identified, of the Coroner's decision to begin an investigation'[149] and further notification requirements then arise.[150] Notification primarily linked to disposal and management of the body, provided upon request, therefore became all-encompassing; linked to the initiation and inauguration of the inquest jurisdiction.

As with the requirement to call the community together to inspect the body, the requirement of notification is thus a technology of jurisdiction. Notification of the family is a device which is directed to the creation of the inquest as a place for establishing the law, and the involvement of the family is a critical part of that establishment. It is unlawful not to notify them; it is notification which calls the family to inquest law, and then notification represents the lawful part they are expected to play. Unlike the historic community, law does not act to overtly compel the acceptance of this place, but enables their engagement or structures itself around their acquiescence. As I explore in later

[147] See Thomas et al 2008, 127 citing the case of *Kasperowicz v. HM Coroner for Plymouth* [2005] EWCA Civ 44, 15.

[148] See inter alia Beckett 1999; Prisons and Probation Ombudsman 2013, para 4.1 and 4.1.7.

[149] R.6, Coroners (Investigations) Regulations 2013, SI 2013/1629, and see further discussion of the practice of notification in Chapter 5.

[150] Where an investigation requires a post-mortem, the Coroner must inform the next of kin or personal representative of the decision to hold a post-mortem, R.13, 2013 Regulations. Further notification requirements arise where material is preserved or retained (R.14) or a decision to discontinue is taken following the post-mortem; and reasons for that decision have to be given (R.17). The body must be released as soon as reasonably practical, and if more than 28 days has passed, the Coroner must notify the next of kin or personal representative of the reason for the delay (R.20). Additional notification requirements in relation to the process of the investigation and inquest are set out in the following section on participation.

chapters, the impact of their absence, from a system which holds them central and seeks to meet their need to know, is therefore more problematic and raises more existential questions about the inquest than the absence of a historic community, who could be directly disciplined if they did not respond to law's demands.

In relation to the body, this early notification of the family represents a shift in the representation of the family from residual recipients of the remains of their member, to active informed agents in the management of the body and the construction of an explanation for the death.[151] It also reflects the fundamental shift in the representation of the role of the Coroner – the Coroner is not just a custodian of the remains of an individual for a specific time and for a specific purpose, but together with their responsibility for the physical body, the Coroner must take custody of the relationship of the family to the body. This goes beyond granting a family member rights if they initiate contact with the inquest by permitting them to attend the post-mortem or carry out their own post-mortem.[152] Instead it is a proactive and structured role in which the defining characteristic is engagement, and thereby an acknowledgment and construction of the family's special relationship with both the body[153] and the inquest. Notification becomes the first step in shaping lawful relations in the inquest, demonstrating the lawful place of the family. It is the first step towards drawing tacit knowledge into the jurisdiction and seeking to constitute the inquest as a place of meaningful participatory revelation.

Binding the family to inquest law II: enabling participation

Once notified, the family take their place as privileged participants. The 2009/2013 changes give all interested persons, including family members, the right to disclosure on request and associated rights. However, the rhetoric of family at the heart, and the representation of the inquest system this rhetoric engenders, does more than simply give family the right to be involved. Critically, as the shift in notification illustrates, the inquest is a jurisdiction in which the place of family is not simply permitted, but is enabled and encouraged. A further illustration of this is found in the way in which the law has reimagined the purpose of the family's right to ask questions in the proceedings.

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[151] This move can be considered in relation to debates about dignity in the context of political and legal debates over ownership and control of bodies and body parts arising out of numerous high profile instances of retention of body parts and I return to consider this in Chapter Six.

[152] *R v Greater London Coroner, ex parte Ridley* [1986] 1 All ER 37.

[153] See Human Tissue Act 1961 s.2 and Human Tissue Act 2004 s.1 – once body released, permission of relatives needed before a further post-mortem is allowed. Also see Bristol Coroner ex p Kerr [1974] 2 All ER 719 and discussion in Thomas et al 2008, 134.

The historical development in statute law in relation to the family's participation in the hearing is outlined above; from a role outwith statute or caselaw, based in practice, over which the Coroner has absolute discretion to allow participation, to an automatic right to participate founded in primary legislation.[154] The impression is one of a slow and incremental development of rights, but, drawing on Riles (2005), attention to the legal reasoning in relation to the right to ask questions illustrates the depth of the radical rupture in the place of the family as participants in the contemporary inquest. Furthermore, this rupture illustrates a fundamentally different form for the inquest.

The historic position is described in the 1888 edition of Jervis, the leading authority on inquest law and practice,[155] in which it is stated that

> It is the duty of the Coroner to examine the witnesses himself, but he has a discretion, in cases where he thinks that it will be of any assistance, to allow questions to be put by, or on behalf of, persons interested. And after each witness has been examined, the Coroner should inquire whether the jury wish any further questions to be put. (Melsheimer 1888, 35)

As noted in Chapter Three, this involvement of the jury was framed as a crucial part of the process, while the place of the family is at the discretion of the Coroner. The purpose of permitting such questions is where the questions will assist – the family is framed as potentially capable of helping the inquest achieve its goals, but their role in questioning witnesses is not an essential constitutive part of that process.

Where the discretion of the Coroner to admit (some) family members' involvement was removed through the 1953 and 1984 procedural changes, the same logic for their role in asking questions remained central. This is clear in the leading case on the exercise of discretion by a Coroner when

[154] In addition to this automatic right to participate, a raft of notification rights are attached to the family's role as participants. New notification rights are set out in the 2013 Rules where an inquest is to be resumed (for example, after a criminal trial), (R.10), or is to be transferred to another Coroner (R.18). As well as longstanding requirements to notify of the date and the right to examine witnesses, the new rights also include a right to advance disclosure, and to consider views re witness screening and videolink. Notably, the Coroner is not required to notify family where a report is made to prevent future deaths; instead reports and responses to reports should be sent to 'every interested person who in the Coroner's opinion should receive it' (R28, 29).

[155] Melsheimer 1888. An indication of the esteem in which the analysis by the authors of Jervis is held is shown in the fact that the battered, binding-less copy of this 5th edition of *Jervis* held by the British Library is stamped 'Home Office, Under Secretary of State's Room.'

deciding who ought to be a Properly Interested Party, that of *Driscoll.*[156] The High Court reviewed the refusal of a Coroner to permit the participation of two sisters in the inquest into their brother's death. Under the CJA 2009 they would automatically be granted the right to participate, but in 1994 their application fell to be considered under the test of a 'person who, in the opinion of the Coroner, is a properly interested person.' The High Court held that there could be circumstances in which a Coroner could conclude that even a close relative (outside the automatic categories) was not properly interested.[157] In the key section of the judgment, Kennedy J held:

> What must be shown is that the person has a genuine desire to participate more than by the mere giving of relevant evidence in the determination of how, when and where the deceased came by his death. He or she may well have a view he wants to put to the witnesses, but there is no harm in that. Properly controlled it should assist the inquisitorial function.[158]

The role of individuals, even where their relationship is very close to the deceased, is focused on assisting in the inquisitorial function. The boundaries for that inquisitorial function are determined by the Coroner, and so from the perspective of the law, the focus of the family remains on assisting the Coroner. There is no caselaw dealing with the reason for permitting automatic entrants to ask questions, but the logic and reasoning remains the same from the historic inquest. That involvement may be of value, but they pose a risk to proceedings if they are not properly controlled and directed to the purpose of the enquiry. Their view of the case does not cause harm as long as it assists with the investigation, and they must be corralled so that irrelevant or illegitimate questions are organised out of the process. This is part of a narrative in inquest law in which the family 'not infrequently strain to pursue their quarry well beyond the bounds set by the Coroner.'[159] The Coroner sets the boundaries in the quest to seek answers to the questions required by statute, and within those boundaries, the family's participation is tolerated because it might make for a more effective investigation.

Instead of an opening concern with risk, the contemporary inquest jurisdiction re-establishes the place of the family's right to ask questions as part of their necessary effective participation, founded

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[156] *R v. HM Coroner for the Southern District of Greater London, ex parte Driscoll* (1993) (1995) 159 JP 45: 1994 COD 91: Independent, November 22, 1993.

[157] A conclusion which now seems difficult to sustain, following Platts v. HM Coroner for South Yorkshire [2008] EWHC 2502, see discussion in Chapter 7.

[158] Driscoll, (1995) 159 JP 45, at p 56B – G.

[159] R. v. North Humberside Coroner, ex p Jamieson (CA) QB [1995] 1.

in the construction of the lawful place of the family. In jurisprudential terms, the critical technology of jurisdiction is directed at enabling their participation, as it is this enabled effective participation which shapes the character of the law of the contemporary inquest.

This development can be first seen in Strasbourg jurisprudence relating to Article 2 ECHR, but deploying a key piece of judicial historicisation,[160] Lord Bingham pulled pre-Human Rights Act inquests into line with that jurisprudence in the key case of *Amin.*[161] In the application by Imtiaz Amin, uncle of Zahid Mubarak, a young man killed by his racist cellmate, Lord Bingham stated it was 'very unfortunate that there was no inquest, since a properly conducted inquest can discharge the state's investigative obligation [under Article 2 ECHR], as established by *McCann v. UK*.'[162] In his discussion in relation to the duty of the state to investigate deaths in custody, Lord Bingham found that

> effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.[163]

Along with a series of other key cases in the early 2000s, Lord Bingham's decision in *Amin* established a sometimes uneasy relationship between the requirements of Article 2 ECHR and the inquest system, and his characterisation of the inquest as providing space for family participation was a critical legal manoeuvre permitting the joining of the two jurisdictions. In the same case, he went on to what family participation might look like. He discussed investigations by the Prison Service and the Commission for Racial Equality, and dismissed them as insufficient because, in part,

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[160] His move, inventing a traditional place for the family in inquest law, is perhaps akin to the invented traditions of Hobsbawm (1983) as a practice of a symbolic nature which establishes a continuity with the past, a response to 'novel situations which take the form of references to old situations' (Hobsbawm 1981, 2).
[161] R (on the application of Amin) v Secretary of State for the Home Department [2003] UKHL 51, [2003] 4 All ER 1264.
[162] *Amin,* 33.
[163] *Amin,* 31.

> the family were not able to play any effective part in [the] investigation[s] and would not have been able to do so even if they had taken advantage of the limited opportunity they were offered.[164]

The crucial emphasis is on the effectiveness of their participation. A later case reflects further on the question of effectiveness, holding, in relation to public funding for representation at an inquest that

> the [Article 2] duty on the state is fulfilled by the Coroner's effective investigation. But, for the investigation to be effective, the family must be able to play an effective part. So, the [question] is whether [representation] is necessary to enable the family to play an effective part. In other words, the decision must focus on the effective participation of the family and not on the needs of the Coroner.[165]

The focus is on the question of the substance of their involvement. An effective investigation by a Coroner can only take place if the family are effectively involved. This does not only apply to the investigation, but to the hearing itself, and by paying close attention to the form of the technical argument, the place of the family in that hearing is revealed. The needs of the Coroner are dismissed, as is the formal right to be involved, and the central issue is the question of the needs of the family, not whether they can assist the inquisitorial function. As a later excerpt from the same case shows, it is not a question of their understanding, and is not about being able to have their concerns raised and dealt with, but is specifically about the substance of their right to speak:

> the [guidance states] that the starting point for consideration of whether funded representation will be necessary is that in the majority of cases the family will be able to participate effectively without the need for advocacy services. It is said that the ability to attend and understand the proceedings together with an opportunity to raise any particular matter of concern with the Coroner will be sufficient. ... [this] seems to overlook the right of a close family member … to question witnesses. Of course some family members will be able to exercise that right competently, although I think it will often be difficult for them to do so. But to suggest that in general it will be enough for them to be able to tell the Coroner of their concerns seems to me to contemplate that they can properly be deprived of their right to question witnesses.[166]

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[164] *Amin*, 37.
[165] *R (Humberstone) v. Legal Services Commission* [2010] EWCA Civ 1479, 79, and see McIntosh 2012 for discussion of the case and the purposes of an Article 2 inquest.
[166] *Humberstone*, at 79.

The right to ask questions, characterised as centuries-old by Lord Bingham, and enshrined in legislation since 1953, is reimagined. The shift is a critical one. From, at best, a helpful adjunct to the Coroner's task, their endeavours subordinated to the inquisitorial function, the right to ask questions signals a jurisdiction endeavouring to combine accountabilities.

This right – arising in all inquest cases, not solely in Article 2 hearings[167] – would be substantially denied if the family's role was limited to listening, understanding the evidence and telling the Coroner what questions they might have. The implication is that the content of the questions they might ask does not characterise their role, and neither does the substance of their concerns,[168] but instead it is the form of their right to ask questions which is key. In this productive interplay between form and substance the family shifts from an assistant in an exercise in expert discernment to a collaborator in meaningful authentication. The familiar legal move in *Humberstone* between form and substance might be framed as instrumental in pursuit of substantive objectives (Kennedy 1976, 1776), but the reappearance here of a changed form of the family in this procedural rule reveals the deeper changed form of the inquest. As the effectively participating family becomes analogous to the effective investigation, the family becomes an analogy of the community in the historic inquest; called to law at its inauguration; enabling and constituting that inauguration; unexcludable from the inquiry;[169] vitally empowered in the construction of the narrative of the inquest; bringing the texture of tacit knowledges and connections to the deceased into the space of the law of the inquest.

Conclusion

This chapter seeks to take the possibility of a revival of convivial forms of accountability seriously, and to explore how concepts of law relate to the possibility of a combination of convivial and technocratic forms of accountability, through a focus on jurisdiction. In so doing, I seek to explore the way in which an endeavour on the part of the contemporary law of the inquest to combine

[167] And notably not all Article 2 cases (ie, non-inquests) require the ability to ask questions, see for example *R. (on the application of Mousa) v Secretary of State for Defence* [2013] EWHC 2941 (Admin).
[168] These are secondary issues – as irrelevant questions remain capable of exclusion by the Coroner, 2013 Rules, R.19(2).
[169] Unlike the public who can be excluded, see 2003 Rules R.11(4) & (5), and see also *R. (SSHD) v Assistant Deputy Coroner for Inner West London* [2010] EWHC 3098 (Admin) and the way in which the European Court distinguishes between the role of next of kin and the wider public in Jordan v. UK: '... there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests' *Jordan v. United Kingdom* (2001, App.no. 24746/94) [2003] 37 E.H.R.R. 2, para 109, approved by Lord Bingham at para 43 of his decision in *Amin.*

accountabilities constructs a place for the family, and seek to draw possibilities of justice from that place and from my account of the role of combined accountability in the law.

My account of law focuses on the systemic, the procedural and the technical questions of law, as well as the way in which the jurisdiction is represented. The law of the inquest is thus not just an official account of death and is not just the form of the procedures which govern the conduct of the space. It is also a question of the textures of lawful relations in the gathering of the inquest, created and revealed through practices of jurisdiction. It is an account of a jurisprudence formed by the joining of accountabilities, but it is also bound up with an ongoing concern with risk, ever present in the possibility of a breakdown in the potentially fragile relationship between structures and formulations which enable different modes of revelation, explanation and justification. The engagement with family is an endeavour to control risk, to join the contingent and contextual to the legal order to produce a process and an official account which encompasses and manages risk. In doing so it carries within it the risk that the endeavour will fail, that an absence of participative family will leave the inquest reliant on a legal order which is narrowly authorised by technocratic conceptions of accountability alone. It is in these relations that the family emerges in the contemporary inquest, and through these means that the claim of centrality can be understood and joined to an account of law.

Critically, this account is one in which the law is represented as enabling family to co-construct; in which the inquisitorial function and the law and procedure of the inquest is shaped by the effective, notified, encouraged family, and in which the authority of the law flows from that representation of jurisdiction. Unlike Tait & Carpenter (2014) for whom therapeutic approaches to family are a new and distinct theme from older themes of medicine and law, this account places family as the heir of community and as central to the law of the inquest. However, unlike the historic community, the family's power to speak the law is not encapsulated in the authority of a verdict, or materialised in the form of a deodand. Where the law of the historic inquest was inaugurated by the gathering of the community, in the contemporary inquest there are more blurred lines between the legal authority of the Coroner and the inquest, making the inauguration of the law of the contemporary inquest a more complex, piecemeal, and crafted process. It is a process in which the family must be called and they must be at the centre.[170] As such, the family is perhaps more critical to the representation of the law of the contemporary inquest than the community was in the historic inquest. Where the historic inquest saw the community gathered metaphorically, if not actually,

[170] It is this constitutive role where my account perhaps differs from those engaged in exploring a therapeutic jurisprudential approach to the inquest.

around the body of the deceased, the contemporary inquest gathers metaphorically around the family.[171] The critical question for the contemporary inquest – a question which I seek to address in my next chapters – is therefore how that gathering is framed: as facilitative, as comforting, or as captivity.

[171] Perhaps a legal fiction, but if so, drawing on Pottage (2014, 156, discussing Thomas (1995)), perhaps a fiction operating not at the level of metaphor but as an 'effective legal construction.'

Chapter Five: first contact, the next of kin and framing

Introduction

Family appear in the statutory framework which has reconstructed the inquest through two devices: the next of kin, and the interested person. This chapter takes the first of these, and examines the ways in which the system initially engages with the family and next of kin. The aim is twofold. The chapter first sets out an account of the initial contact and early engagement between the officer and the family, and then moves to the initial contact between the Coroner and the family, but I also use this account to set out my argument for a naturalistic analysis of the inquest as a system. This approach includes consideration of the role of law as well as typification and routinisation, serial decision-making, and materiality. My contention is that first contact is a key part of an account of the family and the inquest, but is often treated as peripheral from a legal perspective. When it does arise in analysis of the inquest, it is generally in the context of criticism of the way in which the family are told of the death and the details of the investigation, through a lens of lessons to learn.[172] While these are important issues, I seek instead to reflect on the constitutive implications of this first engagement for the inquest and inquest law.

Decision-making in the inquest system

There are two key references to family in the legislation governing the conduct of Coroners and the inquest – next of kin and the list of interested persons in s.47 CJA 2009 (together with caselaw governing when Coroners should exercise discretion to include others[173]). As discussed in Chapter 4, there has been an incremental development in who falls into the category of interested person but the opening obligation to involve the family now focuses on 'next of kin', as set out in Rule 6 of the 2013 Regulations which states:

> A Coroner who is under a duty to investigate a death under section 1, must attempt to identify the deceased's next of kin or personal representative and inform that person, if identified, of the Coroner's decision to begin an investigation.

'Next of kin' is not used in the 2009 Act and first appeared in the 2013 Regulations. As the most recent edition of *Jervis on Coroners* notes, 'The phrase "next of kin" has no current technical meaning in English law and it is surprising that it is not defined for the purposes of the Coroner legislation' (Matthews 2014, 169). The documents accompanying the legislation do not assist in defining the phrase, as the only relevant reference in the Explanatory Memorandum for the 2013

[172] Luce 2003, 142-152; Prisons and Probation Ombudsman 2013, para 4.1 & 4.1.7. Also see reflections in Beckett 1999, 273; Davis 2002, 27.
[173] Further discussed in Chapter 7, and also see discussion of relatives and the body in Chapter 6.

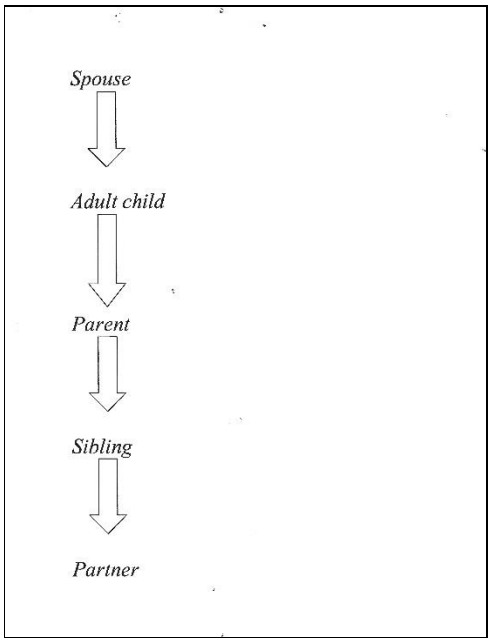
Regulations is an undefined reference to putting 'the needs of bereaved people at the heart of the Coroner system.' Matthews further notes that

> the phrase next of kin is used to denote a person or persons who should be informed of various stages or events in the investigation. It is always an alternative to the deceased's personal representative. Closeness to the deceased, ability to receive and act on information and smallness of number are more important for these purposes than, say, the rules of inheritance or the principle of representation, which work better for the (passive) purpose of obtaining a share in the deceased's estate. And marriage or civil partnership is closer even than blood. (Matthews 2014, 170)

This final assertion is based on the order of individuals in s.47, but, perhaps surprisingly, does not indicate whether Matthews considers that non-married partners are to be considered in priority to blood relatives (as they are in the ordering set out in s.47(2)(a) CJA 2009). In contrast, an officer I interviewed was clear on how to decide this point, as they had guidance,

> (Ed) I'm interested in next of kin – where does it come from? If you have someone who has a brother and a sister, how do you decide which one is next of kin?
>
> (Officer) We have got a list.
>
> (Ed) You've got a list?
>
> (Officer) On my wall, the priority of who would be first.
>
> (Ed) Could I have a photocopy of that by any chance?
>
> (Officer) Yeah, will have to think where, I've put it on my wall somewhere

After the interview, the officer gave me a copy of the list from somewhere on the wall. It had come from a training course the officer had been on and I reproduce it below:



I found the lack of reference for its baldly asserted hierarchy fascinating. As such, it generates its own authority; a source-free statement of law to which no lawyer would automatically accede but which represents law, structuring the approach of those administering the law. Its location is also important; putting it up on the wall further reinforced it as authoritative statement; a tool for quick reference which summarises the norms to be applied in case of dispute. But it had also disappeared on the wall somewhere, and instead of being a rigid hierarchy, had become a flexible guide;

> (Officer) But you would tend to phone whichever one on the list. You would just pick and sort of get an idea, you know, obviously 'I've got your details and your sister's details, which one of you is it best to contact?' And usually they say it's best to speak to me or actually can you contact my sister that would be better and they usually sort it between themselves. Again if they both wanted to be contacted then we would contact both of them but majority of time they would, usually they are all together anyway and talking to one of them so just go through me, so yeah, it is usually not a problem.

The first contact, with whoever was on the list, is therefore key to creating the place of the family. As 'they usually sort it out between themselves', it is a first engagement which indicates the potential flexibility of approach and a concern with pragmatism and practicality, with the possibility that next of kin is not a single point of contact but is a shared responsibility. I explored the same issue in interviews with Coroners, and asked one Coroner specifically how they decided who family was,

> (Coroner) Well, that is a very good question. Technically of course, we have got s.47 of the CJA 2009, which spells out the identifiable, what we might describe colloquially as, next of kin. But my normal sources of information are either going to be the hospital if it is a hospital death to identify primary members of the family, or if the police are involved then police to identify members of the family. It will be impossible to contact each and every family member, we normally would go to, obviously the spouse if there is a surviving spouse, mother and father, a brother or sister if they were taking an interest, but there can be family and I have dealt with them before where there are loosely competing interests between for example the brothers and sisters. I had a case where a sibling was in complete logger heads with another sibling, and applied for an injunction to stop me releasing the body to his sister. They were at each other's throats, so we try and be as inclusive as possible, can I say hand on heart that we succeed every time? No I can't, we try and do our absolute best to make sure that we know.

As these answers demonstrate, the question of who is next of kin is perceived to be a technical legal question capable of being conclusively identified (as Atkinson found with the meaning of suicide Atkinson 1978, 90), but treated practically as a question which is open to negotiation and determination by the people within the category of family. In addition, the answers demonstrate other features of the relationship between the legal form and the decision-makers in the system, including the important role actors outside the inquest system play in decisions about who to notify.

As Matthews (2014, 170) suggests, the emphasis is on closeness of link to the deceased as well as the ability to receive and act on information, but also importantly, to disseminate that information. The answers illustrate that for many of my interviewees, the emphasis from this very first engagement is on informing the entire family, not simply notifying a single next of kin. As such, part of the role and responsibility of a next of kin is to engage the wider family, and they play a critical role in defining who that wider family is.

This emphasis on notification and engagement with the family beyond a single next of kin, and if necessary, notifying and engaging with more than one family member, is limited by considerations of practicality. This includes taking into account available resources, highlighting the importance of material considerations in decision-making, including methods of making and maintaining contact. As one Coroner said

> sometimes families, you can send them material, written material, and you can tell a bereaved person the same thing ten times but they will still ask you the 11th time, it won't

> really sink in … is often that if you speak to a family you can get so much more across than writing long letters.

It was also noticeable that there was very little reference in my interviews to personal representatives. As Matthews (2014, 170) notes, there is no provision enabling individuals to nominate another individual to be their next of kin for the purposes of an inquest. The only way in which an individual could lawfully nominate another to act on their behalf would be by appointing them as executor in their will[174] but a personal representative and next of kin are not the same, and there was no references in my interviews to personal representatives. The clear implication is that the wishes of the deceased are not central to the decision,[175] and that the next of kin is perceived to have priority over any personal representatives.[176] Finally, as subsequent examples show, there was a clear preference for making decisions about who was next of kin informally wherever possible, and only resorting to formal declarations where it was perceived to be necessary.

Critically, these insights from my interviews, together with reflections from my historical and jurisprudential work demonstrated the limitations of a positive approach which ignores the interpretative work which goes on in these processes (as argued by Tait & Carpenter 2014). It is also critical to my approach to avoid an overemphasis on the determination of a discrete case by a rational individual – an approach which can act to disconnect decisions from their contexts. My contention is that an account of the engagement of the family which only engages with the explicit final 'legal' decision of the Coroner (if there is one) is incapable of providing an account which engages with the subtlety and nuance of the interactions which combine to create a place for the family in the inquest. The way in which family is involved includes decisions through deployment of law, but they are also often made in a context in which the explicit rules are not definitive and are in any event only a part of the process of deciding (Gilboy, 1991). Such an approach also ignores the central role of the officer. Drawing on insights from Hawkins (2002), I turn in the next sections to set out systemic features which are key to the construction of a place for family, drawing on the initial contact and engagement between the family and the officer. Much of this discussion draws on the ways in which my interviewees responded to the four vignettes I set out in the introduction – the

[174] Compare, in this regard, the different treatment of family and non-family personal representatives before the European Court of Human Rights; contrast Scherer v. Switzerland, Application no. no. 17116/90 and Thevenon v. France, Application no. 2476/02 with Malhous, Dec. Application no. 33071/96.
[175] A reflection which can be compared to reflections on testimonial autonomy, see Monk (2011 & 2014), Douglas (2014), Hacker (2014), Leslie (2014).
[176] Further reinforced by references in interviews to the fact that even if estranged/out of contact, family members had an important role to play if they got involved in the inquest.

non-adopted daughter and the missing wife (Vignette 1), the girlfriend (Vignette 2), the mother, biological father and the new partner (Vignette 3) and the long lost sister (Vignette 4).

Routinisation and typification

Vignette 1 provided particularly revealing answers in relation to the role of law in approaches to the next of kin, with some references to the law noting that the missing wife was still legally next of kin. However, all interviewees answered that the non-adopted daughter would be likely to be involved in a significant way, even possibly, through negotiation, taking precedence over the wife:

> (Coroner) I think the daughter would be entitled to disclosure and probably would be entitled to the body but the wife has precedence and I would expect reasonable steps to be taken to try and chase down the wife. What happens on the ground really is that there is then a conversation between the wife and the daughter, they say I have never seen him, I am quite happy for you to take the body. That is what really happens on the ground in this sort of situation, they speak to each other and people are very civilised, usually.

This illustrates a common theme across all interviews that the non-adopted daughter would be accepted as next of kin despite the lack of formal relationship. The answers re-emphasised the potentially critical place of the first contact in acceptance and precedence of kin;

> (Coroner) Well, the daughter at the moment is the only person who you have got, so she automatically becomes an interested person at the outset, by virtue of her being brought up as a daughter, other people may well emerge, and we will clearly be looking for them, and they may also be interested persons.

The non-adopted daughter is thus automatically rendered an interested person and next of kin and they will be 'clearly' actively seeking others. Alternatively, her role may not be stated to be automatic, but

> (Officer) You would treat her as his daughter wouldn't you, she is his daughter, she might not be adopted by him, but she is still to all intents and purposes his daughter, you would treat her as his next of kin.

The length of time is important,

> (Officer) she's saying she's lived with him for 35 years she's not aware of anyone else, we would have to accept that she's not lying to us.

And in relation to their investigation

> (Ed) would you ask [the daughter] for details of the wife if she was able to give them?

> (Officer) If she was able to give them, I would just like to know, I mean, legally speaking his wife is still the next of kin, and I mean, I guess there would be some sort of duty down the line somewhere for her to be informed that he had died, and we would ask the police to do that on our behalf, but if the daughter didn't know that we might make some inquiry with the police to see if they can find this individual, but I think we would tend to stick more with the daughter to be totally frank.

In these responses, it is clear that what is at stake is not an application of the technical legal principles, but rather an amalgam of those principles with other considerations, and an insistence on considering the context in which the relationship arose. Crucially, central emphasis was placed on a long standing assumption of the role of daughter, and the instrumental use of that relationship in the inquest as a form of 'fictive kinship' (Al Haj 1995; Jacob 2012). As with the test for interested person status (discussed in Chapter 7), the question is one of the whole of the relationship and it was relevant that the relationship mirrors a familial relationship.[177]

The importance of context was illustrated in another exchange I had with an officer in relation to the biological father in Vignette 3. The opening information given by the mother in the scene set in the vignette was key to the way in which officers and Coroners would engage with him, but importantly in this account, the biological father's initial interactions with the officer would also govern the way in which he was enabled to engage in the inquest. I asked if the officer would take steps to seek the father, and the officer stated no, but if he turned up

> (Officer) We'd have to, you know, weigh up the pros and cons, because, but you know, we would cross that bridge when we come to it.
>
> (Ed) So weighing up the pros and cons, what sort of things would you be wanting to find out or wanting to know in that?
>
> (Officer) What if he came to us? He would have to come to us, we would not go to him, because basically we are saying there that, she doesn't want him told, well I mean that is a matter for her, nothing to do with us, but he is going to find out that his daughter has died, unless he is in Antarctica or somewhere like that, it is going to be in the press isn't it, and he is going to read it, and he may well then make approaches to us, for information, and that is when we would then have to consider his ex-partner. When I talk about weighing up the

[177] See R. v. Coroner of the Queen's Household ex parte Al Fayed (2001) 58 B.M.L.R. 205; [2000] Inquest L.R. 50 and Platts v. HM Coroner for South Yorkshire [2008] EWHC 2502, but noting that these are cases relating to the test for interested person status, not next of kin.

> pros and cons, you just can't sit here and go well, I'd look at that and I'd look at this, because every case has its different merits and different difficulties, so you have to look at it in isolation at the time, I think in the long run you would talk to them, you would certainly start off by talking to the chap, and then you would be taking things on from there but for me to say now what I would do, I couldn't do that, unless you said to me, well, you know, this is what he is like, what are you going to do now?

This lengthy answer illustrates the emphasis on flexibility and responsiveness to the facts as presented to the inquest, but also demonstrates the way in which the actors can be framed as essentially reactive, responding to the presentation of events and information, and critically here, to the way in which the absent father presents himself.

A core theme of many interviewee's responses emphasised the role of family in gathering and providing information to the inquest, and the special place of the family is constructed in the way in which the family are given responsibility for individualising the deceased; fashioning context and history, providing feedback on the process and setting out concerns. As such, the family have a responsibility for reintroducing contingency in the investigation, and possibly providing a counterweight to processes of typification.

In his work on decision-making, Hawkins argues a critical aspect of examination of holistic decision-making is the need to pay attention to the role of typification, or the way in which routine decisions are made the same way (Hawkins 2002, 35-38). Typification is a means by which individual decision-makers can act more swiftly, ordering their work and sorting the routine from the complex. This categorisation of routine decisions, relying on experience, can provide a defence against criticism and justify a particular course of action. In this context, it is important that my interviewees all reflected on the importance of experience, with both Coroners and officers placing importance on the place of experience in being able to do the job properly. In one example, an officer's answer illustrated the importance of experience and made clear that the very first engagement with family was key to the way in which they were framed, with, in this answer, a concern with families seeking to establish blame for the death;

> (Officer) From first point of contact you can usually get an idea of what kind of family you are dealing with, you can get quite a good idea. The more and more you do it the more and more you get it.
>
> (Ed) Ok, so that is experience?
>
> (Officer) Yeah, absolutely yeah.

The crucial aspect of experience here is that experience is valuable for being able to 'deal' with the family, including gathering information from them, and engaging them in the investigation. Experience enables the actors to reach decisions more quickly, and in their view, enables them to better respond to the family's concerns, or to eliminate the risks which arise from a family expressing illegitimate concerns. In one example, I asked an officer whether they would act differently if they thought a family was seeking to place blame on someone else in an inquest

> (Officer) Yes probably to be perfectly honest. There are certain people who would "quote" you [*made quote marks in the air*], well you told me this and it might not even be in the right context, but yes, we are aware that people can take things you say and twist them a little bit to get, to get, what I am I trying to say, to get an advantage over you but yes, some families you would be aware of what you were telling them, obviously you would tell them what they were entitled to but you wouldn't expand on things that you don't need to.

In this account, the risk posed by a family challenging the officer leads to an engagement of the family focused on providing the minimum required, rather than enabling them to play a more expansive role.

Processes of typification can also mask aspects of a situation, as decisions are made that assume particular features of a case, drawing on information from referrals (Emerson 1991). An example of this in the Coronial context can be found in the ethnographic study of the inquest system by Atkinson in the 1970s, and his observation that deaths on the road were not generally investigated as possible suicides (Atkinson 1978, 118).

However, it is also important to explore how their own awareness of the impact of routinisation can affect decision-makers. In the inquest context this awareness is reflected in the two discourses already discussed: the emphasis on the need to get and give information to the family to individualise the deceased and distinguish them from the routine, and the repeated emphasis on responsiveness to the particular facts of the case. A doctor might say who the next of kin is, but could then say,

> (Officer) You might want to speak to the daughter rather than the wife. Especially with very elderly people, a lot of the time it is not necessarily appropriate to speak to the wife, it may be better doing it with the children but it is all dependent on the situation, ascertain the actual next of kin and start at that point go from there.

Similarly,

> (Officer) Sometimes if you get a next of kin, like if I have an elderly gentleman, really confused, doesn't really understand what you are saying so we then would say, is there someone else there or have you got a relative that we might be able to contact? Then you would go through that person as well, obviously keep that person aware of what we are doing but just so that we are 100% sure that that next of kin knows exactly what the process is because you sort of get the idea that he may not be sure of what is happening so yeah, we would then take it to find someone else to give the information to as well.

This important role of the family is amplified by another consequence of typification; the way in which it can produce administrative precedent, whereby organisational and administrative rules can take on the same force as legal rules (Hawkins 2002, 36). As the priority list provided to me illustrates, administrative rules of unclear provenance can take on the force of legal rules, but even as they appear to be binding rules, the actors may not act as if they are bound by them, and instead seek to solve problems as they arise (Hawkins 2002, 40). In this context, hard line rules can create particular difficulties and apparent injustices;

> (Officer) I suppose one of the main difficulties is, if someone has been with someone … 20 odd years, not married and there are children, things like that. Sometimes, depending on how the relationship went down with the family, that can be a bit of bother. Obviously there are certain things – common law marriage and cohabiting and other things like that – but it is difficult if you have got someone who has been with someone for say ten years and they might have never married and they have got a daughter, and she's like 'no I'm next of kin' but you are not married and it can be hard because obviously she's lived with that person day in day out, but they just didn't choose to get married. Sometimes can be hard.

Hawkins observes that attention has to be paid to the way in which general rules are translated into decisions made on the periphery; such rules may be regarded unfairly binding or open to broad variation, as examples above have shown. He argues that this does not mean rules are irrelevant, but that is important to explore, given such variety, how rules are engaged with at the periphery; perhaps through translation into simpler concepts (with the simplified list of next of kin), and perhaps through an engagement with rules as formal justifications for actions. In the inquest, such engagements can be seen to be particularly varied because of the enthusiasm for competing approaches to conceptions of the centre and the periphery of the system; the centre could be variously, the High Court, the Chief Coroner or the local Senior Coroner, whilst the periphery moves from the whole of a Coronial district to the decisions of the individual officer.

In contrast to this variability, a positivist analysis focusing solely on statutory rules as basis for decisions would suggest that once next of kin was notified and those family members who expressed an interest were enabled to participate, the duties of the Coroner and officers would be fulfilled, with any other relationships exercised as a matter of individual discretion. However, the systemic emphasis on family involvement generates additional requirements; including the exploration of whether the next of kin is able to contact other family members, and for some of my interviewees, direct notification of family members other than the next of kin as an apparent responsibility. In these circumstances the jurisdictional tool of notification goes beyond a technical legal rule, and becomes representative of law; it is binding beyond law's requirements and essential to the character and authority of inquest law that someone is found to be notified, and that every family member who might be interested is engaged with the investigation, as far as is possible.

Sequential decision-making

This requirement to notify widely, and the reference to 'hard cases' in the quote above highlights another crucial feature of the way in which decisions about next of kin are made; the role of sequential decision-making processes, and the importance of decision-makers outside the inquest system. It was emphasised by many interviewees that the ultimate decision in relation to next of kin status was not a decision for the inquest system; that if family members disagreed about whether they were next of kin, they would need to go to court to get a decision.[178] It was also emphasised that decisions taken within the inquest system would often rely on decisions taken by actors before the inquest system was engaged, and the role of the decision-makers in the inquest was consequently circumscribed. For example, in relation to the missing wife in Vignette 1, officers suggested they could make some investigations themselves (with some noting that they could check marriage registers or use a company to investigate), and Coroners stated they would expect inquiries to be made, but most of my interviewees emphasised that,

> (Coroner) There is a limit, officers are not expected to go to unreal lengths to trace family and everyone else, so if she says to you there is a husband, it is not for the officers to go round searching all the counties' telephone directories or whatever.

[178] Whilst there is no caselaw directly on this point, this assumption does not appear to be correct. In the event of dispute, the courts have jurisdiction to determine who is entitled to determine how to dispose of a body (see Conway 2003) but the question of who is next of kin for the purposes of the inquest is not necessarily the same (although it is closely linked, as the discussion in Chapter Six illustrates). The decision is therefore the Coroner's, subject to the jurisdiction of the High Court in the event of a perverse or irrational decision.

At this point in this interview, an officer came in, and the Coroner took the opportunity to ask what steps they would take. The officer stated that they would ask the police, who would check CRIMINT, the police intelligence database.

> (Coroner) So the police do it, and if that comes up negative, we are not going to go running. We say to the daughter well, we haven't managed to find him, and it may be for witness statements something will come up, or very often when someone has died people come out of the woodwork.

As this (and similar references to 'the woodwork' in other interviews) illustrates, family can emerge as part of the inquest process, and it was clear that the interviewees were used to responding to ongoing situations where individuals sought to be involved as the investigation developed. This quote also illustrates a common theme of the role of trust and expertise in systems of decision-making. As the fortunately timed interruption by the officer shows, my Coroner interviewees expected their officers to have expertise and to act on initiative, with perhaps some assistance or guidance:

> (Ed) You would just say to your officers I think you should try and find them and your officers would?
>
> (Coroner) Well that is their department, I mean we might brainstorm it together – can either of us think of any other avenue we can explore.

A positivistic analysis of decision-making presupposes that a final decision-maker is provided with factors and has a range of possible decisions, whilst a systemic approach seeks to explore how earlier decisions can shape, require or avoid a final 'legal' decision. These earlier decisions range from a formal explicit decision to implicit informal and unevidenced or hidden decisions and might mean that effective power to decide might thus be consciously or unconsciously exercised by individuals not granted the formal power to decide (Lukes 1974).

Importantly, the Coroner and their officers operate in a system in which the police and other agencies have some responsibilities for the efficient conduct of the investigation;

> (Officer) As far as we are concerned, it is down to the police to track down next of kin, they do obviously present themselves when, you know, they'll realise something, they'll hear through the grapevine locally that something has happened, then they'll telephone us, and things sort of unravel a bit or become clearer but initially we have the one point of contact and find out as much as we can as we go on.

Furthermore, as with 'big' – i.e. newsworthy – cases in regulatory authorities (Hawkins 2002, 35), 'big' inquests have more serial elements, with greater scope for the decisions to be shaped by decisions taken in external investigations by, for example, the police or investigatory/regulatory bodies like the Independent Police Complaints Commission[179] as with the long-lost sister in Vignette 4;

> (Officer) In a case like this, she would probably come to us via the police. People don't necessarily think to contact the officer first, if someone has died in police custody, they would ring the police first and then they would speak to the investigating officer who would get the details and often we would then get a call saying this woman has rung up she is the sister and give us the telephone number and we will contact them. We don't sort of take everybody on trust, but it generally pans out that they could make an inquiry and people who aren't legitimate wouldn't go through the police.

The long standing relationship between the police and the inquest system has been the subject of a great deal of academic discussion and criticism,[180] but they are only one in a range of actors who can make important decisions which affect the inquest as another officer emphasised;

> (Officer) a death in the community, in hospital, or an expected death we may have GP or hospital doctors contact us and we may be able to get the next of kin details from them as well, and a lot of time they might advise us who the best person is to talk to and who they would prefer to be our point of contact.[181]

Furthermore, it is not only State agents, but the actors also regularly have to trust the family, as excerpts from four separate interviews illustrate;

> (Officer) unfortunately we have to trust what the police provide us as next of kin or Doctors or GPs, and just speaking with the people that you have got details for and trusting what they are saying to you.
>
> (Coroner) it is slightly a question for the officers what level of proof, I would take people on trust.

[179] See INQUEST (2013).
[180] see, inter alia, Cowburn 1929; Thurston, 1962; Scraton, 2002.
[181] See, inter alia, on the relationship between doctors and the inquest system, Gilleard 2008; Tuffin et al 2009; Barnes, Kirkegaard & Carpenter 2014.

> (Officer A) The problem is with identification of next of kin obviously we can only do so much establishing who that is because we are not private detectives. (Officer B) And we trust people don't we, if they say, we are next of kin then we don't argue
>
> (Coroner) Well, we can ask who she is, but you ask who they are, you ask their contact details name and address, but there is good faith in this, you know.

All of these answers illustrate the way in which the process is shaped by a range of other decisions made by individuals inside (and outside) of the category of family, by external actors including the police or the hospital, as well as by the officer.[182] In relation to a decision about interested person status for example, a combination of prior decisions might force a Coroner to decide in a particular way, or alternatively might mean the decision is made before a Coroner ever needs to make a formal ruling. An approach to analysis of the law recognising the contemporary role of family cannot ignore the multiple ways in which these actors act in reliance or in response to those earlier decisions; and the ways in which expertise and conceptions of jurisdiction are employed to respond in particular moments in that process. This conception also draws attention to the ongoing nature of such decisions in a lengthy process – that decisions can be revisited, affirmed, subtly reshaped or radically revised, but cannot be seen as separate from the processes which have created the circumstances which require (or obviate the need for) a decision.

These answers also reemphasise the ways in which the actors perceive themselves to be responding to facts and to the family and reacting to their presentation of themselves and their concerns, as the following discussion between two officers about initial contact with the long lost sister in Vignette 4 demonstrates,

> (Officer A) We tend to take people on face value
>
> (Officer B) Yeah, we don't say, well, look, can you come in with your birth certificate, no we tend to take people on face value, I mean, I think, once you start talking to people, you would pick up if there was something wrong
>
> (Officer A) If it was something dodgy, yeah

[182] For example, in relation to the impact of decisions by the family on other decisions, see Tait & Carpenter; 2014, 9-11, in relation to suicide verdicts. In relation to the important role of otherwise hidden 'non-legal' actors, see Castellano 2009.

> (Officer B) If somebody was to ring me up and say well I am Jimmy Smith's sister, I perhaps wouldn't tell her everything on the first telephone conversation, I might talk to her and try and establish just a few little facts, before I was to really relay everything to her

As this answer also illustrates, these are not solely abstract considerations; they are bound up with material concerns; from attending the office with a birth certificate, and assessing credentials of a putative family member based on their telephone manner. Exploring the place of materials is a vital part of examination of notification and enabling participation as technologies of jurisdiction, and is therefore a crucial part of an account of how a jurisdiction is created and shaped, who is engaged in that jurisdiction and how they are bound to law.

Materiality

Vignette 4 provoked interesting reflections on the role of the material, in particular in relation to what the long lost sister might need to produce to be recognised as next of kin. One Coroner proved very willing to accept non-formal family relationships in earlier discussions of a case in which an informal adoption had occurred, but was also clear that evidence was needed to support a claim to be next of kin;

> (Coroner) She can presumably establish that she is the sister?
>
> (Ed) Well that was going to be a question, would you take any steps to seek to establish that?
>
> (Coroner) Yes, I would want her to establish the relationship.
>
> (Ed) What would you be expecting from her to establish that?
>
> (Coroner) I would want a birth certificate that shows she has the same parents or same parent singular at least, as him. And if she was saying well, you know we weren't formal but we were brought up together, she'd have to establish something otherwise she's just Joe Public who has popped out of the woodwork and said 'oh, I'll play a hand in this '
>
> (Ed) So she would need to provide some evidence to persuade you that they were brother and sister?
>
> (Coroner) Yeah, whether real or defacto.

The emphasis on evidencing the tacit, informal family reveals this Coroner's engagement with balancing the requirements of technocratic formal accountability and convivial accountability, and thus seeking an authority for the law grounded in that combination. The technical, detailed face of

law is both deployed (in the request for evidence) and subverted (in the emphasis on non-formal but substantive connections) with the aim of engaging law with a contingent family construction.

In relation to precisely what evidence might be needed, another Coroner suggested a letter from the sister would usually suffice, while a different Coroner stated they would want evidence, and when asked what evidence, stated

> (Coroner) I suppose what we tend to do, thinking about it now, is they ask them to write in, because we get phone calls, so we always ask them to write in, and probably we would take it very much at face value.

The emphasis here is on a written record, not as a way of transmitting information but as a means of establishing truth in itself. At one level, this is the material of law at its most abstract, with little attention to form as compared to some other documents, for example, consent forms (Jacob 2012, 58). The content and form of the letter are largely unprescribed and are relatively unimportant, as with the illegible *tofes haskama* or consent form Jacob found used in an Israeli transplant centre (Jacob 2012, 59-61). However, unlike the *tofes haskama*, the existence of the letter is crucial, introducing a 'reflective pause' (Jacob 2012, 54), and limiting flexibility and liquidity (Hogle 2003, 87). As with the evidence from the missing sister, the letter introducing the family thus represents ongoing endeavours to satisfy the demands of the convivial and the technocratic; where relationships are taken at face value in an endeavour to bring in the tacit community but are also subject to a minimum of law-type oversight, capable of being objectively justified and evidenced. Part of an ongoing process, and as such capable of reversal or reaffirmation, it is a moment at which the family is reified and perhaps otherwise tacit relationships are made concrete. It is the moment at which family are identified as separate from the community, and it occurs through operation of legal writing, because a telephone call is not enough.

It can therefore be seen as a vital moment in the process of family being called to law. As Dorsett & McVeigh argue, legal writing calls people to law and inaugurates the power of law; from a claim form to a parking ticket (Dorsett & McVeigh 2012, 60). Here, the letter from the family is part of a process of family being called to law; a process which, as well as the letter from the family, could include telephone calls and letters and official forms being sent from the Coroner to the family. These material processes carry the authority of law, and it was revealing that I was told anecdotally that some actors in the inquest system felt the officially created forms (enclosed within the 2013 Regulations) lacked official authority because of their layout. In this context, I was told of some Coroner's offices who acted to 'improve' them by inserting a crest at the top of the form.

It is not only the letters and forms from the Coroner which carry the authority of the law – in some respects the family have the authority to speak the law; to determine who is family, and as part of a law represented as having authority through combining accountabilities. This combination requires the engagement of family, and reemphasises the importance of recognising sequential decision-making. As such, the role of materials in engaging family in making decisions in sequence cannot be ignored – as the Coroner stated in the quote at the beginning of this Chapter, speaking to a family might be a better way of getting information across than writing long letters, but even then, information might not 'sink in.' When the family have a central role in shaping decisions, their response to the demands of the system is an important part of understanding the system, and the materials which transport and transform that information are crucial.

Wider concerns

Similarly, other systemic matters cannot be ignored. Another criticism of positivistic decision-making is the emphasis on making each individual decision independent of other organisational concerns. In my interviews, it was clear that that converse was true and that in the inquest context, there is a great deal of attention to the implications of the current handling of a case for a particular way of handling other cases, and the relationship between an individual case and the wider context. One example of this was a Coroner's reflections on relations with a wider community;

> (Coroner) in this area we have a large Muslim and Jewish population and quite often there will be representatives of the Muslim or Jewish faith who want to make representations to me about, for example, not having a post-mortem or releasing the body sooner, and I will regularly meet them.

These comments, along with a range of other comments by Coroners about their caseloads and comparisons with the activities of Coroners in other districts, including decisions to hold post-mortems, made it clear that decisions are regularly made which take into account the impact of a decision in one case on other cases. This wider context, together with the implications of typification and serial decision-making, mean that an analysis of decisions in the inquest system which looks at individual cases without considering the broader systemic issues would be necessarily flawed, and it is for this reason that I turn to framing as a way of understanding how decisions are made.

Framing and the Coroner's first contact with the family

I use framing as an analytical tool to explore the ways in which my interviewees made sense of the situations we discussed in our interviews.[183] The frames deployed by my interviewees reveal how

[183] For reflection on the relationship between my use of framing and Hawkins' (2002), see Appendix A.

questions are understood, how issues are organised into or out of a particular decision, and how factors are classified and interpreted. They were sometimes used strategically by my interviewees and sometimes engaged with apparently less deliberately, and the emphasis in them on combining accountabilities or a concern with risk links my empirical work to the themes developed in my historical and jurisprudential analyses. As with Bourdieu's account of the way in which the activities of the state creates and recreates the family, framing can be seen as a method of subjective categorisation; part of the Bourdiesian cycle of the reconstruction of the objective social category of the family (Bourdieu, 1996). In considering the individual experience in this cycle from objective social truth to subjective category and back again, Bourdieu argues that it is necessary to pay particular attention to the ways in which state agents uncritically and spontaneously employ reference to a familial norm to understand circumstances and justify their decisions.

Importantly in the inquest, this family norm is not necessarily the family as constituted by the law. My interviews suggested that the family norm employed instead prioritised a 'wider and deeper ethics' of care (Held 2006, 17), as shown by the contrast between the automatic involvement of the informal relationships in my interviews (the non-adopted daughter and the 'defacto' sister – who might have been missing for some years but was still entitled to be involved) and those with formally constituted relationships but circumstances which suggested a lack of caring ties (the missing wife who may not be sought and the biological father, who was only reluctantly permitted engagement by most interviewees). Examination of the deployment of framing provides a tool for a critical exploration of those decisions, and the way in which the same factors, framed differently, can reveal differences in approaches. To explore how framing operates in relation to factors, and how I reached my two core frames, I draw on answers to my initial substantive question in interviews with Coroners.

My opening questions were designed to set the scene as I asked each Coroner about their previous experience and factual questions about their area, including how many deaths were reported to them each year and how many inquests they opened. After this, I asked each Coroner 'how and when do you first have contact with the bereaved?' The answers I was given illustrated the ways in which the same factors could arise, but be given opposite interpretations. In these interpretations, two themes were clear; on one hand a concern with avoiding or mitigating risk, and on the other endeavours to combine the authority of law with effective engagement of the family, to enable their contribution and to make the investigation meaningful for them. One answer emphasised the necessity to maintain a distance from the family, and the role of the officers in working with them, but

> Where there is great anxiety, and lots of questions, it is helpful to the officer in the first place who gets beleaguered by requests and demands, to defuse worries, and if there is any problem, I'll say to all my officers just suggest they are offered a hearing in court. In principle an independent judicial officer should not be speaking to interested persons outside court.

Thus concerns arising from anxiety and worries could be averted by meeting the Coroner; but this engagement had to be done in court. The frame adopted was one in which the Coroner sought to combine the technocratic authority of the general principle and formal courtroom with the convivial accountability which could only arise from recognising and being responsive to the concerns of the family. Furthermore, in this account, adopting this approach was also an endeavour to avoid the risks which could arise from failing to properly combine forms of accountability, including the risk of disorder and demands. Another Coroner adopted the same frame of focusing on the need for combined accountability, but perceived the role of the family as central to the meaning to be given to judicial independence – for this Coroner, independence was a factor to be demonstrated to the family through direct early contact. I asked whether this would be via telephone or in person:

> I will do both if necessary, what I can't do is I can't compromise my judicial independence, because the Coroner's job is somewhat unusual in that you are not an arbiter between two parties, you are an inquirer, and sometimes it is necessary to have hands-on contact with the family either on the phone or in person. A lot of it is simply explanation, and sometimes the families like to see the person that they are actually going to possibly have the inquest dealt with. … For example in the inquest I have just completed, I had to speak to the deceased's father very quickly because the post-mortem [raised questions over the quality of the emergency care received], which then introduced the topic of second post-mortems, and I had to explain the pros and cons of all this.

The essential components of a convivial approach to the inquest, in which meaningful explanation is allied to an inquiry in which the family are enabled to play an effective part, are combined here with formal concerns to avoid threats to perceptions of judicial independence which might arise from failing to get 'hands-on' contact with the family at an early stage. In so doing, this Coroner expressly rejects central aspects of the triadic form, demonstrating a concern with evidencing the independence of an inquiry to the family similar to that advocated by a Select Committee in relation to statutory public inquiries.[184]

[184] see recommendation by the Select Committee on the Inquiries Act 2005 that chairs of inquiries should meet victims and families as early as possible in the inquiry process (2014, 73-74).

In contrast, for another Coroner, judicial independence was a factor in the decision which was framed by reference to concerns about the risk of appearing to be biased:

> Usually, the first contact with the bereaved that I have personally will be in the courtroom. And that is because of the appearance of bias. Because the bereaved is only one of any number of interested persons before the inquiry, it is inappropriate for me to have any close contact or communication with them before the inquest.

Other interviewees emphasised the general nature of the rule:

> General legal principle is, you don't have contact with interested persons directly, you do it through the officer, in that way you can never be accused of bias.
>
> As far as Coroners are concerned, we don't come into contact with the bereaved until the inquest.

These three answers did not start with concerns the family might raise or with attention to making the process meaningful for the family, but instead focused on judicial independence as a factor which meant they were obliged to keep their distance from the family. The question was understood as a matter of general principle, in which an adherence to a general legal principle promised to control the risk of a perception of bias and reduced the Coroner's scope to act. Alternatively it was framed as a discretion open to the Coroner, but interpreted through a desire to avoid the risk of bias through appearing too close to the family. In this context, it could be that a combined form of accountability could be achieved through the role of the officer in engaging with the family, as suggested in another Coroner's approach where the emphasis was on the officer as responsible:

> As far as a lot of the contact is concerned it is through the officers, and of course putting the family central is partly reflected in the range of duties of notification by officers and explanations and we do our best to support the officers in meeting that.

The officer is framed here as expert in engaging with the family, which was a common theme in some of my interviews. The question of how best to engage is itself part of a wider organisational context, including issues of resource. As one Coroner explained:

> I am fortunate in the sense that this is a reasonable sized jurisdiction, well resourced, so I don't have to go out as some part-time Coroners do – who don't have the resources [and] have to actually be more hands on in the earlier stages.

For this Coroner, proper resourcing means that matters can be delegated to officers. The implication, in contrast with other answers, is that there is no advantage to a Coroner being hands-on at an early stage, and that there is little difference between what a Coroner and an officer would do at those early stages. In comparison, another interviewee emphasised the expertise of the Coroner:

> I may have contact with the bereaved family very shortly after the death ... I normally don't allow my staff to do these difficult conversations because sometimes I have to do them because I am the horse's mouth, so quite often I will have to speak to families shortly after [the death]

As with judicial independence, expertise is therefore a factor which can be interpreted in different ways depending on the understanding of the Coroner; it is either inseparable from the Coroner's engagement with the family, or it is an aspect of the investigatory and administrative functions of their officer. Both approaches can result from a framing of the issues which focuses on combining forms of authority, as this framing will focus on the question of whether initial engagement of the Coroner or their officer can best elicit the engagement of the family, facilitate the introduction of tacit knowledges and seek meaningful contextual revelation. Alternatively, if the decision on engagement with family is made through a risk-oriented frame of perceptions of partiality or abdicated via a reliance on law's generalised promise to contain risk, then a triadic form of accountability is prioritised, and the officer is called to act as a buffer between the system and the family.

My interviews illustrated that the decision-makers' perception of an ideal inquest is often one in which a combined form of accountability is fashioned, but that this combined accountability can be constructed in very different ways. Where it is sustained, this framing supports a representation of inquest law as founded on a combination of technocratic and contextual convivial demands for accountability. However, where there is a perceived risk to the delicate balance within this default framing, the frame can shift to assert the pre-eminence of technocratic forms of accountability, drawing on representations of the law grounded in expertise, distance, technocracy and neutrality.

Importantly, as some of the responses from the officers above indicate in relation to quickly perceiving and responding to the 'kind of family' in a particular case, the interpretation of the approach of the family can result in the frame shifting. However, the approach of the family cannot be understood as independent from the way in which the inquest system both reaches out to and reacts to the family, including the physical ways in which the family is engaged; at home in person by officers or the Coroner, in the court room, over the phone, and in writing. This is illustrated by the

facts of *Brown v. Norfolk Coroner*,[185] a case in which the High Court dismissed a claim by Mr Brown that the Coroner had shown bias against him after he (the father of the deceased) raised concerns about the conduct of the case. Paragraph 19 of the judgment states

> On 7 September 2011 Mr and Mrs Brown attended the Coroner's office for a pre-inquest review. They were waiting in a room alongside the Coroner's office when it became apparent to them that the Coroner was speaking to DCI Firm and DS Clabon in their absence. Mr Brown asserts that he could overhear DCI Firm describing the deceased as aggressive, suicidal and drunk, and describing Mr Brown as difficult. So incensed was Mr Brown that he entered the Coroner's room and informed the occupants that he and his wife could hear what was being said. DS Clabon accepts that during their meeting with the Coroner DCI Firm explained that the deceased had had a drink problem and that Mr Brown had been a difficult man to deal with because he would not accept what he was being told by the police. The officers were concerned that he would use the opportunity at the inquest to question [individuals] with a view to establishing that they were in some way to blame for his daughter's death. DCI Firm accepts that he summarised the evidence relating to [the deceased] and that he may have used words such as 'needy', 'insecure' and 'aggressive at times' to describe her.

At paragraph 20, the court held that

> It seems to me entirely understandable that Mr and Mrs Brown should, as a result of this experience, have felt marginalised by the process that was taking place. They were attending what they understood to be a meeting of interested persons preparatory to the inquest yet the officers with whose efforts they were, rightly or wrongly, dissatisfied were being given access alone to the Coroner, the Coroner knowing from Mr Brown's e-mail of 4 September 2011 of their unhappiness. No doubt, as the officers were carrying out inquiries on behalf of the Coroner, this was merely a preliminary discussion of issues. However, the effect was to engender in Mr and Mrs Brown a concern that their interest was being treated as secondary.

The court went on to 'unhesitatingly reject' allegations of misconduct or dishonesty by the Coroner or officers.[186] In my analysis, focussed on questions of risk, the investigating officers were concerned with a risk that Mr Brown might use (in their eyes, misuse) the inquest to seek to establish that others were responsible for his daughter's death. He was being 'difficult'; pushing them to investigate in particular ways, and was dissatisfied with their work, initiating various complaints

[185] Brown v Norfolk Coroner and another [2014] EWHC 187 (Admin).
[186] *Brown*, 33.

about them and formally informing the Coroner of these concerns in writing. In contrast, the officers were informally briefing the Coroner in terms which maligned the family, while on other occasions, officers turned up to meetings with Mr Brown without being properly prepared to discuss the case and one officer was found to have intimidated Mrs Brown.[187] The series of engagements with the family in this case thus made it impossible for accountabilities to be combined. These engagements, from initial discontent with officers at a face to face meeting, to failures to disclose evidence, to emailed complaints, cannot be coherently separated from the physical context in which they occurred. The comments about Mr Brown and his daughter are particularly disturbing because of the context; from Mr Brown's perspective, an insight into the informal engendering of bias by privileged participants, overheard as he waited outside.

The public space of the court room is held out as the solution to concerns of private bias and as the proper place to engage with the family and other interested parties. The prospect of that space also acts to contain risk of the appearance of bias, ensuring the relationship is properly maintained, as HHJ Thornton held, in relation to Mr Brown's concern about email correspondence, 'Even the use of first names may not look good to an outsider, particularly to somebody of the older generation. Coroners should only write letters (and e-mails) in the course of their work which will stand the test of looking fair and unbiased if and when read out in court in litigation.'[188]

However, this public space is not easily available for all Coroners, and will depend on the physical and financial resources available in a particular jurisdiction (discussed further in Chapter 8). A lack of resources can present other risks to the inquest process (Wheatley, 2012); and shows that perceptions of risk arising as a result of others (rather than the family) does not necessarily result in a shift of framing towards a risk-orientation and away from combined accountability. In an example from my interviews, one Coroner expressed a concern at the possible implications of a common resourcing shift under which many officers have moved from police to local authority employment. It was important for this Coroner that for deaths in police and prison custody there was an independent investigator, and

> unless local authorities brought in an independent investigator for deaths in residential care homes etc, I would be greatly troubled to think that they would be employing the officers, because sooner or later there would be well, we pay you, what the hell do you think you are doing investigating and criticising or eliciting evidence that enables the Coroner to criticise etc. In my view there is a real risk of lack of independence, and perception of bias.

[187] *Brown,* 25.
[188] *Brown*, 44.

This is not a risk which can be removed by meeting in a public space. It is a risk to the triadic authority of the coronial office, threatening the inquest system's ability to claim independence and objectivity. It also potentially poses a risk to the potential for the inquest to achieve convivial accountability, as it undermines the capacity of the actors in the inquest to engage in the creation of a space in which meaningful revelation can be achieved. The framing by the Coroner recognises this delicate balance, as the concern with bias is a concern with demonstrating independence to the family. Importantly, as these engagements show, risk is a mobile theme, which emerges in different forms in the construction of the inquest, and does not necessary solely serve to undermine the prospect of seeking to achieve convivial accountability.

Conclusion

The first engagements between the bereaved family and those investigating a death is crucial. Concerns by family members often begin with questions about discrepancies in the information they are given in their first few contacts, or with concerns about the way in which they were told of the death.[189] This first contact is therefore key for the people involved in an inquest, and sets the tone for future encounters, but remains underexamined from the perspective of the relationship with law.

I have focused on this first engagement in this Chapter for two reasons; the impact on the jurisdiction of the inquest, and to reveal and justify my methodological approach. I argue that the notification of family is key jurisprudentially because it inaugurates a representation of law in which authority is given to inquest law by way of the family's responsibility for overseeing the proper, dignified, individualised conduct of the inquest. As I argued in previous chapters, this representation relies on combined forms of accountability, and does so through an endeavour to enable the ongoing participation of the family. As a result, the tone-setting undertaken in this first contact has ongoing jurisprudential implications, demonstrating the importance of engaging with the meanings and understandings of the actors in the inquest and of examining the inquest systematically. This examination deepens my account of a jurisdiction built on combining accountabilities, as it demonstrates the place of family through material practices and efforts to notify and seek participation beyond the requirements of the law. It also highlights how themes and framings of risk arise, and illustrates ways in which they impact on endeavours to craft a jurisdiction combining convivial and technocratic forms of accountability.

[189] As noted above, and see inter alia Beckett 1999, 273; Davis 2002, 27; PPO Report 2013, paras 4.1 & 4.1.7.

A key argument of this chapter is that notification illustrates the place of family in reintroducing contingency and resisting typification. In the next chapter, examining the body in the inquest, I develop this further, with a particular focus on the question of dignity.

Chapter Six: the family, the body and dignity

Introduction

In this chapter I address the central family's relationship with the body of the deceased through a key theme, that of dignity; the dignity of the body, the dignity of the family, the dignity of the inquest, and the relationships between these formulations of dignity. This has two distinct but interlinked aspects: the relationship of family with a body under the control of the Coroner, and responsibility for disposal of that body once the Coroner no longer needs it. Once released by the Coroner, law envisages a hierarchy of responsibility for disposal, but in practice, as my interviews revealed, this is a far more negotiated process, with family at the centre of those negotiations. Prior to release, while the body remains within the inquest jurisdiction, the role of the family has significantly changed in the contemporary inquest – a change which I argue amounts to a reimagined role for family as supervisor of the management of the body. In relation to both aspects, I argue that dignity is the critical pivot around which the relationships between the inquest, the family and the body are constructed, but that dignity can be imagined in different forms. Developing this insight by drawing on Dorsett & McVeigh's work and an analysis of my interviews, I argue that approaches to questions of dignity in the inquest can be framed through a concern with the inquest as a public process, with family as office-holders with a range of rights and duties, or through a concern with morality and conscience, with attention to dignity as care, humanity and kinship.[190]

My argument is in six parts. I open by briefly expanding on my claim for the critical relationship of family with the body by describing the disappearance of the body from the inquest, before turning to explore and analyse Dorsett & McVeigh's jurisdictional conceptions of dignity. In the third section I develop my analysis of the role of the family in relation to the body in the contemporary inquest, before examining post-mortem examinations, narratives of how the framing of dignity can shift, and engaging with the release of the body by the inquest.

The disappearance of the body

By the nineteenth century, the gathering of the community around the body had been transformed into a fundamental legal requirement that the jury view the body of the deceased. As Burney describes, in late Victorian Britain this requirement came under increasing attack on public health

[190] For selected reflections on dignity in this context, see for example Partington; 2004; Razack 2011. Importantly, despite its centrality to the issues, dignity is rarely an express consideration in the law in this area, and there is a great deal of discussion of dignity in other scholarship, see (a very small selection) for some discussion of the problems and potential of legal conceptions of dignity, see inter alia, Hale 2009; Carr 2012; Dupré 2012.

grounds.[191] Through these attacks, the body moved from essential evidential object to an insanitary and inefficient item which enabled juries to form judgments based on the inapposite external visage of the cadaver, rather than the expert opinion of the pathologist. In addition, 'Local councils, concerned among other things with the cost and the specular "excesses" of inquests, looked to the abolition of the view as a way of scaling down the ritual.'[192] In response, some Coroners resisted abolition, focusing on the central place of the dead body in the authentication of their office but this opposition foundered by the 1920s, and the requirement to view the body was abolished in the 1926 Act.[193] In the contemporary inquest, in practice, the body under the control of the Coroner is never viewed by the jury,[194] and not always by the family.[195] Photographs of the body are treated with great caution and Coroners are encouraged to share them first with relatives in a sensitive manner if it is necessary for them to be used.[196] The body is now a matter for the Coroner and the family, who engage with the dignified management and disposal of the body away from the public space of the inquest. In the context of this focus on privacy, sensitivity and caution, and drawing on Dorsett and McVeigh (2012), I turn to explore two jurisdictional conceptions of dignity.

Jurisdictions of conscience and jurisdictions of civility

Dorsett & McVeigh contrast approaches to dignity in jurisdictions dealing with assisted dying. They differentiate between a 'thin' account of dignity, concerned with questions of office,[197] civility and public status, and a 'thick' account which focuses on the complexity of the individual person, and on questions of morality and their humanity.[198] In the examples they explore they first examine approaches to assisted dying which start from considerations of the concerns of the State as to who can act and how they can act, and establish links to public status and honour. These approaches deliberately leave aside ethical questions of what it means to die well as concerns beyond law. They contrast these jurisdictions of civility with a jurisdiction of conscience, in which the law explicitly

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[191] In relation to Victorian engagements with mourning, death and a nascent public health agenda see inter alia, Jupp 1999; White 2002 & 2003; Rugg 2013b, Amadei 2014; Lemke, T. 2014; Trabsky 2015). Public health was a critical plank in the argument of the early cremation movement; Sir Henry Thompson, founder of the Cremation Society argued that 'sentiment should choose for its beloved dead 'a physical condition that is neither repulsive nor injurious to others'' (Jupp 1999, 25). Jupp links this to an Ariesian (1981, 614) concern with the invisibiliation of death, in which a focus on public health was to the detriment of bereaved families, 'whose needs have too often been overlooked' (Jupp 1999, 25) and notes the development of rights of the next of kin in relation to the choice whether to cremate (Jupp 1999, 24).

[192] Burney, 2000.

[193] Although could still see if a majority of the jury wanted, a right which was abolished in 1980, see Matthews 2014, 257.

[194] Matthews 2014, 257.

[195] See in this context, Dix 1998. One Coroner told me, in relation to deaths on the railways, 'The family are usually discouraged from viewing, and, they can, it is usually ok.'

[196] Dorries 2014, 157-8.

[197] See Condren 2006 for an extended discussion of office.

[198] Dorsett & McVeigh 2012, 81-97.

engages with moral philosophy and a conception of dignity based in consideration of truth and autonomy, including addressing the meaning of a good death. They argue that 'attending to the jurisdictional variety of the regulation of the end of life also complicates the ways in which we might understand authority and the authorisation of law. To view such regulation simply as an act of sovereign will or reason is to impose more uniformity than is present in legal practice' (Dorsett & McVeigh 2012, 95). Taking up this call to attend to jurisdictional variety, the next section turns to explore different conceptions of dignity and the place of the family in relation to the regulation of disposal of bodies.

Dignity: the body and the next of kin

Dorsett & McVeigh's distinction is set in a context in which matters of conscience which originally arose in canonical law have now been superseded by the common law's focus on honour, manners and ultimately, ideas of office. In one example of the relationship between the two jurisdictions, they argue that the historic rule that there is no property in a body amounted to common law declining jurisdiction for the body in favour of the law of the Church, and the demise of ecclesiastical law left the dead body poorly bound to law.[199] They note that one area in which ecclesiastical law continues to hold authority is in relation to burial, exhumation and reburial in consecrated ground.[200] In contrast, burial, exhumation and reburial in non-consecrated ground is determined by the civil courts. Once buried, it is a criminal offence to exhume a body without a licence (from the Secretary of State in relation to unconsecrated ground, and from the consistory court for consecrated ground[201]). This jurisdictional division enables an instructive comparison of approaches to dignity, highlighted in two leading cases.

In the ecclesiastical jurisdiction, in the case of In Re Blagdon Cemetery[202], heard in the Arches Court of Canterbury, the question was whether the court should permit the exhumation and reburial of Steven Whittle. The Court set out general principles, emphasising the 'aura of permanence' (para 304D) associated with burial, and drew on a paper on the theology of burial by the Bishop of Stafford which contrasted 'commending, entrusting, resting in peace [against] "portable remains," which suggests the opposite: reclaiming, possession, and restlessness; a holding onto the "symbol" of human life rather than a giving back to God' (para 305C). As a result, the court approved the reluctance of the consistory court to grant faculties for exhumation and reburial, but still allowed the application, permitting Steven's exhumation and reburial. Critically, the decision of the court

[199] Dorsett & McVeigh 2012, 44, 69-71, and see Troyer (2008) in relation to the body as a quasi-subject of law.
[200] Dorsett & McVeigh 2012, 77 – also noting that ecclesiastical law is now primary founded on the common law.
[201] See s.25 Burials Act 1857.
[202] *In re Blagdon Cemetery* [2002] Fam. 299.

explores Steven's views, his parents' views and their needs, and the wider dictates of religious teaching. It was central to the decision that Steven had died suddenly when he was young, having expressed no opinion about where he would like to be buried and was buried in Somerset in a community he had no link to. His parents, employed in the pub trade, had moved regularly and lacked a permanent home at that time, but had made it clear they wanted to move him when they had such a home, eventually buying a triple plot in Suffolk when they retired. The court also discussed the increasing ill health of Steven's parents (making it difficult for them to travel to his grave) and the support of his other closest relatives for the move. The fact that there was community support was not important; the court held that the amount of local support, whether clerical or lay, would normally be irrelevant.

By contrast, there was considerable community opposition to the disinterment and reburial of Father Josef Jarzebowski.[203] Father Jarzebowski was a priest who, according to the judgment, achieved almost saint-like status amongst the Polish Roman Catholic community in the UK, and is under consideration for beatification.[204] He was a member of the order of the Marian Fathers, and was instrumental in developing a school and church at Fawley Court in Henley in the 1950s. Upon his death in 1964 he was buried there on his own express wishes. In 2008, the Marian Fathers sold Fawley Court and decided to move his remains to an unconsecrated site in a local authority graveyard, requiring them to make an application to the Secretary of State.[205] The grounds for their decision were that moving his remains would mean he was buried with other Marian Fathers, and it would be easier for those who wished to visit his grave to do so. Around 2,000 people wrote a letter of opposition, including Father Jarzebowski's first cousin once removed, Elzbeita Rudewicz (who, aged seven when he died, had never met him, but who had visited his grave on a number of occasions). Nevertheless, the Secretary of State approved the order to disinter and rebury his remains, as the views of the next of kin were regarded as of particular importance, and in his case, the Marian Fathers were the relevant next of kin. Father Jarzebowski's views on his place of burial were not relevant as the 1930 constitution of the Marian Fathers states that the decision in relation to place of burial is for the head of the order. In addition, if his remains were moved they would be reunited with the brothers with whom he worked, and it would be easier for members of the public to visit his grave. The Court noted that

> 13. The Secretary of State did not ignore the counterveiling factors, which he identified as (i) the priest's wish to be buried at Fawley Court, (ii) the stress which would be caused to many

[203] [2012] EWCA Civ 499, and see discussion in Hill (2013).
[204] See para 35 of the judgment and see 'Priest's grave moved at night' in the Henley Standard (2012).
[205] Under s.25 Burial Act 1857.

> members of the Polish community by the priest's disinterment, (iii) the possible feeling of 'disrespect' that his decision might be seen as signalling to the Polish 'heritage', and (iv) the objections of the priest's nearest living relative. Nonetheless the Secretary of State decided to grant the application.

Elzbeita Rudewicz sought judicial review of the decision on public law grounds of mistake in law, irrationality and disproportionality. While the Court did not expressly undertake a review of the merits of the decision, the judgment contains significant details, and the combined approach of the Secretary of State and civil courts can be contrasted with the approach of the consistory courts. The decision finds that the theology of burial and permanence is irrelevant in the context of reburial in unconsecrated ground (even where the original burial may have been in consecrated ground[206]). The court held that the principles applied in the consistory courts were peculiar to that jurisdiction (in particular the theological emphasis on permanence), and could not be extended to provide interpretation for burials in non-consecrated ground simply because they were the same as the religion of the person buried. With this move, the court shifted the frame away from questions of conscience to focus on questions of civility and the public sphere (Kennedy 1999; Conaghan 2014). Father Jarzebowski, in his office as priest, was under the direction of his Order, who as his next of kin had the clear right to decide where he should be buried. His express wish to be buried at Fawley Court was overridden, with attention instead directed to his accessibility to the public. The dignity of his burial was thus left primarily to be determined by the Marian Fathers,[207] and concerns about disrespect to his wishes and the indignity of impermanence were noted by the Secretary of State and court but were outside the jurisdiction of the secular orientation of the Secretary of State and courts. Critically, albeit in passing, the decision notes that the church at Fawley Court was built at the expense of an émigré Polish prince, Prince Radziwill. The prince was buried in the church, which was sold along with the rest of the site, and in relation to his remains the Secretary of State had refused an application to disinter and rebury following objections by his son.[208]

In Steven Whittle's case, the court had engaged with questions of the humanity of those before it, exploring the autonomy (or lack thereof) of both Steven and his parents, forced into transience by their trade. Central to the decision are questions of conscience and the competing demands of a

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[206] It was not clear whether Fawley Court was consecrated although the court treats the site as if it was unconsecrated, see para 34 of the judgment, and for discussion of cemeteries as secular spaces, see Rugg (2000).

[207] The judgment explicitly states that the constitution permits choice of burial site, but is silent on whether the constitution expressly deals with questions of exhumation and reburial. In the absence of express reference to such a power, it must be presumed the constitution does not include such a provision.

[208] In line with stated policy, see R (HM Coroner for East London) v. Secretary of State for Justice & Susan Sutovic [2009] EWHC 1974 – a case in which the family's opposition to exhumation was key.

form of dignity focused on the individual; the theology and dignity of a Christian permanent rest, and the humanity and dignity of the desire for family unity.

By contrast, the decisions in relation to both Prince Radziwill and Father Jarzebowski emphasise the centrality of the decision of the next of kin in the treatment of the body. This is a 'thin' form of dignity, in which the determining factors are questions of status, and in which those with the office of next of kin are primarily responsible for determining what amounts to a good death and a good resting place, final or not.[209] Where a jurisdiction of conscience picks apart the relationship of family and the deceased and examines their separate but interconnected humanity, here the status of kinship is conflated with the dignity of the body. Attention is directed to establishing that status, and once established in the office of next of kin, the law both grants and draws authority from that status. Questions of the autonomy and conscience of the deceased fall outside law's jurisdiction, while questions of the dignity of family and next of kin become questions of the ways in which they have upheld, denied or despoiled their office rather than focusing on questions of their humanity in the context of their bereavement.[210]

Dorsett & McVeigh describe how modes of jurisdiction are overlaid in modern law so that it can be hard to pick apart distinct jurisdictional engagements with conscience or civility (Dorsett & McVeigh 2012, 91) and the case of Father Jarzebowski also highlights this complexity. In the judgments of the Court and Secretary of State a deeper consideration of humanity is engaged in the context of seeking to unite Father Jarzebowski with other Marian brothers. However, even here, his personhood is tied up with his office, as moving him would mean that access to his grave would be unimpeded and 'would have the advantage of being combined, for those who wished, with visiting the graves of his former brothers' (para 12).

In their different approaches, these cases highlight contrasting ways to engage with the family and the body as persons subject to law, and I turn next to explore these framings in the contemporary inquest.

The family and the body: from recipient to active supervisor

In the historic inquest the role for the family in relation to the body was limited to receiving the body once the Coroner released it, and in the contemporary system family remain primarily responsible for the body in practice. The responsibility for the body comes with a direction to maintain its

[209] On which see Jassal (2015) on mobility as resistance to 'necropower.'
[210] Which might be framed as procedural, rather than substantive, dignity, see Carr (2012).

dignity, to inter the body 'until it is properly buried'[211] and the formal legal right to possession falls on the personal representatives of the deceased, rather than on the family or next of kin (Conway 2003). Where executors or administrators decline their duty, others can be granted responsibility (Matthews 196), with the local authority as ultimate backstop,[212] but where a personal representative claims the body, their primary claim cannot be supplanted.[213] In the contemporary system, delays in obtaining a grant of probate means that in practice, administrators are unlikely to be involved, and in most cases, arrangements will be made by executors or members of the family.[214] However, the emphasis of my interviewees was on identifying family and one or more next of kin, not on identifying those with a formal legal right as executor (Hernandez 1999); an emphasis which is understandable in the context of the majority of people who die intestate.[215] The implication of this is that the dignified disposal of the body falls within the family's autonomy to act[216] once the body is released to them by the Coroner.[217]

Prior to release of the body, the historical position was that the Coroner had a very broad discretion over the management of the body while it remained under the Coroner's control. Through a series of judicial decisions[218] and legislative changes,[219] the family developed enhanced rights in respect of the treatment of the body prior to the 2009/2013 reformulation of the inquest, and a doctrinal analysis of the contemporary inquest would note that the family now have a raft of rights in respect

[211] Clerk & Lindsell on Torts, cited with approval in *Dobson v. North Tyneside Health Authority & Another* [1997] 1 W.L.R. 596 600E and see discussion in Haddleton (2006). While the majority of bodies in England and Wales are now cremated (75%, Pharos 2014, 30) emphasis remains on proper and decent disposal, see inter alia Conway 2003, 426.

[212] Public Health (Control of Diseases) Act 1984, s.46(1).

[213] Conway 2003, and see Bremenstul 2013 for a discussion of the law in the US.

[214] Matthews 2014, 196, and note Note 20 that the family members and executor/administrator/person entitled to letters of administration might be the same person.

[215] Research varies, with one poll in 2014 suggesting 35% of UK citizens had a will (Dying Matters 2014), while a survey in 2014 suggested that 48% of the UK population had a will (Will Aid 2014).

[216] There is a wealth of scholarship on issues linked to autonomy and property in the body in the context of law in relation to human tissue, see inter alia, Hernandez 1999; McEvoy & Conway 2004; Vines 2009; Gallagher 2010. I draw on this work, but it is important that where some of this scholarship focuses on one-off decisions about disposal/ownership of body parts, my attention is on decisions specifically located in the ongoing inquest process. My attention is also on the broader question of dignity, of which autonomy is only a part, see Woods, 2014, 336.

[217] However, this is an extra-legal responsibility, as once a body has been passed on, unless another individual with a responsibility to bury complains, there is no enforceable obligation to actually dispose of the body through cremation or burial, see Matthews 2014, 197-8, also see Metters, 2003; Leiboff, 2005. Contrast contrary opinion (with no contemporary caselaw) in Archbold, as discussed in McBain (2014). It is however a criminal offence to prevent the lawful burial of a corpse, see R. v Hunter [1974] QB 95, R v Skidmore [2008] All ER 146.

[218] See for example R v. Bristol Coroner ex p Kerr [1974] 2 All ER 719.

[219] Including the right to be informed of and represented at the post-mortem examination and to reject a pathologist if they work at the same hospital, introduced in the 1953 Rules, see R.3 & 4.

of the body,[220] together with a significant narrowing of the discretion open to the Coroner. For example, where the Coroner previously had a discretion to release the body early, the 2013 Regulations have shifted this into a requirement to hand over the body as soon as is reasonable practicable,[221] and if it is not released within 28 days, to explain the reason for the delay to the next of kin or personal representative.[222] Notification and participation rights for the next of kin similarly arise in relation to keeping and disposing of material preserved or retained from the body,[223] and the family's voice has become increasingly important in relation to decisions about the post-mortem.[224]

This responsibility to notify, explain and engage with the family is a duty to account to the family for the way in which the inquest system has treated the body. It is the family to whom transparency is particularly owed,[225] and they are the only people who are able to hold the Coroner to account if those requirements are not maintained. If the Coroner has not notified them, and thereby failed to meet the standards in the legislation, it is only the next of kin who would know and would be able to raise a complaint.[226] Similarly, in the event, for example, that a Coroner had refused to release a body to an eligible individual or had breached the requirements in relation to retention of post-mortem material, the family would be likely to be the only people who would have a sufficient interest for the purposes of a judicial review. While both avenues of enforcement are highly circumscribed, the imposition of duties on the Coroner, allied with these potential avenues for recourse, frame the family as responsible for primary oversight of the way in which the inquest system treats the body. It is important that the context in which these rules have been developed lies in high profile scandals[227] in which families have suffered the distress of discovering after many

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[220] For example, see, para 7.2 of the Explanatory Memorandum to the 2013 Regulations: 'The Coroners (Investigations) Regulations 2013 … update relevant provisions in the Coroners Rules 1984, putting particular emphasis on Coroners notifying bereaved relatives and other interested persons of developments with the investigation.'

[221] R.20, 2013 Regulations.

[222] Thus, even though as Matthews 2014, 197 notes, there is no right for the next of kin to receive the body they are entitled to an explanation for the delay in release.

[223] Contrast for example *Dobson v. North Tyneside Health Authority & Another* [1997] 1 WLR 596 where samples were kept and then disposed of, and there was no involvement of family members as they had not applied for probate so were not entitled to body parts.

[224] R.(Goldstein) v. HM Coroner for Inner London North [2014] EWHC 3889, and see Cowan 2014.

[225] Thornton 2012a.

[226] See Guide to Coroner's Services, Para 11.4, 11.5: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-Coroner-service.pdf and see CJA 2009, Sch.3, para 13. Although it is important to note that these possibilities are limited, and the procedures closely prescribed see the Judicial Discipline (Prescribed Procedures) Regulations 2013; s.115 Constitutional Reform Act 2005, and note, as Matthews states, that recent examples of what constitutes misbehaviour are 'rare' (2014, 48).

[227] See for example, the foreword to the Home Office Position Paper, which explicitly refers to the Bristol Royal Infirmary and Alder Hey public inquiries (2004, 2), see Kennedy 2001; Royal Liverpool Children's Inquiry 2001.

years that body parts of deceased relatives had been retained. In these cases, indignity was engaged through the exclusion of the family, with organs and body parts nominally retained by medical professionals for the purposes of a wider public interest. In the inquest, the framing of family as private interest in opposition to a public interest in the body is complicated by the ways in which family participates on behalf of a wider community interest. In this account, family is a conduit to the community and represent a public interest in transparency and the proper treatment of the body, juxtaposed with the indignity represented by a body under the control of an opaque, paternalistic and inaccessible medical bureaucracy.[228]

This account of the law re-envisages the relationship as one founded in dignity, under which the family, acting for themselves, the deceased and the wider public, uphold and enforce the dignity of the deceased whilst the body is under the Coroner's jurisdiction.[229] The focus is on the family's humanity and bereavement, on an ethical framing based on recognition of relationality and care (Held 2005, 9-28) and the family's role in what Partington (2004) has described as 'salvaging the sacred.'[230] The attention of the inquest, as a jurisdiction shaped by the technologies of notification and enabling participation, is on meaningfulness and understanding, and on the dignity of family as conscience. I asked one interviewee why the family got involved in an inquest

> (Coroner) Well, there are several answers to that question at different levels, firstly because it is a legal requirement, because we have got to notify them, under the new Coroners Investigations rules. They have rights to express for example, about what happens to tissue and organs taken at post-mortem, so we need to ascertain their wishes with regard to that. Some families will take a keen interest and it is so variable, some families will want everything, some families won't want anything, some families don't want to participate at all, I think it is important that they do participate because it is their loved one and it is so they can have an understanding of what happened to them.

The legislation phrases this as an opportunity for the family, but from a systemic perspective it is important that they do engage, not only to exercise their rights, but to achieve understanding. Thus notification and opportunity is translated into encouragement, enablement and a need to understand, and where decisions are taken about the body, questions of memorialisation and ethics

[228] Contrast Mason & Laurie (2001).
[229] And the body here is not limited to the entire body but extends to a broader concept of remains, discussed further in Prior 1989.
[230] Partington 2004, at 16 describes her trip to 'rescue and protect' her sister's remains while they were under the control of the Coroner, placing memorial items with her bones as 'a chance to act in a situation that was still out of our hands' while the trial of her sister's murderer was ongoing and the remains could not be released.

(Woods 2014), and the ongoing relationship between the family and the body (Drayton 2013; Leichtentritt et al 2014) are taken into account.

The attention is on dignity as conscience, and the attention to nuance, context and meaning bring it into a framing focused on engaging with convivial forms of accountability. However, my interviews also demonstrated ways in which this framing could shift to focus on dignity as public status, through concerns with risk and a desire to protect and hide. As one Coroner put it:

> We have a dominant culture that is simply in denial, we do not generally discuss death of ourselves or our loved ones. As a country we have the lowest incidence of ever seeing a dead body, whereas in Ireland for example, it is on display and everyone sees it, so people are deeply shocked when they come to a Coroner, they don't know what has happened.

For some of my interviewees, this concern with a shocked family provoked a desire to put up a defence to protect the family from being upset (Dix 1999), and to protect the family from threats from outside. In this framing, family becomes the protector of the private space around the body. This status was evident in some reflections on the role of the girlfriend in Vignette 2, and the role of family as gatekeepers. One Coroner who was not sure of recognising the girlfriend as an interested person in the inquest stated that she would be encouraged to be in contact with the family, and in another interview, two officers discussed this together with explicit reference to the body,

> (Officer A) She is not his next of kin if that is what you are thinking about, we would treat her probably, as we would a next of kin -
>
> (Officer B) Well it depends what the family want you see.
>
> (Officer A) Yeah.
>
> (Officer B) If she is insisting on seeing him, we would have to ask his parents assuming they are still alive.

There is no basis in law for a requirement of consent by the next of kin where another individual wishes to view a body. It is for the Coroner to decide. However, as this quote makes clear, the practice is negotiated, with the family's wishes key, even to the extent of potentially excluding other formulations of kin from contact with the body. The family is framed here as guardians of decency and dignity, determining the acceptability or otherwise of possible family members, and the possibility of their entry into the privacy of death. Critically, this formulation, even as it is engaged with the private space around the body, is a focus on public status – those in the office of family are responsible for determining dignity, and the question for the girlfriend is whether she is able to

negotiate with those in the status of family, not whether her bereavement needs to be recognised. It is only on her insistence that these concerns arise, and it is in this possibility of challenge that the framing slips from a concern with conscience to an engagement with risk. This is a thin form of dignity, focused on avoiding risk, shielding the system from critique and providing protection for those confirmed in the office of family, and is thus an attention to the inquest as a public space separated off from the private space of family, with consequent attention to official duties and rights of family in those spaces.

The impact of this formulation is that, in the public space for which the Coroner has responsibility for ordering, the family can also present as risk, provoking an engagement with dignity in which they are perceived to be failing to uphold their public office, and act to undermine the dignity of the inquest. The clearest example of this formulation was in reflections of some of my interviewees on post-mortems and cultural difference.

Dignity and the post-mortem examination

Drawing on Scott Bray's (2006) dissonance between 'representing the dead body in (medico) legal discourse and remembering, or memorialising, the dead in culture' (2006, 42), Carpenter, Tait and others have published a series of papers on empirical work they have undertaken exploring the effect of 'a push towards therapeutic jurisprudence' (Carpenter et al 2013, 2) on autopsy (see Carpenter et al 2011, 2013, 2014, 2015a). Their research, along with other work (see inter alia Clarke & McCreanor 2006; Selket, Glover & Palmer 2014) highlights the tension between the treatment of a body as an object containing truth to be scrutinised, and the role of the body in grieving practices, but they also highlight a potential distinction between the coronial system, with staff who 'are able to empathise with the position of families' (2014, 174) and medical and police staff, who valorise scientific method. [231] Their research in relation to post-mortems in Australia suggests that where religious objections are communicated to the Coroner, less invasive techniques of investigation tend to be prioritised (2011, 334). However, the communication of that religious difference, particularly profession of an Islamic faith, can engender distrust in a medico-policing environment in which Islam is invoked as 'culturally backwards as well as unyielding and dogmatic in its allegiance to faith' (2015a, 122), and which then feeds suspicion into the coronial system 'as evidentiary truth' (2015a, 121).

The construction of the Muslim community as a 'suspect community' is also a feature of contemporary British society with a 'corrosive effect on the relations between Muslim communities

[231] Even in light of evidence of poor practice, see NCEPOD (2006); Jones (2014), although for some reflections on the value of post-mortems and scientific method, see Ambade et al (2011); Chattopadhyay (2014).

and the police' (Pantazis & Pemberton 2009, 662[232]). Two Coroners reflected on their engagement with members of the Islamic community, with the first in particular reflecting on the ways in which the uncooperative suspicious Muslim family could be framed as a risk to both an individual case and beyond,

> (Coroner) We have a fairly cooperative community. Perhaps there isn't the suspicion about us, we are not seen as the police. Some of the religious faith are more suspicious aren't they, than others, you do have Muslim deaths but you don't have as many as [somewhere else] where you tend to find with those kind of deaths, they are trying to push for religious reasons to arrange for the funeral to take place, or they don't want a post-mortem and all that sort of thing, and when you have got that conflict between the laws of the land and their religious beliefs, it does bring about suspicion, and they do think that you are being difficult etc etc, and I think that then permeates out.
>
> (Coroner) We are increasing, we find particularly the Muslim community don't want post-mortem examinations done, more than the Jewish, but some sections of that community will make complex complaints where they expect everything to be done the day before yesterday, but expect you to do that in a vacuum of no evidence, or making unsubstantiated allegations. I have to have evidence, and that is a problem.

The accounts are of families posing risks to the system, unfairly seeing the Coroner as difficult, resisting the necessary management of the body, pushing and complaining. The response to these risks is an endeavour to protect the dignity of the inquest and an emphasis on the ways in which these families fail to uphold their office; charged with the status of next of kin, they are refusing to engage with the obligations of their office by prioritising private religious concerns over the 'laws of the land' and failing to grasp the place of substantiation of evidence. Suspicion is unavoidable and cyclical, permeating out and presenting a risk to the link between the Coroner and the wider community. It also permeates downwards into the process, obscuring the caring links which give dignity and autonomy to the body,[233] losing attention to the individual deceased in the suspicion, mistrust and miscommunication between system and family.

In contrast, a focus on dignity as conscience emphasises a space for engagement with the family where the starting point was open to their contextual engagement. Another Coroner's reflections on this demonstrated this endeavour,

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[232] Also see Pantazis & Pemberton's (2011) response to Greer's (2010) acerbic critique of their original article.
[233] I draw here on reflections around the expression of autonomy through relational links, see inter alia collected papers in MacKensie & Stoljar 2000; Christman 2004; Mackensie 2008.

> (Coroner) We do our best but sometimes we have got to have PMs, and normally the families if they are explained, I mean it is, a lot of nonsense talked about this, Jewish and Muslim faiths have recognition and acceptance of this, what has to be has to be, if it can be avoided or limited so be it, that is what we do.

Critically here there is no opening initial concern with suspicion, and the potential for conflict does not mean the decision is initially framed as a question of risk. The approach engages them in discussion, opening space for reflections on questions of conscience and the dignity of both the family and the deceased. In this role, the family are not intransigent exercisers of oppositional rights, but are an essential effective part of a process engaged in the dual goals of meaningful revelation and satisfaction of technocratic responsibilities. The process is framed as participatory, and family opposition is not framed in absolute terms as necessarily destructive of their dignity or the dignity of the inquest. The approach is open, and instead of a tension with the law or the conflict between the approach of family and the available evidence, the emphasis is on the possibility of avoiding or limiting if it can be done. This Coroner discussed the possibilities of non-invasive approaches to post-mortem investigation, highlighting that they were not appropriate for all cases, but with enthusiasm for their potential in providing a means of combining forms of accountability.[234] This approach is therefore capable of shaping an outcome which recognises the legitimacy of difference, religious or otherwise, not from a potentially entrenched starting point of rights, office and status, but from a perspective of constructive dialogue.

In a discussion about post-mortems which did not explicitly touch on religious or cultural differences, another Coroner also highlighted dialogue, stating that there were circumstances where people would request that there should be no post-mortem, or,

> maybe there is some element of uncertainty about the death, but the doctor is reasonably confident and then the issue with the family is going to be well, if you are content to accept some degree of uncertainty, I can sign this one up, if you want better information we can go to autopsy, and they will have some choice in the matter, in the end the decision is mine of course, but we will listen to their views.

The scenario is reversed, but the emphasis on flexibility and responsiveness is the same, recognising that in some cases some families are willing to undergo invasive post-mortem procedures to establish the medical cause of death (Rankin et al 2002; Sullivan & Monagle 2011), while for others

[234] For a less enthusiastic review of these possibilities, in the light of the *Goldstein* case, see Cowan 2014. For some reflections on the possibilities of non-invasive approaches, see inter alia Brogdon 2012; PMFDI 2012; Ruder & Rutty 2013; Ruder & Ampanozi 2013.

an autopsy causes additional distress (Biddle 2003; Robb & Sullivan 2004; Drayton 2011; Barnes, Kirkegaard & Carpenter 2014). Critically, these framings of dignity are not fixed, and some Coroners and officers told me stories which illustrated the ways in which frames could shift.

Shifting dignities

In one interview, I read out Vignette 4 and asked two officers how they would respond to the appearance of the long lost sister:

> (Officer A) Fine
>
> (Officer B) OK
>
> (Officer A) Are you going to pay for the funeral then?
>
> (Officer B) That's what we say, are you taking on the funeral?
>
> (Officer A) And they say, no, we haven't seen him for 30 years, but – and then the local council or his executors have to do all the arrangements
>
> (Officer B) But even if the environmental health people deal with the funeral, if she says she wants to be involved, that is fine, it doesn't matter. We get people really upset because they cannot afford, they haven't seen Dad for years, he was difficult, he drank, they can't afford to pay for the funeral, but they are really upset, to us it doesn't matter, if they want to know what is going on and they are entitled to know what is going on, we don't judge, we just involve them as much as we can

Here, the initial question of the dignified disposal of the deceased is for family to resolve, but crucially in this account, the dignity of the family in the process is severable from the dignity of the deceased because of considerations of conscience.[235] The family, having justified their abandonment of office to the officers, are not judged, and are engaged with despite their failure. The upset family's demeanour and explanation – they were not in contact, he was difficult, they are poor – is understandable, forgivable, and important. Evidencing their (frustrated) care and humanity, and invoking a conception of dignity as conscience, they provide for a shifting of the frame from risk to combined accountability, meaning decisions about their involvement are framed through a focus on endeavours to effectively engage them 'as much as we can.'

It is an account which reillustrates the crucial role of the approach of the family. One Coroner contrasted families who 'act with dignity' to 'people who make a fuss and sit down and scream and

[235] Particularly in light of growing funeral poverty, on which see Harris 2014; Woodthorpe et al 2013, and the work of Quaker Social Action's Down to Earth campaign.

wail' while an officer contrasted 'graceful' and 'ghastly' families. Another Coroner told a story about a scenario perceived to be laden with risk, in which illegality, immigration and 'strangeness' were central concerns. However the mother's calm display demonstrated dignity as public status and honour and thereby fulfilled aspects of office, in particular, providing justification for conduct which the Coroner had otherwise found inexplicable;

> (Coroner) We do have such strange requests. We had one where a skull and the legs of a body was retrieved from the sea after months, and the lady concerned had been born, I can't remember the country, somewhere in Africa. Her mother wanted to view the remains, she said she'll identify the body, I said we've got DNA, we are satisfied, no – she will do her own DNA test. And she insisted, and we were very concerned, I mean we had two concerns, one was she using this as a reason to get into the country, to utilise that route as a means of getting access, but two, was she someone strange? I spoke to my officer later and she said, she was absolutely quite cold and calm, and she smelt the bones and she said she was satisfied that that was her daughter, and I think, I don't know whether perhaps it was the look that the officer gave or something, but she said 'in our country people vanish and what we find are the remains after leopards and lions and jackals and hyenas have been at them, it is not always possible to make visual identification, we smell them, they smell of our family.' Now I can't explain how precise that is, whether it is to be relied upon at all, whether it is a load of rubbish, I don't know, but that lady went away satisfied, that it was her daughter whose remains had been found and retrieved from the sea.
>
> (Ed) Did you have an inquest in that?
>
> (Coroner) I had to have an inquest yeah
>
> (Ed) Did she have questions, was she involved?
>
> (Coroner) No, she didn't come. She came over, viewed the limited remains we had, and went back to Africa, and took no further part, in fact we never managed to make contact with her again.
>
> (Ed) What happened to the remains?
>
> (Coroner) They were dealt with by the local authority I believe. The local authority buried them or cremated them. The officer was the only person at the funeral.

The composed and politely insistent mother had engaged with office on her own terms, acting on her right to see the remains but resisting its requirements in respect of the investigation. Her

dignified actions engaged the dignity of the remains of her daughter, creating a narrative shift from remains to personhood, with the conclusion that the officer attended the funeral. Cultural difference is here framed as difference, but not illegitimacy; whilst initially presented as risk, strangeness and false intention, the mother's approach transforms the frame into a focus on humanity and her meaningful contingent revelation. As such, it is another account of a way in which a frame of risk can move to a frame of conscience and combined accountability, through perceptions of dignity of the family.

In contrast, another account engaged with a narrative shift of dignity from a conception of dignity as conscience to a concern with risk and conflicting offices:

> (Coroner) We had a body found on the rocks, and the evidence suggested he had been dead for some time. He was lying comfortably on his back, and had a hat he had taken off and put under his head. The cause of death was impossible to determine but the pathologist view was that it had probably been hyperthermia, died of exposure. He was a refugee from Iran or Iraq or somewhere, and he had a cousin in this country who was the sole point of contact. He was a medical doctor, and he wrote to me and said you have got to carry out extra tests because he couldn't accept that the cause of death couldn't be ascertained. I said there aren't any other tests to carry out, pathologist's done everything they can, no more information we can get, 'he would not have laid down and died like that, that doesn't happen' 'it does happen, I have had other cases where people have died of exposure.' It was a bit disturbing for a doctor who couldn't see this at all, and I think, at the bottom of it, he believed that because his cousin had been a refugee, he had been overlooked, mistreated, kicked about, police had a hand in it, all sorts of insinuations, not outright allegations but insinuations, that were just not supportable.
>
> (Ed) Did he attend the inquest?
>
> (Coroner) No, I don't think they were particularly close, but because he was the only family member here, apparently the burden fell on him, because that is their culture apparently, I think of course, he got stuck with the costs of the funeral and the whole expense over here. I found it disturbing that a doctor could be absolutely adamant that there must be more tests; you are a doctor, tell me what tests, 'he would not have done this, he would not have laid down and died' – people do, they don't intend it to happen, it is not a conscious decision, I mean, "he should've been found" – why? He was out of sight, there was no-one, I've been to walk and he couldn't be seen from above because the cliff overhung where he was.

In this account, the body is portrayed as dignified, hidden and comfortable. The actions of the family challenge this dignity, raising questions of foul play, racism and mistreatment, which the Coroner resists as misplaced, emphasising the cousin's medical expertise. At the same time, the cousin is perceived to be reluctant to act, engaged because of the dignity and honour of his family. The Coroner is sympathetic to a cousin who was not close to the deceased, who has been apparently compelled into an unwanted status and obliged to speak for the deceased. However, the Coroner is critical of that cousin's failure to properly uphold the status of doctor; to mediate between the inquest and the wider family, and to approve the dignity of the corpse, and is ultimately left disturbed by a case which threatened the dignity of professional office.

Dignity and disposal

Often in my interviews these shifts in framing focused on crystallisation of disputes over who was entitled to receive the body and arrange the funeral. The starting position for all of my interviewees was very similar; that it was a question for family to decide. However, such answers revealed a complex interplay of considerations, with attention to both office holders and legal rights to possession, and considerations of conscience and the relationships within which the deceased lived and died. As such, in relation to the non-adopted daughter in Vignette 1, as one Coroner quoted in Chapter Five demonstrates, the actors would be keen to pass the body of her informal father on to her, but there might need to be negotiation with the absent wife if she presented herself or was found. Similarly, an officer would 'happily go along' with the non-adopted daughter if she wanted to organise a funeral. Thus answers emphasised the autonomy of family to determine the dignity of the deceased, with an emphasis on caring links, but also raised the possibility of the system intervening to protect the interests of the dead as provided by law:

> (Coroner) Yeah, I mean we try and get the family to tell us, do it that way round rather than us saying right the body is going to you, or whoever, and we do have circumstances where there is a dispute, and before, when I first started here it always used to seem to be whoever got to the funeral directors first to get the body, but we tend to insist that it is the legal next of kin, that is what we try to do, and then the onus is on them to say why that shouldn't be the case.

The emphasis on legal next of kin could be framed as a concern with office, but the attention of the Coroner is on protecting the body from arbitrariness and instead focusing on the substance of the relationships. The next of kin is a rebuttable presumed recipient, but as discussed in Chapter 5, the potential malleability of the concept of next of kin leaves additional scope in this approach to engage with questions of morality, of the lived experience and of the conscience of the bereaved and the

deceased. In these accounts, attention is directed to what people are willing to do, not in terms of their manners and status, but in demonstration of their humanity as expressed through relationships of care, with some interviewees describing circumstances when broader conceptions of kin would be engaged if they were willing to 'take on the funeral.'

However, unlike decisions where the body remains under the Coroner's jurisdiction, the ultimate decision in relation to release of the body is not for the inquest system (Conway 2003). This means that wherever a dispute crystallises, the frame shifts swiftly to focus on legal rights and risk, in which the decision-makers emphasise their lack of technical responsibility for the decision;

> (Coroner) One of the commonest disputes is, who do you release the body to? And I get that at least every month here, and the answer is reasonably simple, I need to be satisfied that it is to somebody who has that right to receive it and usually there is more than one person, it is not for me to judge between them, it is for the family to sort out, and so unfortunately sometimes the body is sitting here while they sort it out. I am not intervening, it is not within my power or jurisdiction to do that, so that causes problems. … It is for you to sort, this isn't my job. Of course that then doesn't please the local authority because of the costs of storage, there comes a point where I might have to make a decision, sometimes I release it and then another next of kin pops out of the woodwork and we never knew they existed and they are up in arms and need an explanation, I am going to have to explain that we only have to notify the people that we know about and we are very sorry, there was not a preference for one person or another, we just did our duty.

All of my Coroner interviewees emphasised their ultimate lack of capacity in relation to this decision. For this Coroner it is a common issue (it was not for others), and is not for them to decide, but importantly sometimes a decision has to be made. When this happens, the too-late indignant family can present as a risk, to which the Coroner responds with an apologetic reliance on legal technicality. The focus in these situations is on status, and on the right to claim the body, but also on avoiding litigation where possible, and many interviewees indicated that despite a lack of jurisdiction, actors in the inquest would seek to avoid the cost and indignity of litigation between family members;

> (Coroner) Try and see if you can come to some sensible agreement amongst yourselves because I am not empowered to decide for you, all I can do is give an indication of the pecking order and that I would be likely to agree to release it to the spouse or the parent or whatever.

It might not even get as far as the Coroner, as officers play a part in judging when a dispute has crystallised between family members which needs to be communicated to the Coroner. The perspective of the officer is therefore particularly important, and all of my officer interviewees emphatically emphasised the autonomy and responsibility of family to decide, as one example shows where I had asked about a potential dispute between siblings,

> (Officer) I would send them away, and tell them to bang their heads together and sort it out … That does happen and you have got to say to people look you have got to be grown up about this, be adults, sort yourselves out, … you get that with opposing sides of families that the poor chap is resting up there in the hospital for weeks until they sort themselves out.
>
> (Ed) And your place would be to say to them, you have to sort this out.
>
> (Officer) Well I would yeah, we all would the same. I think we'd speak quite curtly to them as well and say well, look, grow up, well I would, certainly I would.

The indignity of the deceased alone and isolated in hospital is contrasted with his family members behaving like children – eschewing their public facing responsibility to behave with dignity; they need to grow up, as their behaviour is affecting the dignity of their poor father. The possibility that there might be a legitimate disagreement about how to respond to the body is dismissed, along with questions of conscience and ethics, because of the risk of disrespect to the deceased is framed through their failure to fulfil their office. Similarly, one officer told a story of a body which had been in the 'freezer at the hospital' for 'years' because his mother believes he had been murdered,

> (Officer) He has had several investigations into how it was all dealt with and it is quite clear that he has taken his own life but Mum just refuses to believe it and refuses to do anything with his body.

Refusing to let the body disappear, the mother is confronting the endeavour to manage her through an official emphasis on her responsibilities. Her stance draws power from a law which does not explicitly require her to 'do anything' and challenges a discourse of duty to provide for a particular form of dignity; critically, rather than not doing anything with the body, the something she is doing – the act of resistance she is engaged in – is perceived to be undermining her dignity, the dignity of the deceased and the dignity of the inquest process.

Conclusion

The potential paradox for the inquest as a site committed to caring for the dead (Matthews 2014 ix) is that indignity has been found to lurk in the strategies adopted to respond to the appearance of the dead, from the inaccurate and insanitary jury view to the indignities which lie in a medicalised

disappearance, the disconnection from memorialisation and invasion of autonomy represented by autopsy and the deep indignities and distress caused by ad hoc appropriation of remains in Alder Hey (Royal Liverpool Children's Inquiry 2001) and Bristol (Kennedy 2001). The place of family in the contemporary inquest system is an endeavour to bridge this paradox, to explicitly situate dignity in the inquest as the recognition of the centrality of bereavement. As such it looks to account for a form of dignity in the tie between people (Butler 2006), a dignity which does not start from liberal individualism, but which starts from an acknowledgement of 'persons as relational and interdependent, morally and epistemologically' (Held 2005, 13). The challenge to this account falls when the requirements of a public accounting invade the nuance and context of this dignity; when the tacit relationships of kin are transformed to status and called to the duties and rights of office, and in their transformation and potency can thereby pose a foundational challenge to the ordering of the inquest. The challenge for the inquest system is the construction in each individual case of the delicate framing of a jurisdiction which avoids grasping the easy legal tools of status and office, and instead gently holds onto the openness, nuance and tacit relationships needed for a meaningful accounting. It is to this task, the making of interested persons and the disclosing of evidence, that I turn to next.

Chapter Seven: Investigating – in the driving seat

Introduction

This chapter explores the apparently mundane and procedural questions of who is an interested person, and who is entitled to disclosure. These questions are interlinked, and are critical to the shaping of the time of the investigation before the inquest, although my reflections on them also shift into the hearing of the inquest itself. My focus is on the ways in which traditional legal concerns about status and rights do not play out in the ways in which law would expect them to, and that attention to them on their own will not capture the reflexive and reactive relationship of the family and the system. This chapter explores these issues in two broad sections: firstly examining the management of the question of who constitutes an interested person, and secondly analysing the ways in which disclosure is undertaken.

Interested persons

Framing interested persons

The only appearance of family members other than the next of kin in inquest legislation is through the lens of 'interested person.' As set out in Chapter 4, this category has expanded,[236] as have the notification and participation rights attached to those deemed to be interested persons. Legislation does not differentiate between the rights of interested persons, whether next of kin, family or non-family:[237]

> (Coroner) The law requires that those who are interested persons have an opportunity of disclosure, have an opportunity to make submissions on the scope of the inquest, have an opportunity to participate. So they are very much, all of them, in the driving seat, it is not to say that the decision is theirs, the decision is still the Coroner's, but it is to say that there is an accountability – I think is probably right – to interested persons. … I have to consider all interested persons equally, it would be quite wrong of me to consider the family because of

[236] A change which should be viewed in the context of legal and political engagement in definitions of family which has received widespread critical academic discussion, (see inter alia Buss & Hermann (2003); Glennon (2005); Pylkkanen (2007); Leslie (2014); Smart (2009) Cornford, Baines & Wilson (2013); Roseneil et al (2013); Douglas (2014)) as well as sociological critique of the usefulness and ambiguities of family (see inter alia, Bourdieu (1996); Roseneil & Budgeon (2004); Wilson (2007); Reimers (2011); Atkinson (2014)). There is particular cross over with critical academic discussion of succession and inheritance law, and I draw on that work in this chapter, but have sought to avoid an over emphasis on that literature to avoid skewing my focus towards questions of the intent of the testator and crystallised disputes between individuals rather than focusing on negotiated relationships and systemic attention on the family (see Monk 2011 & 2014, Douglas et al 2011 & 2014, Hacker 2014, Leslie 1996 & 2014).

[237] Interested persons are set out in s.47(2)(a)-(m) Coroners and Justice Act 2009 and includes specific classes of family member, beneficiaries of a life insurance policy, anyone who might have caused or contributed to the death and a range of other possible interested persons, with a final catch-all category of other individuals with a sufficient interest.

> their bereavement were primes inter pares, they are not. Of course they need to be handled sympathetically.

They may not have any additional formal rights, but the role of the family in practice is very different to other interested persons. Many interviewees described active families expanding the evidence needed, while another reflected

> (Coroner) I see the family as driving the investigation, because with a hospital death, to you it may look natural, when you go to take the statement from the family, the family say well, they weren't given any water, they weren't given any food, there was never any nurses around, all the care aspects, the neglect aspects come out at that point, and of course then you have to go down a different route for the investigation, so we are reliant on the family to almost point the investigation down the right channels.

The role of the family is central, and their participation fundamentally shapes the conduct of the investigation. My interviewees all stated that family was more likely to be involved in the contemporary inquest than previously, and although legislation only initially requires notification of next of kin, all my interviewees emphasised that they had a responsibility to go further, to notify and involve a wider family.[238] This involvement was necessarily enabled or restricted by my interviewees, and systemic frame-based analysis of their decisions reveals the role of these technologies of jurisdiction in the representation of the law of the inquest, as these decisions are key questions of jurisdiction; who can participate in the construction of law and how that law is given authority.

An example of the implications of framing can be found in the different approaches of the High Court and the Coroner in the case of *Platts v. HM Coroner for South Yorkshire*.[239] The case related to Madhi Al-Jaf, who died after he stepped in front of a lorry in April 2005. In the days before his death, as he exhibited 'increasingly bizarre behaviour'[240], he had made a series of implicit or explicit suicidal statements in interactions with the police, medical services and other state agents. Ms Platts had been in a relationship with Mr Al-Jaf, and sought to be involved in his inquest. When the Coroner refused, she applied for judicial review of his decision. In the High Court, she did not pursue an argument that she was his partner, and focused instead on the Coroner's general discretion to admit properly interested persons. Wilkie J held that despite 'the caution with which this court

[238] Including, for some of my interviewees, a requirement that they would seek to contact the absent father in Vignette 3, although others did not consider themselves bound to seek to establish contact with him.
[239] [2008] EWHC 2502 – a case which pre-dated the 2009/2013 reforms.
[240] *Platts*, para 43.

should approach an invitation to interfere with an exercise of judgment which the rules impose on a Coroner,'[241] the Coroner had been wrong to exclude Ms Platts. [242]

The differences are stark. The Coroner's assessment was founded on concerns with establishing legitimate formal categories and controlling the scope of the inquiry, and the first question was one of traditional family. He found that Ms Platts had been the partner of the deceased for well over a year, but before his death he had 'ended the existing family arrangement between himself and Ms Platts.'[243] Critically, despite her protestations to the contrary, the Coroner found as a fact that the deceased and they were no longer partners and she was therefore 'a stranger to the inquest.'[244]

Having narrowly interpreted the meaning of partner in the context of a relationship which clearly subsisted in some form,[245] the Coroner then framed Ms Platts' purposes for wanting to be involved, and dismissed them as irrelevant and illegitimate;

> First, it seems to me that Ms Platts seeks to participate in this inquest because she is concerned about how 'the system' allegedly let down her former boyfriend, and because, in her words, she has 'carried the guilt for three years.' Whilst one may have considerable sympathy with Ms Platts as to the latter point, I am not satisfied that she has any reason for guilt, but, even if she does have any reason for guilt, in my view that is not sufficient to enable her to participate in this inquest.

Her concern with systemic failings is excluded as conspiracy theory using 'scare marks',[246] while her misguided guilt is doubly dismissed as unwarranted and insufficient. Similarly, the second reason the Coroner identified – the possibility that Ms Platts wished to gather evidence for a civil claim – is

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[241] Para 43, and the extent of discretion is highlighted by the reluctance of the court to intervene, revealed by the fact that permission for judicial review of the Coroner's decision was initially denied, before the application was renewed, para 2.

[242] The Coroner also found that Article 2 was not engaged in the particular circumstances of the case, and Ms Platts' application for judicial review challenged both of these decisions. In relation to the Article 2 point, Wilkie J held that, even within the considerable breadth of discretion available, the Coroner had been wrong to hold that Article 2 was not arguably engaged. See para 33-37.

[243] Quote from Coroner, *Platts,* para 40.

[244] *Platts*, para 42.

[245] Mr Al-Jaf had moved out of her home five weeks before his death but he and Ms Platts continued to speak on the telephone every day in the weeks before he died, and there are numerous references to his 'girlfriend' (presumably Ms Platts) in the witness statements of the various professionals who engaged with the deceased in the hours before his death, see para 17-32. As with some of my interviewees, the judgment suggests the Coroner may have conflated cohabitation with partnership (see discussion of this point in relation to the previous test of 'enduring family relationship' taken from adoption legislation & caselaw, discussed Sloan 2011, and see inter alia Re T (Adoption) (2010).

[246] Also known as sneer quotes, see Piety (2000) and Nacey (2012).

further evidence of the threat she posed, and the resulting need to protect the limited, technocratic, blame-free inquest.[247]

In contrast, the Court emphasised the need to look at the whole of the relationship between Ms Platts and Mr Al-Jaf, including their very close connection, as well as the connection between their break up and Mr Al-Jaf's behaviour and eventual death. The focus is on the substance of that relationship; where the Coroner saw bright-lines and leapt from partner to stranger, the Court preferred nuance. Wilkie J's decision therefore represented an endeavour to reconcile law with the practices and complexities of kinship[248] rather than a superimposition of the strictures of formal relationships. This framing is also attentive to purpose, removing the scare quotes and emphasising the genuineness of her concern with systemic failings. It was legitimate for her to want to be involved, and any potential compensation claim does not make those concerns any less reasonable and substantial. Paying attention to judicial directives to exclude those with only trivial, contrived or idle curiosity meant Ms Platts should be involved, and the Coroner's decision was therefore unreasonable.

Answers in my interviews similarly demonstrated the divide. Where actors understood their role as combining technocratic and convivial forms of accountability, they adopted an expansive approach, attentive to the realities of emotional connections and the need for meaningful outcomes. Effective participation was elevated, both in its own right and as a way of ensuring the inquest reached a better outcome, and they focused on the substance of inclusion, not on the formality of an obligation to include. Where decisions to include were inevitable, the framing meant attention was directed to why and how such individuals ought to be involved. In relation to disclosure and participation, a combined accountability frame meant actors focused on explanation, understanding and interaction. This framing is of an account of law given authority through a blend of forms of accountability, including the crucial effective participation of those closely connected to the deceased.

In contrast, where endeavours to combine forms of accountability were challenged or frustrated, or where the actor prioritised concerns with control and order, risk framings were deployed, and law's authority thinned out, derived solely from a technocratic emphasis on neutrality and objectivity. Where risk gave meaning to the situation, decisions focused on office and status, emphasising

[247] The judgment of the Court is generous to the Coroner on this second point, accepting evidence from Ms Platts that the Coroner overstated her desire to be involved in order to seek compensation, but finding that the 'slip' by the Coroner cannot be criticised.

[248] I use kinship in this chapter drawing on Butler's (2004) emphasis on practices of kinship to distinguish between the (potentially imbricated) formal status of family and others in relations of intimacy.

formal legal categories, as well as a concern with protection and pre-empting. Interested persons were engaged with where required, and actors were concerned with privacy and limits to scope. Attention on who could assist the inquiry was narrower, with sole focus on relevant evidence, not on whether their participation was effective and integral to constructing a meaningful narrative. In relation to questions of disclosure, a risk frame could be preoccupied with protecting the family from the risk of hurt, distress or indignity, or could emphasise minimum requirements and a presumption of family initiation.

Platts demonstrates these sharp differences, but critically, it was a case in which someone representing kinship sought to be involved, meaning convivial accountability was possible. The real challenge for the system arises when there is no family or family do not respond as required, making impossible the construction of a participative, meaningful inquest.

Making it work: the need for family

Without an interested family, as the Coroner quoted in Chapter Six states, an inquest is a bit sad, and it is unclear who is to be satisfied. Two other Coroners reflected on conducting an inquest hearing without family:

> (Coroner 1) It feels somewhat daft sitting there, either nobody in court or one tedious reporter.
>
> (Coroner 2) There are quite often occasions when I am sat in court with just me and the officer, and I am reading evidence even if the press aren't there.
>
> (Ed) How does that feel?
>
> (Coroner 2) A bit odd, but you get used to it. It is recorded as well, and it wasn't always recorded, but now under the 2009 Act it is required, and a copy of the recording is available to interested persons, so the basic requirement for the inquiry and the inquest takes place even though there are no bereaved as such, no family and no-one present. Of course it is not expanded any more than that unless I obviously have concerns.

While a 'tedious' reporter may not combat the 'daftness' of an inquest without family, the oddness of the empty room may be partly countered by the role of technology, extending the public space into the future. In either case, it is a diminished space, narrowed by the absence of the bereaved to participate and to hear the law, and where the proper place of family to oversee the process is vacated, the Coroner is left trying to fill the gap. Crucially, this gap is not simply in the public hearing, but in the investigatory space which shapes the hearing, as another Coroner said; if there is no family,

> (Coroner) Then we have to almost step into their shoes and look deeper. You may have some medical notes there and the doctor has given you a statement to say that they died from bronchopneumonia, due to immobility, following a fall, and if there is no family, then we may spend more time on the notes, just checking that we are happy with them, that everything was as it should be.

This scrutiny by family is not the forensic examination of the expert, but the contextual scrutiny which comes from a connection to the deceased. Family's protection during life is here extended into death, and the Coroner cannot fully take their place, but will be forced to do so if necessary. However, it is a better investigation if the Coroner does not have to rely on medical notes or almost step into their shoes, and when it gets to the inquest, where the audience is not the tiresome media or an imagined future listener. Critically, family's engagement represents social connection, generating and buttressing a narrative of relationship resistant to themes of isolation and abandonment.[249] If there is no family, the system is forced to turn elsewhere. One Coroner told me they would not recognise the girlfriend in Vignette 2, and in response I asked if this would be different if there was no other family

> (Coroner) If he didn't have any other family it might be, but – in a case like this, goodness gracious you would want someone there. This is the sort of case that can run for years, it will be subject to loads of inquiries, and I would like to have somebody represented, to represent the interests, so I would be looking for, someone, even if it was a cousin or an uncle or something like that, we would want a next of kin for this, and if there is absolutely no-one else then I would consider it, but you do have to have some contact.

Another Coroner said where there was 'absolutely no family' and a longstanding friend of 30 years wanted to participate, they would normally exercise their discretion. There does have to be some connection, 'a closeness' or 'a genuine interest, they are not just nosy parkers or interfering busybodies' as other Coroners put it, but the system will search for someone to represent kinship and connection.[250] Importantly, this connection is not necessarily founded in legal status, and the way in which the system shapes this ability to speak does not necessarily flow from legal rights. Instead the critical question is one of framing, as demonstrated by one Coroner's reflections on the missing sister, who would have an automatic right to be an interested person

> (Coroner) I would be very happy for her to be involved, she is not going to be able to give an awful lot of information to help us, but she has every right to ask questions as the only

[249] See discussion in, inter alia, Searle (1995); Klinenberg (2001); Kellehear (2009).
[250] Contrast here Carol Smart's account of 'new kinship' in Smart (2009).

> representative. Indeed it is always difficult to do an inquest with nobody representing the family, unless I have reason to believe she has other interests if you see what I mean, on behalf of someone else or some other interest.

This quote neatly demonstrates the shifting nature of framing; the Coroner is very happy for her to be involved, unless she has 'other interests' and someone else is hiding behind her, seeking to gain entrance to the inquest by stealth. The frame then shifts to one of risk, to concern with protecting both the inquest and the idea of kinship from opportunists seeking to misuse the forum and the office of family. The critical issue in framing this decision is therefore not the question of law – does she fulfil the necessary criteria to cross the threshold of interested person – but is a concern with the perceived purpose of her involvement.

Thinking about purpose

Prior to the implementation of the 2009 Act, there were two categories under which family could participate, either automatically, or at the discretion of the Coroner as a 'properly interested person' or PIP. Chapter Three notes that it was common for all participants to be described as PIPs, even after specific categories were added when 'properly' only applied to those outside the automatic categories. The requirement for propriety thus bled through to all participants, illustrated by the above response to the missing sister – she may be an automatic entrant, but the properness or otherwise of her interest remains relevant. Many answers in my interviews reinforced this point, that whilst it is no longer an explicit factor in the formal exercise of coronial discretion or a revealing tag for the automatically involved, the 'properness' of the nature of the interest remains an implicit and central concern of the inquest system.

My interviewees consistently indicated that a perceived interest in the therapeutic possibilities of the inquest – seeking closure, explanation and certainty – was proper, and encouraged actors to make decisions and interpret engagement through a combined accountability framing. More challenging were questions of liability, blame and compensation, perceived by some interviewees as improper,[251] and encouraging a shift to focus on risks, resulting in an emphasis on excluding individuals and narrowing issues. This approach was clearest amongst the officers I interviewed,

[251] And see Hall-Tomkin 1999, 11-12, in which Brian Hall-Tomkin, Coroner for North Devon for over 30 years from 1967 describes how 'it is quite common to hear remarks indicative of our increasingly materialistic society. Almost always, after the conclusion of an inquest on a road traffic fatality, someone will ask, "well, is that it? Who is going to pay then?" Apart from the obvious failure to appreciate the purpose of the inquest, it is a sad reflection on modern society's wish to deal with death by reducing it to monetary terms.'

who all mused on the impact of a perceived compensation culture.[252] As one officer volunteered, contrasting the biological father with the rest of the family in Vignette 3, the

> (Officer) Family may be satisfied with an explanation, father might say, chi-ching[253], you know, speaking callously.

The distinction is stark; a bereaved family might be entitled to compensation, but do not seek it, whilst the biological father is only interested because of the distasteful pursuit of money.[254] In such an account, the interest of the family in proceedings is closely connected to accounts of dignity. The family demonstrate the human dignity of close emotional ties through refusing to prioritise financial reward, while the separated father is to be tolerated as an office holder whose actions have undermined the dignity of his office.

However, blame is not necessarily improper; it can be wholly legitimate to seek blame and compensation and it can be a crucial part of accountability. One Coroner told me

> I think it is unhelpful to simply trot out that the Coroners court is not a court of blame [as] questions as to whether an act or omission caused or contributed to the death will properly arise in the course of some investigations. But a coroner's court cannot make a conclusion apportioning blame to an individual.

Although 'very cautious' at the start of their career, this Coroner focussed on efficiency and systemic technocratic accountability, arguing that if there is litigation ongoing at the same time, the inquest can promote cost-savings and settlement in civil proceedings.

Even where there was acceptance of the role of blame, there was caution about seeking individual or systemic fault, and some Coroners expressed particular aversion about the role of campaigning organisations in this context. One Coroner related a situation in which they were asked to approve an interested person who had been assisting the deceased in a care home, but who was also involved in a campaign group which had raised ongoing concerns about the institution. Describing their decision-making process, the Coroner reasoned that

> (Coroner) if there is no other next of kin and she is the next best thing, then she would be an interested person, but if I have got a next of kin who is engaged, who is asking the questions on behalf of the family, I don't necessary need A N Other. The intention of being an interested person is about having people who are involved in it by virtue of the nature of

[252] On which see discussion in Lewis, Morris & Oliphant (2006); Morris (2007); Lewis & Morris (2012).
[253] mimicking the sound of a cash register.
[254] See Douglas (2014, 231) and judicial concern with 'distasteful' arguments and appropriate relationships.

> their relationship. … There is also another issue, that if the family aren't asking, you don't know the extent to which having this other interested person is desired or requested.

Crucially, this was a fine judgment, and once again, the key to it is whether there were any engaged relatives. If there were not, and an individual was able to show they had caring links, the Coroner would grant interested person status. There is a hierarchy, with family at the top, but the system will construct 'the next best thing' as a form of 'fictive kinship' if necessary.[255] In a risk-framed scenario, reliance on proper connection to the deceased may be a way of excluding someone who presents as a threat to the system.[256] However, it is also important for a combined accountability framing, because the role of kin is to make convivial accountability possible, and unless there was a relationship with the deceased, the interested person cannot be part of generating a contextual, nuanced and meaningful account.

This Coroner also highlights the possibility that the friend might raise questions the family do not want asking. Challenging the family's interests in this way is not framed as legitimate, whereas a friend raising blame with the tacit or explicit approval of a family raised far fewer concerns, as another Coroner reflected

> (Coroner) It depends … they may say for example, well I visited him in hospital on a regular basis, his family lived a long way away, they didn't visit, but I have known him for years so I visited him in hospital, I'm not very happy with the way the nurses managed him, or something. You have got the family in court, they are clearly properly interested, they have come from miles away to be there on the day, but the friend was actually the one that was in the hospital and has relevant questions to put, so yeah, sure.

In both accounts, the connection with the deceased is central, with both emphasising a link founded on caring, but framed through concerns with combined accountability, both demonstrate the importance of engaging with a broader tacit community and recognising the possibilities of non-family kinship.

In the second account, the friend is critical in constructing and combining forms of accountability, while the family play a more passive role. Other Coroners reflected on an apparently quiescent family, and – at the opposite end of the scale from a concern with blaming – the potential risks posed by such a family failing to live up to their proper role. Their purpose is again critical, as

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[255] Al-Haq 1996; Jacobs 2009 & 2014. And see reference to permitting interested persons entry who have a close similarity to those in the automatic categories in R. v. Coroner of the Queen's Household ex parte Al Fayed (2001) 58 B.M.L.R. 205; [2000] Inquest L.R. 50.

[256] See, for example, the case of *Allman v. HM Coroner for West Sussex* [2012] EWHC 534 (Admin).

decisions here are concerned with avoiding the risk the inquest will not achieve a therapeutic outcome, and actors expressed disappointment with family who frustrate endeavours to combine accountabilities, as one Coroner described

> (Coroner) There are those where you can't make them engage though. Sometimes I think, get cross about this … and I think my officers often say to them unofficially look, have you sought any legal advice. We can't point them to anybody, you can't make them go to anybody, but there are cases where families just want it finished, it is their way of getting closure, they don't want this running on for ages.

Similarly, the focus can be on creating opportunities for an uninvolved family to participate, as one officer demonstrated, in an account of a father who was separated from the rest of the family,

> (Officer) suddenly two months after the death the father appears on the scene and he is saying, what should I do? I said, you are making representations on behalf of your son, you are seeking assurances that this event is likely to have caused him to have done what he did. Then I say, have you had an opportunity to speak with the rest of the family? He said yes. I said, they have sought representation. He said, do you think I should? I said, it is a choice for you, but you should be reassured that that could be your best course of conduct, now there is nothing more that I can say.
>
> (Ed) And so is he now-?
>
> (Officer) He is going to see a solicitor

The emphasis in this account is on responding to a direction-less father to prompt him towards his proper role, endeavouring to make his engagement as full and as meaningful as possible. By contrast, a framing focused on the risks of an overly suspicious family does not actively seek to extend their role,

> (Officer) it may well be that something hasn't gone quite right, but it is not our place to say to the family, are you getting a solicitor, the minute you say 'are you getting a solicitor'- 'Well, do I need one?' It is not for us to say.

Solicitors create more work, and with a linked concern about families who are 'looking at pound signs' in the words of another officer, this account presents a thin form of family autonomy in which their engagement is founded solely on their own resources. The role of the family may not be restricted, but it is not promoted, and as family are responsive to the actions of the officers, the system has the capacity to shape their purpose for involvement. Engaging with families in this way is

therefore an endeavour to resist the illegitimacy of compensation which flows from the involvement of lawyers. It also demonstrates the ways in which involvement of the family is a series of decisions about how they are involved. While statute law focuses on status and associated rights, the legal approach in the system ignores or defers questions of threshold, preferring to deal in contingency, equivocation and informality.

Making and not making decisions

There is no requirement that decisions about interested person status are publicly announced and my interviewees all emphasised the ways in which their general approach is rarely explicit and determinative. Instead, decisions are taken without formal rulings unless 'there was any argument about it, there isn't usually.' One Coroner described the decision about interested person status as 'usually blindingly obvious right from day one … a parent or a partner or a spouse or something', while another stated that 'very often, in 90% of cases, it is obvious who the interested persons are.' [257]

One demonstration of the blindingly obvious was the unanimously positive responses of my interviewees to the claims of the non-adopted daughter in Vignette 1. She was automatically an interested person because of caring links and reciprocity[258] despite lacking the legal status of daughter. Her implied and unchallenged relationship with the deceased echoes the tacit relationships central to Morgan's account of convivial accountability, and her automatic involvement in the inquest illustrates the inquest's potential for engagement with alternative formulations of kinship.[259]

Vignette 3 also revealed insights into framing and sequential decision-making. The vignette was deliberately designed to provoke reflections about the treatment of a violent absent and otherwise unconnected biological father, contrasted with an informal father. Many of the answers reflected this, framing the biological father through a risk-lens, and adopting different approaches to the new partner. In a common approach, one Coroner reasoned that the new partner would see the papers anyway, going on to note that granting him interested person status would serve to antagonise the biological father. This risk-focused framing positioned the new partner as engaged in the public proceedings as the mother's representative, as the Coroner decided that he would be allowed to ask questions, but it would be made clear that it was on the mother's behalf. This focus on public roles

[257] Potential family members included in s.47 are a spouse, civil partner, partner, parent, child, brother, sister, grandparent, grandchild, child of a brother or sister, stepfather, stepmother, half-brother or half-sister; and separately, a personal representative of the deceased or a beneficiary of a life insurance policy; S.47(2)(a), (b) and (d) CJA 2009.
[258] Finch (1989), also see Douglas (2014).
[259] Where they mirror family, as discussed further below.

enables a gesture of justification towards a biological father unhappy with the involvement of the new partner, but simultaneously denies the substantive relationship between the new partner and the deceased child.

Another Coroner likewise felt there was no need for a formal decision about his status:

> (Coroner) Well now, there is no rush. Firstly, as they are partners, they are not in a situation in which she would want all the disclosure to be duplicated, it is going to go to her anyway, so I would expect my officers to just say further down the line we have got a PIR and inquest, we can deal with these issues then. We would explain to her what rights she has and if what she is actually saying is she wants the father, the partner to be asking the questions of the witness rather than her, I have no problems with that at all, because she has asked for that, to be a representative, and it is likely as not that that will be in consultation with her. And therefore I would give him that status, but we may not come to that because if they are both going to appear in court, and I am helping them out, it may be he will give advice to the mother who will ask questions, and he will not need to be an IP, as he will have sight of the prior disclosures to the mother.

This Coroner initially appears to be focused solely on questions of status and legal rights, only to dismiss them as unimportant. Instead the emphasis is on enabling the effective participation of the family. This framing was even clearer when the same Coroner went on to explore the substance of the relationship between the new partner and the child, and reflected on the difficulty if the biological father objected to the new partner being involved

> (Coroner) which he is entitled to say. I am somewhat reluctant to allow other people to prevent others from becoming interested persons if it is around emotional personal reasons of their relationship, it needs to be on the relevance to the inquest. And if this has effectively been the father, it might be what we want to know for example is, how independent the child was, what were the circumstances in which she was allowed to walk home, well the real, the partner is far more likely to know that and ask relevant questions based on his knowledge of her character and behaviour.

This response to a legitimate challenge by the biological father is not a reliance on legal status but is instead an engagement in the substance of the relationship between the new partner and the child, with a telling near-reference to the new partner as ‘the real’ father. The new partner’s involvement in the inquest is likely to produce a meaningful account of what happened, and to create a hearing

which combines forms of accountability, but decisions about it will be avoided if possible, and if necessary, will be taken incrementally without rushing.

In contrast, risk-framing adopted by other Coroners focused on a concern to keep order and prevent the new partner and the mother 'both chipping in simultaneously',

> (Coroner) He doesn't need to be a properly interested person, she is a family member, we don't need another one, his interests are not going to be against the mother's, so I don't want to use the word superfluous, but he is not needed, I mean I have got no problem with him sitting next to her, and providing her with questions to ask if it is appropriate
>
> (Ed) And if he sought to ask the questions?
>
> (Coroner) I would ask him on what basis he feels he needs to ask questions when she can. It is possible if she is so distressed that she can't then I might accept him, but it would be on her behalf, not him as a properly interested person.

Where decisions employed a combined accountability frame focused on the relationships of the new partner and the child, instead attention here is on the mother. This focus on risk, and therefore a concern with controlling the inquest, does not look to any judicially mandated test for the possible involvement of the new partner, but rather rests on pragmatism and necessity, adopting a 'natural emotional hierarchy' with the mother at the apex.

The hierarchy of family

In 2006, in evidence to a Commons Select Committee, Victor Round, former Honorary Secretary of the Coroners' Society and HM Coroner for Worcester, was asked how Coroners dealt with a number of potential interested persons. He stated that

> We have the natural emotional hierarchy in a family, which tends to elect a boss, a leader, a family spokesman, and if it is a split family maybe two of them, but we cope with that regularly.[260]

[260] See Oral evidence attached to report of Constitutional Affairs Select Committee, 8th Report of Session 2005-06, response to Q114, 13 June 2006, http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/6061302.htm

As well as this natural emotional hierarchy, Mr Round emphasised associated legal regimes,[261] and in the context of a proposed extension to include friends of long standing,[262] argued that this emphasis on a hierarchy is important

> Otherwise you do, I am afraid, particularly with mental patients, have friends of long standing popping up all over the place, and nowadays we say to them, 'Look, the family are in charge here, not you' and I would have hoped we would still be able to say that.[263]

The approach is bound up with concerns about risk, and seeks to deal with challenges through reliance on status. As Mr Round's reference to the family being in charge makes clear, the hierarchy is necessary to exclude and control risk. Critically, although the framing emphasises family autonomy, it suggests it is a matter of nature and fact where family stops. It ignores the ways in which family practices enact and simultaneously construct[264], and the recurrent cyclical interaction of that construction with both law and the range of informal decisions being made by officers and Coroners potentially deploying uncritical state thinking about the shape of family.[265] One Coroner reflected on this, stating it was a question for the officers how far family extended, and officers didn't have training on it, they just

> (Coroner) know enough about engaging with all of them, so it is funny isn't it, they know where to draw the line, some step son or I don't know, some great aunt or something like that.

To gain entrance to the inquest, the crucial factor is not necessarily a question of legal status, but is rather whether the individual falls within a negotiated social category of family.[266] This factor will be framed by reference to a concern with accountability or with risk, and crucial shaping decisions will be made before the Coroner engages with the case. An example is the risk-framed hierarchy of

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[261] Citing the Administration of Estates Act 1925, which deals with priority in relation to probate rules. See critical discussion of the application of the probate rules and the way in which they can make will writing a political act in Monk (2011).

[262] The inclusion of 'friends of long standing' in the draft Bill was criticised by the Constitutional Affairs Select Committee during pre-legislative scrutiny, and was removed from the Bill as introduced, see para 139 of the 8th Report of Session 2005-06, http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/90208.htm#a27

[263] See Oral evidence attached to report of Constitutional Affairs Select Committee, 8th Report of Session 2005-06, response to Q114, 13 June 2006, http://www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/902/6061302.htm

[264] See eg Morgan (2011).

[265] See Bourdieu (1996); Maclean and Eekelaar (2004); Cornford, Baines & Wilson (2013); Atkinson (2014).

[266] Finch & Mason (1993), and see Reimers (2011), in relation to the connections between practices of kinship and bereavement.

importance demonstrated by one officer in relation to scenarios like the new partner in Vignette 3. The idea of him asking to be granted interested person status

> wouldn't arise. [The mother] is next of kin, she would be the interested party, he can come along as it is public but why would he need to be treated as the father?

The framing is a limited conception of the inquest, with the dismissal of any substantive emotional connection between the child and the new partner who, presented with an officer who did not see any purpose in his involvement, would be excluded from interested person status without any coronial involvement. It would appear naturally as if the family had elected a spokesperson. In such circumstances, the role of the officers is key, and as another officer explained, the

> Coroner wouldn't ever say, right who is the mother, who is the father, at an inquest. It would just be, we would just say, the mother is sat here, she will be the one asking questions.

Similarly, this officer will have managed the question of interested person in advance. In this context, it is important that some Coroners were suspicious of the possibility of perceived family overreach, emphasising that it was for the Coroner to determine who was an interested person, but the operation of serial decision-making means that a formal decision may never be required by the Coroner, and where a decision is needed, it will be inevitably framed by information provided by family and decisions taken by family (see Davis et al 2002, 29 for a critical reflection on this). Family thus have a critical part to play in determining their own formation, in particular when decisions are framed through a concern with risk, privacy and protection, as two officers' reflections on the role of the girlfriend in Vignette 2 demonstrated

> (Officer A) If they had a child together then we would probably treat it a bit different because they are joined by that child, so I would give them a bit more, but again you would liaise with the family. We wouldn't be giving out information to people without the family being aware, but if you just had boyfriend and girlfriend living together I don't think-
>
> (Officer B) We would involve the family and the boyfriend and girlfriend wouldn't we
>
> (Officer A) Yeah, a lot of the time we hope that they speak, touch wood, the majority of family would be aware of his girlfriend and they would be in contact

The separation of the girlfriend and family, and the emphasis on liaising with family, even in a situation where the girlfriend would have a very strong argument to be an interested person,

illustrates the application of a natural hierarchy and the potential role of family in policing its own edges, as also suggested by another officer

> (Officer) I would say that we contact the family and ask them if they would like to contact the girlfriend … we wouldn't be able to give her any information, we would suggest that right we'll contact the family and if you're happy for us to give the family your details then hopefully they can contact you and let you know what's happening.[267]

Similarly, a Coroner who was not sure of recognising the girlfriend in Vignette 2 as an interested person stated that she would be encouraged to be in contact with the family. This hierarchy also places family in a critical position in relation to managing privacy and communicating with those deemed outside family, as illustrated in a story told to me by another Coroner about a young man who had 'taken his own life in unusual circumstances, and we had a letter from someone who went to school with him for many years, they had been very very close and had heard he had died in an accident, and would I write and tell him what the circumstances of the accident were?' The family were embarrassed by how he had died, and the Coroner 'felt justified in the circumstances saying you are not a properly interested person' and told him he had to contact the family. The family informed the Coroner they would not attend any hearing, and when the inquest was held, nobody else attended. Sympathetic with their discomfort, this Coroner passed responsibility to the family for deciding how to engage beyond their own circle, and it was unsurprising that the investigation was able to be closed 'on the basis of a written statement, in a public setting.'

Resisting the natural emotional hierarchy

In contrast to this narrow risk-framing of family-as-gatekeepers, some interviewees reflected on situations where, although they perceived family to have a key role in delineating their own 'edges,' they would seek to subvert the natural emotional hierarchy, as with the girlfriend in Vignette 2;

> (Officer) Say you have got someone, they have barely been going out with each other for any time at all but their relationship was very intense, and quite often, they are more distraught than the immediate family because they have got more invested in the relationship. We still have to go through the next of kin and what the Coroner says, but anyone can go to an

[267] In addition, it is interesting to note that in relation to the responses by officers in this section, I also interviewed Coroners in those areas, who stated that the girlfriend would be granted interested person status. This illustrates the importance of serial decision-making, as it is possible that steps taken by the officers in this scenario might make it less likely that the girlfriend would have an opportunity to become an interested person. However, it should also be noted that some of the officers interviewed stated they would be likely to approach the Coroner with questions in this case, and in any event they would act with particular caution and sensitivity, not least because as some officers and Coroners noted, it was not unusual in their experience for deceased soldiers to have both a wife and a girlfriend.

> inquest and as a final resort that is, we can keep in touch with them, and we can tell them when the inquest is going to be.

Rather than focusing on the risks presented by the distraught girlfriend, the officer is attentive to the substance of the intense relationship, and seeks to resist her exclusion and the perceived impositions of law. They remain bound by the dual dictates of the family and the Coroner, but sympathy arising from recognition of the investment in the relationship frames their endeavour to seek to engage them, and, at the last resort, enable their attendance at the inquest. A similar attention to the substance of the relationship was evident in the reflections of a Coroner in relation to how they would approach this vignette

> (Coroner) Would she be counting as a partner within the meaning of section 47? It depends, I think at first blush I would probably say yes, I will call you interested if you really have been his girlfriend for ten months, if his parents popped up and said this woman led him astray etc and there is no way you should regard her then I might hold a pre-inquest hearing to say now come on, tell me why you think you should be interested when the parents say you have been a bad influence on him.

The initial approach, oriented towards a broad tacit conception of kinship, is made provisional by family challenge, in which case the Coroner will be obliged to make an explicit decision about her status. Critically, the basis for that challenge reveals the Coroner's opening presumption of a relationship built on reciprocity, because when it is queried, the relationship is evaluated against an ethics of care.[268] It is an account of the Coroner building and negotiating family, making decisions about status, but importantly the considerations are not those of law; the fact of a family relationship, or a reasonable and substantial interest. Instead it is directed towards practices and the qualities of the relationship, exploring the wider context, reaching a decision accessible to non-technocratic knowledges, and making possible the construction of a contingent, individualised, convivial space. The Coroner does not acknowledge the potential dangers in this delicate construction, including the danger of legal challenge, but rather than adopting a risk framing and resorting to the protection of law, the approach gambles on reconciling the participants, or at least reaching a decision which is comprehensible and acceptable to them.

Another mode of resistance to law's structured promise to control risk was to sabotage the narrative of the central interested person:

[268] See, inter alia, Held (2005); Slote (2007).

> (Coroner) I probably wouldn't recognise her as a PIP, but in effect, other than the provision of disclosure, and of course there will be sensitivity because of the army, there is not going to be very much difference, ok they wouldn't have the day to day contact with our office, but they would be advised of the hearing and she could come to the hearing, in fact we would suggest she comes to the hearing, we would go that far.

In going as far as suggesting she comes to the hearing, the importance of interested person status is dismissed. The only significant difference in this account relates to disclosure, and with this in mind I turn to consider the place of disclosure.

Investigating and disclosing

A key criticism of the pre-2009 Act was a lack of a requirement to provide disclosure to families,[269] and a consistent theme in my interviews was that the centrality of the family in the contemporary inquest is reflected in the new disclosure regime. Another was that the Coroners I interviewed had always provided disclosure anyway.[270]

Viewed through a jurisdictional lens, disclosure is an essential part of enabling the effective participation of the family, and as such, it is a critical part of understanding representations of the authority of law. Interviewees emphasised the reciprocal nature of disclosure, that they 'have got to make sure communication is exchanged', and in that process it is again possible to distinguish the deployment of the two different frames.

The distinct place of family

One Coroner reflected on disclosure, stating there was an

> (Coroner) entirely unsatisfactory state of affairs previously where they would turn up and hear this evidence about their loved one for the first time, sat there with everyone else, I would think that would be quite distressing in certain cases.

Hearing the evidence for the first time, the family could thus be caused double distress, not only hearing distressing facts, but hearing them in a public forum with no time to prepare. Critically, they would be sat there with everyone else and not singled out for special separate treatment.

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[269] Although caselaw emphasised the need for as wide disclosure as possible in cases where Article 2 was engaged, see inter alia *R (Smith) v Assistant Deputy Coroner for Oxfordshire* [2008] EWHC 694 (Admin) at 37. See Scraton & Chadwick 1986, 95, for a critical reflection on lack of disclosure in relation to deaths in custody.

[270] although one went on to state that disclosure was wider now, and rather than selectively disclosing, they now disclosed everything. Also see discussion in introduction about selection of interviewees; as a convenience sample, it was a partly self-selecting group, but from a range of areas.

Disclosure in this framing is thus directed towards recognising and constructing the distinctly different place of family; with a focus on dignity and their primacy in grief.

As well as emotional preparation, decisions about disclosure are focused on procedural preparation, as one Coroner explained; 'If you haven't done the prior preparation and you just busk it on the day then you are going to end up with egg on your face.' Officers were clear that

> what we don't want is any nasty surprises, and any questions that can't be answered at the inquest leaving people feeling that they have missed their chance.

Disclosure gives families a chance to go through the papers carefully – 'they do go through them with a fine tooth comb' – and a combined accountability framing of decisions in relation to disclosure and communication aim to ensure a more effective and meaningful investigation, with Coroners better able to focus the evidence collection process on the concerns of the family. In the contemporary inquest, interviewees suggested communication by email and telephone were common, and a recurring theme in my interviews was an assertion that electronic communication meant that

> it is much easier for there to be an information flow happening … officers therefore have a lot more contact with the family day to day.[271]

Coroners and officers also discussed who this might exclude and how those people might be engaged, with positive reflections on the new possibility of differential approaches. One Coroner described a recent case in which they offered institutional interested persons inspection and disclosure on request, but gave the family disclosure, without their request,

> because I thought, I don't want them to be at a disadvantage, even though the law says you could've inspected, they weren't hugely educated they would have found it difficult, they probably needed to take it to people to get advice on its significance.

Questions about accessibility in relation to electronic communication also focused attention on the possibilities of broader meaningful engagement:

> (Coroner) there is certainly much more of a team effort now than was once the case. Some more mature family members may not be computer literate, which will now engage their younger family, who can prepare detailed letters or statements or queries or questions to be

[271] Although electronic disclosure was a particular issue for some interviewees who felt they had inadequate systems to manage it properly.

> answered, so it is much more of a team effort now, and I would encourage that, because I think it means that people's understanding will be different.

Thus disclosure enables and encourages the participation and sharing of different understandings which are central to convivial forms of accountability. As argued above, a combined framing includes knowledges built from a tacit community grounded in a wide conception of kinship. However, the material of disclosure can act to crystallise that community, foregrounding pragmatic concerns with practicality and cost. Combined framings recognise this and emphasise the ways in which disclosure is capable of being shared, as one Coroner reflected in relation to the new partner in Vignette 3,

> (Coroner) what you would do is keep all the liaison with her, and if she chose to share it with the new partner, that is fine, but if he wanted to ask questions at the inquest I would say fine, he has brought her up hasn't he.

Liaising with the mother is a question of practical provision as the new partner had a caring parental relationship with the deceased child which legitimates his involvement. In an interesting comparison, this Coroner took a harder line to all the other Coroners I interviewed in relation to the involvement of the absent father. Where others considered themselves bound to recognise the biological father as an interested person, based on the mother's assertion that he is the father, this Coroner would not accept this as sufficient

> (Coroner) It would be for the natural father to prove paternity, because he is not on the birth certificate.
>
> (Ed) But if [the mother] has said to you that he is the father, although he is not on the birth certificate, would you be telling your officers to take steps to-?
>
> (Coroner) No. No I wouldn't, not in this circumstance, because he is not on the birth certificate, if he was it would be a different matter.

While this Coroner went on to confirm that if the biological father was able to prove paternity otherwise, he would be entitled to interested person status, the deployment of legal technique to deny his engagement is in stark contrast to their framing of the decision in relation to the new partner. Where one scenario is understood and organised in relation to concerns with risk, engaging in questions of order and status, the other is framed through a concern to create a meaningful outcome and engage with substantive relationships based on care.

The response also demonstrates the central place of materials in the processes by which law reflects, shapes and influences family practices. For this Coroner, the absence of his name from the birth certificate was key, and enabled the coalescence of family practices and law, a result which avoids the discordant inclusion of the unconnected biological father.

Disclosure, engagement of the family, and the community

Family participation also has a critical relationship with the constitutive materials of the inquest, as Coroners and officers[272] described seeking additional reports and evidence arising out of family questions and concerns. This development carries the potential for the inquest to mirror settlement practices in civil litigation, as for some interviewees, identifying questions arising out of disclosure provided an opportunity to answer queries in advance of the public hearing.[273] One Coroner stated that questions which were 'not too wide or difficult' could be answered before the inquest 'and that saves the need for the witness to come to court.' An officer described how, in

> straightforward [cases] often, once they have seen the disclosure, they don't feel they have to come to the inquest. I would say we get less families coming now that we do the advance disclosure. They have seen all there is to see. Some people come just as a mark of respect or to get a bit of closure [if the Coroner decides there is no need to hear any evidence]. But if the family come back and say, actually I have got some questions, the Coroner is very good and will try and get a witness if the family have a burning desire to, but it all runs a lot more smoothly now because they see they can, you know, we don't lie to our families.

This response illustrates the range of reasons for family to attend, and the crucial role of disclosure, with the system responsive to their needs, whether that is seeking to close off the investigation or to interrogate the circumstances of death. Critically, such a central place for the family, with emphasis on resolution in advance, dramatically illustrates the changed nature of the inquest as a public space, revealing the family's role as conduit to the wider public. Commandeered to guarantee truth and banish deceit, the family act to ensure transparency and oversight on behalf of the wider public. The framing is also revealed in the reflections of one Coroner in relation to non-family attendees at an inquest

> (Coroner) What sometimes happens is you have got some people with the family who think they are being helpful by asking a question to clarify something and the problem is they

[272] For example, in one account told me, an officer described how they had acted on their own initiative without consulting the Coroner in relation to a natural causes death which involved a previous period in detention - they had sought additional reports in response to concerns and questions raised by the family.
[273] Many of the Coroners I interviewed suggested that endeavours would be made to resolve questions before an inquest, and some more of these accounts are also discussed in Chapter 8.

> haven't had the papers, so the answer's in the papers and that is why the family hasn't asked it, do you know what I mean, so that can be quite difficult to manage.

In such a scenario, attention is not directed towards general public revelation, but rather towards a form of explanation which is meaningful for those engaged, excluding those outside that advance engagement. Non-family attendees seeking to clarify matters actually make them more difficult, as their proper place is to both rely on and focus on the family's primacy in understanding. Another Coroner reflected on how to respond to the risk of public misunderstanding through exclusion, describing how they would hold informal pre-inquest meetings which interested persons attended but which were not open to the public.[274] Their concern was with evidence which might never be needed at the full hearing, and that

> (Coroner) if we had a whole hearing and the press and Joe Public have the right to attend they may ask why I am not hearing from Joe Bloggs, because Joe Bloggs says such and such, and there might be a good reason why Joe Bloggs is just not relevant, it might not be necessary for the purposes of the inquest. But of course Joe public or the press go away thinking oh it was important.

In contrast, the family, who would have had the disclosure and would have seen why Joe Bloggs was not relevant, did not present such a risk. The concern with risk is central, as disclosure presents and prevents risk, and the process must be managed to respond to that risk.

Disclosure and risk

As well as managing the community, disclosure is a way of seeking to manage family expectations, but as such it is a technique with limitations as people 'will perhaps read them but not really digest them or understand, so they will come expecting me to do an inquiry into everything.' Framed through concerns with order and control, disclosure could also present significant risks to the Coroner's management of information, as one Coroner reflected

> (Coroner) what I do is I write to say, look this is made known to you on the basis that it can only be discussed with a legal representative or member of the family, it is not published, it is not copied or distributed, strictly it should be returned to me on closure, unless you wish to retain it at that stage and you should contact me then.

Similarly, officers expressed concerns with privacy and preventing family members from 'gaily transmitting medical information around.' Another Coroner stated that they did not 'like emails

[274] It was not clear whether this Coroner was describing previous practice or current practice, but the Inquests (Rules) 2013, R.11 now requires that all pre-inquest hearings are to be held in public.

from non-professional email addresses.' Web-based email was 'just unreliable', after all 'how would you like it if I was to give information about what happened to your mother to anybody who emailed in with initials and a yahoo address?' The central concern is with dignity and protection and the risk of challenge if privacy was to be breached.

Risk framing could also focus on protection of the family from harm caused by contact with death,[275] with, for example, interviewees emphasising that post-mortem reports were not sent out automatically – (Officer) 'it is graphic and very medical' (Coroner) 'it can be very distressing, so I wait until someone requests it' – and demonstrating the shaping role of the officers,

> (Officer 1) if they are asking about other things then we would mention that the pathologist will produce a full report that I can send to you … if someone has no idea and they don't talk in a way that they are wanting to know any more then we wouldn't ultimately offer them anything. … Otherwise I think we'd be there forever copying things, sending things out, but ultimately if they did request more information it would be down to the Coroner whether or not he would release that.
>
> (Officer 2) Post-mortem reports do not go to families unless they request it. So yes, unless they ask for something, we wouldn't send anything really.
>
> (Ed) How would they know if there was something that they could get?
>
> (Officer 2) They wouldn't to be perfectly honest would they? We don't offer it. Not unless we feel it might help them, but otherwise no.

Conclusion

My central endeavour in this chapter has been to reveal and complicate the way in which the family are engaged in the inquest before the public hearing. Decisions (and non-decisions) tacitly and sequentially made by both themselves and the key actors in the inquest shape their appearance and their role, as the system seeks to call the possibility of convivial accountability into the law, and frames the family as primarily responsible for establishing the connection of the inquest to a meaningful context.

Mirroring and reimagining the possibilities of the deodand, the system emphasises the need for accounts which tie the individual death to law, and creates a space for family to construct a contextualised contingent account within the law. Where the historic inquest had little in the way of process before the hearing, the contemporary inquest is inseparable from that process, and cannot

[275] See Dix 1999 for critique of this aspect of the system.

be understood without it. Similarly, as with the abolished deodand, it is the material which lends authority to the law and simultaneously acts to constrain it. Where the deodand gave power to the community, it is the disclosure in advance of the hearing which acts to empower and limit in the contemporary system. The material possession of documentary evidence by the family underpins the possibility of critical engagement and opens a space for resistance to injustice, but it also acts to formalise and privilege the family, shaping the proceedings, and potentially narrowing the possibility of the inquest as a site of wider meaningful public revelation. However, critically, it is not solely the material of disclosure which acts to contain risk and bring contingency into the law, it is also the physical appearance of the family in the inquest hearing. Whilst their engagement in the process before the hearing gives meaning and authority to the law, fusing privacy and kinship with transparency and oversight, it is their physical attendance and representation of kinship and connection which authorises the inquest as a public space. Their absence, or their refusal to conform to the demands of the process or the hearing risks leaving the public hearing as remnant, thin and undignified.

Chapter Eight: the inquest hearing

Introduction

In this final chapter I examine the ways in which my interviewees perceive the family's engagement with the construction of the public space of the inquest hearing. My contention is that a binary public/private model fails to capture the ways in which the hearing moves along a continuum, through a series of formulations of public in an individual case interpreted through a range of factors – the physical space, the approach of the family, the decisions of the Coroner, officers and others, the law, the 'mode' of death (Atkinson, 1978), and the identity of the person who died. These factors interact with decisions about whether a jury is called, how disclosure affects the hearing, how much information is given out and what information, what is said in a public forum and what is not, how people gather and who gathers.

My attention is on the space of the hearing itself, rather than on the conclusion of the inquest, although I come to consider this at the end of this chapter. The conclusion or verdict receives a great deal of attention, and particularly in doctrinal law, on the appropriate legal tests for particular verdicts, as well as empirically based concerns with inconsistencies between areas in verdicts. It is undoubtedly often important for the family, but as Davis et al note 'arriving at a correct verdict is a small part of what goes on in the inquest' (Davis et al 2002, 60). Drawing on Scott Bray's insight that '"facts" found by Coroners are not unproblematic findings' (2010, 574) and can only be understood in their wider social and legal context, my endeavour here is to reflect on that wider context and in particular on the questions of how those facts emerge from a public hearing, and how family fit into that public hearing.

A public hearing

One of the aims of the 2009/2013 reforms was to have fewer inquests, with the ability to discontinue an investigation before the inquest where, for example, the death was a result of natural causes and there were no other concerns.[276] Where an inquest was to be held, the Chief Coroner has emphasised that the 'more modern look' of the inquest system is based on fewer delays and more hearings being held in public (see Chief Coroner 2013-14, 11). Inquests must now be opened in a public hearing wherever possible and dates for any future hearings must be announced.[277] Any pre-inquest hearings must be heard in public, and there must be a final hearing

[276] s.4 CJA 2009.

[277] R.11 Coroners (Inquests) Rules 2013, SI 2013/1616. If the Coroner does not have access to a court, then they can be opened in private and announced at the next available juncture.

within six months.[278] When it arose in my interviews, my interviewees were unanimous in their perception that no-one (including family members) attended the public opening, and while many of them supported the idea of listing cases at that first hearing, some had difficulty with this. One Coroner summarised the problem

> I am lucky because I have got access to a court whenever I want one. The biggest problem is court access, so I can settle and run my own diary because I know when my court sessions are going to be.

Of my eight Coroner interviewees, four did not have a purpose-built courtroom, while the others had a court, in some cases attached to their offices, in some cases elsewhere. [279] These differences in provision are longstanding,[280] and Hurren (2005, 240-248) describes the battle of the late-Victorian Coroner for Oxford to get his own court. His arguments, founded on grounds of morality and public health, were unsuccessful. At the same time in the 1880s, his counterpart in Melbourne was having more success in obtaining a purpose-built court, a space which Trabsky (2015) argues was an exercise in community memorialisation, bringing the bodies of the living and the dead into a forum of law (Trabsky 2015, 18). In the contemporary hearing, as Chapter Six reflects, the dead body has disappeared from the space of the inquest, and for some Coroners, the space for considering the circumstances of their death can vary considerably, as one told me

> (Coroner) I personally have held inquests in a police club, where they switched off the bandit and put a cover on the snooker table, and in the loft space of the community centre. My predecessor held them in what was not much more than a large broom closet at the old hospital. We hold them still in the lecture rooms of the hospital. I make use of the magistrates court where they have a court which is relatively redundant, so I usually use that

[278] R.8 Coroners (Inquests) Rules 2013, SI 2013/1616. In addition, where inquests last for over 12 months, the Chief Coroner has to include details of them in an annual report to the Lord Chancellor (s.36 CJA 2009). Lengthy delays between the death and a final hearing has been a longstanding criticism of the inquest system from the perspective of the bereaved (see inter alia Davis et al 2002, 26; Biddle 2003; Samuels 2011; Hawkes, 2014; Sense about Science 2014), and many of my interviewees expressed support in principle for the six month rule, describing concerns about Coroners in other areas who were not progressing inquests quickly enough, but many also emphasised that it could be difficult to meet this timescale in practice, particularly in complex cases when other inquiries were ongoing.

[279] The legislation now provides that Coroners must have accommodation that is appropriate to their needs: S.24 CJA 2009 – and some of my interviewees stated that a purpose built court was in the process of being arranged.

[280] See for example the discussion in Richardson (2001) of the picture of an inquest held by Thomas Wakley, in which he sat at a table surrounded by the jury. Also, in relation to Coroners courts and use of other buildings see, inter alia Graham 1995; Burney 2000.

> one without too much problem. Last week because it was a major one, I used a court in the crown court complex, which was very good. But otherwise I have to go all over the place.

As the major case in the crown court indicates, the variety in space was not solely about availability, but was also a question of perceived suitability. As another Coroner stated,

> 80% of cases are the straightforward you could do it round a table, in fact I do do it round a table in certain cases, there is no point bringing an 80 year old lady into a court room to hear her husband's inquest when in fact it is not disputed.

At the other end of the scale, as a quote below illustrates, where there was a risk of disorder, a court room would be preferable. Further research on the staging, spacing and placing (Carlen 1976) of the contemporary inquest is needed,[281] but these responses show the potential adaptability of the public space of the hearing, and perhaps demonstrate the ways in which the ordering of this space can bring matters into the reach of the family or put them out of their reach (Keenan 2009, 187). These are accounts of a hearing partly shaped by, anticipating, or in response to a bereaved family, but also by tensions between resourcing and concerns with dignity and effective participation, forced to remake cupboards and loft space into spaces for law and to situate dignity alongside the covered snooker table and unplugged one-armed bandit. Such flexibility also risks unforeseen distress to families, as with one account I was told, about a Coroner who shared a space with the wedding registrar;

> Another Coroner was telling me a while ago that it never really came home to him until a widow in front of him said rather wistfully 'well the last time I was in here was when I was getting married' – and that is distressing, you know, you can't but feel sympathy for the poor lady she has to say, been in this room twice, once to marry her husband and once to be at his inquest.

The account is affecting, the circularity of events and restraint of the widow no doubt leading the Coroner to repeat it to me (the only story I was told of another Coroner's direct experience in an inquest). In retelling it, and highlighting the role of the other Coroner in previously failing to appreciate the impact of the use of space, it gave emphasis to the importance of the room as an unanticipated actant. At the same time it gives weight to an account of the inquest as a place of significance; framed as opposite to a wedding day, but likewise touched by law's ritual and authority.

[281] See Davis 2002, 32 & 34; Tait & Carpenter 2013, 96 for some reflections on this issue.

It is the combination of these contrasting moments of dignity in the same public space which gives the story poignancy, evincing particular sympathy from this Coroner.

One Coroner reflected explicitly on the public nature of the space of the public hearing, stating that

> I don't believe I have ever had a general member of the public come in and see what is going on, I have had people there who are properly interested persons or who have a link of some sort with the deceased, a friend or work colleague or something of that nature, member of the same organisation, there is a link. I don't honestly think I have just had a general casual, I have an hour or two to kill, I will pop into the Coroners court.

It is thus, in the majority of cases, a public space populated by those linked to the deceased, those in selected offices of the state – Coroner and staff, pathologist, police officer, doctor – and perhaps the media (Davis 2002, 72-3). Of the three publics identified by the Warwick Inquest Group (1985, 51) in the inquest into the death of James Davey – the jury, the press and the public gallery – in most contemporary inquests it is only the media who are likely to attend. I asked one Coroner if they had a lot of press attendance,

> Surprisingly little. If they know of some particular death, they will say can you keep us advised of that, but I don't issue any sort of communique to the press saying this week I am going to deal with Fred Bloggs and Uncle Tom Cobley and all, if someone rings and asks we'll tell them where and when.

In such an account, the press are not prevented from attending but their help in creating a public space was not actively sought, instead reliance was placed on the family to determine who, if anyone, ought to be aware of the proceedings. In apparent contrast, other Coroners made information more readily available to the media, including details of their lists on websites;

> There is a lot more information out in the public domain now, I have got a website, we are trying to upgrade it, we have got a list of our cases, we have got procedures.

However, this Coroner went on to note that this was so that people could take an interest, and contrasted with a situation 'a few years ago [where] there was certainly a lack of provision of evidence to families.' The attention of both is on constructing a hearing which enabled those who had a connection to the deceased to attend and participate.

In addition to creating awareness of the inquest, the family are key to media representations of the death. Butler describes the role of the media as critical in determining what amounts to a 'grievable death' (Butler 2006, 20). In this context, Davis et al's (2002) account of the inquest as obituary and

the case study of the social welfare inquests in Chapter Three reveal the intimate relationship between the construction of a grievable death in the public forum of the inquest and the media reporting of that hearing, while the interaction between the media and the inquest process can also play a key role in a death being not grievable, in particular in relation to deaths in custody (see inter alia Scraton & Chadwick 1986; Pemberton 2008; Erfani-Ghettani 2015). In both cases, the individualising, personalising account of and by the family plays a critical part in the framing of that narrative by the reporters in attendance.

Where the media is not in attendance, or where they are but strategies are deployed to limit their engagement (discussed further below), and where there is no jury or public attendance, there is no audience unconnected to the deceased, and the inquest moves from 'theatre' (Warwick Inquest Group 1985) to 'mini state funeral' (Davis 2002). Rehearsing the rhetoric of a still-public hearing in cases where 'the little old lady is attending her husband's inquest on her own, and there is nobody else there but me and her' misses the ways in which such hearings are intimate and ceremonial, a mixture of the eulogical and the investigative. Critically none of these potential formulations are fully realisable in the absence of family, and, if framed through endeavours to combine accountabilities, without their effective participation.

An enabled family, in an orderly hearing

Most families in inquests are unrepresented, and I asked Coroners about their experiences of unrepresented family members asking questions in the hearing, including the purpose of family asking questions. In discussion with one Coroner, I asked whether the objective of family asking questions was to assist the Coroner in answering the four questions of who the person was, and how, when and where they died. The Coroner responded,

> I would like to think that I was going to get there by myself unaided, but they may have points which I wasn't aware of, in which case yes, it would be proper to ask them, but other than that, no, the principle reason for them being there is to ensure they leave satisfied that the system has operated properly.

Adopting a risk-framing, in which the law of the inquest promises to control risk through categorisation and attribution of danger, this Coroner saw a limited role for family as responsible for oversight and maintaining public confidence in the system. They might assist in establishing the facts of a case, but the Coroner was not primarily focused on the quality of their participation. Critically, an absence of family in such circumstances would not affect the outcome – as the same Coroner reflected in relation to a case where a family member had complained that they had not

known about the date of a hearing 'I may well reopen it, we'll get the records and we'll go through it again, but it is not going to change anything.'

In contrast a combined accountability framing focused on the effectiveness of the family's engagement in the hearing. This included encouraging them to ask questions, but also emphasised preparation and identifying concerns, in advance of the hearing or at the hearing itself, and the limits of the possibilities of preparation,

> (Coroner) Of course if you are skilful what you try to do, as it is an inquisitorial process, is to ask the questions in court before it is the turn of gets to the family.
>
> (Coroner) Sometimes you will turn up and you'll have a family who haven't said anything, they will turn up on the day with a long list of questions or who want to ask about all sorts of things and you have no idea where it is coming from.

All interviewees commonly described holding hearings with unrepresented families who needed help. They could be 'nervous' or could need help with 'phrasing' a question, which included giving direction; 'Is this what you are trying to ask?' Interviewees sometimes focused on managing the risk of the family overstepping the bounds of the inquiry but not always (Davis et al 2002), and I was particularly interested in the reflections of my interviewees on the difference between represented and unrepresented families. As one Coroner stated in relation to whether questions put to witnesses had to be limited to the strict scope of the inquiry, the Coroner stated not necessarily, 'You do better with me possibly if you are a relative than if you are a legal representative.' I asked why; 'I think it is their only opportunity to ask these sort of questions and I don't think it is right that I should limit it.'

One Coroner laughed when I asked this question, indicating it was almost a matter for some embarrassment,

> That is an interesting question, oh you have done your research haven't you, that is very interesting. Well, I think I choose these words; that I probably give family representatives more latitude. Where I might pull up a lawyer and say, I don't think this is appropriate or relevant, I might see where it is going with a family. That is partly because I don't want to create an image and a perception that I am unfriendly or they are inadequate, we need to build a relationship and a process. But I must be fair to all IPs.

The discomfort for this Coroner appeared to be a concern with the possible risk to their professional image, but they went on to explain how they would seek to cautiously intervene, it would 'take a

little longer' but the key is effective engagement with the family, and the building of a meaningful account.

Another Coroner emphasised the cost and effort of organising an inquest in support of allowing an unrepresented family a broader scope, and a common answer was that as long as questions were 'within reason' they would be permitted. Where the line of 'within reason' is drawn was not clear (Davis 2002, 50), but my interviews suggested a shift of framing to focus on concerns with risk and restraint of the family might occur where they were concerned with issues of blame. However, it might depend on how the questions were put,

> Obviously we are saddled with the fact that they should only ask appropriate questions and we should stop inappropriate questions but they are not lawyers, and I do always have in the back of my mind that they need these answers, so I would probably only stop it if it was, well if it was aggressive, if it was about blame, although that is quite wide isn't it, you know if there is someone saying, you killed my Mum didn't you, that sort of thing I would stop. But if they were saying, well you didn't do this, that and the other, I would allow it, yes. I am not strict, I am probably a bit soft at times, I have more of a luxury of time than some of my colleagues in some of the more busy areas.

Appropriateness acted as control, saddling the inquest, but it was a soft restraint, only exerting a pull on the progress of questions when the family were hostile. Critically, the framing of the appropriateness of the approach of the family cannot be separated from the context, and the actions of the other interested parties, as,

> if the hospital are fighting tooth and nail, that something is not relevant, then I am likely to take a slightly different line from if the hospital are completely relaxed about it, and I will give the family a greater degree of freedom and flexibility, so long as they are not getting silly about the boundaries of the inquiry.

And the response of the hospital might depend on the family. At one inquest hearing I attended, a lawyer from the mental health trust attended along with a witness, but had not sought interested person status, even though the circumstances suggested they might have been open to criticism. I asked why, and they told me that as the family were unrepresented they had not felt it necessary. Similarly, as one Coroner reflected,

> if a family is represented and are seeking answers to difficult questions, it is bound to put people on a defensive mode and it is bound to have a knock-on effect.

Thus the place of representation is key in constructing the hearing and in the way in which the inquest is framed (see also, Warwick Inquest Group 1985, 47). Whilst lawyers for the family may be asking the same questions, and are likely to be asking them so that a family can engage in the process, they will be held to a higher standard of relevance, and are more likely to be restrained from pursuing a line of questioning, than if the family was unrepresented. This may be because the involvement of lawyers forces a narrower focus by all involved on technical questions, because of a concern with subsequent litigation, and because there is less need with lawyers representing the family to build a process and a relationship (although as highlighted below, some Coroners saw lawyers as part of a team generating a meaningful thorough inquiry). It was also revealing that where there were lawyers, the possibility of blame and a 'difficult-not-difficult family,' a risk framing could see the lawyer for the family deployed as ally,

> if you have got a particularly, difficult is not the right word for the family, but a family that don't quite understand what it is all about and want to have a trial and hang someone out to dry, then it is helpful to have a lawyer who is familiar with inquest work who can help you to say to the family look I'm sorry that really isn't a matter for the inquest.

The lawyer here acts as buffer – a role which can also be helpful to the Coroner where the risk is not a risk to the proper scope of the inquest, but is where the approach of family present a risk of disorder. In these cases, the risk- framing is more unambiguously deployed,

> sometimes family members can be quite abusive, quite personal, quite emotive, and quite adversarial – that is not often, occasionally they can be – and you have to protect the witnesses too, and I am trying to balance everything in court.

Coroners described strategies for maintaining order when the cause of disorder is family. These included anticipating the possibility of disorder and the risk that the inquest might not effectively combine accountabilities, and taking organisational and administrative steps to engage with the family, including having contact with them in advance 'so it makes life easier to manage when it comes to the inquest', and making sure that correspondence was filed properly,

> The court originally organized case files with all communications in one file, and I said no, you file separately the interested persons communications, because the Coroner needs to see them in conducting any hearing. It is key to know what have they said and what have we said to them. And that is the backdrop to what you need to know in court; they have made a moan for 3 months about X, and how have we responded to it? If you know that you

> are in a better position of how to handle them in court. A coroner must consider submissions of IPs on how to conduct the inquest and what evidence to call.

The possible attendance of the biological father in Vignette 3 prompted some of my interviewees to reflect on the possibility of violence and disorder in the hearing, with one Coroner stating,

> I would ensure that I had police presence. I have had these situations where have had to keep people apart in case there is trouble.

Another Coroner would emphasise the dignity of the deceased and an inquest as 'mini state funeral' to counter unrest, as well as 'certainly' reflecting on an appropriate space for the hearing,

> We normally get the officer to go and meet them and say that, to respect the deceased we would want you to behave in an appropriate way. If she was saying, look there are going to be real problems then we might have to get the police there. Certainly we would have to think about where we are going to hold the inquest, we might try and arrange it in the magistrate's court.

The selection of a magistrate's court emphasises ordering and formality, a rigid space with an official aura, in which it is easier to contain, separate and restrain. The answer also highlights the key role of the officer in advance management, which was a theme another Coroner raised,

> The officers here are very good, you have got a pretty good sense of the what the family's concerns are and how they have been reacting , of when you are going to have issues to deal with , or indeed when they are going to be so quiet that you are going to need to be more proactive, and so I would know at the outset usually of how to handle things, and what has been said before and been explained.

Crucially in this account, disorder and the need to handle the family does not just arise from a family expressing agitation, but also a family who are too quiet and who need to be encouraged. Their engagement and understanding are essential, and if they are too passive or reticent, there is a risk that the inquest will lack the contextual and contingent, undermining the prospect of combining both a meaningful and expert explanation of death. Finally, disorder was not limited to inappropriate questions, concerns with aggression and the risk of violence or the overly passive family; other accounts reflected on engagement, order, and control of a confident and potentially unruly family attending en masse, even where a spokesperson has been nominated to speak on their behalf. Two examples of these common narratives are set out below;

> (Coroner) It doesn't stop the others asking questions, that has happened, particularly with schoolteachers for some reason, one of them acts as the main advocate and usually you have several, and you'll find the brother, who is possibly another school teacher, still wants to ask questions, but I don't mind.
>
> (Coroner) If they come mob-handed you know, lots of them, and they don't know any law, they can all start chipping in and if you are not careful you can lose control so you need to make clear, and I do this through my officers, make sure before they come that they know that they have got to choose a spokesman to put their questions. Then when you start you say right, and you take them through what an inquest is all about, it is a fact finding inquiry it is not a trial da-da-da, all the usual preamble, and you say and I hope that you've someone to be nominated and they will usually, yes it's him, but once you get going inevitably Uncle Joe, Uncle Bert and Aunty Joan and cousin Amanda will start chipping in and I'm afraid sometimes you have to say I am sorry remember what I said I will only hear one of you, or if you are generous, and I try to be generous, I might say well I will come to you in a minute but one at a time, you can't all chip in at once and we will take it in a logical sequence, it can't be all butting in and chipping in at the same time.

In these accounts of a nominated single spokesperson and the limited engagement of others, a common theme in my interviews, the emphasis is on family, and it is noticeable in the second that the Coroner refers to uncles, aunties and cousins, all of which are outside the automatic interested person categories. Critically, the limits to their involvement do not flow from questions of legal right or their status in inquest law, but from a concern with ordering and management of the hearing. The endeavour of the Coroners is to combine order and the requirements of convivial accountability for meaningful effective engagement founded in a tacit community. That task is easier for the Coroner if one office holder acts for that community, but recognition of dignity as humanity and the consequent potency of their demand for effective engagement makes their claims hard to resist. This task of management can be far easier when the office-holder nominated on their behalf is not one of their own, but is instead a lawyer, who can free up the Coroner to do their job, because,

> If I am representing anyone I am representing the deceased, and if no-one is there to represent [the family], I have to do my job harder. I am more likely to be difficult, I adjourned quite a testy inquest relatively recently to take more evidence, because I was dissatisfied with the questions I was being given, and there was nobody there to fight for this person who was unrepresented.

A 'lawyered up' hearing

Lawyers representing the family mean that someone other than the Coroner is going through records 'with a fine toothed comb' and where the Coroner is engaged in constructing a process which will combine forms of accountability and effectively enable family participation, lawyers can be a crucial part of the team. One Coroner used other lawyers in attendance to check if there were any legal issues or advice that the unrepresented family needed, asking 'Is there a matter, even if it is not the interests of your client, that should be drawn to their attention?' Another Coroner emphasised the importance of the perspective of lawyers for the family in a complex case,

> The best inquests in the more complex cases are in fact a bit of a team effort, the better the representation, the better the quality of the inquiry. It may be impossible for me to see or recognise a particular issue or a piece of information which you may be privy to and which I may not be privy to. I have always thought, and this is a personal view, in what we might describe as the Article 2 cases, there truly should be no issue about means – the family should be publicly funded if the State has any involvement, if not you are getting a completely unbalanced line of inquiry, and they always say well it is up to the Coroner, but it is just not fair because how are they going to participate properly? It is becoming more and more of a problem for those trying to seek funding.

Without lawyers for the family in those Article 2 cases it is an unbalanced team; a situation described by Walsh as the State represented by 'an army of lawyers while the family sits alone' (Walsh 2015, 1).[282] Obtaining legal aid for families is increasingly challenging in the context of 'austerity justice' (Hynes 2012) with indications of errors in Legal Aid Agency decisions which could lead to eligible families not getting legal aid (Nicholls 2014, 24). One interviewee highlighted that a potential civil claim can be a way of families obtaining legal representation,[283] but, emphasising their experience, downplayed concerns with risk, suggesting that for most families this was a route to obtaining funding so they could meaningfully engage in the inquest. In contrast, another Coroner framed the factor of subsequent litigation as a risk which undermined the inquest hearing,

> Quite often I have barristers in front of me, which makes my inquests last longer, makes them more complex, makes them cost more money, and you can tell there is an eye to

[282] Palmer, the Chief Executive of AvMA, critiques a Ministry of Justice assertion that families do not need representation in inquests, arguing that 'our own experience … which overwhelmingly suggests that the outcomes of inquests from the families' point of view are very significantly improved when they have been represented than when they have not' (Palmer 2015, 1).

[283] as lawyers can reclaim some inquest costs as costs preparatory for a civil claim if they are awarded inter partes costs in a subsequent claim, see Roach v. Home Office [2009] EWHC 312

> litigation at the end, that is happening increasingly, cases that eight years ago I would have dealt with in an hour will now take half a day.

It is the lawyers who make the inquest more complex, taking up more time and money, without improving that hearing. The concern here is with good lawyers, but the risk of poor representation was a theme in many more interviews, with many Coroners stating that poor representation 'increases the pressure on the Coroner and officer', and with one Coroner expressing concern with changes in rules which 'mean that anyone could be representing the family, it doesn't have to be a lawyer, it could be the office cat if you want.'

Whether the family has a poorly qualified representative or none, a concern focused on risk emphasises formal legal equality, and the difficulties that can arise for the Coroner,

> If everyone else comes to the inquest with a lawyer and if the family doesn't, it puts the family and the Coroner into a difficult position. The Coroner is supposed to be neutral conducting a fact-finding inquiry, and yet is expected to assist the family to tease out the real issues in the case, and there is a real danger that he or she will be seen to be partisan by the lawyers for the police or the prison service or whomever.

Partisanship on the part of the inquest system is a longstanding concern from the perspective of those engaged with deaths in custody (see inter alia, Warwick Inquest Group 1985, 43-44), but the emphasis in my interviews was more often a concern with the risk of appearing partisan in favour of the bereaved rather than the State. One Coroner described how,

> I went to watch one of my assistant deputies and it made me step back and think about how I approached it because [they were] gushing all over the family trying to be nice, but for somebody watching it, it didn't look fair.

Framed through a concern to avoid risk, this concern with the appearance of fairness is resisted through judicial neutrality, an appeal to technocratic objectivity. The alternative, 'gushing all over the family', risks judicial impartiality, as the Coroner went on to describe,

> It looked as though possibly there was some obvious bias towards the family, and I think you have got to be careful with that. I know they are there to find out why their child or husband or wife died, and we are all there to support them in that, but I think people can do it, whilst still making them the focus, approaching it in a professional way as well.

The professional way is balanced between risks; the risk of bias, and the risk that the family will not be effectively involved. 'Equality of arms and everyone on a level playing field' provides a simple

solution, but causes increased risk of an appearance of bias if there is no legal representation. In contrast, a combined accountability framing is less concerned with the appearance of bias, but is rather primarily directed to a concern with making sure the family can participate properly. In complex cases, this means they should have lawyers, but if they do not, there is an acknowledgement that while the family do not have any more rights than anyone else, their understanding of what is going on is a central concern of the inquest. As such, this framing focuses on seeking to enable them to bring their account into the law:

> I will say to the family, this is the process in which you can make submissions about conclusions. What I am going to do is to go to the lawyers first, see what they say, and then I will come to you – so they see how it is done – and I will say, you can make submissions, but what has been said by X seems to me to be the sort of things that you might be saying in this instance, and I might help them through with it, so that they understand.

The family need to understand the process, they need to understand their role in the process, and to understand what the conclusion can achieve. The emphasis on channelling their understanding might be framed as an endeavour to restrain them but is also a recognition of the need of the system for the family. Thus the Coroner is going through the process of training and enabling the family because the system needs the family to be engaged with understanding how the deceased died. Reflections on two further aspects of the inquest – the role of the jury, and the place of the family in making the hearing less public – further illustrate this theme.

A more public hearing: the family and the jury

In the contemporary inquest, inquests with juries are rare, occurring in around 1% of inquest cases (Chief Coroner, 2015). A jury must be called in certain circumstances[284] and there is also a discretion open to the Coroner to call a jury, if there is 'sufficient reason for doing so.'[285] One Coroner told me 'I tend to use my discretion quite freely to sit with a jury.' I asked whether they would exercise a discretion when people don't request, and the Coroner paused, then stated 'I have, but it would have been very infrequent.' Critically, where it is not obligatory, it is the family who will make that request,[286]

> There are sometimes applications, I mean no Coroner in their right mind would have a jury for fun, I know we have the discretion to do it, it is just so much work.

[284] Detailed in s.7(2) CJA 2009, including violent or unnatural deaths or death from an unknown cause in custody or state detention, deaths resulting from an act or omission of the police in the execution of their duty, or from a notifiable accident, poisoning or disease (eg a health and safety breach).
[285] S.7(3) CJA 2009
[286] Although not always, see Tweedie & Ward 1989.

That additional work includes the need to take detailed notes for their summing up, but it is not only this,

> (Coroner) As soon as you make a case a jury case it takes three times as long, the amount of effort I have to put in is enormous.
>
> (Coroner) I have to consider their breaks, you can't do so much evidence in a day, I have to make sure they are understanding the issues.

Critically, just having a jury is inherently risky,

> I have to be very careful that any statement I have made is supported, and that my directions are absolutely water-tight because I am going to be judicially reviewed if I am directing the jury wrongly, so there is a lot more work for me. It is exhilarating, it is exciting, it is a huge challenge, it is exhausting, it is legally more risky.

In relation to a risk framing, one Coroner was very clear that changes which meant that deaths in mental health secure units had to be heard with a jury would significantly undermine the inquest into those deaths,

> I am an expert in this field and I genuinely think I really don't need a jury and I am running a deeper, fuller and more complex inquiry without them because I can really explore the evidence in ways that you don't have to simplify when you have a jury. It inhibits me. I am really really fed up about it, and I really don't believe it is going to deliver any better service in this jurisdiction.

The framing is concerned with the specific risk that the shift undermines technocratic accountability. The necessity of making the information accessible to a jury inhibits effective expert interrogation, investigation and rule setting. In contrast, Pannick (2010) argues that the presence of an inquest jury ensures public confidence in the rule of law, and, critically, opens up the case to public scrutiny, refuting possible allegations of a cover-up (2010, 31-32). Another Coroner drew on this, but linking the family to that analysis, framed the role of the jury through a concern to create a space for meaningful revelation for the family,

> Where it is a matter of a public interest , and the family, and this is not one of the criteria under the Coroners and Justice Act, it just all comes within my discretion, I sometimes find that it is important in certain cases where the family are very hung up about what's happened, to the extent that, they would feel better with the case being judged by their

> peers, and I know it is not judging is it – but do you know what I mean – the facts judged by their peers rather than from some perhaps case hardened Coroner.

This Coroner told a story about a complex case which involved mental health treatment and multiple agencies, and concluded that it was

> a classic example of where the jury deciding on the facts, looking at whether or not there was systemic problems in the different agencies; to me it would have been an appropriate case in any event, even if I hadn't had to do it under statute anyway.

The complexity of the case and the concern with revealing systemic issues are factors in both accounts. For the former, the need to achieve technocratic accountability organises public interest concerns in a very different way to the second Coroner, for whom accountabilities are combined by the engagement of the jury. In a similar vein, another Coroner told me a story about a case in which a jury member asked a critical question that the Coroner and six sets of lawyers had missed, arguing that

> jurors have a quaint ability to see something afresh and ask something that is very helpful. Of course it goes the other way, and you may get irrelevant questions.

The jury combine irrelevant questions with penetration through a fresh perspective, but they also require the Coroner to think more carefully about the exposure of evidence,

> (Ed) Do you prefer to sit with a jury?
>
> (Coroner) (pause) from a personal point of view it breaks it up a bit, but that is not a good reason. It makes you think sometimes more deeply about the questions you ask, because of course, in the Coroners court as you know, the Coroner starts by basically dealing with the evidence in chief. When there is a jury present, it needs greater attention to detail, because when they are not there, people know most of the facts in any event, but a jury has seen nothing, and I think in certain cases that is an area where Coroners could improve on. You get into a pattern of how you ask questions, and we need to turn it up a notch when it comes to dealing with a jury.
>
> (Ed) So is the implication of that that certain things would be assumed if there is not a jury?
>
> (Coroner) Yeah.
>
> (Ed) And it would be a quicker process?

> (Coroner) Yes, we push on, we can't push on with a jury, or if you do, you soon know about it because the jury will then ask questions, because of course they can ask questions.
>
> (Ed) And will the family play that role in circumstances where there isn't a jury?
>
> (Coroner) The difference there is that the family have, now they have got disclosure, they have got an understanding about the case, so you know very often I will say to a witness, "we are aware of the background," but a jury aren't going to know that.

The role of the jury is therefore critical in bringing evidence out at the hearing. An inquest might be heard in public, but facts can be assumed and evidence abridged unless the jury are present to force the hearing to go slowly and from the beginning. The family's role in the investigation before the hearing makes their role fundamentally different. They are aware of the background, and disclosure to them is an integral part of enabling the inquest to abbreviate the evidence. In a hearing without a jury, 99% of hearings, it is thus the family who enable the conjoining of efficient truncation of evidence with a narrative of public justice. It is their meaningful interaction that matters, and as a result their actions can be critical in making the public hearing less of a public event.

A less public hearing

At the opposite end of the scale, Coroners discussed the possibilities of resolving concerns away from the public hearing, with the emphasis on the role of disclosure in answering questions, and in some situations the role of the Coroner reimagined as aiding the family to act on their own behalf rather than acting as proxy for them (a move which can be seen in the light of comparable shifts in civil litigation, see Dingwall & Cloatre 2006). Two Coroners described their role in facilitating this:

> In this area we arrange for the hospital to meet with the family in advance of the inquest, and it is minuted. Most of the problems in the hospital death are around communication and not understanding, and they suddenly feel that the hospital has buttoned down the hatches as soon as the person has died, and they can't get the answers, so we waste a lot of time at inquest, them finding out things that they could have easily found out prior to the inquest had the hospital been open with them. So we have this agreement with [the hospital] that they will meet with the family if the family want to, with the senior staff involved and as I say it is minuted. In 80% of the cases it does help the inquest.

The focus is on time saving and efficiency, but an underlying concern with risk remains, leading the Coroner to emphasise the formality of the meeting, the minutes providing protection and holding those present to account. Another Coroner was less concerned with the risks of impropriety and

contradictory understandings, and saw the meeting as a linked but separate pliant process, engendering flexibility and the possibility of a more amicable approach,

> I will often encourage families to have a meeting with the consultants beforehand if they want to or indeed afterwards so that they can sit around the table and actually have a slightly more friendly discussion and explanation, which sometimes can be terribly helpful to clarify things which they previously thought were set in stone which were never set in stone.

In both cases, the effect is to take issues out of the inquest, and another Coroner also highlighted this possibility, stating that a family may have had concerns but 'The thing to remember is, it may well be that all the concerns they may have had have been dealt with outside of the inquest process.' The framing seeks to promote the meaningful engagement of the family, and also emphasises the role of the pre-hearing decisions in determining the community around the deceased. Instead of evidence and engagement in a publicly accessible hearing, the ability to engage is determined away from the public gaze, potentially reinforcing formal family ties, and so potentially excluding other forms of kinship (Reimers 2011), undermining the possibility of convivial forms of accountability.

This is further illustrated by the role of family in enabling what one Coroner described as an 'office inquest', in which no witnesses attend and evidence is read out by the Coroner. One Coroner explained that they would write to a family who had said they did not propose to attend and tell them they would only be reading out written evidence,

> But if any other member of the family wants to attend, then will you please let me know because it may be necessary to set another date when I know I will have the physical presence of a witness.

Witnesses introduce cost and can make arranging the date of an inquest more difficult. They also introduce formality and ceremony, and the possibilities of surprise, revelation and spectacle. Their presence makes an inquest a more accessible and substantive public event. It is critical therefore, in the account of the Coroner above, that it is not simply the fact that family have concerns which provokes calling witnesses, but the very possibility of any family attending. Another Coroner provided a specific account of a case in which it was suggested that had family been involved, witnesses would have been called. The story related to an investigation into a death in a care home, when an elderly person had rolled out of bed when the side of the bed was down. The Coroner collected evidence and, 'I looked at that file and had slight concerns about risk assessments and how this could have happened, but on seeing these reports had been undertaken subsequently, I was

satisfied that whatever steps needed to be taken had been taken', so in the end the Coroner read out the evidence and did not call witnesses.

It is not solely the approach of family which determines the decision to call witnesses, and as with the Coroner's initial concerns in the case above, one Coroner emphasised that in cases of 'public interest' witnesses would have to be called. In other cases, the approach of family is key, particularly where the death was,

> let's say a suicide. Husband is found hanging in the garage, we investigate it, we provide them with facts, disclosure if they want it, and then we do a summary and that is read out.

Media reporting, particularly sensationalist or inaccurate reporting of suicides can cause great distress to the bereaved (see inter alia, Barraclough & Shepherd 1977; Harwood et al 2002, Biddle 2003), and attempts have been made to reduce this distress with, for example, the Wright Committee (1936) recommending that the press should be prohibited from publishing an account of the inquest in cases of suicide, and that suicide should be replaced by a verdict that the deceased died by their own hand with no enquiry into the state of mind of the deceased (Wright Report 1936, 65). In the contemporary inquest an attending family may have the impact of reducing the prospect of a suicide conclusion (Tait & Carpenter 2013[287]), and in suicide cases, Coroners are often sympathetic to the desire for bereaved families to keep information from a prurient media (Davis 2002, 33-34), with evidence of Coroners adopting strategic approaches to the management of publicly available information in suicide cases (Gregory 2014, 10-11). As the above account indicates, one way in which the information which is available can be limited is if the family 'don't want to engage in the process of an inquest.'

As well as a concern with privacy, that lack of engagement might be because the family don't see any need for the inquest, and one Coroner sympathised with that,

> In quite a lot of my cases, the family have said it is absolutely straightforward, there is no issues in the case, quite often they will say please Coroner get on and deal with it on the documents alone, we don't want to come, I have quite a lot of those. Sometimes I sit thinking to myself this is a complete waste of time, occasionally because no-one is making a fuss, family is happy, but I have to do the inquest for technical reasons, what for? To what purpose?

[287] Although it is interesting to contrast my (not necessarily representative) interviewees assertions that family members now attended more hearings with the rise in suicide verdicts since 2007, see Coroners Statistics 2014, 9.

The death is unambiguous and uncomplicated, the family are not fussed, and consequently the Coroner is left with a rump technical duty with dubious purpose, open but not accessible, public in only the most formal terms. In such cases, it is the family who are unhappy and who are making a fuss who shift the inquest from perfunctory tedium to meaningful investigation. One Coroner reflected on this impact of the family in relation to all of their cases;

> Families differ, don't they, greatly, and the truth is, depending on the nature of the family, it can certainly influence the length and comprehensive nature of the inquest. Apart from the family obviously I have a statutory duty to determine those four facts and I do that, but if it is a very active family who have got lots of questions, that can expand the nature of the evidence at the inquest, so it does make a difference. If the family show no interest, have no issues, then it can be a more swift inquest.

The family's attitude is a 'very big determining factor' for the comprehensiveness of the inquest for this Coroner, affecting the detail, the focus, the range and the length of the inquest hearing. Where families want to engage, Coroners frame the inquest hearing as a place in which as far as possible, they will get understanding.

A hearing with meaningful revelation, explanation, and closure?

The need for family to understand was a key theme in my interviews (and see Davis 2002, 47). My interviewees were keen for family to attend the hearing – one stating since the new Rules that 'it is more common practice that people are almost encouraged to come to the inquest.' If they are not there, it causes a problem for the inquest,

> (Coroner) we do have a number of deaths where there isn't anyone. That's not to say family don't exist, but because of breakdowns in relationships and marriages etc, it may be that the family are there but have absolutely no interest in the death, for all I know they are organising a dance for the occasion, there can be that degree of antipathy. It is a bit unkind but it exists.
>
> (Ed) Commonly?
>
> (Coroner) No, happily no, it is uncommon.
>
> (Ed) Is that something you have noticed any change?
>
> (Coroner) It has always been there, it is just a bit sad when we have to deal with it because it makes it difficult to know who, if anybody, we are trying to satisfy, as an individual. I mean

> obviously the registrar wants to know, general records office have an interest, everyone who acts on the statistics we generate does.

As this Coroner sees it, it is a bit unkind to note situations where a family has broken down and has no interest in a death, and happily, it is uncommon. Where it does occur, families can be seen to be resisting endeavours to construct a frame of combined accountability, leaving the inquest asking the question of who, if anybody, it is seeking to satisfy. Critically, in relation to questions of dignity, the actions of such a family leave the dignity of the inquest thinned out, falling back onto a framing of law-as-risk-avoidance, a technocratic formulation, focused on legal requirements and official statistics, and silent as to meaningful convivial revelation. Focused on the public status of the dead, it 'is a bit sad' to be separated from the attachments of an involved family, office holders refusing to take up their office, leaving the inquest dissatisfied. If there is no-one there to represent the family, then, as one Coroner explained,

> I have got to think what is it that that person would ask, so that actually I am conducting it fairly, and it is more difficult with nobody there, at least I have got somebody who can ask those questions.

The involvement of family makes the inquest fairer. This Coroner was discussing the long lost sister in Vignette 4, and it was not her knowledge which is key, but rather her connection to the deceased and her resultant ability to help create a space where accountabilities can be combined, to think about and ask the types of questions which family need to ask.

Where family do attend, all my interviewees emphasised that they sought to enable them to understand what happened to the deceased. For one Coroner this included 'translation' of complex evidence, and putting their own expertise to one side

> In court I am as naïve as possible. I will ask the simplest of questions, because I need to get the family to understand it.

As this quote re-emphasises, the production of family understanding is obligatory, a foundational requirement of the inquest. This task was often expressed in therapeutic terms, with an emphasis on closure, and as above, often meant permitting questions which went beyond the question of cause of death. One Coroner related how they would go further, and act in expectation of such questions,

> this is their opportunity to ask questions of the witnesses themselves, so it could be something as simple as, do you think he suffered before he died, and we have to anticipate that kind of question because that is so common, and I often ask that to the doctor who has

> certified death and I think they are sometimes, not lying to you, because that is too strong a word, but for the sake of the family they may be being a little economical with the truth, so they will say something along the lines of 'I am pretty sure this was instantaneous, they would have known nothing about it' but they don't know that, the doctor, but it is a nice thing for the family to go away with, not worrying about that aspect.

The anticipation of the Coroner, and the 'not lying' response of the doctor, are oriented towards protection of the family from the risk of further distress. They demonstrate the ways in which attention to risk can shift the inquest from a jurisdiction focused on enabling family engagement and understanding to a focus on a paternalistic well-intentioned granting of understanding. The intention is pro-therapeutic but the impact can be anti-therapeutic and undermine therapeutic engagements with the law (Dix 1999; Freckelton 2007, 593). As Davis et al note, for family members 'the inquest can be an event of enormous symbolic significance', and contemporary Coroners have to respond to a wide range of feelings from bereaved individuals (Davis et al 2002, 70). However, as Howarth argues, rather than devising and imposing a model of grief, the engagement with grieving should recognise the differentiated experiences of the bereaved, with an aim to 'amplify the whispered communication across the boundary between the living and the dead that has hitherto been muffled by the noisy, dominant discourse and prescriptive professional rituals of modernity' (Howarth 2000, 136). A risk-based approach to the family's understanding can drown out this whispered communication, whether the risk is perceived to be hurt to the family, or whether, as in the next quote, the risk appears to arise from the family's approach to the investigation;

> I have done well over a thousand inquests of all types and most people just want to know what happened. Even if someone has done something dreadful, doctors are really good at this, they will get in the stand, they will say, "I did this this and this, I am so sorry, I should have realised I wish I had read the notes better, I should have realised they were allergic to penicillin, I can't believe I prescribed it I am so sorry," and that is often all the family wants actually. Doctors are really good at it, or even if they have not done anything wrong, they will get to the end of their evidence and then they'll turn round and they'll say, "excuse me, I'd just like to address the family, I am really sorry, I give you my sympathy for your loss," and it is devastating, it works really well in court.

The apology is devastating, from the Latin *devastare*, to lay waste completely. From the approving perspective of the onlooking Coroner the complete laying of waste is a martial move specific to the court, leaving any perceived family strategy in the room desolate and empty. It is perceived as a feint which works really well, leaving the family disarmed, their objectives simultaneously achieved

and apparently destroyed (although it is important to note that the apology and the acceptance of that apology may be no less genuine for that perception by the Coroner). The interpretation of the apology thus frames the family as inherently antagonistic, despite just wanting to know, and a risk to be managed.

The devastating apology here is an adjunct to the main business of the inquest, occurring at the end of the gathering of the witness' evidence. In contrast, a framing which is engaged in combining forms of accountability takes the meaningfulness of the hearing as its focal point, creating space for the family to generate their own understandings, as one Coroner described,

> There are a range of simple inquests that I could just read, but I feel if an interested person needs to understand an explanation, it is right that they have somebody to ask the questions to, even though I understand it all, because I can't give the answer, and nor can I explain what is down there. Probably the best example is a cot death. In many cases I don't need to call a witness, the pathologist and clinician give the expected results and I could read the whole thing, but how terribly unsatisfactory is that for some families? The family may want to ask questions like, "did it matter that I put them on their side?" and that is part of closure, so depending on the case I would try to call either the pathologist or the clinician, it depends a bit on the case and circumstances but I would try to have a witness for them to question if the family want. Occasionally the family are too distressed and don't want it. I suppose that increases my backlog doesn't it, because it adds another hour, a bit more work, but I think that is right.

These questions and answers may not be needed for the Coroner's purposes, but their exclusion, when they are desired, is terribly unsatisfactory. This Coroner is again engaged in the language of therapy and closure, but the emphasis is on creating a space for family's differentiated experiences of bereavement. However, this space can be risky. One Coroner described a road traffic inquest in which a child had been killed. The driver who had run over the child was very distressed at what had happened, and at the conclusion the family asked to say something. The Coroner acceded to their request nervously,

> and of course, I don't know what they are going to say, but they say something like, could you make it clear to the driver of the car that we don't blame him in any way and we hope he has not been adversely affected – I remember being considerably affected by it – they said it's not his fault, no blame on him at all.

In addition, as the rise in narrative conclusions illustrates,[288] it is the creation of a space out of which a contextual conclusion can be produced (Scott Bray 2010, 587). Tait and Carpenter (2013, and see Carpenter et al 2015) have highlighted the role of the family in influencing conclusions, and while my focus was on the hearing and not on the conclusion, one Coroner did reflect on this in detail in my interviews,

> closure is important so that is partly about addressing the issues and worries as far as we can do it through the process of the inquest, and it is partly about reaching conclusions that seem appropriate to that. One of the ways I do that is I have a lower threshold for doing a narrative conclusion. If the family appear to need an explanation, or if there are complexities, my worry is if I provide a short form conclusion of natural causes, and button it all up, that it looks as if I have just dismissed everything. I know in law I might be entitled to do that, but if there are recorded one or two relevant circumstances, I think that the family are often happy that they have been listened to and it is there. The statisticians don't like it, I don't know if the chief coroner likes it, but I think that sometimes that's appropriate.

The concern is with dismissal of contingency and complexity, and the attention of the Coroner is on a meaningful conclusion which recognises the participating family. As the Coroner notes, the rise has left statisticians concerned about accurately coding deaths (Hill & Cook 2011), but may be helpful for more nuanced contextual studies of death (see Brown 2014), and has to be considered in the context of other critiques of the accuracy of death statistics, particularly in relation to suicide (see inter alia Atkinson 1978; Cooper & Milroy 1995; Tait & Carpenter 2013; Palmer et al 2014). However, concerns about statistical accuracy and the function of death statistics are not limited to suicide (see Prior 1985; Pemberton 1988), and it was revealing that in another set of reflections on conclusions a Coroner demonstrated two sides of this debate. Firstly, reflecting on the importance of statistics coming out of inquests in relation to deaths from asbestos, the Coroner stated that the key was that 'suddenly we get some reliable statistics on how prevalent it is' and this enabled action to be taken against widespread use of asbestos. The same Coroner later stated that over the past decade they had witnessed a 'considerable uplift' in criticism of doctors where individuals had undergone elective surgery which had gone wrong and resulted in death. The Coroner's concern was that 'I suppose misadventure would cover it, as willing acceptance of a known risk, but misadventure doesn't clarify it to a lot of bereaved people, who think misadventure means someone has done something wrong.' The attention of the Coroner was therefore not on the collation of

[288] Narrative verdicts/conclusions are included with other non-standard conclusions in the unclassified category, which has risen from 1% of verdicts in 1995 to 18% of conclusions in 2014 (see Coroners Statistics 2014, 19).

statistics, but was rather directed to making sure the outcome avoided the risk of blame. They described their practice in such circumstances of crafting a conclusion 'to make it clear' to the family that the death was a result of medical intervention but the doctor was blameless.

Conclusion

The inquest hearing needs family; their attendance may arouse concerns with ordering, but the absence of kin poses a greater threat to the undertaking. They may embody, connect and channel a wider tacit community, and they can precipitate the transformation of the hearing from formally public into a substantively public space, expanding the focus of the hearing, provoking the need for the presence of witnesses or a jury, and connecting the death to concerns of dignity and a narrative of an individual lived life. Paradoxically, the need for family, expressed through a jurisdictional technology of disclosure as part of enabling their participation, can simultaneously act to limit the public nature of the hearing itself; meaning families do not see the need to attend, or enabling the curtailing of evidence made available in the public space.

It is a public space ostensibly directed towards reaching a conclusion, but as Davis et al argue, the conclusion of an inquest is only a small part of the purpose of the investigation.[289] However, it can be a very important part from the perspective of the family, and my interviewees highlighted many of those reasons, including a risk that families blamed themselves for the circumstances resulting in death. One Coroner felt it was important that

> where someone is blaming themselves, by having an inquest where they are exonerated, I am not saying that an inquest is there to exonerate people, but where it is so clear and it is said to them that they would have died anyway, then it brings them that bit of closure.

This quote encapsulates the wider ambiguity of the inquest; a space which appears required only to answer four limited questions and record the details required by the Registration Acts, but which, when viewed through a jurisdictional lens, can be seen to act in and through legal means to exonerate; to reveal, to explain and to require justifications; to uncover, attribute and obscure blame; to set standards; and ultimately to establish a responsive meaningful account of who someone was, and how they died.

[289] For Davis et al (2002, 59-60), this is a point particularly powerfully made in relation to road traffic accidents; they argue that it is 'implausible' to regard inquests into deaths on the roads as being directed towards a verdict, as they will invariable result in a conclusion of road traffic accident (now changed to collision, unless the high threshold of unlawful killing is met, see Matthews 13-46–13-59 & 13-65).

Chapter Nine: Reimagining the politics of death & kinship, and the possibilities of justice

In my account, the critical rupture between the historic and the modern inquest is encapsulated in the abolition of the deodand, which had previously simultaneously represented, embodied and reaffirmed the connections between community, the dependant bereaved and the law of the inquest. The replacement of the deodand with a fatal accident claim split these three, and a simple argument for this thesis might have been that contingency and community was lost to the inquest in this moment, never to return. Continuing this line of argument, a rough caricature of the subsequent shift which I have described as the move from the modern to the contemporary inquest could note the growing but limited role of the family, involved at the behest of the Coroner as part of the governance of social responses to death. Such an account might conclude with an examination of the ways in which the inquest system continues to restrain, control and discipline the family and exclude the wider community.

However, such an account would require the assertion of two fundamental theoretical tenets, which I have sought to disrupt through empirical and jurisprudential analysis: the assumption of a fixed (or even fixable) category of family and in the presumption of a fixed bio-political focus for the inquest as part of a medically focussed politics of death.

In contrast, my account has sought to enrich existing literatures on jurisprudence, death, family and kinship by integrating power, contingency and fluidity into an analysis of the contemporary inquest system and the law of the contemporary inquest. Examining the ways in which notional divisions into public and private are troubled by my research, exploring the critical role of the process of investigation before the hearing, and responding to the key role of materials in the construction of the inquest, I argue that looking at the inquest through the negotiated category of family makes possible a fundamental reimagination of the politics of death. Furthermore, I argue that this shifting response to death calls for a reconfiguration of the politics of family and kinship, and that an acknowledgment and engagement with the contingent co-constitution of kinship and death opens up questions of law and the possibilities of justice.

In this conclusion, I set out reflections on these themes in three final sections, and argue that that the contemporary inquest's rediscovery and refashioning of the constituent themes of the deodand – those of contingency and community – has recalibrated the politics of death, family, and the relationship of law and justice.

The politics of death: the conclusion of the inquest

Prior's ground-breaking analysis of the 'social organisation of death' in Belfast in the 1980s argued for acknowledgement of the ways in which death remained visible throughout the twentieth century, but only through 'an objective and scientific language which speaks of mortality, disease and causation, rather than one which speaks of attitudes, sentiment and awareness' (Prior 1989, 11). Drawing on Weber, he argues that 'such investigations tell us nothing about the meaning of the world or of the objects within it' (Prior 1989, 11). Prior's work emphasises this with a division between public and private accounts of death. The first section on public narratives discusses this medico-legal discourse, including extended focus on the work of the Coroner. Family and the bereaved are entirely absent from this section, organised out of the 'public' into the second part on 'private discourse.'

As my account above shows, the place of family in the contemporary inquest means such a stark divide is no longer coherent. This is not solely – as I have discussed at length – the role of family in the investigation and public hearing, but also in relation to the conclusion of the inquest (until 2013, the verdict). Critically, the 2009/2013 amendments, which turned the inquest verdict into the inquest conclusion, left the contents of that conclusion unprescribed, beyond a direction that 'straying from the list [of approved short form conclusions] will usually be unwise' (Chief Coroner 2015, 6). Coroners and juries can thus use a short-form conclusion of their own choice, or replace or supplement a short form with a narrative conclusion.[290] Many of my interviewees described the conclusion as important for constructing the family's understanding of what happened, and the Chief Coroner emphasises this, along with the importance of 'clarity': describing the importance of reaching a conclusion which is 'accessible for bereaved families and public alike, and also clear for statistical purposes.'[291]

My account takes this contemporary emphasis on understanding and explanation as foundational, and in exploring these themes, I argue for the need for a critical re-examination of Prior's account, in particular in relation to the ways in which a central family in the inquest impacts on the 'public' aspects of systemic responses to death.

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[290] With some limitations and directions for the use of such conclusions, see Chief Coroner 2015 and Matthews 2014, 311-347. It should also be noted that even a short form conclusion will include the inquest's answer to the question of 'how' a person died with a short summary of their findings of fact.

[291] Chief Coroner 2015, 6. The Chief Coroner emphasises that this means that 'wherever possible Coroners should conclude with a short-form conclusion' and that long narrative verdicts in comparison 'achieve neither clarity nor accessibility [and] make it difficult to assess for statistical purposes' (2015, 6 & 8).

With a focus on how deaths get into the Coronial system and how they are classified,[292] Prior points to the ways in which a public health/medical focus on pathology compels particular forms of knowledge about death, concentrating on the 'recording, measuring and (causal) explanation of human mortality' (Prior 1989, 12).[293] It is thus an account which links closely to Foucault-inspired reflections on risk as a method of governance (Ewald 1991; Castel 1991; Green 1999). Crucially, risk has moved as a theme through my analysis; the need to combine accountability and the risks of failing to do so, and the risks which that endeavour is perceived to present to ordering or grieving. However, a critical distinction between risk in my account of the contemporary system and that of a more explicitly Foucaldian account is the role of pathology in promoting consciousness of risk, and encouragement to manage our own risk. Where Prior argues that the inquest individualises death, I argue, drawing again on Butler (2006), that the inquest can reaffirm, refashion and reveal interconnectedness.

As I note in my introduction and as I explore through the interview materials, the risks which can be identified in this reformulated inquest system are not only the risks bound up in identification and promulgation of statistically verifiable dangers and an encouragement to plan to avoid those risks, it is also the risks inherent in social connection, and the dangers to identity of a loss of that connection. This is not a risk formulation in which risk is assessed, captured and provided for through reduction to numbers, but is instead a risk that the inquest will fail to engage in the critical interpretative task of opening up and exploring the meaningfulness of context and connection.

It is my argument that it is in the contested space created by these competing and (potentially) complimentary narratives which a recalibration of the politics of death can be situated. This account draws on the analysis of Burney (2000) and the productive interplay in the historic-modern inquest between narratives of scientific and legal expertise on one hand and popular sovereignty on the other. In the contemporary inquest, this productive tension is between narratives of public health and a reinvigorated narrative of kinship. It is the newly reinforced power of the bereaved which, for example, has forced the reopening of high profile historic investigations from Hillsborough to Deepcut barracks; inquests which give greater voice to family and open up possibilities of nuanced, contextual and powerful critiques of the State.[294] Situated in an individually negotiated space

[292] For some more contemporaneous accounts of the relationship between medical professionals and the inquest system see inter alia Gilleard 2008; Tuffin 2009; Barnes, Kirkeegard & Carpenter 2015.
[293] And see Buchanan & Mason 1995; McGowan & Viens 2010; Hill & Cook 2011; Hawton et al 2014 for the ongoing strength of this approach and consequent criticism of the mixed messages produced by the contemporary inquest, and see Annex A, Coroners Statistics 2012 for research on coding of narrative verdicts.
[294] I have not engaged at length with such high profile cases in this research. While I contend that they merit far more academic research, in this analysis I have sought to focus on the more mundane and commonplace investigations which receive even less scholarly attention.

between the requirements of medical/legal knowledge and the engagement of a tacit community around the deceased, the contemporary inquest strives to encompass both the pathological and the relational. Crucially, it is not the aim of this thesis to assess whether an individual inquest succeeds or fails on these terms, but rather to argue for an analysis that each is necessarily constructed through such an endeavour.

Other research has identified this tension, and has highlighted, as some of my interviewees suggested, a prioritisation of understanding in the individual case over attention to governmental aims. Tait & Carpenter (2013) raise the question of whether this 'relative disregard for the governmental aspects of the Coronial role' (Tait & Carpenter 2013, 200) means that Coroners have 'allocated themselves a role within' what Rose terms the 'therapeutic community' (Rose 1990). Miller & Rose argue that this rise of therapeutic authority is enacted through a process of problematisation, diagnosis and intervention (Miller & Rose 2008, 142-3), and an analysis of the inquest founded on this would frame the Coroner as acting in a calculated way to resolve the psychological trauma caused by death. Drawing on their interview material, which has close parallels to mine in many parts, Tait & Carpenter query whether the focus on closure means the inquest is part of 'the governance of subjective experience' (Tait & Carpenter 2013, 200); but go on to counsel against simple binaries, concluding that 'The English Coronial inquest appears to have an equally complex relationship between its bureaucratic and pastoral functions, a relationship that has yet to be fully, or even partially, resolved' (Tait & Carpenter 2013, 200).

It is the ambiguity and openness in this negotiated relationship that creates the potential for a flexible response to death and a thicker form of accountability for death through the inquest, and, as part of this, a negotiation of kinship.

The place of kin-family

It is central to my account that the family in the contemporary inquest is constructed in the contingent development of the investigation and cannot be pulled away from that context and defined without reference to it. There is thus no fixed category of family in my analysis, but instead I observe the concept of family as a critical template against which actors inside the system and 'family' members themselves determine boundaries of the tacit community around the deceased.

My research thus seeks to reveal the ways in which formal legal categories and rights diminish in importance in comparison with entry to the category of 'family'; constructed both outside and

through the inquest process through the negotiations which receive the family as other.[295] In this process, family's autonomy to determine its own edges works in productive interplay with the system's desire for ordering, in 'an experience which welcomes what is to arrive, but preserves a tentative – and incomplete – mastery over the event' (Pavlich 2005, 104). Family is thus the way in which the tacit community crystallises – it is the way in which the inquest joins the need for a substantive connection to the deceased to the ordering of law.

This negotiation is not unboundaried, and critically, the systemic need for the bereaved means the contemporary inquest necessarily engages with a more fluid conception of family, representing a shift in the politics of family in this context from formal licit relationships to a greater emphasis on kinship. Such individuals could be termed 'kin-family' – involved by dint of a connection to the deceased which is made more important than formal family by the need for a meaningful investigation and outcome, but still inseparably connected to notions of formal family. The potentially ambiguous relationship between the two is exposed in the sometimes uneasy slippage in official language between 'family' and the 'bereaved',[296] the fixed and fluid categories of 'interested persons' and the undefined 'next of kin.' Critically, as my interviews demonstrated, an endeavour to explicitly interrogate these categories in the abstract founders on a preference for assessment of individual facts and circumstances case-by-case. It is here that the vignettes were particularly important for my research; demonstrating the contingent ways that boundaries are set – by kin-family themselves, and by actors in the system. The emphasis was on openness to kin-family, in their own right, and as a link to a wider community, with potential implications for the 'public' nature of the inquest.

My research argues that inquests may be public hearings, but they are also intimate and personal hearings, often with no-one there except for individuals connected to the deceased, and the methodological and theoretical questions which arise in relation to consent in such public intimate spaces is an area ripe for further research. The contemporary inquest makes the kin-family complicit in the construction of this space; a paradoxical role in which their tacit network of relationships with the deceased and their willingness to engage is critical to the authorisation of that law whilst they are simultaneously crystallised as subjects of the law of the inquest. This is because kin-family bring a texture of debate which resists typification and reinforces links to community (Morgan 2006, 259); acknowledging the ways in which we are 'socially constituted bodies, attached to others [and] at risk

[295] And which are 'bound to life' and thus 'degrees of historically situated mastery and calculation are unavoidable' (Pavlich 2005, 105).
[296] See, for example, Ministry of Justice 2013.

of losing those attachments' (Butler 2006, 20). It is the essence of kin-family that they can provide this necessary contextual tenor, and examination of the process of investigation reveals the negotiation of this ambiguity, with systemic deployment of provisional 'decisions' taken on trust, seeking a tentative balance between an emphasis on relationality and the perceived reliance of law on formality and objectively verifiable status.

As my analysis shows, this process is delicate and can be skewed when risk is focused not on the loss of attachment but on the dignity of the process, transforming the concern with connection and conscience into an emphasis on office and legal rights. In an individual case, the impact is that kin-family can give way to formal status, and that concerns with privacy and protection shut out alternative possibilities of kinship or close down the space for the bereaved.

There are three critical moments in this construction: (1) the separation of kin-family from the wider community – which takes effect through the use of legal writing and notification; (2) the enabling of the effective participation of family through disclosure of papers to the family; and (3) the form of the family's ability to question. These legal devices are central to the place of family in the inquest as a jurisdiction which seeks to create an engagement with convivial accountability. Where the abolition of the deodand demonstrated a reassembling of death and the family as legal subjects constituted by knowable relevant factors, stripping away identity (O'Malley 2009, 66), the construction of the kin-family in the contemporary inquest can be framed as a return to ambiguity, an endeavour to reimagine the politics of both death and family; reinserting identity, emphasising emotional connections ahead of formal relationships, and thereby re-engaging law with the unknowable and contextual. This ambiguity and openness points to the prospect of a reimagining of the role of law and the possibilities of justice.

Looking for justice: the possibilities of law

The inquest in my account is a space in which the lawful place of family is key, constructed by a focus on effective participation without a determinant idea of what that effective participation is oriented towards. My work calls for an attention on the form of the place for kin-family, a question which is a primary procedural issue for law, revealed by attention to a concern with jurisdiction. In this account therefore, law is not a tactic of governance or an exercise of sovereign power, but is perhaps a place from which forms of justice can become, in a space created by the de-centering of technocratic accountability and expertise and the insertion of the indeterminacy and contingencies that the bereaved can bring. It is a call for us to imagine justice otherwise.

The inquest is not an obvious place to look for justice. My interviewees did not discuss justice, and findings of fact and conclusions are not framed as declarations of justice. Families may not be

seeking a traditional notion of justice, and where they are seeking it, may find their search frustrated; as Razack (2015) shows, the inquest can be a place of deep and abiding injustice. However my research project has sought to explore the inquest as a place charged with going beyond the medico-legal to engage with a meaningful accounting of life and death. My argument is that approaching the inquest through the place of the kin-family, an emphasis on legal process and jurisprudence, and a broad conception of accountability, is to approach justice tangentially. I suggest that this approach is productive, resisting accounts of a determinate and closed approach to justice, and enabling me to seek out prospects of an open-ended justice, a justice which is instead 'never, never fully answered' (Derrida, in Pavlich 2007, 110). In this context, as Pavlich notes,

> It is thus important to approach local calculations of justice with a sense of disquiet, remaining vigilant to their inevitable dangers and open to other possible computations. This underscores the importance of opening up to the arrival of unexpected events, ideas, and thereby preventing any image of justice from declaring itself as necessary, or as intrinsically better than any other. (Pavlich 2007, 110)

Pavlich (2007) argues that one way of opening up to the unexpected could be to draw on Derrida's notions of hospitality, and suggests that this also offers a way of conceiving critical engagement without judgement (Pavlich 2005); a focus on the negotiation, and welcoming features of hosting the other as a means to engage with indeterminacy;

> The contingency of hospitality is crucial to an uncertain, undecided, set of negotiations that deliberate on how to be (how to live) with others. And the negotiations are unique to the extent that they require the host to receive the other as other, without denying or yielding the mastery entailed by the role of law. (Pavlich 2005, 104).

The legal techniques I identify are critical in this open negotiation. The notification of kin-family separates them from a broader community, and enables them to co-construct their relationship with the system and speak for – and to – the wider community. Where the deodand once represented ancient common law liberties and gave power to the jury, the material of disclosure transfers authority to the kin-family, while the second aspect of enabling their participation – the form of their right to ask questions – calls us to attend to the ways in which the effectively participating kin-family is now analogous to an effective investigation and to engagement of forms of the public. The implication is that the openness to the unexpected – the possibility of justice – in an inquest is constructed through law, through engagements with the lawful presence and participation of the bereaved. My focus has been the inquest process, and I do not seek to make broader claims, aside from a closing suggestion that an implication of a focus on process and on the potency of kinship

might be an opening up of conceptions of law outside the inquest, for accounts of the authority and authorisation of law, and for possibilities of justice in other contexts.

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