



Response to *Coroner Reform: the Government's Draft Bill*

Introduction

The Childhood Bereavement Network (CBN)

The CBN is a national, multi-professional federation of organisations and individuals working with bereaved children and young people.

The CBN is supported by all the major bereavement care providers and has approximately 300 members across England and the UK; around 70% are organisations. Most of these organisations operate in the voluntary sector, and have charitable status. All members subscribe to a *CBN Belief Statement* that states

'all bereaved children and young people have the right to information, guidance and support to enable them to manage the impact of death on their lives.'

The work of the CBN is informed by a Consultant Panel. Current organisational members include

- Acorns Children's Hospice
- Barnardo's
- Bereavement Services Association
- Cruse
- Essex CAMHS
- Jigsaw4u
- Macmillan Cancer Relief
- Marie Curie Cancer Care
- National Children's Bureau
- Northern Ireland CBN Steering Group
- Norwich PCT
- Notre Dame Centre/ Seasons for Growth
- Release - Nightingale House Hospice
- SeeSaw
- St Christopher's Hospice
- The Child Bereavement Trust
- The Laura Centre
- University of Gloucester
- Wigan Family Support Team Counselling Service
- Winston's Wish

CBN is hosted by the National Children's Bureau (NCB). NCB promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

As an umbrella body for the children's sector in England and Northern Ireland, NCB provides essential information on policy, research and best practice for our members and other partners. NCB aims to:

- challenge disadvantage in childhood
- work with children and young people to ensure they are involved in all matters that affect their lives
- promote multidisciplinary cross-agency partnerships and good practice
- influence government policy through policy development and advocacy
- undertake high quality research and work from an evidence-based perspective

- disseminate information to all those working with children and young people, and to children and young people themselves.

NCB has adopted and works within the UN Convention on the Rights of the Child.

The issue

Approximately 53 children a day are bereaved of a parent in the UK, equating to around 20,000 bereaved children and young people each year.¹ The death of a parent, sibling or other close relative or friend can have a devastating impact on the life of a child or young person, and their family. Bereavement and loss can significantly diminish a child's resilience and affect their emotional and physical health in both the short and long term.

At key transition points in their life, bereaved children will revisit and reassess the impact of the death. These periods of readjustment - which may occur years after the death - may also affect their physical and mental health and behaviour. Bereaved children are particularly vulnerable to being bullied and to school exclusion.

The death of a significant member may also have an adverse, traumatically disruptive effect on family dynamics, relationships and functioning.

There is increasing evidence that the experience of bereavement - if not properly acknowledged and supported - can lead to negative outcomes for children, young people and their families, and may have an adverse and enduring impact on emotional and physical health. Unfortunately, lack of research and comprehensive statistical data has inhibited informed debate on the issue and the development of effective policy and practice in the field of bereavement care for children.

Response to the draft Bill

The Childhood Bereavement Network welcomes publication of the draft bill, in particular the new focus on the involvement of bereaved families.

A draft of this response was sent for consultation to the CBN Consultant Panel and Parents' Forum.

General points

We are pleased to see the Bill written in plain English, and to be accompanied by explanatory notes. However, the status of these notes is not clear and in sections, what appears to be an explanation of the bill may simply be an aspirational interpretation of it. It would be helpful if the notes' status could be clarified.

Our comments are restricted to clauses and provisions which are likely to affect bereaved children and young people. They may be in contact with the coroners' system as witnesses at inquests, or as interested people.

If a lone parent dies, the child or children may become looked after by the local authority, and may be moved out of the area. In these circumstances it may be

¹ Statistics supplied and verified by Winston's Wish, a bereavement support service for children and young people.

more difficult for a child or young person's rights as an interested person to be upheld. It is vital in these circumstances that the Coroner's office investigating the death maintains contact with the child's social worker.

Specific clauses

Clause 30: Directions prohibiting publication of information

Many families experience serious and persistent intrusion into their lives following the publication of details of a death in the press. Misrepresented or sensationalised details can be particularly difficult when families are trying to explain the circumstances of the death to a child or young person, which is known to be a critical process to aid healthy grieving.

The notes suggest that publication of some details would be banned in the cases of suspected suicides or child deaths. We would argue that the same protection should be offered to families where children are likely to be affected by invasion of privacy.

Clause 41: Presence of public at inquests

It is not only the reporting of details of an investigation which distresses families, but also the presence of other people at the inquest. The Bill does not clarify the circumstances in which the proposed Coroners' Rules would exclude the public from an inquest - the only circumstance mentioned here is that of safeguarding national security.

We would suggest that the Coroners' Rules need to include provision for holding inquests in private if there are compelling reasons why a public inquest would distress the family.

Clause 44: Evidence of person under 17 through live link etc

We welcome provision for children and young people to give evidence through live link or in a cleared courtroom.

We note that directions can only be made under this clause if the senior coroner believes that they would improve the quality of the child or young person's evidence. There are circumstances in which giving evidence via live link might not make a difference to the quality of the evidence, but it would make a difference to the child or young person's well-being. Therefore the senior coroner should be able to make these directions if it is felt that the child or young person could be caused distress.

We are concerned that the Bill does not include provision for the restriction of publication of the name or other identifying details of a witness who is a child or young person. The explanatory notes suggest that even when those under 17 are giving evidence in a 'cleared courtroom', one nominated member of the press will remain. The coroner should be able to restrict reporting which might identify a witness under 17.

Clause 53: Retention of human remains

Many families express distress and concern about remains being kept for long periods. This can cause difficulties in viewing the body and in arranging the funeral. Some children and young people want to view the body of the person who has died and this can help them to understand the permanence of death. If the

body is kept for a long period it may deteriorate to a point where it is not suitable for viewing.

Therefore we welcome the provision that coroners cannot retain human remains for more than 40 days without applying to the Chief Coroner, and the provision for families to request early release of the body for personal, cultural or religious reasons.

Clause 57: Training and guidance

We welcome the duty on the chief coroner to provide for appropriate training and guidance for coroners and their staff. Training should incorporate an increase in coroners' knowledge of the way that bereavement affects children and young people, improving skills in dealing with witnesses under 17 and an exploration of how the coroners' system affects children and young people who are interested persons.

The intention that guidance should cover support to bereaved people should be extended to support to bereaved children and young people. This could include signposting to childhood bereavement services and information for parents on supporting their children.

The status of this guidance should be made clear, in particular whether it will be an aspirational framework or a set of requirements.

Clause 65: Guidance by the Lord Chancellor

We support the Lord Chancellor being given power to issue guidance into the way in which investigations and inquests affect interested persons. We also welcome the publication of the draft Charter for Bereaved People. However, we realise that the Charter is an intended document rather than one which the bill actually provides for, and we would like to know what power the Charter will actually have.

We also welcome the intended publication of information leaflets about the coroners' system and support available to bereaved people. This information should include up to date contact details for local and national childhood bereavement services. It could incorporate suggestions to parents about how to support bereaved children.

Clause 76 "Interested person"

We note that many of the categories of 'interested persons' defined in the Bill could include children and young people. Children and young people may need special assistance in realising their rights as interested persons and we feel that more clarification is needed on how this would be made available.

Illustrative draft charter for bereaved people who come into contact with the coroner service

We welcome publication of this illustrative draft, and feel that this will improve the understanding which bereaved families have of their rights and roles in the system.

As mentioned above, the proposed status of the Charter should be clarified.

We notice that the Charter refers to bereaved families as ‘bereaved people’ ‘next of kin’, ‘the family’ and ‘interested parties for the purpose of investigations’. Not all family members will be interested parties, and vice versa. It would be useful for the Charter to define these terms. The Charter should also show how the diversity of opinion which may be found in one family will be represented.

Objectives and values

Children and young people are mentioned specifically in only one of the objectives, to inform and consult them during the investigation process. If they are to be mentioned at all, they should be included in the other objectives, such as being helped to understand the cause of death of the person who has died and being informed of their rights and responsibilities. This may be particularly important for children and young people who are looked after by the local authority.

Point 19: this makes provision for families to visit the court and be made familiar with the court layout before an inquest. This should include children and young people who may be appearing as witnesses or otherwise attending.

Point 25: availability of support and bereavement services

Information available to bereaved families should include up to date contact details of local and national childhood bereavement services. The coroner system could also consider developing a leaflet or resource for families about supporting a bereaved child or young person in contact with the coroner system.

Point 28: review and appeal rights of coroners’s decisions

The charter says that family member who are interested parties will be consulted about a number of decisions, where they have indicated a wish to be consulted. The charter should make clear how families will be able to indicate this, and whether they will be given opportunities to change their mind about being consulted as the investigation proceeds.

This section should include guidance on decisions about whether witnesses under 17 should give evidence via live link or in a cleared courtroom.

Case studies

Case study one

Staff at Winston's Wish, the charity for grieving children and their families, worked with a young person aged 12 whose father had been seriously injured in a road crash and later died. The young person hadn't been present at the crash and the mother was afraid to establish the facts and answer questions about what had happened and why, for fear of making things worse. Gaps in the young person's understanding were being filled by conflicting and upsetting gossip in the local community.

Staff at the service helped the mother to explore her concerns and explained how knowing the details of the father’s road accident and subsequent death could help her child. Being supported to read and understand the coroner’s report of the road accident and reading all the witness statements helped the young person to find out what had really happened and to build up a coherent and accurate story, rather than one based on gossip. The young person continues to do well and feels confident to handle any gossip that may come up about the father’s death.

Key points

- Bereaved children and young people need to understand the cause of death. The objective of the coroner service in the draft Charter which refers to 'help bereaved people to understand the cause of death of the person who has died' therefore must also include children and young people
- Gossip in local communities can impair children and young people's ability to build an accurate picture of what has happened. It can upset them greatly and be seen as disrespectful to the person who has died. Coroners should take this into account when liaising with the press
- Some family members find it difficult to communicate with each other following a death. Coroners must be aware that sometimes one member of the family cannot represent the whole, and must make arrangements for all interested parties to be involved.
- Coroners must be aware that it is natural for family members to not speak openly. This can be especially relevant with regard to children. Adults in the family often have an inbuilt desire to protect which can leave children with an incomplete picture, together with a sense that this subject is not to be talked about. Often a more emotionally neutral third party like a coroner or specialised child bereavement service can be a useful starting point to give parents the confidence to involve their children in matters that affect them greatly

Case study two

A coroner decided that a full inquest needed to be held into a death through a suspected drug overdose. Knowing that children were directly affected by the death, the coroner included a copy of Beyond the Rough Rock, a publication from Winston's Wish about supporting children bereaved through suicide, when notifying the family about the inquest. This had helped the family talk to the children about what had happened.

Key points

- Coroners should make information about supporting bereaved children and young people available to families as early as possible in their contact with them. This information should include up to date contact details for local and national sources of support.

For more information about this response or the work of the Childhood Bereavement Network, please contact

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