

## CBN response to Ministry of Justice Discussion Paper: Sensitive Reporting In Coroners' Courts

The **Childhood Bereavement Network** (CBN) is the national, multi-professional network of over 300 organisations and individuals working in the field of childhood bereavement. CBN promotes the interests of bereaved children, young people and their families and encourages the development of quality support for them. It is hosted by the National Children's Bureau.

### General comments

We are disappointed that Clause 30 of the draft Coroners' Bill has been removed. Notes accompanying the clause suggested that the reporting of some details of inquests would be banned in the case of suspected suicides or child deaths. In our response to the draft Bill, we suggested extending the proposed to situations where bereaved children were likely to be affected by the invasion of privacy.

Given the removal of Clause 30, we are strongly supportive of the proposed refinements of the Press Complaints Commission's code of conduct for the press, and the drive to increase public awareness of the Code. It would be helpful to publish case examples alongside the revised Code, to guide journalists and editors' decisions. Hopefully, this would embed the revisions in journalistic practice without bereaved families having to bring complaints as a way of driving change forward.

As the cases in the discussion paper show, 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.

Although this paper relates specifically to press reports around the time of the inquest, families also report adult and children's distress at reports immediately following the death, around the funeral and at other times. Bereaved families report that if a later death bears similarities to the one which affected them, their story is often brought up again, with pictures and details being reprinted, adding to their distress. If appropriate we could provide the Editor's Committee with examples of this.

### Specific comments relating to clauses

*5.ii) When reporting suicide, care should be taken to avoid unnecessary detail about the method used, and editors should be sensitive to the effects reports may have on those who are bereaved, including children.*

We welcome the addition to this clause.

*6.vi) Editors should be particularly sensitive to the effects reports of the deaths of children may have on grieving family members.*

We welcome this new clause, and suggest that it could be made more explicit by replacing 'grieving family members' with 'grieving family members, including other children'.

*6.vii) Editors should be sensitive to the effects on children when reporting the deaths of parents or other adult family members*

We welcome this new clause but suggest replacing 'other adult family members' with 'other family members or friends'.

*6.viii) When reporting the evidence given by children at inquests, the press should, even if legally free to do so, think carefully before identifying them by name and consider, in particular, what effect the report may have on their private lives.*

We welcome this new clause but feel it is rather weak and leaves much room for interpretation. We suggest it could be strengthened to 'The press must not, even if legally free to do so, identify children under 16 giving evidence at inquests'

#### Suggestions for improving public awareness of the Code

We agree that revisions to the Code must be accompanied by greater public awareness of it, and the processes by which complaints can be made.

Families report press intrusion starting in the immediate aftermath of a death. This means that Coroners' offices should be publicising the code as soon as they are in contact with bereaved families. Other statutory and voluntary agencies – including hospital staff, police, Victim Support and bereavement support organisations - have a shared responsibility to publicise the code, although this may be beyond the scope of this paper.

However, providing information about the Code may not be sufficient. Coroners' offices and other organisations should be able to provide advice and ongoing support to families in bringing complaints. This will have training implications for staff in these organisations.

We would be glad to play a part in increasing our members' (childhood bereavement practitioners) awareness of the Code and their capacity to support families in bringing complaints. We would be pleased to work in partnership with the Coroners Unit and/or the Press Complaints Commission to develop any or all of the following:

- an article about the Code in a forthcoming newsletter
- a speech at our national conference
- input into our series of regional meetings for childhood bereavement practitioners.

#### Case study: the experience of a bereaved family

*'When my partner died, a local reporter on a dubious rag made unseemly attempts to get a story. She made an assumption that my partner had died from a hospital-acquired infection and wanted to name her as another statistic in her attack on the dreadful NHS. Not only was she wrong about the cause of death but my experience of the two hospitals my partner was in and of the staff was that they could not be faulted.*

*At a time when I, and the children (although they were not aware of this reporter's behaviour), were trying to say our goodbyes and begin to look for ways forward I was having to seek legal advice to stop the intrusion. All went quiet after a letter from my solicitor until I had a scribbled note on a tatty bit of paper from the said reporter who had called at the house. We were out but if my eldest had been at home he would have answered the door and who knows what methods would have been used to feed this person's distorted storyline.*

*The Coroner's office were helpful in arranging closure by letter rather than an open inquest but I have to say I was all at sea without any idea as to how to manage things.'*

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

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