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Tuarascáil maidir le Scrúdú ar Oibriú na Seirbhíse Cróinéara

Feabhra 2023

Joint Committee on Justice

Report on an Examination of the Operation of the Coroner's Service

33/JC/32

February 2023

Table of Contents

CATHAOIRLEACH'S FOREWORD 2

COMMITTEE MEMBERSHIP 3

Joint Committee on Justice 3

COMMITTEE RECOMMENDATIONS 6

SUMMARY 8

CHAPTER 1 - Engagement with Stakeholders 10

Introduction 10

CHAPTER 2 - Summary of Evidence 12

1. Implementation of the recommendations from the Department of Justice's Review of the Coroner's Service 12
2. Re-organisation of the structure of the Coroner's Service 14
3. Implementation of recommendations following an inquest 15
4. Selection of a jury for a coroner's inquest 16
5. Resourcing and renumeration of the Coroner's Service 17
6. Methods of appealing the verdict of a coroner's inquest 18

CHAPTER 3 - Summary of Submissions 19

1. Qualifications or experience required to become a Coroner 20
2. Selection of a jury for Coroner's inquest 22
3. Experience of the inquest process for relatives of the deceased 24
4. Implementation of recommendations made following an inquest 26
5. Recommended changes to the current Coroner's Service 28
6. Additional Points 31

APPENDICES 33

APPENDIX 1- ORDERS OF REFERENCE OF THE COMMITTEE 33

APPENDIX 2 - LIST OF STAKEHOLDERS AND SUBMISSIONS 40

CATHAOIRLEACH'S FOREWORD

The Committee was pleased to facilitate an examination of 'The Operation of the Coroner's Service'.

The Committee was cognizant that a number of media reports had examined this topic over the last year and had highlighted various areas of the Coroner's Service that were in need of further scrutiny and reform.

While recognising that previous efforts to reform areas of the Coroner's Service had resulted in some legislative reforms being implemented, including the passing of the *Coroners (Amendment) Act 2019*, the Committee recognised that other recommendations and proposed legislative reforms have not yet been implemented.

In reaching out to stakeholders to gain diverse perspectives on the operation of the Coroner's Service, the written submissions and witnesses provided the Committee with an insight into several areas where they deemed it was most important to make improvements. Among the key areas identified include the structure and resourcing of the Coroner's Service; the selection of a jury for a coroner's inquest; and the follow-up and implementation of recommendations stemming from a coroner's inquest.

The Committee has made a number of recommendations for these areas and a copy of this report and recommendations will be sent to the Minister for Justice. The Committee looks forward to working proactively and productively with the Minister to address the issues identified regarding the operation of the Coroner's Service.

I would like to express my gratitude on behalf of the Committee to all the witnesses who attended our public hearing to give evidence and those who forwarded written submissions to the Committee.

James Lawless TD (FF) [Cathaoirleach]
February 2023

COMMITTEE MEMBERSHIP

Joint Committee on Justice

Deputies

James Lawless TD (FF) [Cathaoirleach]

Patrick Costello TD
(GP)

Alan Farrell TD
(FG)

Pa Daly TD
(SF)

Aodhán Ó Ríordáin TD
(LAB)

Martin Kenny TD
(SF)

Thomas Pringle TD
(IND)

Niamh Smyth TD
(FF)

Senators

Robbie Gallagher
(FF)

Vincent P. Martin
(GP)

Michael McDowell
(IND)

Lynn Ruane
(IND)

Barry Ward
(FG) [Leaschathaoirleach]

Notes:

1. Deputies nominated by the Dáil Committee of Selection and appointed by Order of the Dáil on 3rd September 2020.
2. Senators nominated by the Seanad Committee of Selection and appointed by Order of the Seanad on 25th September 2020.
3. Deputy James O'Connor discharged and Deputy Niamh Smyth nominated to serve in his stead by the Fifth Report of the Dáil Committee of Selection as agreed by Dáil Éireann on 19th November 2020.
4. Deputy Michael Creed discharged and Deputy Alan Farrell nominated to serve in his stead by the Fifteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann on 28th June 2022.
5. Deputy Brendan Howlin discharged and Deputy Aodhán Ó Ríordáin nominated to serve in his stead by the Nineteenth Report of the Dáil Committee of Selection as agreed by Dáil Éireann on 8th November 2022.
6. Deputy Jennifer Carroll MacNeill was discharged, pursuant to Standing Order 34, on 21st December 2022.
7. Senator Barry Ward was elected as Leas-Chathaoirleach at the Committee meeting on 15th February 2023.

COMMITTEE RECOMMENDATIONS

The following recommendations were made by the Committee in relation to the topic:

1. The Committee recommends that rules should be established to inform the threshold necessary to reach a verdict in an inquest, in order to ensure consistency of approach by coroners across different jurisdictions.

2. The Committee recommends that the existence of a website and adequate information on the Coroner's Service and its processes be promoted to the public and that adequate information on coronial processes be provided to the families involved.

3. The Committee recommends that consideration be given to link the registration of deaths with the Electoral Register and other public databases.

4. The Committee recommends that the Coroner's Service should be re-structured to establish an office of the Chief Coroner and an office of the Deputy Coroner, to steer leadership of the Service.

5. The Committee recommends that a 'Central Coroner Service' be established as a new statutory agency, to uphold the fundamental principles of the Coroner's Service and assist with administrative and organisational duties. An Inspectorate should also be appointed to monitor consistency in practice.

6. The Committee recommends that a structured and formalised process for implementing jury and coroner recommendations following an inquest should be introduced, similar to English and Welsh 'Prevention of Future Death Reports' (PFDs).

7. The Committee recommends that a central database be established for all recommendations made by coroners.

8. The Committee recommends that a formal jury selection process be established for juries presiding at inquests.

9. The Committee recommends that the resourcing of the Coroner's Service be re-evaluated to ensure that it receives adequate funding, for example, in terms of staffing levels.

10. The Committee recommends that consideration be given to the introduction of an accessible process to appeal the verdict of a coroner's inquest.

11. The Committee recommends that a Coroner Service Advisory Committee be established.

12. The Committee recommends that research be commissioned to examine and eliminate all forms of institutionalised discrimination within the Coroner Service and its support agencies.

13. The Committee recommends that a national training programme for existing and newly appointed coroners be developed without further delay. It should pay particular attention to delivering a client-centred model that informs and supports bereaved families.

14. The Committee recommends that work-related counselling for coroners and staff be provided.

15. The Committee recommends that, in line with other Legal Aid schemes, Legal Aid be made available to all bereaved families seeking legal representation at inquests.

SUMMARY

The Joint Committee on Justice identified the topic of 'the Operation of the Coroner's Service' as an issue that merited further examination and discussion by the Committee.

The Committee acknowledges the importance of an efficient Coroner's Service to society and endorses the statement heard during its public engagement that, 'The Coroner's Service is for the living and the dead'. While it is essential that the Service is equipped to ensure that coroners can carry out their functions effectively, it is equally important that families which take part in an inquest process feel that they are informed, supported and treated with compassion throughout this process.

In exploring this topic further, the Committee invited written submissions seeking the views of various stakeholders on this topic. Stakeholders, in addition to any general observations on the topic, were asked to comment on how the jury for a coronial inquest is selected**;** the experience of families during the inquest process; what mechanisms there are to follow-up on the implementation of recommendations made following an inquest; and the changes they would prioritise in relation to the Coroner's Service.

Based on the evidence to the Committee, the need for adequate funding, re-structuring and consistency of practices within the Coroner's Service were highlighted as vital reforms. Restructuring the Service to establish offices of the Chief Coroner and Deputy Coroner would bring leadership and consistency to the Service, while the introduction of rules to inform the threshold necessary to reach a verdict in an inquest would ensure consistency of approach by coroners across different jurisdictions.

In particular, the need to implement the recommendations arising from a coroner's inquest was highlighted. The Committee heard that 'the dead open the eyes of the living' and agreed that introducing an obligation for inquest recommendations to be followed up with would have immeasurable value for society in general, to prevent additional deaths from occurring.

The discussion surrounding the operation of the Coroner's Service and potential solutions to the issues identified are outlined in the following section.

CHAPTER 1 - Engagement with Stakeholders

Introduction

The Joint Committee on Justice invited submissions from stakeholders on the topic of ‘the Operation of the Coroner’s Service’.

On 31st May 2022, the Committee held a public engagement with several of these stakeholders, as laid out in the table below:

Table 1: List of public engagements with Stakeholders

Organisation	Witnesses
The Coroners Society of Ireland.	Professor Denis Cusack, senior coroner for the district of Kildare;
Massey and King	Mr. Steven Smyrl, director of Massey and King and an accredited genealogist Ms Nicola Morris, president of Accredited Genealogists Ireland.
ICCL	Ms Doireann Ansbro, head of legal and policy Ms Sinéad Nolan, communications manager
Co-authors of the book *Medical Inquests*	Mr. Roger Murray, SC Mr. David O’Malley, partner Callan Tansey Solicitors Ms. Doireann O’Mahony BL

The primary focus of these meeting was to allow for an engagement between the Members and stakeholders to discuss how the Coroner’s Service currently operates and areas of the service which could be improved upon.

This report summarises the engagements and the key points considered by the Committee when drafting the recommendations set out in this report.

A link to the full transcript of the engagement can be found here.

CHAPTER 2 - Summary of Evidence

In the course of the public hearing, a number of important points were raised. A summary of the main areas discussed in evidence to the Committee follows.

1. Implementation of the recommendations from the Department of Justice's Review of the Coroner's Service

Members and witnesses discussed previous efforts to reform the Coroner's Service and questioned what the status was of the recommendations made within the Department of Justice's Review of Coroner's Service in 2000. The Committee was told that 107 recommendations were made as part of this report, however, witnesses stated that several of these recommendations had yet to be fully implemented, 22 years on from the review.

It was pointed out that the passing of *the Coroners (Amendment) Act 2019*, had introduced some reforms, for example those relating to inquests into maternal deaths. However, several other recommendations from the Departmental review which had been included in Part 2 of the *Coroners Bill 2007,* [restored in 2011] had lapsed with the dissolution of the Dáil in 2016.

Of the recommendations highlighted by witnesses as being in need of urgent review included the re-organisation of the structure of the Coroner's Service (see Point 2); the implementation of recommendations following an inquest (see Point 3); the selection of juries (see Point 4); and the adequate resourcing of the Coroner's Service (see Point 5).

Alongside these, the Committee was told that the following reforms should be considered:

- **Set of consistent rules established**

A set of consistent rules should be established to guide the criteria necessary for coroners to decide upon a verdict in an inquest. This would introduce a standard

approach towards reaching verdicts and ensure consistency and clarity for families and legal advisors.

- **Information on the Coroner's Service**

Information on the Coroner's Service should be open and accessible to the public and there should be a national information system for coroners, alongside the publication of an annual report or presentation on the coronial service.

It was pointed out that providing sufficient information to families about coronial processes, e.g. what the coronial system does and what the family members can expect from a post-mortem, would not be a costly exercise but would significantly enhance the experience of families navigating these processes.

In addition, witnesses underlined to the Committee that families must be treated with compassion and respect by all those they encounter throughout an inquest.

- **Registering deaths**

In evidence to the Committee, Mr Steven Smyrl suggested that a review of the operation of section 41(1) and (2) (and related sections of the Civil Registration Act 2004) be undertaken, in order to bring it into line with section 42 of that Act. This would allow the coroner/registrar to issue a certificate regarding the cause of death to the next-of-kin or other party and ensure their input to the registration process.

2. Re-organisation of the structure of the Coroner’s Service

The Committee was informed that the structure of the Coroner’s Service needs reform and restructuring. An office of the Chief Coroner and an office of the Deputy Coroner should be established, to direct leadership and consistency of coroner practices across regions.

It was suggested that coroner districts should be re-organised into a larger regional structure, which would share operational, administrative and investigative capabilities. Alongside this, more full-time coroners should be hired to assist with staff shortages.

It was put to the Committee that a ‘Central Coroner Service’ should be established as a new statutory agency, which would uphold the fundamental principles of the Coroner’s Service. This service should be equipped to assist with duties including payment of salaries and expenses, organisational matters and training and development to maintain high-quality provision of coronial services.

3. Implementation of recommendations following an inquest

It was highlighted to the Committee that the recommendations made during a coronial inquest should be put on a statutory footing, to ensure that there is an obligation for these recommendations to be followed up on and implemented.

Witnesses highlighted to the Committee that a useful model to follow are the 'Prevention of Future Death Reports' introduced in England and Wales in 2013. This places a requirement on the coroner to compile a 'prevention of future death report' on any fault or gap identified during the inquest that contributed to the death of the individual. This report is then sent to the body or authority responsible for the issue highlighted and within 8 weeks this body must report back to the coroner to detail how it is intended to address this problem.

The Committee was told that it is vital to introduce a similar system in Ireland to ensure that different coroners are not making the same recommendations during inquests which are not being acted upon or implemented. The potential to establish a central database to record these recommendations should also be examined.

Introducing such a system would provide comfort to families and would bring immense benefit to the wider public, by ensuring that similar, preventable deaths do not occur.

4. Selection of a jury for a coroner's inquest

Witnesses commented on the value of juries providing their input into an inquest process, however, it was put to the Committee that the current system of selecting juries must be reformed.

The Committee was told that in certain areas, the same individuals re-appear to take part in the jury for an inquest and other witnesses said that they have heard of Gardaí approaching members of their local community or even putting requests on social media to ask individuals that they take part in a jury for an inquest.

Witnesses said that juries must be representative of the community that they serve and that there should be an uneven number of jurors to enable a verdict to be reached by a simple majority vote.

It was recommended that a formal jury selection process must be established and it was suggested that this process could entail a random selection of jury members.

5. Resourcing and renumeration of the Coroner's Service

Questions were raised regarding the resourcing of the Coroner's Service and the renumeration of coroners.

The Committee was informed that information surrounding the renumeration of coroner's is publicly available and has remained the same since the renumeration scales were negotiated in 1997. For example, a coroner would receive €129 for each completed report of a death; €180 for undertaking a post-mortem and €520 for carrying out an inquest.

However, from this renumeration, coroners must also pay for expenses of running their services, including payments for the work of pathologists, for the results of toxicology from the State Laboratory and for witnesses' expenses, which are certified by the coroners and then provided by the Local Authorities.

In terms of the resourcing of the Coroner's Service as a whole, the Committee was told of the impact of staff shortages and pathologist shortages have had on the service. For example, in some situations bodies of deceased individuals have been moved 100km away due to a lack of available pathologists in the local area.

Lack of resourcing results in some inquests being held in unsuitable locations or facing significant delays, which adds to the trauma experienced by a family when engaging with an inquest process.

It was recommended that the resourcing of the Coroner's Service be increased, including funding towards expanding staffing levels and enhancing support services such as pathology and toxicology services.

Witnesses told the Committee how studies have demonstrated that sufficiently resourcing the Coroner's Service would prove more cost-effective to the State overall, as it would ensure that the Service would be best equipped to address any unanswered questions that families may have in relation to an inquest and would bolster public confidence in the Service, thus avoiding the cost of an appeal.

6. Methods of appealing the verdict of a coroner's inquest

Questions were raised by Members in relation to the procedures for appealing the verdict of a coroner's inquest.

The Committee was told that the current process of appealing a decision through a judicial review in the High Court is an incredibly expensive and time-consuming process that many families do not wish to undertake in addition to the grief they are feeling at the loss of their loved one.

It was recommended that as an alternative, a set of coroners' rules be laid down, alongside the establishment of a review board or review panel, which may provide a more accessible method through which some families could appeal a coronial verdict. This Board could include a member of the Attorney General's office, a coroner, a pathologist and a layperson, and issues of appeal could be referred to this body as they arise.

CHAPTER 3 - Summary of Submissions

This note summarises the key issues identified in the submissions received by

- Ms. Ann Murphy, The Irish Examiner
- Mr. Roger Murray SC, Callan Tansey Solicitors LLP
- Ms. Doireann O'Mahony B. L.
- Mr. David O'Malley, partner at Callan Tansey Solicitors LLP
- Irish Council for Civil Liberties (ICCL)
- Mr. Steven Smyrl, Massey and King Legal Services
- Professor Denis A. Cusack, Senior Coroner for the district of Kildare

The Committee also received submissions from the following stakeholders

- Mr. Frank O Connell, President of the Coroner's Society of Ireland

These submissions highlighted, among other area, the qualifications and experience necessary to become a Coroner; the current system for selecting a jury for an inquest; the process of implementing recommendations made following an inquest; and changes recommended by stakeholders to improve the Coroner's service.

1. Qualifications or experience required to become a Coroner

The following main points were outlined in relation to the qualifications and experience necessary to become a Coroner and how stakeholders felt this could be improved.

- Reciprocal training should be made available for legal and medical professions operating in the Coroner's Service.
- Participation in continuing professional development should be obligatory and a national training programme for newly qualified Coroners should be developed.

Stakeholders questioned whether Coroners should be medically or legally qualified and it was highlighted that only qualified lawyers can apply to be Coroners in Northern Ireland. Some stated that ideally, a Coroner would have legal and medical qualifications, but that overall, it was preferable for a Coroner to have legal training, as witnesses can provide medical knowledge. It was pointed out that the current system works well as many medics train themselves in legal knowledge. Other submissions argued that Coroners should be more highly trained and specialised and that there should be reciprocal training, so that Coroners who are lawyers would receive medical training and Coroners who are doctors would receive legal training.

It was pointed out that Coroners have no standardised system of qualifications, training or support. Some stakeholders argued that Coroners should receive appropriate training and be required to undertake continuing professional development and others argued that a national training programme for existing and newly appointed coroners should be developed.

It was highlighted that under Section 14 of *the Coroners Act, 1962* a Coroner must be a registered medical practitioner, barrister or solicitor and have at least five years' experience post-qualification. Submissions differed in how much experience they believe individuals should have:

- ICCL recommended that all new Coroners should be required to have legal training and to have practiced for a minimum of five years as a barrister or solicitor.

- Mr. Roger Murray stated that he believes that the period for qualification should be extended to 10 years, similar to applicants for judicial offices.

2. Selection of a jury for Coroner's inquest

The following points were outlined regarding the selection of a jury for a Coroner's inquest:

- Current election process does not keep with principles set out in De Burca (1972) as it is not an appropriate cross section of society.
- Juries should be randomly selected from the Register of Electors.
- Coroners should be selected through a formal public appointments process.

Stakeholders highlighted that there is no formal system for selecting an inquest jury and emphasised that juries selected for an inquest should be representative of society as a whole.

Stakeholders highlighted instances where jurors who were known to the Coroner were selected or where juries are comprised of those who happen to be available, e.g. students or those who are retired. Submissions stated that a jury cannot be said to be impartial if it is not formed through random selection and it was underlined that this principle was constitutionally enshrined under *De Burca v Attorney General.*

It was recommended that a Coroner's jury should consist of seven jurors rather than six to avoid an even split when coming to decisions and that international evidence demonstrated that smaller juries are more effective as those who may be more introverted would be more likely to express their opinions in a smaller group. It should also be clarified whether a majority verdict refers to a majority, such as in a criminal or civil case, or a numerical majority.

The majority of submissions recommended that legislation should address the situation of jurors being re-selected for different inquests and that juries should be selected randomly from the Register of Electors. It was suggested that legal representatives should also be able to question the formation of the jury, particularly in high profile or contested cases.

Mr. David O'Malley stated that while the process of selecting Coroner's themselves appears to follow a public appointments process, he believes that Deputy Coroners,

who may be relatives or employees of current Coroners, often step into this role. He recommended that a profile of each district should be taken to ascertain the number of relatives or other employers that are simply taking over the role, as he believes the importance of the Coroner's job warrants a public appointments process to be followed when selecting a new Coroner. He also pointed out that the age limit for Coroner's appears to be 72 and recommended that this be capped at the ordinary retirement age.

Ms. Doireann O'Mahony argued that, in terms of accountability and transparency, the Minister for Justice should be responsible for the appointment of Coroners nationwide, rather than solely in Dublin and that there should be formal selection procedures and interviews for positions.

3. Experience of the inquest process for relatives of the deceased

The following main points were outlined regarding the experience of the inquest process for relatives of the deceased:

- Families desire, above all, that Coroners are professional and thorough in their investigations.
- Coroner's service should be more user-friendly.
- Families should receive, among other things, bereavement counselling, information on how to access legal advice, and information on the purpose and function of the Coroner's court.

Stakeholders emphasised that the purpose of an inquest is to establish facts surrounding the death of an individual and its purpose is not the same as a trial or to act as a counsellor for the deceased's family. However, ICCL highlighted that many families do not feel they achieve justice from the current system or that it establishes the truth surrounding the death of their relative, particularly in cases where the individual has died in contested circumstances. Another submission highlighted that a verdict of death by misadventure can cause more questions for families than it answers.

Other stakeholders pointed out that the inquest process was strengthened under the *Coroners (Amendment) Act 2019*, which provided the Coroner with the power to compel witnesses to answers questions, to attend court and to produce documents where requested.

Stakeholders outlined several areas in which the inquest process could be more considerate of the deceased's relatives. It was stated that, first and foremost, families desire inquests to provide a fair, thorough and professional investigation into the circumstances surrounding the death of their loved one. Submissions outlined that Coroners should always strive to be professional and that if they are dismissive or disinterested this can cause upset, anxiety or anger for the relatives of the deceased. It was argued that ensuring a high-level of training (see Point 1) and high standards of professionalism amongst Coroners would increase public confidence in the Coroner's Service. It was pointed out that Coroners should endeavour, where possible, to

accommodate reasonable requests made by families of the deceased, for example, allowing medical consultants who cared for their deceased relatives prior to their death to attend the inquests if requested.

Other submissions pointed out that there is currently too much latitude in how some Coroners explore matters which may fall under Sections 30 and 31 of *the Coroners Act, 1962,* while other Coroners follow a stricter interpretation of these sections. They recommended that if there are issues of liability in relation to a death, Coroners should receive guidance from Formal Coroner's Rules regarding the extent to which questions may be asked which may be relevant, for example, in a civil case.

ICCL made the following recommendations, among others, on how to improve the inquest process for relatives of the deceased

- Bereaved families should receive information on how to access appropriate legal advice and representation; advice on the purpose, function and objectives of the Coroner's court; access to bereavement counselling; should be advised of the reasons for holding post-mortems and on how to access the findings; and should be advised that details contained in post-mortem reports will be displayed at the inquest and could be reported by the media.
- Individuals conducting interviewers with the bereaved or other witnesses should be trained in trauma-informed practice and bereavement awareness.
- Recommended that legal aid be made available to all bereaved families as it is currently granted on a discretionary basis and particularly in cases where the death occurred in custody or where the Coroner considers a case to be in the public interest.
- Appropriate supports should be given to bereaved families and the vulnerabilities of those giving evidence as witnesses should be acknowledged. It was recommended that appointing an independent family liaison to families could be beneficial to help support them.

4. Implementation of recommendations made following an inquest

The following main points were outlined in relation to the implementation of recommendations made following an inquest:

- A structured and formalised process for implementing jury and Coroner recommendations should be introduced, similar to English and Welsh 'Prevention of Future Death Reports' (PFDs).
- Implementing recommendations is important to prevent further deaths and to help provide families with a sense of comfort.

All submissions emphasised the need for there to be a structured and formalised process to implement jury and Coroner recommendations and to follow up on the implementation of these recommendations.

It was pointed out that recommendations carry a moral weight however, without a mechanism to monitor how they are implemented, recommendations are currently ineffective and are 'lacking teeth'.

Stakeholders pointed to the 'Prevention of Future Death Reports' (PFDs) in England and Wales, which provides a statutory duty on Coroners to write to the relevant body if the inquest uncovered a health and safety fault or similar which led to the fatality and which could cause another fatality in future.

PFDs stipulate a Coroner in this situation must write to the body in charge of this area and mandate that further action should be taken. This body must respond to the Coroner within eight weeks and confirm what steps they have taken to rectify this error and the timeline within which they expect these steps will be carried out.

Stakeholders highlighted that PFDs provide an invaluable opportunity to learn from and prevent further deaths from occurring. They pointed out that the implementation of these recommendations can provide a source of comfort to relatives of the deceased.

Stakeholders recommended that the practice of PFDs be adopted in Ireland.

It was also recommended that there should be regular reviews of narrative verdicts delivered by juries in situations where deaths occurred in similar circumstances and where systemic or recurring shortfalls are identified in institutional practices.

5. Recommended changes to the current Coroner's Service

The following recommendations were suggested by several stakeholders:

- **Appointment of Chief Coroner**, to drive reform, oversight and consistency of inquest processes
- Bringing in a **formal and published set of Coroners Rules,** which would ensure consistency of the services provided by Coroners across the country.
- **Increased resources for the Coroner's Services** – for example, Coroners often work part-time and have insufficient resources to allow them to support relatives through the full inquest process. It was recommended that there should be more full time Coroners as districts are amalgamated and caseloads increase and that resources should also be used to provide appropriate facilities for Coroner's Courts.
- That a **structure Coroner Service Agency**, with an Agency director, be established.

<u>Mr. Denis Cusack</u>

Recommended that the following be introduced:

- That Coroner's districts be re-organised within a larger regional structure, which would include shared operational, administrative and investigative frameworks and support.
- Provision of support service arrangements for pathology post-mortem exam, toxicology and histopathology.
- That Coroner's Investigation Offices be appointed on a regional basis.
- That a Coroner Service Advisory Committee be established.

<u>Ms. Doireann O'Mahony</u>

Recommended that all parties at an inquest should all be working together to create a factual and accurate narrative to assist the Coroner and should ensure that all relevant documentation is included in the inquest hearing.

Mr. Roger Murray

Recommended that the overhaul of the Coroner's Service be carried out, as was suggested in the Working Group established in 2000. This would introduce a total remodelling of the Coroner's Service, through adopting a Chief Coroner for the Country and a division of appropriate districts.

Mr. Steven Smyrl

Highlighted that since the introduction of Section 41 of the *Civil Registration Act 2004,* the majority of registrations have not recorded the deceased's date of birth and or the deceased's place of birth and parents' names. He recommended that Section 41 (1) & (2) and related sections be brought in line with section 42 of the 2004 Act, to allow Coroners to issue a certificate regarding the cause of circumstances of death to the next-of-kin or other party and ensure their input in the registration process.

ICCL

Recommendations include

1. **Institutional Independence**
    - Coroner system should be made fully independent, and be independent of an Garda Síochána (AGS), and the State.
2. **Institutional Reform and Oversight**
    - Among other areas, to appoint an Inspectorate to monitor consistency in practice.
3. **Inquest Procedural Reform:**
    - All proceedings in inquests should be recorded and made available to relevant persons and transcribed if requested.
4. **Charter for the Bereaved**
    - This Charter would provide an overview of the statutory role and obligations of AGS and other State agencies in inquests; commit relevant bodies to a statement of rights of the bereaved; establish a timeframe within which an inquest should be completed; and be

made available to all those who suffer sudden bereavement in contested circumstances or through tragedies.

5. **Role of the Media**
    - The media should ensure that they report within the Press Council of Ireland's Code of Practice and the Broadcasting Authority of Ireland Codes and Standards when reporting on the details and outcome of an inquest.
6. **Research on Institutional Racism**
    - ICCL recommended further research be done to help eliminate all forms of institutionalised discrimination within the Coroner Service and its support agencies like AGS, particularly discrimination against the Travelling Community.

6. Additional Points

In addition to the above key issues, some stakeholders indicated specific interest in certain areas, as follows:

- Findings from Coroner's Inquest admissible in later legal action

Stakeholders recommended that findings from Coroner's inquests should be admissible in later legal action on the same incident. They cautioned that there is a statutory prohibition against self-incrimination in the *Coroners (Amendment) Act 2019,* which entitles a witness to the same immunity when giving evidence and that this could prejudice the outcome of a later inquiry if they are answered. ICCL recommended the Committee to examine the current model in England and Wales in this regard.

- Appealing the outcome of an inquest to the High Court

Stakeholders pointed out that judicial reviews are available as a remedy in situations where individuals feel that an inquest was unfair or contained arbitrary decisions or other elements. They stated that the cost of taking a judicial review in the High Courts can have a chilling effect and that the process can be very time-consuming, thus dissuading families from pursuing this option. Stakeholders pointed out that the review system is not user friendly compared to review mechanisms available within the courts and that this should be rectified.

It was also pointed out that there is a very high bar set in terms of challenging a Coroner's decision and that Courts can be hesitant to interfere with a Coroner's decision, due to the wide degree of discretion available to them in terms of decision making. Submissions highlighted that successful judicial reviews in respect of Coroners are rare occurrences.

Submissions recommended that a review board be established that could review matters that are referred to it before, during or after an inquest and which would save time and costs involved in the current process. It was recommended that this board

consist of e.g. a member of the Attorney General's office, a pathologist, a Coroner and an outsider.

It was also highlighted that the introduction of Coroners Rules would help in ascertaining whether or not a Coroner had conducted their inquiry within the permitted and in a reasonable manner.

APPENDICES

APPENDIX 1- ORDERS OF REFERENCE OF THE COMMITTEE

Standing Orders 94, 95 and 96 – scope of activity and powers of Select Committees and functions of Departmental Select Committees

Scope and context of activities of Select Committees.

94.(1) The Dáil may appoint a Select Committee to consider and, if so permitted, to take evidence upon any Bill, Estimate or matter, and to report its opinion for the information and assistance of the Dáil. Such motion shall specifically state the orders of reference of the Committee, define the powers devolved upon it, fix the number of members to serve on it, state the quorum, and may appoint a date upon which the Committee shall report back to the Dáil.

(2) It shall be an instruction to each Select Committee that—

(*a*)it may only consider such matters, engage in such activities, exercise such powers and discharge such functions as are specifically authorised under its orders of reference and under Standing Orders;

(*b*) such matters, activities, powers and functions shall be relevant to, and shall arise only in the context of, the preparation of a report to the Dáil;

(*c*) it shall not consider any matter which is being considered, or of which notice has been given of a proposal to consider, by the Joint Committee on Public Petitions in the exercise of its functions under Standing Order 125(1)[1]; and

(*d*) it shall refrain from inquiring into in public session or publishing confidential information regarding any matter if so requested, for stated reasons given in writing, by—

(i) a member of the Government or a Minister of State, or

(ii) the principal office-holder of a State body within the responsibility of a Government Department or

(iii) the principal office-holder of a non-State body which is partly funded by the State,

Provided that the Committee may appeal any such request made to the Ceann Comhairle, whose decision shall be final.

(3) It shall be an instruction to all Select Committees to which Bills are referred that they shall ensure that not more than two Select Committees shall meet to

[1] Retained pending review of the Joint Committee on Public Petitions

consider a Bill on any given day, unless the Dáil, after due notice to the Business Committee by a Chairman of one of the Select Committees concerned, waives this instruction.

Functions of Departmental Select Committees.

95. (1) The Dáil may appoint a Departmental Select Committee to consider and, unless otherwise provided for in these Standing Orders or by order, to report to the Dáil on any matter relating to—

(*a*) legislation, policy, governance, expenditure and administration of—

(i) a Government Department, and

(ii) State bodies within the responsibility of such Department, and

(*b*) the performance of a non-State body in relation to an agreement for the provision of services that it has entered into with any such Government Department or State body.

(2) A Select Committee appointed pursuant to this Standing Order shall also consider such other matters which—

(a) stand referred to the Committee by virtue of these Standing Orders or statute law, or

(b) shall be referred to the Committee by order of the Dáil.

(3) The principal purpose of Committee consideration of matters of policy, governance, expenditure and administration under paragraph (1) shall be—

(*a*) for the accountability of the relevant Minister or Minister of State, and

(b) to assess the performance of the relevant Government Department or of a State body within the responsibility of the relevant Department, in delivering public services while achieving intended outcomes, including value for money.

(4) A Select Committee appointed pursuant to this Standing Order shall not consider any matter relating to accounts audited by, or reports of, the Comptroller and Auditor General unless the Committee of Public Accounts—

(a) consents to such consideration, or

(b) has reported on such accounts or reports.

(5) A Select Committee appointed pursuant to this Standing Order may be joined with a Select Committee appointed by Seanad Éireann to be and act as a Joint Committee for the purposes of paragraph (1) and such other purposes as may be specified in these Standing Orders or by order of the Dáil: provided that the Joint Committee shall not consider—

(a) the Committee Stage of a Bill,

(b) Estimates for Public Services, or

(c) a proposal contained in a motion for the approval of an international agreement involving a charge upon public funds referred to the Committee by order of the Dáil.

(6) Any report that the Joint Committee proposes to make shall, on adoption by the Joint Committee, be made to both Houses of the Oireachtas.

(7) The Chairman of the Select Committee appointed pursuant to this Standing Order shall also be Chairman of the Joint Committee.

(8) Where a Select Committee proposes to consider—

(a) EU draft legislative acts standing referred to the Select Committee under Standing Order 133, including the compliance of such acts with the principle of subsidiarity,

(b) other proposals for EU legislation and related policy issues, including programmes and guidelines prepared by the European Commission as a basis of possible legislative action,

(c) non-legislative documents published by any EU institution in relation to EU policy matters, or

(d) matters listed for consideration on the agenda for meetings of the relevant Council (of Ministers) of the European Union and the outcome of such meetings, the following may be notified accordingly and shall have the right to attend and take part in such consideration without having a right to move motions or amendments or the right to vote:

(i) members of the European Parliament elected from constituencies in Ireland,

(ii) members of the Irish delegation to the Parliamentary Assembly of the Council of Europe, and

(iii) at the invitation of the Committee, other members of the European Parliament.

(9) A Select Committee appointed pursuant to this Standing Order may, in respect of any Ombudsman charged with oversight of public services within the policy remit of the relevant Department consider—

(*a*) such motions relating to the appointment of an Ombudsman as may be referred to the Committee, and

(*b*) such Ombudsman reports laid before either or both Houses of the Oireachtas as the Committee may select: Provided that the provisions of Standing Order 130 apply where the Select Committee has not considered

the Ombudsman report, or a portion or portions thereof, within two months (excluding Christmas, Easter or summer recess periods) of the report being laid before either or both Houses of the Oireachtas.[2]

[2] Retained pending review of the Joint Committee on Public Petitions.

Powers of Select Committees.

96. Unless the Dáil shall otherwise order, a Committee appointed pursuant to these Standing Orders shall have the following powers:

(1) power to invite and receive oral and written evidence and to print and publish from time to time—

(a) minutes of such evidence as was heard in public, and

(b) such evidence in writing as the Committee thinks fit;

(2) power to appoint sub-Committees and to refer to such sub-Committees any matter comprehended by its orders of reference and to delegate any of its powers to such sub-Committees, including power to report directly to the Dáil;

(3) power to draft recommendations for legislative change and for new legislation;

(4) in relation to any statutory instrument, including those laid or laid in draft before either or both Houses of the Oireachtas, power to—

(*a*) require any Government Department or other instrument-making authority concerned to—

(i) submit a memorandum to the Select Committee explaining the statutory
Instrument, or

(ii) attend a meeting of the Select Committee to explain any such statutory instrument: Provided that the authority concerned may decline to attend for reasons given in writing to the Select Committee, which may report thereon to the Dáil,
and

(*b*) recommend, where it considers that such action is warranted, that the instrument should be annulled or amended;

(5) power to require that a member of the Government or Minister of State shall attend before the Select Committee to discuss—

(a) policy, or

(*b*) proposed primary or secondary legislation (prior to such legislation being published),

for which he or she is officially responsible: Provided that a member of the Government or Minister of State may decline to attend for stated reasons given in writing to the Select Committee, which may report thereon to the Dáil: and provided further that a member of the Government or Minister of State may

request to attend a meeting of the Select Committee to enable him or her to discuss such policy or proposed legislation;

(6) power to require that a member of the Government or Minister of State shall attend before the Select Committee and provide, in private session if so requested by the attendee, oral briefings in advance of meetings of the relevant EC Council (of Ministers) of the European Union to enable the Select Committee to make known its views: Provided that the Committee may also require such attendance following such meetings;

(7) power to require that the Chairperson designate of a body or agency under the aegis of a Department shall, prior to his or her appointment, attend before the Select Committee to discuss his or her strategic priorities for the role;

(8) power to require that a member of the Government or Minister of State who is officially

responsible for the implementation of an Act shall attend before a Select Committee in relation to the consideration of a report under Standing Order 197;

(9) subject to any constraints otherwise prescribed by law, power to require that principal office-holders of a—

(*a*) State body within the responsibility of a Government Department or

(*b*) non-State body which is partly funded by the State,
shall attend meetings of the Select Committee, as appropriate, to discuss issues for which they are officially responsible: Provided that such an office-holder may decline to attend for stated reasons given in writing to the Select Committee, which may report thereon to the Dáil;

and

(10) power to—

(*a*) engage the services of persons with specialist or technical knowledge, to assist it or any of its sub-Committees in considering particular matters; and

(b) undertake travel;

Provided that the powers under this paragraph are subject to such recommendations as may be made by the Working Group of Committee Chairmen under Standing Order 120(4)(*a*).'

APPENDIX 2 - LIST OF STAKEHOLDERS AND SUBMISSIONS

The Committee received submissions from the following stakeholders

- Ms. Ann Murphy, Irish Examiner.
- Mr. Frank O'Connell, President of the Coroners Society of Ireland.
- Mr. Roger Murray, SC.
- Ms. Doireann O'Mahony BL.
- Mr. David O'Malley, partner in Callan Tansey Solicitors.
- Irish Council for Civil Liberties (ICCL).
- Mr. Steven Smyrl, director of Massey and King and accredited genealogist.
- Professor Denis Cusack, senior coroner for the district of Kildare.

[Submissions are available in the online version of the Committee's Report, which will be accessible at https://www.oireachtas.ie/en/committees/33/justice/].

CC_01

To whom it concerns,

Thank you for your correspondence regarding the Justice Committee's upcoming examination of coroners in its programme of work for this year.

The following report published in the Irish Examiner on Saturday, February 26, is a focus on the concerns of families that recommendations made at inquests are not legally binding: 'Anything that causes some good and prevents deaths should be taken more seriously' (irishexaminer.com). The piece contains interviews with a number of people who tell of their experiences with the current system.

As part of this work, I contacted bodies including county councils, the Department of Health and An Garda Siochana for updates in relation to individual inquests where recommendations had been made regarding these bodies. This work will continue as it is by no means a complete overview of the situation at present.

A follow up interview with a mother from Kildare whose daughter died by suicide five years ago highlighted concerns by her that recommendations made almost three years ago at her inquest still have not been implemented. She wants to prevent tragedies similar to the one that befell her family from happening to other families. See her story here: Maxine is being 'failed in death' mum says, as recommendations at her inquest still not enacted (irishexaminer.com).

Many families feel that the issue of recommendations is not the only area that needs to be addressed. For example, the method (or lack of) used in the selection of juries for inquests has been highlighted by a number of people, while others believe the verdict delivered does not always give them the closure they hoped for. Secondly, death by misadventure is a verdict which can cause more questions for families, judging by the experiences of families I have spoken with. Appealing inquest results is seen as out of many people's reach because of legal costs. There are also situations where people have been upset that the verdicts at inquests cannot be admissible later on in subsequent actions regarding incidents which resulted in the deaths of loved ones.

I have no comment to make on questions 1, 3 and 6.

It is also not for me to recommend what changes should be made to the current coronial system. A report published by the Irish Council for Civil Liberties in April 2021 is an important one as it also contains the views of families as well as experts regarding the many areas of the coronial system would they believe would benefit from reform. The council also has concerns about why recommendations made in a 2000 report on the future of the coronial system in Ireland have not been followed through in their entirety.

Many thanks for your interest in our work at the Irish Examiner.

Regards,

Ann Murphy,

Irish Examiner

CORONERS SOCIETY OF IRELAND

CC_02

SUBMISSION TO THE OIREACHTAS JOINT COMMITTEE ON JUSTICE

AN EXAMINATION OF OPERATION OF THE CORONERS SERVICE

1. To qualify for appointment to the Office of Coroner, the applicant must be a practising barrister of at least five years standing, a practising solicitor of at least five years standing or a registered medical practitioner for at least five years prior to such appointment - Coroners Act, 1962 section 14.

2. Every citizen aged 18 years or upwards residing in a Coroner's district is qualified and liable to serve on the jury at any coroner's inquest unless otherwise ineligible or disqualified under the Jurys Act 1976 or is amongst the list of exempted persons specified in Part 2 of the First Schedule of that Act. Subject thereto, summoning of the members of a jury will be done in the manner prescribed by section 43 of the Coroners Act, 1962 as amended by section 27 of the Coroners Amendment Act, 2019. Selection should be on a random basis with special care taken to ensure that no member of the jury is related to or otherwise connected with the deceased or any person concerned with the circumstances attending the death of the deceased. It is not clear what is meant by "*representative and balanced*" but persons from all walks of life are eligible and do serve on coroners inquests. The selection process has, on occasion, been problematic and will need reform.

3. The inquest process i.e. the purpose for which an inquest is held, is to establish:-

   (a) the identity of the person in relation to whose death the inquest is being held.

   (b) how, when and where the death occurred.

   (c) to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred.

   More often than not, the identity of the person, where the death occurred and when the death occurred are mere formalities and will not be the subject of any controversy. HOW the death occurred and the circumstances in which the death occurred can, in some cases, be difficult to establish or controversial and this is presumed to be the context in which your Committee has asked whether the relatives of the deceased are given sufficient consideration in order to provide them with closure. Closure is a subjective and emotive issue. I believe that every coroner will do his or her level best to establish and make public, the facts surrounding a death. Coming to terms with those facts and with the loss of a loved one, often in tragic or violent circumstances can take a long time and so it cannot be said that the conclusion of a coroner's inquest will give closure. The Coroner will liaise with the next of kin from the time that the death is first

reported until the conclusion of the inquest and registration of the death.

4. Yes. Where the recommendation concerns a fatality in a place or in circumstances which are regulated by a public authority, that authority will be formally notified by the coroner of the recommendation made at the inquest. In the case of a road hazard, a joint review will take place between the Roads Authority and An Garda Síochána following a fatality. We would see our role as ensuring that the relevant authority is notified of the recommendation.

5. Strictly speaking, an appeal to the High Court does not lie. Instead, a person who is dissatisfied with the manner in which some aspect of an inquest has been handled may apply to the High Court for judicial review of the coroner's decision. Some years ago, the Coroners Society shared the view that this was an undue burden for ordinary citizens and advocated a system of appeal. In the initial draft of the Coroners Amendment Bill, dating back to 2007, there was a proposal for an appeal on limited grounds to a Chief Coroner. Subsequently, the proposed structure of a service headed by a Chief Coroner was withdrawn. However, an entirely new and very useful provision was introduced in Section 62 of the Coroners Amendment Act, 2019 which allows a coroner to apply to the High Court for directions on a point of law regarding the performance of his or her functions whenever he or she considers it appropriate to do so.

   This new power to make a Case Stated for the determination of the High Court, will resolve many of the type of problems which have given rise to judicial review in the past.

6. The effectiveness of any enquiry is a subjective assessment and will depend on the individual circumstances of that case. The vast majority of sudden deaths are investigated on behalf of the Coroner by a member of An Garda Síochána or the Garda Síochána Ombudsman Commission. The coroner will often direct his own enquiries or direct further enquiries through An Garda Síochána. By and large, this system works effectively with enquiries being made by trained professionals. In the vast majority of cases, there is no question about the effectiveness of the enquiry or the facts surrounding the death of the deceased. Occasionally, in cases where there is a lack or conflict of evidence, not due to any failure or lack of diligence on the part of the investigator, there may be allegations or suspicions which cannot be substantiated or disproven. These are rare cases albeit the cases most likely to attract publicity.

7. The purpose, rules of evidence and burden of proof in a criminal trial or in a civil action are different to those at a coroner's inquest. An inquest is not a trial. Secondly, the admission of such evidence would in itself be hearsay evidence which is generally prohibited at any trial, civil or criminal. A legal representative can however put it to a particular witness that he or she gave certain evidence at the inquest. A Coroner is obliged to adjourn an inquest if requested, pending the outcome of criminal proceedings and this is invariably the case, so the inquest will come after a criminal trial.

8. The changes most urgently needed within the Coroners system, at present, relate to structural needs and supports for the coroners' work and that of the Pathologist who carries out the post mortem. Most acutely at present, there is a need for proper support in the provision of pathology services for coroners. The service currently available is most precarious and its future uncertain. I would like to refer the committee to the recently published report of the Faculty of Pathology of the Royal College of Physicians of Ireland a copy of which I am sending with this submission for reference. The committee will note the conclusions and recommendations of the report.

   An acute issue is the need for a dedicated histological service for coroners post mortems at regional centres throughout the country. Whilst a dedicated toxicology service is provided in the State Laboratory, it is struggling to keep pace with demand. Generally speaking, the Pathologist will wait for twelve or fourteen weeks for the results of a toxicology test report on blood or urine samples and this in its turn gives rise to delays in reporting the results of the post mortem to the coroner and as a consequence, in the registration of a death or the setting of a date for the inquest.

Dated 4th of April, 2022.

Frank O'Connell

President

Coroners Society of Ireland.

CC_02(1)

A review of the provision of the coronial autopsy service- Histopathology Standing Committee

January 2022

Histopathology Standing Committee [1]Members

Dr Michael Bennett

Dr Niamh Bermingham

Dr Margot Bolster

Dr Francesca Brett*

Dr Caroline Brodie

Dr Tara Jane Browne

Prof Louise Burke*

Dr Stephen Crowther*

Dr Aoife Doyle

Prof Aurelie Fabre

Dr Brendan Fitzgerald*

Dr Paul Hartel

Dr Cynthia Heffron*

Dr Clive Kilgallen

Prof Rob Landers

Dr Maire Lavelle

Dr Michael McDermott

Dr Linda Mulligan

Dr Niamh Nolan

Dr John O'Dowd

Dr Marie Staunton

Dr Mary Toner

Dr Ann Treacy

**Autopsy Subgroup*

The report was compiled with the support of Mairéad Heffron, RCPI Policy Specialist

[1] The Histopathology Standing Committee was formerly known as the Histopathology Working Group and re-branded in April 2021

Executive Summary 4
Recommendations 6
1. Introduction 8
2. Coronial Autopsies in Ireland - Background and Statistics 9
3. Training in autopsy 14
4. Mortuary Facilities - Current Situation 16
5. Survey of Consultant Pathologists 18
6. Survey of Histopathology Trainees 26
7. Discussion 28
8. Recommendations 32
Appendices 34

Executive Summary

In Ireland, in cases of sudden, unexplained, or unnatural death (for example suicides, drug overdoses, poisonings, road traffic collisions), occurring either in the community, or in a hospital, the death is reported to the local coroner. In these cases, the coroner may direct an autopsy. An inquest may also be held.

Provision of autopsy service to coroners

Hospital based pathologists (specifically, histopathologists) provide an autopsy service to local coroners. Histopathology is the branch of pathology that deals with diagnosis and study of disease in tissues and organs. Most coroner-directed autopsies (approx. 96% of over 5000 annual coronial autopsies) in Ireland are performed by hospital consultants or by supervised trainees in histopathology.

When there are no suspicious or criminal implications, the coroner requests that the autopsy is performed by a local pathologist, usually in a hospital mortuary. The vast majority of mortuaries are attached to hospitals and are usually resourced by the Health Service Executive (HSE). In cases of suspicious and criminal circumstances, or where a death occurs in state custody or detention, the autopsy is carried out by forensically trained pathologists of the Office of the State Pathologist (OSP).

Hospital histopathologists also conduct autopsies when requested to do so by hospital clinicians (consented autopsies), in order to answer specific clinical questions when the cause of death is known. In practice, these numbers are small compared to the number of coroner-directed autopsies carried out. For example, in one large teaching hospital in Dublin in 2020, over 95% of autopsies performed on hospital patients were directed by the coroner.

Oversight

A number of government departments and entities are involved in the oversight of death investigation and provision of the coronial autopsy service in Ireland.

- The Department of Justice (DOJ) is responsible for policy relating to the coroner service and for resourcing the Dublin District Mortuary and Dublin coroner's service. The Office of the State Pathologist also comes under the remit of the DOJ, as an independent agency within its governance structure.
- Outside of Dublin, local authorities are responsible for financing the coronial autopsy service in their respective areas.
- The Department of Health is ultimately responsible for effective management of health service resources including HSE hospital mortuaries.

The autopsy services provided to the coroner by pathologists are not usually covered by their HSE contract and are paid for separately on a case-by-case basis by the local authority. The local authority (council) is also responsible for financing transport of deceased persons to the hospital. As a result of local authorities being responsible for financing the autopsy service, there may be other adjunct local arrangements in various hospital mortuaries around the country. One exception to this structure is Dublin District Mortuary, which is managed by the Dublin Coroner and resourced by the Department of Justice.

Histopathology Standing Committee – Survey

The Faculty of Pathology is the national professional and training body for pathology in Ireland, working to ensure the highest standards in laboratory medicine. The Histopathology Standing

Committee (HSC) within the Faculty, conducted surveys in 2020 to understand the views of trainees and consultants in histopathology in relation to the coronial autopsy service. The survey also set out to assess mortuary facilities around the country, in the wake of the COVID-19 pandemic. The HSC was concerned that autopsy was not considered attractive to its trainees and members, and that as a result there may be a future shortage of histopathologists trained in, or willing to conduct coronial autopsies.

The surveys revealed that:

- More than a quarter of consultants surveyed did not do coronial autopsies, citing reasons such as lack of time due to surgical pathology commitment, difference in skillset and concerns about inquests.
- Most consultants felt the current coronial autopsy service is not sustainable and that a restructuring is needed. The concept of a centralized or regionalized service with dedicated autopsy specialists was desirable.
- Some trainees and consultants felt that the autopsy exam for Irish trained histopathologists (Certificate in Higher Autopsy Training -CHAT), which is an exam of the Royal College of Pathologists (UK) should not be mandatory (30% of consultants and 62% of trainees).
- Just over half of trainees (53%) said they do not like coronial autopsy work and 42% said they do not see themselves doing coronial autopsy work in the future.
- There are challenges in provision of specialised autopsy in paediatric and perinatal cases. This will be addressed in the near future with appointments in perinatal pathology and in the provision of specialised posts.
- The COVID-19 pandemic has also highlighted the lack of adequate mortuary facilities to deal with highly infectious autopsy cases.

Recommendations

In response to the survey findings, the HSC recommends the following:

Make autopsy work more manageable within the hospital pathologist's normal work environment and commitments

1. Development of autopsy as a subspecialty, with appropriate training and staffing.
2. Autopsy to be developed as a 'special interest' within histopathology departments, leading to a pool of interested consultants, thus enabling the development of a regionalised service (main training centre supported by regional hospitals) in time (see Appendix D for suggested collaborating hospitals/groups).
3. Protected time for conduct of autopsy and inquest responsibilities.
4. Appropriate levels of dedicated secretarial support.
5. Inclusion of autopsy in consultant histopathologist job descriptions with specific outlines of the expected commitment in each post.

Deliver appropriate and responsive autopsy training and exams

6. Ensure training and exams are responsive to the needs of the Coronial autopsy system.

7. Ensure ongoing feedback to the Histopathology Speciality Training Committee (STC) and trainers to monitor issues around training needs including:
    a. Approach to CHAT exam.
    b. Appropriate rostering of autopsy service within trainee rosters.
    c. Ensure ongoing incorporation of training needs around autopsy into current study day programmes.

Ensure a robust and sustainable future death investigation system

8. Ensure that autopsy has a formal standing through an Irish Human Tissue Act.

9. Begin evaluation of local mortuary facilities in order to start the process with the HSE which will result in ensuring that infrastructure and facilities nationwide are of good standard, fit for purpose and that all have access to appropriate laboratory, secretarial and social service system support.

10. Consider a change to the current system of death investigation (in line with proposals from the 2000 Review of the Coroner Service and by the 2021 research report published by the Irish Council for Civil Liberties[2]).
    - Initially a hub and spoke model, where a group of collaborating hospitals includes a university teaching hospital. This opens up rotation possibilities for trainees to get more autopsy exposure and allows for possibility of better communication between practicing autopsy pathologists, improved standards and options for peer review and subsequently improved training.

    - Ultimately, this could evolve into a regionalised autopsy service where the main hospital base is a centre of excellence and works closely with the forensic pathology service.

[2] Death Investigation, Coroners' Inquests and the Rights of the Bereaved by the Irish Council for Civil Liberties published April 2021 https://www.iccl.ie/wp-content/uploads/2021/04/ICCL-Death-Investigations-Coroners-Inquests-the-Rights-of-the-Bereaved.pdf

- Such collaborative groups would ensure access on a regional basis to specialist expertise in neuropathology, perinatal and paediatric pathology and allow the development of radiology support services.

Ensure availability of specialist autopsy expertise

11. Ensure sufficient perinatal and paediatric pathology expertise/posts so that each region is appropriately resourced, and that appropriate referral of cases can be made.
12. Establish a clear protocol for perinatal and paediatric cases to avoid inappropriate referrals to the forensic pathology service.

Next steps towards implementation

- Circulate this proposal to histopathology consultants nationwide
- Establish a discourse with stakeholders (HSE, Department of Justice , coroners, county councils, Faculty of Pathology) with the aim of :
    - Agreeing collaborating hospital groups and function of each hospital within these groups
    - Appointing additional consultant pathologists with dedicated autopsy sessions
    - Sourcing appropriate funding.

1. Introduction

The Faculty of Pathology, established in 1981, is one of six postgraduate specialist training bodies based in the Royal College of Physicians of Ireland (RCPI). The Faculty has over 300 Fellows, who are experienced consultant pathologists and leading experts in their field. The Faculty is the national professional and training body for pathology in Ireland, working to ensure the highest standards in laboratory medicine. The Faculty is accredited by the Medical Council of Ireland to deliver postgraduate specialist training in six pathology specialties.

Histopathology is one of these six specialties, and the Faculty delivers postgraduate training at basic specialist level (BST) and higher specialist level (HST). On successful completion of HST, a histopathologist is eligible for registration on the Specialist Register of the Medical Council and can apply for consultant posts. Histopathologists diagnose and study all forms of disease in tissues and organs, including cancer. They also perform autopsies to determine cause of death.

Within the Faculty of Pathology, the Histopathology Standing Committee (HSC) provides assistance and advice pertaining to histopathology to the Board of the Faculty. It reports to the Dean of the Faculty.

In 2019, the HSC discussed the issue of the coronial autopsy service, noting a concern among members that there would be a shortage of histopathologists willing to perform coronial autopsies in the future. There were concerns that among trainees, autopsy was not considered as attractive as work in other histopathology areas such as cancer diagnoses. Some hospitals, as well as individual consultants had opted out of performing coronial autopsy work and this was a concern.

The HSC initiated this project to generate data on trainees and consultants' attitudes and experience of coronial autopsy, to understand whether their concerns were borne out in reality, and if so, to understand what potential solutions may exist which would support the vital work of the coronial autopsy service in the long term.

To this end, the HSC carried out the following

- An online survey of trainees
- An online survey of consultants
- An email survey of mortuary facilities throughout the country

2. Coronial Autopsies in Ireland - Background and Statistics

Death investigation is the term given to the system in place to determine cause and/or circumstances of death, in all deaths that are not certified as natural causes or where the medical cause of death is not known, or where there is not a doctor in a position to certify the medical cause.

Jurisdictions vary in how the death investigation system is structured. In some jurisdictions, such as England and Wales, a coroner has responsibility for the death investigation (either a medical doctor or a lawyer, depending on the jurisdiction) while others, such as North America, have a medical examiner system, whereby a medically qualified doctor (usually a forensic pathologist) carries responsibilities often divided between a coroner and a forensic pathologist in a coroner or coronial system.[3] In other parts of Europe, death investigation is led by a legal person such as a judge/prosecutor/procurator fiscal (Scotland) and the medical expertise of pathologists or legal medicine specialists is heavily relied on.

The Coronial Service

Ireland operates a coronial system of death investigation which is unique to this country. What is referred to as the 'Coroner Service' is a network of independent coroners located throughout the country. There is also a Coroner's Society of Ireland, which plays a role in representing the views of coroners as a body.[4]

Coroners are barristers/solicitors or registered medical practitioners, of at least 5 years standing, and are appointed by either the Local Authority (LA), or in the case of the Dublin District Coroner, by the Minister for Justice.

A coroner's core function is to investigate sudden and unexplained deaths so that a death certificate can be issued.[5] A coroner may request that an autopsy is carried out as part of this process. The autopsy is carried out by a trained histopathologist or forensic pathologist, depending on the circumstances surrounding the death.

Coronial autopsies – annual figures

Usually, a histopathologist carries out autopsies only in cases where there are no suspicious circumstances around the death, whereas forensic pathologists, who are trained in anatomical pathology, histopathology, and the forensic interpretation of injuries, carry out autopsies in cases where there are unusual/criminal/suspicious circumstances surrounding the death.[6]

Most coroner-directed autopsies (approx. 96%) carried out in Ireland are done by hospital consultant histopathologists or by supervised trainees in histopathology. This is the case for sudden, or unexplained death, in the absence of any suspicious circumstances. These are referred to colloquially as "coronial autopsies". An inquest may also be held in some cases, at which the histopathologist may be required to give evidence.

In cases of suspicious and criminal circumstances, or where a death occurs in state custody or detention, the autopsy is carried out by forensically trained pathologists of the Office of the State

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[3] http://www.justice.ie/en/JELR/RCPI_Review_of_the_Office_of_the_State_Pathologist.pdf/Files/RCPI_Review_of_the_Office_of_the_State_Pathologist.pdf

[4] http://www.justice.ie/en/JELR/Pages/SP18000297

[5] http://www.coroners.ie/

[6] OSP website. http://www.justice.ie/en/JELR/Pages/office_of_the_state_pathologist

Pathologist (OSP). These cases are known colloquially as “state cases”. Such autopsies comprise approximately 3% of the total coroner-directed autopsies done annually in the Republic of Ireland.

The remaining 1% of coroner-directed autopsies are non-suspicious autopsies carried out by pathologists of the OSP. In 2019, the majority of non-suspicious autopsy examinations undertaken by the OSP were performed by an acting deputy state pathologist as part of an agreed proleptic training programme, which was completed in March 2020.[7]

The chart below (figure 1) shows the annual number of coronial autopsies carried out in Ireland. The figures include state autopsies performed by the OSP, with the figures disaggregated here from 2015 onwards (from OSP annual reports).

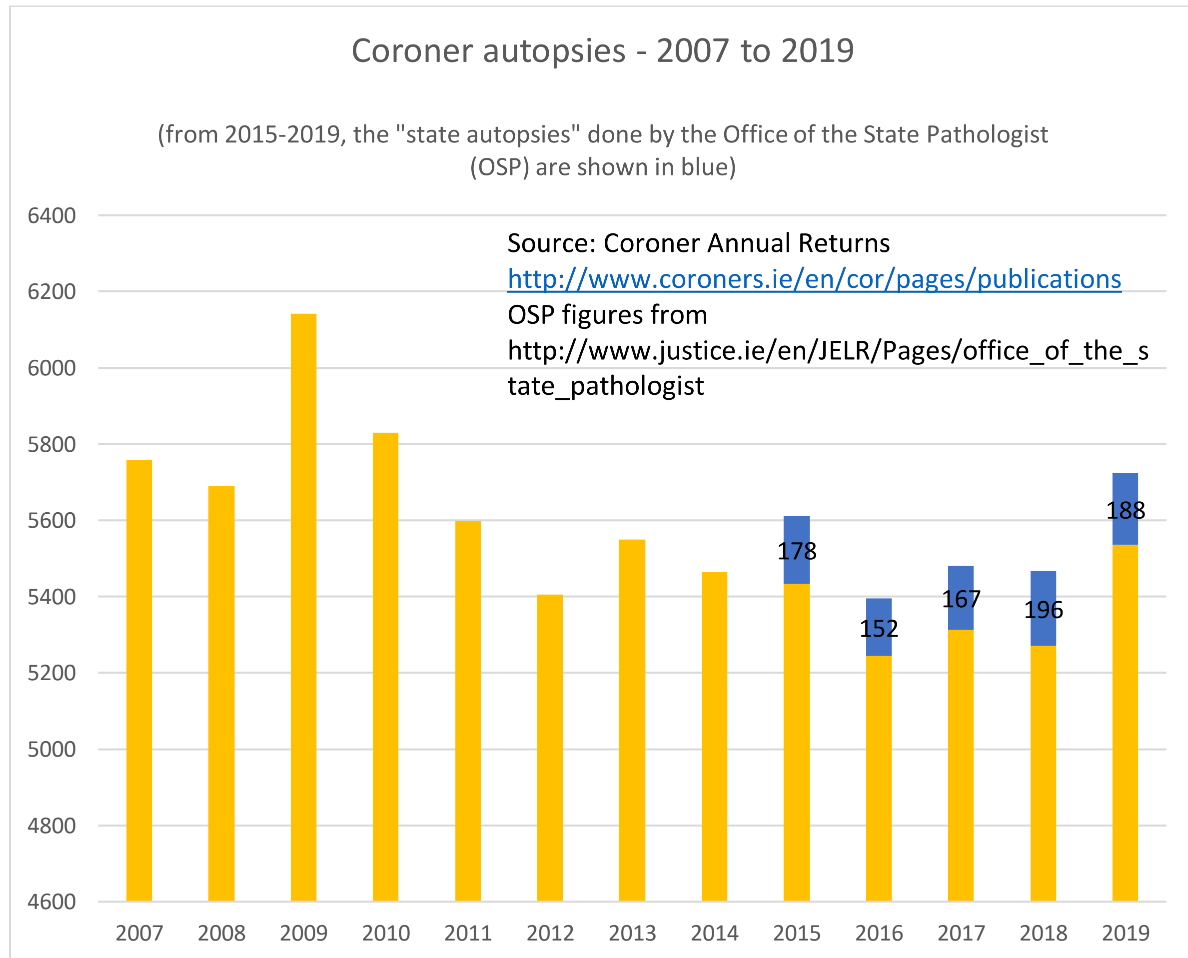

Figure 1: Coronial Autopsies- Annual Figures

Looking at the breakdown of autopsies by coroner areas, Dublin has the highest number by a significant amount. In 2019, the 1,895 coronial autopsies in the Dublin Coroner’s area represented

[7] http://www.justice.ie/en/JELR/Pages/office_of_the_state_pathologist (OSP Annual Report)

just over a third of all autopsies in that year (33%).

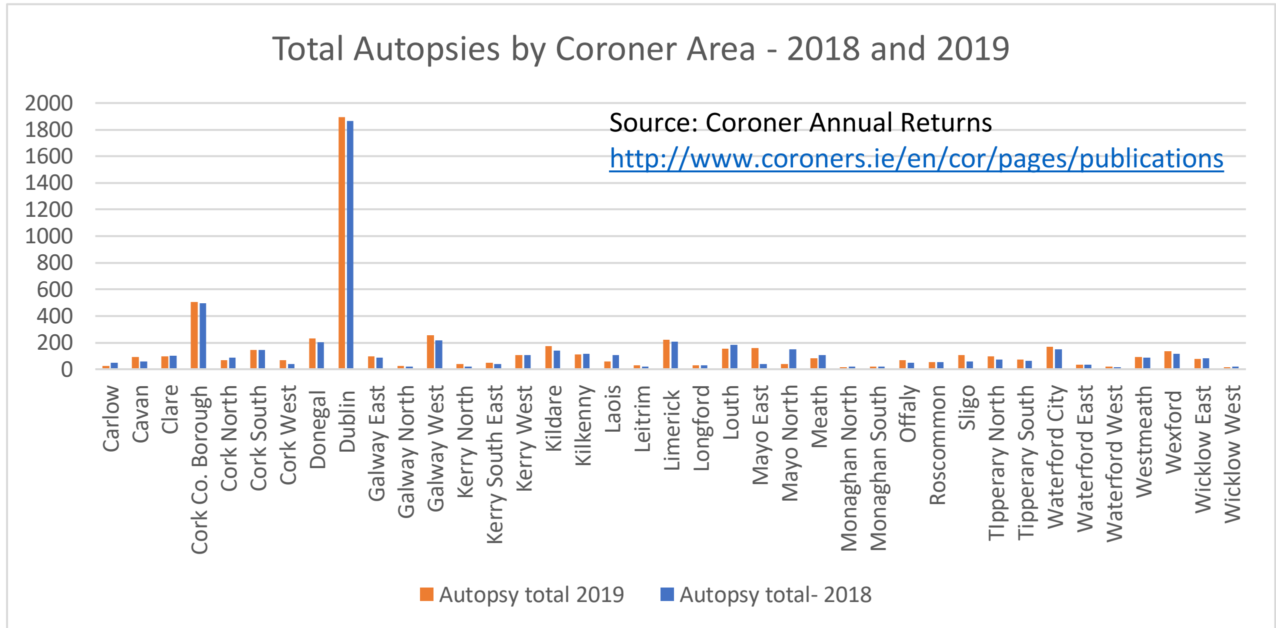

Figure 2: Autopsies by Coroner area

Removing Dublin from the chart, we have the following breakdown by Coroner Area:

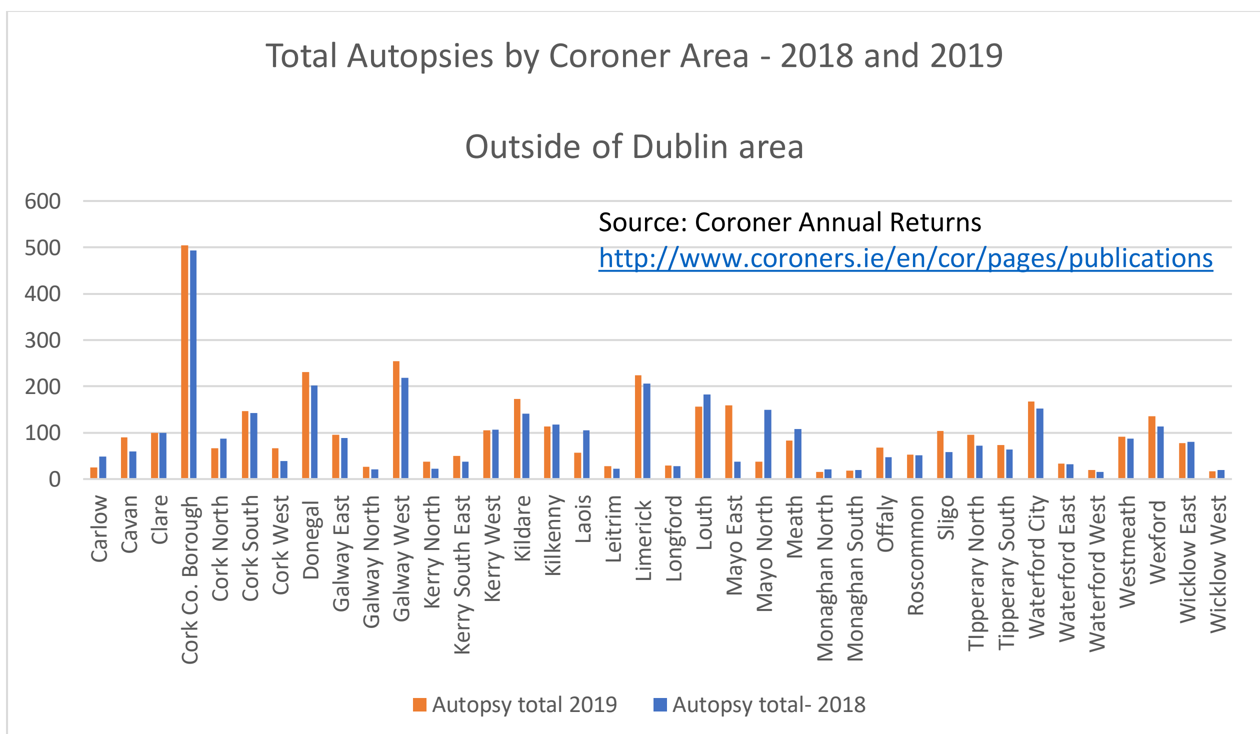

Figure 3: Autopsies by Coroner area (outside of Dublin)

Departmental responsibilities and funding of coronial autopsy

The Department of Justice has responsibility for the policy and governing legislation of the State's Coroner Service. It is also responsible for the funding and resourcing of the Dublin District Mortuary and Dublin District Coroner.

Elsewhere, local authorities fund the operation of the coronial service in their district, including the transportation of bodies from the community to the mortuary, if required. Departmental oversight and budgets for local authorities are through the Department of Housing, Local Government and Heritage. There is no central funding provided to local authorities for the financing of the coronial service and the service is financed from their own resources.[8]

The fees and expenses payable to the person who performs the autopsy, assists in the autopsy or for special laboratory examinations (histological, microbiological, toxicological, and biochemical tests) are set by legislation.[9] The histopathologist receives a fee of €321.40 for performing nonsuspicious coroner-directed autopsies with a report to the coroner. Where attendance at the inquest is also required, the fee payable is €535.68 (which includes the original autopsy fee). [10]

The Department of Health is ultimately responsible for effective management of health service resources, including HSE hospital mortuaries and their staff.

Observations from the RCPI review of the Office of the State Pathologist

A 2019 Review of the Office of the State Pathologist conducted by RCPI for the Department of Justice reported several observations relating to the other coronial autopsies (non "state cases"). [3]

The review was tasked with examining the functioning of the Office of the State Pathologist only. For this reason, the observations below were not included in the main body of the report, but the steering group for the review felt it was important to note these observations, which were included in an appendix to the review.

[8] https://www.housing.gov.ie/sites/default/files/publications/files/vfm_report_no_31_coroner_service_in_local_authorities.pdf

[9] Not always expensed or paid for

[10] Statutory Instruments. S.I. No. 155 of 2009. Coroners Act 1962 (Fees and Expenses) Regulations 2009

Observations relating to death investigation and autopsy

This review has been focused on the OSP and a review of the coronial autopsy system was not within the terms of reference. However, there are several observations which the steering group found of interest, and pertinent to record for any broader future work on the death investigation system or coronial system in Ireland. These recommendations are not 'findings' in any sense; there are simply points of interest that may merit further exploration in the future.

- Most coroner-ordered autopsies (approx. 96%) carried out in Ireland are done by HSE or Hospital Consultant Histopathologists or supervised trainees in Histopathology (sudden, or unexplained death, in the absence of any suspicious circumstances).
- This work is carried out as independent work outside of the consultant's HSE contract or Hospital contract. That is, it is not part of the contractual commitment to provide this service to the coroner (although in practice most do provide this service).
- This differs from the contractual commitment to perform hospital autopsy work (not directed by the coroner) ordered by the hospital for clinical reasons, which would form part of a consultant's contractual commitment (clinical duties).
- Similarly, the pathologists based at the OSP (apart from the current Acting Deputy) are not contractually obliged to perform coroner-ordered autopsies where the circumstances are not suspicious (non 'state cases'). The Acting Deputy is only obliged to perform these for the duration of her training contract.
- Autopsy competency is a mandatory component of histopathology training in Ireland. However, in some jurisdictions it is an optional competency. In some cases, this means that trainees are choosing to opt out of autopsy competency (UK, Australia).[1 2 3]
- In many jurisdictions, the national forensic pathology service carries out most of the coronial autopsy work in addition to homicides and suspicious cases. However, the OSP in Ireland would not have the mandate or the capacity to respond to any additional coronial work under the current service delivery model or staffing levels.
- While there are divided views as the usefulness of Post-Mortem CT scanning, it may be of benefit primarily in the area of non-suspicious coroner-directed post-mortems. More analysis of how this technology could be used in the future in death investigation may be useful. Factors such as cost of equipment, additional training would have to be examined.

Figure 4: Additional Observations from the RCPI Review of the Office of the State Pathologist (2019)[11]

[11] HSC notes on these observations: Regarding bullet point three, the HSC would like to clarify that consented autopsies are requested by the clinicians ' not ordered by the hospital. While under the last bullet point where post-mortem CT scanning is mentioned, it is more appropriate to consider postmortem radiology techniques, rather than only CT scanning.

3. Training in autopsy

Autopsy is one of the pillars of histopathology practice in Ireland for decades and as such, competency in autopsy has been a core element of histopathology training in Ireland at both basic and higher specialist training.

The current specialist training requires that trainees perform ten adult autopsies over the course of basic specialist training (BST) while the higher specialist training (HST) curriculum now (requires that trainees perform 50 adult autopsies, thus an average of 15 per year (reduced from 100 in July 2021). In addition, it is a requirement of the curriculum that a trainee performs one directly observed autopsy (DOPs). Trainees are also required to attend 20 neuropathology sessions during their training programme. It is desirable that trainees observe 5 paediatric autopsies during their training programme.

These curriculum requirements are reviewed annually by the members of the histopathology specialty training committee (STC). Currently, the curriculum is undergoing transformation to an outcome-based education (OBE) approach, which focuses on competency and quality rather than quantity and thus the need for the completion of a specified number of autopsies will no longer be a requirement.

Training in autopsy is undertaken at most hospitals in the country involved in BST and HST training. Hospital pathologists no longer undertake autopsy at Cork University Hospital (CUH), St James's Hospital (SJH), Dublin and the Mater Misericordiae University Hospital (MMUH), Dublin and thus autopsy training is focused in other hospitals within the training hubs.

Study days have been an integral part of training with all areas covered, including autopsy. In recent years, study days with a focus on inquest training in particular have been facilitated by RCPI. Specific BST study days are being run with autopsy part of the curriculum. Training and progress in all aspects of histopathology including autopsy is discussed by trainees with their consultant trainers at least quarterly and also with the National Specialty Director (NSD) at their end of year assessment.

Obtaining the Certificate in Higher Autopsy Training (CHAT) from the Royal College of Pathologists, UK (RCPath) is required for our histopathology trainees to obtain their Certificate of Satisfactory Completion of Specialist Training (CSCST). Before the introduction of the CHAT by the RCPath in 2012, autopsy competency was examined as part of the FRCPath (Fellowship of the RCPath) Part2. The uncoupling of the autopsy exam from the final FRCPath examination has allowed trainees to undertake this exam at an earlier stage. It consists of practical examination which is done in the candidate's choice of mortuary. This is done with an internal and an external examiner. The second part is an objective structured practical examination (OSPE) which is done in the Royal College of Pathologists in London. This has since gone online after the COVID-19 pandemic. The histopathology STC has several histopathologists who are now CHAT examiners for the first part of the exam. The STC has established close links with the lead pathologist for the CHAT examination for the RCPath (Prof K Suvarna) who is also delivering talks as part of the RCPI histopathology study day programme.

Training in autopsy in the UK is mandatory in the early years of histopathology training and some minimum requirements have to be met before progression onwards. Undertaking the CHAT examination is optional for UK trainees.

Training in autopsy remains part of the American Boards examination in Anatomical Pathology.

Training in autopsy in Canada is also mandatory and experience in both general adult autopsy and forensic autopsy forms a core part of their curriculum. Autopsy is examined within their pathology exams.

As mentioned above, currently three large teaching hospitals (SJH, MMUH and CUH) do not incorporate autopsy work in the normal daily departmental work. Special arrangements for training are in place for trainees based in CUH. The situation in Dublin is relatively recent and ad hoc arrangements only exist. This is a serious situation for the affected trainees and highlights the need for this report.

From a training perspective, it is important that NCHDs working in the Mater and St James' Hospitals have appropriate training and support for their exams. The Histopathology Specialty Training Committee in the Faculty of Pathology oversees training and works with trainers and trainees when informed of training issues. Trainees in Cork University Hospital (CUH), have established links and arrangements are in place for autopsy training. Dublin units should be encouraged to develop similar arrangements for trainees during their rotations to these departments. In addition, support for experience leading up to and for the practical examination will be required off site for exam candidates working in these units. The Histopathlogy STC is aware of the issues in autopsy training and these are borne in mind when arranging rotations in Dublin in particular.

4. Mortuary Facilities - Current Situation

The HSC drafted a set of questions relating to mortuary facilities. These questions were sent to lead autopsy consultants in all mortuaries in the country. A copy of the questions is in Appendix A.

In total 28 facilities received the questions, and 12 responses were received. This represents a response rate of 43%.

Location

The following facilities provided responses:

1. Letterkenny University Hospital
2. Our Lady of Lourdes Hospital, Drogheda
3. Sligo University Hospital
4. St Vincent's University Hospital
5. Dublin City Mortuary/Dublin District Mortuary (DDM)
6. St Columcille's Hospital, Loughlinstown, Co Dublin
7. Mayo University Hospital
8. University Hospital Galway
9. Children's Health Ireland at Crumlin (Separate mortuary in Temple Street but currently cases referred to Crumlin in the absence of onsite consultant)
10. Tallaght University Hospital
11. Cork University Hospital
12. University hospital Kerry

Four facilities indicated there was a proposal to regionalize provision of autopsy services.

All facilities that responded indicated they performed coronial autopsies.

Staff

- 11 had a mortuary manager
- Ten had an anatomical pathology technician (APT) available at weekends and out of hours (including one informal arrangement)
- In most (7 of 12) of the departments in which the lead consultant was based, all consultants of that department conducted autopsy.
- Six units had trainees/rotations of trainees. In these units, the proportion of trainees doing autopsy under consultant supervision varied.
    - One said all autopsies were done by trainees
    - Two said most autopsies were done by trainees
    - Two said a minority of autopsies were done by trainees
    - In one unit, no trainees did autopsy.

Additional services

- Most mortuaries did not have dedicated secretarial support. Instead, most indicated secretarial support was provided through the main histopathology laboratory
- Ten had onsite availability for autopsy biochemistry and microbiology.
- Nine indicated they had onsite availability for autopsy imaging.[12]

[12] This does not reflect the experience of HSC members. In practice availability is often conditional and delays autopsies

- Eight said they there was a radiologist on site who could report the autopsy imaging.
- Seven said the mortuary was on NIMIS (National Integrated Medical Imaging System).
- Four had a formal arrangement with the radiology department in the hospital (where the mortuary is located) for carrying out the autopsy radiology, a further two had an informal arrangement.
- Nine centres said that histology was performed on-site.

Facilities

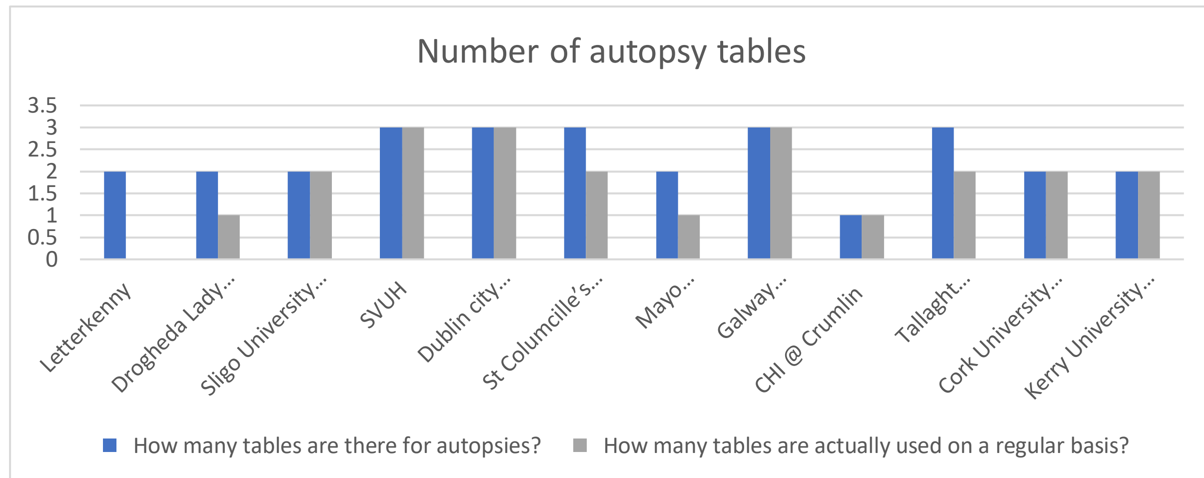

Figure 5: Autopsy tables

- All respondents said they had adequate refrigeration capacity in the mortuary for their regional workload requirements.
- All respondents said they had adequate autopsy equipment.
- Ten respondents answered the question on staff facilities. All ten said that there was a separate changing area for staff, toilet, and shower facilities. [13]
- Most (nine of ten valid answers[14]) said there was an office facility for paperwork, phone calls, microscopy etc., one mortuary said, "not specifically for the doctors".
- All (ten of ten valid answers) said there was a facility for families to view/identify their deceased relatives.
- Most (of ten valid answers) said they had full availability of protective clothing.
- On whether there were isolation facilities for infectious cases (hazard group 3,4)
    - Only two of ten valid responses answered "yes" to this question
    - One mortuary said that it has full room ventilation allowing for hazard group 3 infections, while a forensic room is isolated and could be used for hazard group 4 (the response noted that mostly autopsy should be avoided in those cases.)
- On ventilation:
    - Four said they had downdraft ventilation only
    - Three said they had full room downdraft

[13] It should be noted that responses were not received from all mortuaries. Also, notwithstanding the responses to the survey, it is the experience of HSC members is that many mortuaries, including some which provided responses do not have adequate changing facilities
[14] 2 responses returned with pages missing

5. Survey of Consultant Pathologists

The HSC prepared questions on autopsy for consultant pathologists. The survey questions were uploaded to the Qualtrics platform, and a link to the survey was circulated to all consultant Histopathologists registered with the Faculty of Pathology. A copy of the survey questions is included in Appendix B.

A total of 52 consultants responded to the survey, of whom 49 were happy to have their data included in the report.

Profiles

Time in post	Percentage of respondents
<5 years in post	24%
5-10 years	24%
10-20 years	28%
>20 years	22%

- 16% work in a level 3 hospital, 71% work in a university hospital, 12% other (CHI, office of the state pathologist).
- Most (73%) carried out coronial autopsies.
- 89% of those surveyed carry out consented hospital cases.
- Most common reason for autopsy was BID ('brought in dead') from community/ death in the community.
- The numbers of cases per centre vary with a range from 30 to 650 cases per year, the mean being 75 cases per centre per year. The wide range is significant, reflecting an uneven workload.

Sites

People were asked at how many separate sites they carried out autopsy

The majority carried out autopsy at just one site. This was the case for 44 of 52 respondents.

Facilities at site

The table below shows the percentage of respondents who said the facilities at site were adequate. The proportion who said the mortuary equipment (e.g. tables, ventilation) were adequate was high-reflecting the responses of the lead consultant survey. A smaller proportion said that clerical support was adequate (41% below). Most indicated that this support was provided through the main histopathology laboratory.

Table 1 : Facilities at site, consultant survey

1 - Number of tables	88.89%
1 - Number of dissecting stations	83.33%
1 - Ventilation	86.11%
1 - Changing facilities	69.44%
1 - Refrigeration for bodies	66.67%
1 - Doctors' office	61.11%
1 - Clerical support	41.67%
1 - Capacity for infectious disease cases	25.00%

Main motivation for doing coroner autopsies

Some of the answers given to this question included:

- "Interest".
- "serve the family involved".
- "part of the job".
- "interesting work, maintain skills, remuneration".
- "professional and moral obligation".

Discussion/meetings with colleagues

- 58.33% take part in morbidity and mortality meetings.
- 95.24% find these meetings were either moderately, very, or extremely useful.

Coronial autopsies on cases from other hospitals

- 41.67% carry out coronial autopsies on cases from other hospitals.
- 80% receive the case notes from the other hospital 'always' or 'most of the time'.

Inquests

- When supervising an NCHD (non- consultant hospital doctor) in doing a coronial autopsy, it is usually the consultant or both together who prepare the deposition for inquest.
- When asked who attends the inquest
  - 14.29% said the consultant and NCHD attend together
  - 19.05% said NCHD only
  - 66.67% said Consultant only

Reducing the autopsy burden

The graph below shows the answers to the question: “What factors in your opinion reduce the autopsy burden?”

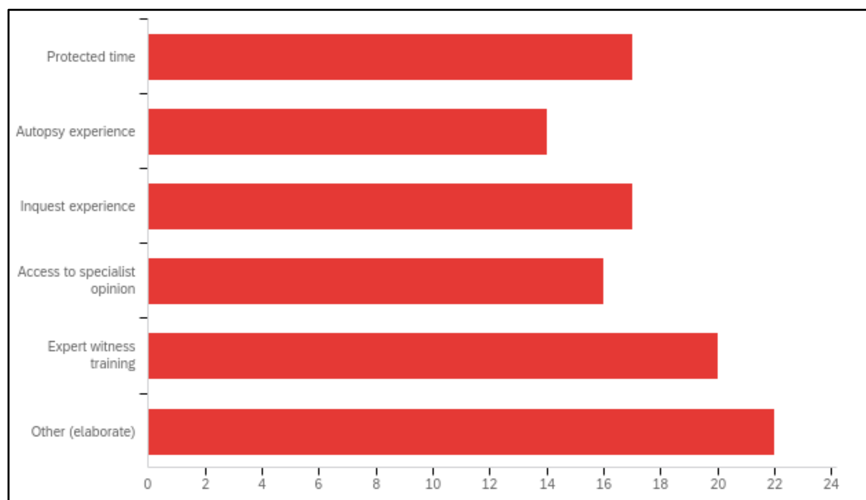

Figure 6: What factors in your opinion reduce the autopsy burden?

Examples of issues mentioned under ‘other’ was

- “adequate staffing”.
- “emotional burden”.
- “better selection of cases”.
- “more time for autopsy”.

Those who do not do coronial autopsy - why not?

The graph below shows answers to the question: “What factors contribute to your decision not to do coronial autopsies?” This question was visible only to those who indicated they did not do coronial autopsy. Most frequently mentioned factors were:

- Lack of time due to surgical pathology commitments.
- Concerns about medico legal environment.
- Skillset has changed.
- Inquests- concerns about inquest attendance and negative experiences of inquest in the past.

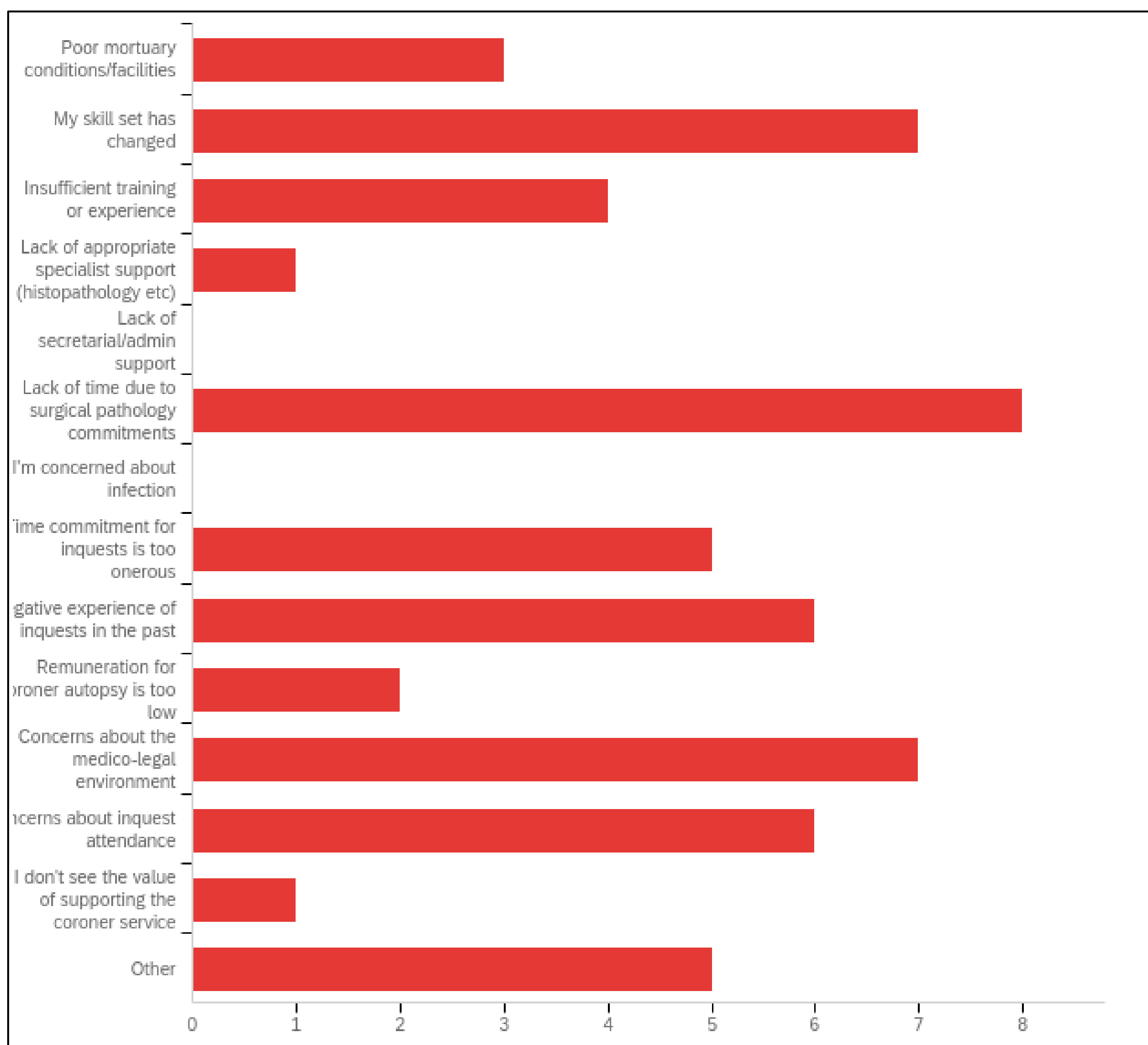

Figure 7 : What factors contribute to your decision not to do coronial autopsies?

Those who said they did not perform coronial autopsy were asked what factors would encourage them to carry out coronial autopsy. Answers are shown in the graph below.

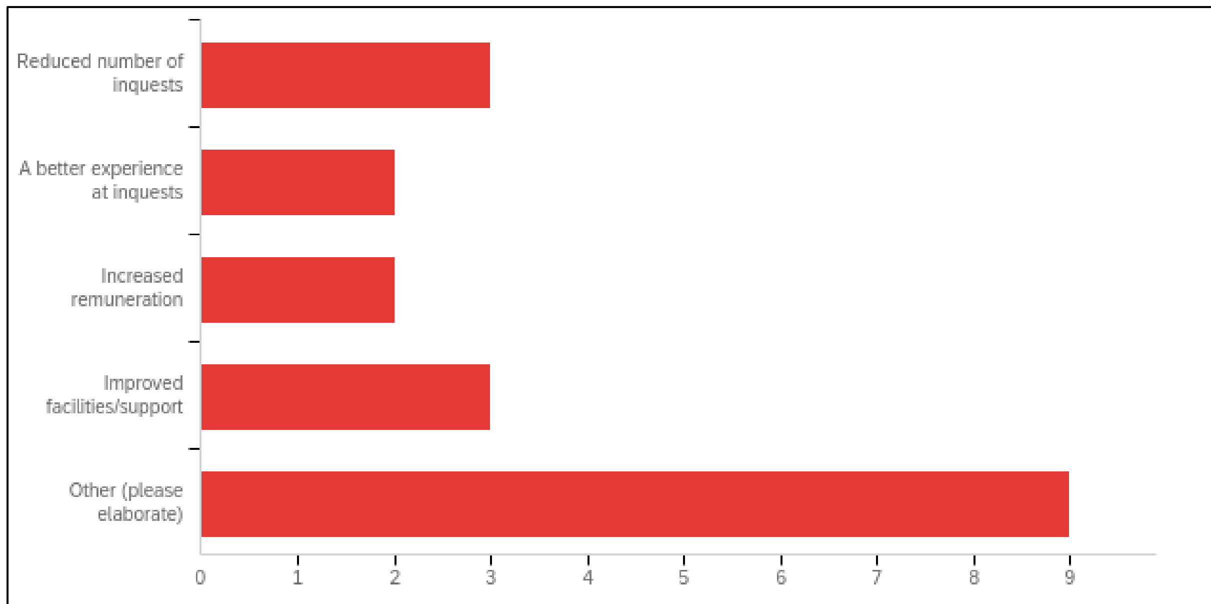

Figure 8: What factors would encourage you to carry out coronial autopsy?

Under 'Other', a number said none:

- "None. Coroner's service should be restructured as medical examiner of death and specialisation as such in post mortem practice".
- "I would not be willing to do them under any circumstances".

Other comments included:

- "if they were properly resourced and were an organised structured part of a hospital pathologist's contract".
- "more time on rota to do the PM and the report".

Model for coronial autopsy

51.02% answered that non-forensic coronial autopsies should be undertaken by full-time regional autopsy pathologists (medical examiners) working alongside state service. See graph below

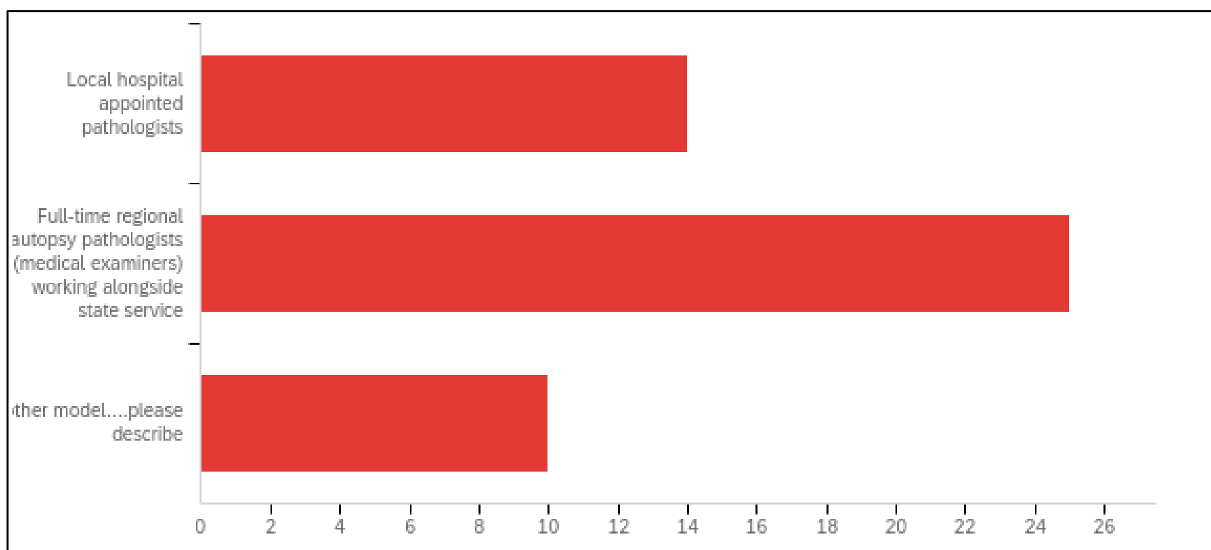

Figure 9: Views on a model for coronial autopsy

- 38.78% felt a hospital pathologist should not be required to do coronial autopsies and 28.57% answered 'probably not'.

Payment

- Majority said current payment for the coronial autopsy was inadequate (60%).
- However most, said that an increase in payment would not encourage pathologists to restart autopsy practice (suggesting that pay is not the only or strongest factor at play).

Autopsy service

Respondents were asked whether they felt that the coroner service was undervalued. 77.55% felt that this was the case. Comments provided included:

- "an essential service provided well by a small group of doctors".
- "information gleaned from autopsies is not sufficiently being fed back through MDTs".
- "in a hospital setting, where the priority is diagnoses in living individuals (as it should be) that autopsy work gets deprioritised and left until last. It is almost an afterthought."
- "If properly structured, the coronial autopsy service could provide a basis for histopathology gross anatomy, specialised autopsy and forensic training and could contribute significantly to public health and epidemiology in this country."
- "Chaotic arrangements, pathology time markedly undervalued, highly variable coroner training and practice all suggest a Cinderella service in need of a program of professional restructuring."

Most feel the current service is not sustainable (42% definitely not, 38% probably not).

Most felt the service should be restructured (77%).

Comments on how it should be restructured included the following suggestions

- A regionalized or centralized service.
- Dedicated autopsy specialists.
- Fulltime coroners.
- Consideration of a different system of death investigation (e.g., medical examiner).

Specialized autopsy

Hazardous autopsy

A minority of consultants said they had training in infectious disease autopsy (28%) while just over half (53%) said that, with appropriate PPE and facilities, they would be willing to conduct coronial autopsies in cases of communicable disease such as COVID-19.

Perinatal/Paediatric autopsy

Respondents were asked about the availability of perinatal autopsy expertise and paediatric autopsy expertise in their area:

- Only 12% said they perform (or were willing to perform perinatal autopsies).
- Only 10% said they perform (or were willing to perform paediatric autopsies).

This reflects a broader shortage of perinatal and paediatric pathology expertise which has been highlighted in various reports.[3,15]

Training

A majority felt that autopsy was an important part of the training of the histopathologist who will be working in Ireland (60% said extremely, or very important). See graph below

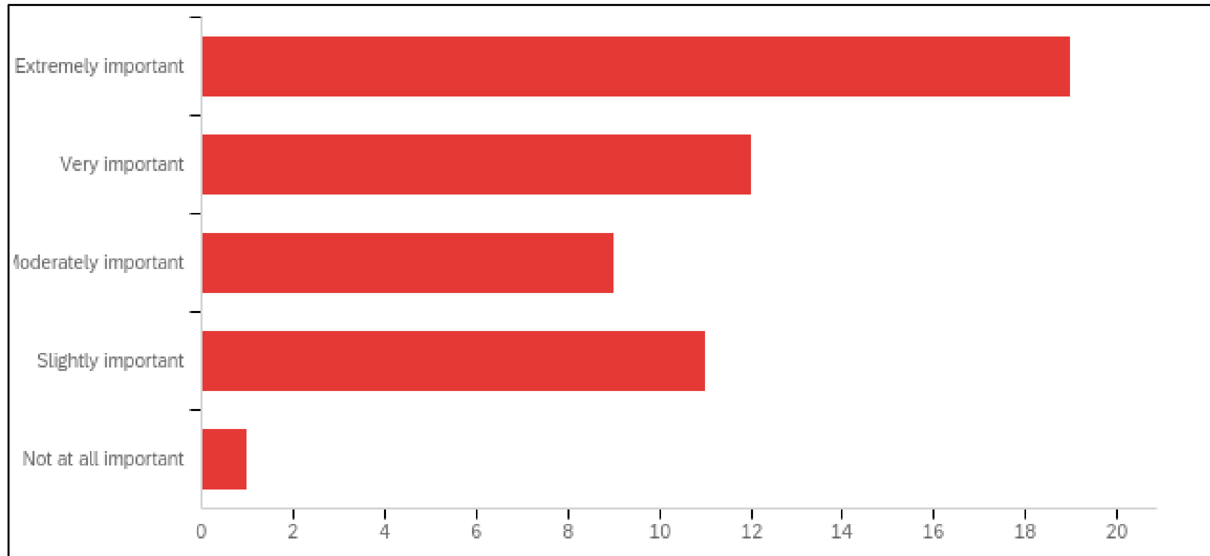

Figure 10: Is autopsy an important part of the training of the histopathologist who will be working in Ireland?

- A majority said their department has enough cases to allow the NCHD current recommended number of 100 cases in their training (60% definitely yes or probably yes).
- Most cases had 200 or more in their department (46%).
- Most considered that attendance at inquest was a useful part of training for the NCHD (68% said either extremely or very useful.)

CHAT Exam

On whether the CHAT exam should be mandatory, more said Yes (40%) than No (30%).

Reasons people gave for why the CHAT exam should be optional:

- "Irish trainees are now at a disadvantage compared to UK trainees who can get CSCST without CHAT and may be eligible to apply for jobs in Ireland before a pathologist trainee in Ireland."
- "Autopsy detrimental to recruitment of pathologists. Surgical pathology training should be maximised in limited training time available."
- "It is not mandatory in the UK. A UK trained pathologist may be appointed to a consultant post in Ireland without having sat the CHAT. It has become quite specialised and perhaps is not suitable for pathologists in general training."
- "RCPATH control exam and UK appear to be diverging from Irish autopsy practice. Completion of specialist training entirely reliant on RCPATH; while ok for surgical pathology no reason our STC cannot sign-off autopsy training based on our own assessment.

[15] National Clinical Programme for Paediatrics and Neonatology: A National Model of Care for Paediatric Healthcare Services in Ireland (https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/paediatric-laboratory-medicine.pdf)

Consultants trained outside Ireland are now being appointed to consultant posts in hospitals where no autopsies performed (CUH, SJH)."

Additional comments

"Overall, I am glad that autopsies are part of my work, even though meeting with tragic situations repetitively can sometimes get you down."

"Pathologists across the country are largely employed by the health services. Maintenance of a Coroner's service is not a contractual obligation and as long as surgical services remain under-resourced and all-consuming maintenance of a Coroner's service will become more and more precarious."

"Could consider an Irish version of CHAT."

"I favour continuing to train Irish pathologists in autopsy pathology but propose the development of an Irish qualification."

"I would not like to see a situation where non-forensic pathologists with adequate experience and expertise are discouraged from autopsy practice because the faculty has made recommendations around sub-specialty forensic expertise."

"Training in autopsy is mandatory at present for our trainees as we are training them for the current outdated hybrid system. If we had clearly defined separate autopsy specialists, it would be reasonable to make the CHAT exam optional, but I'd recommend that BST trainees should still have autopsy exposure. Until the entire coroner's autopsy system is reformed however, I think trainees need to be certified in autopsy pathology to achieve CSCST in Ireland, and the RCPath CHAT exam does the job for this."

"… I strongly believe they should not be mandatory for trainees to be signed off for their CSCST. ...Most importantly the CHAT exam is now specialised in the UK and harder for Irish trainees to pass. Why are we not keeping up with the times and organising a separate autopsy training scheme which is optional for our trainees as in the UK- if we are making them do the UK CHAT exam the least we can do is train them the same way as the UK to prepare for it. Autopsies should be carried out by interested and appropriately trained pathologists . They should not be forced upon those who are focusing on diagnostic surgical pathology and who have no background forensic or specialised autopsy training."

6. Survey of Histopathology Trainees

An electronic survey was sent to BST and HST trainees in histopathology, by email, to the email address supplied by the trainee to RCPI. A total of 59 trainees were surveyed.

A copy of the survey questions is included in Appendix C

A total of 36 trainees (response rate of 61%) completed the survey, including 8 BST trainees and 28 HST trainees. 44% of respondents had completed the CHAT examination and 14% had completed the FRCPath Part 2 exam.

Overview

While most trainees see a value in autopsy work, they highlighted issues in relation to training, both autopsy and inquest involvement, and having sufficient time to undertake their autopsy duties as issues which, if improved, might encourage involvement in autopsy practice. As a result, 39% of trainees said they liked autopsy work, with 53% of trainees responding that they did not like autopsy work.

Issues the trainees encountered included:

- "*balance(ing) autopsy workload with increasing clinical workload and study.*"
- Autopsy work was seen as an "*add on to the regular workload.*"
- It is felt that "current practice "*compromises the quality of the autopsy significantly*" with training in autopsy being "*insufficient*".
- There is "*fear of being unsupported at any potential inquests*".
- With trainees feeling that they were "*never properly trained to carry out an autopsy to the standards of FRCPath or the textbooks*".
- Trainees worry *"about things (they) have likely missed or done incorrectly*".

Training and consultant posts

Training standard appears good- most feel they will probably have enough experience at the end of training. 28% of trainees felt they *definitely* will have enough autopsy experience when they finish training to be competent in autopsy and 44% of trainees felt they *probably* will have enough autopsy experience when they finish training.

Many said they have no protected time for autopsy (44%).

Most say they have attended inquest (giving evidence), but inquest is a source of worry for many. 75% of trainees had attended an inquest. 48% of trainees had given evidence at an inquest. 44% said inquest was a source of worry for them.

The vast majority want to work in a large cancer center post when finished training. 78% of trainees hope to work in a large cancer centre hospital post or university hospital post in the future.

Significant number said they were not interested in doing autopsy as a consultant. 42% of trainees do not see themselves partaking in any autopsy work as a consultant.

Improved facilities and support were the biggest factors identified by trainees that would encourage them to continue with autopsy practice, with 30% of trainees replying that this would influence their decision to continue with autopsy work.

Autopsy training

When asked what was missing in autopsy training currently, a recurrent theme in answers received was structured autopsy teaching and support, with dedicated teaching and observation of dissection particularly at the start of BST training.

CHAT exam

With regards to the CHAT exam, 62% of trainees felt it should not be a mandatory component of training in Ireland. If the CHAT exam were optional, 70% of trainees would sit it or would consider sitting it.

Some trainees and consultants feel that this a UK based exam and thus may not be entirely relevant to the Irish situation. However, many trainees did feel that a consequence of making the CHAT exam optional would result in them being at a disadvantage when applying for consultant jobs in Ireland and thus having the CHAT would make them more competitive. Interestingly, trainees felt that making the CHAT exam optional would potentially help improve autopsy practice and standards by ensuring that those interested in autopsy would do the exam and that autopsy could be developed as a subspecialty.

7. Discussion

From the large amount of data generated by the survey, the HSC has concentrated on ***staffing, facilities and specialist services*** and has used this to make recommendations for training and for the system in the future.

Staffing

The concern among HSC members that there will be a shortage of histopathologists willing to perform coronial autopsy in the future, appears to be borne out in the responses to the surveys. For example, 42% of trainees do not see themselves partaking in any autopsy work as a consultant and just over a quarter of consultants who responded to the survey did not carry out coronial autopsy work.

Not all hospitals carry out coronial autopsies and there is no legislative requirement for them to do so. Hospital pathologists no longer undertake autopsy at Cork University Hospital, St James's Hospital, Dublin or at the Mater Misericordiae University Hospital, Dublin. The autopsy service at Limerick University Hospital is provided usually by two locum consultant histopathologists.

St. James's Hospital coronial cases are sent to the Dublin District Mortuary (DDM) and hospital cases are sent to Blanchardstown hospital. MMUH send all coronial autopsies to DDM. Both of these factors have resulted in a doubling of the DDM workload in the last two years, which is placing a strain on the DDM Whitehall facility and there is now no capacity to take on further work.

If the trend of withdrawing services to the coroners continues, there will not be enough histopathologists in the future to do all the coronial autopsies required within a reasonable time frame. We do not therefore recommend making the CHAT examination optional for trainees currently. The importance of autopsy work in medicine was emphatically highlighted by the recent SARS-CoV-2 pandemic, where autopsy practice provided invaluable information about the natural history of the virus. Autopsy builds on and expands medical knowledge and the formulation of a cause of death and clinicopathological correlation is a valuable skill with important clinical and legal applications.

From the survey findings we see some of the reasons why autopsy practice work may not be attractive to histopathologists. For example:

- Other clinical duties take priority.
- It not a contractual requirement.
- Appearances at inquests are challenging and many histopathologists may not want to/are not trained to do this.
- Many consultants feel the coronial service is undervalued and many would like to see change of the current model (for example there were suggestion to move to a centralized model, with dedicated autopsy specialists).
- Among trainees the majority want to work in a large cancer center post when finished training (78%). This of itself does not exclude autopsy practice and the majority of cancer centres retain an autopsy service in their department.

Availability of histopathology services to the coroner

A review of the Coronial service in 2000 identified that histopathology services to the coroner were essentially provided on the basis of goodwill. [16]

> *"For example, pathologists, though an obvious critical element of the coroner system, are only available on the basis of goodwill between the professions. However, there are some cases where crises have only been avoided on the basis of the drawing down of goodwill and the introduction of emergency arrangements from time to time. This cannot be the basis on which the coroner system of the future will operate*."

The review recommended that arrangements should be put in place to guarantee this service. That review did not specify exactly how this should be achieved, but mentioned that "*some form of formal, perhaps contractual arrangements, either with pathologists or with hospitals will be needed."*

International trends

A similar trend of reluctance to engage in autopsy is observed internationally and many histopathologists trained in the UK in particular, are choosing not to complete autopsy competency within specialist training. Autopsy competency remains a mandatory component of histopathology in Ireland, however.

The HSC believes that development of autopsy as a subspecialty will greatly assist in ensuring the service. Individual departments may need to be aware of the expectation of their hospital and the regional local authority and coronial requirements in relation to the autopsy service and to address this when recruiting consultants.

The provision of specific consultant autopsy contracts was discussed. This would be difficult without subspeciality designation and would also impact the perceived independence of the autopsy pathologist as an agent of the coroner. Local authorities currently fund the professional element of the service and they need to be involved in any discussions around this. Of course, any potential change to consultant contracts would also have to be approved by the HSE, IMO and IHCA.

Developing the practice of the 'limited autopsy', which became more acceptable as a result of COVID-19, could reduce the burden on individual pathologists . However, this would require case by case assessment, discussions with the coroner, local arrangements regarding PM radiology to be formalised, forensic radiology protocols to be standardised, and above all, the provision of adequate forensic or autopsy radiology trained consultant radiologists to interpret the investigations. Outside of radiological investigations, limited autopsies where an external examination, review of the medical notes and toxicology are performed (e.g. the "view and grant" system in Scotland and Australia), could perhaps be discussed with each coroner as a move to reduce autopsy workload. Any such changes would have to be done with the support of the coroners and probably on a case - by case basis.

Ensuring administrative support at all stages from the organisation of the autopsy, quality assurance, to secretarial services would also help to make autopsy work less onerous to individual pathologists. This seems to vary greatly from unit to unit.

[16] http://www.justice.ie/en/JELR/ReviewCoronerService.pdf/Files/ReviewCoronerService.pdf

Many comments centred on the lack of protected time to dedicate to autopsy. This is an important factor, but one that can be remedied at local level. Some departments have a 'rolling rota ' for autopsy duty to ensure equal distribution of cases amongst senior and junior colleagues. However, this usually results in autopsy being performed alongside other duties. In the experience of members of the HSC who have worked with both types of rotas, dedicated, protected time is preferable.

Mortuary facilities

Not all units/mortuaries which do autopsy – only 12 of 28 units -responded to the survey issued by the HSC. It is clear from the survey that the majority reported good ventilation, (7 of 10), but there were few isolation rooms and no perceived health and safety training for infectious cases. There is a clear lack of dedicated clerical and other support. The experience of members of the HSC is that facilities are far from adequate in many mortuaries throughout the country. All of these issues have been highlighted by the recent pandemic, resulting in the need for the Faculty of Pathology to issue a guidance document on COVID-19 and mortuaries/post-mortem examinations in May 2020. [17] An updated version of these guidelines is due to be published in 2022.

The HSE is currently undertaking work to improve a number of hospital mortuary facilities around the country. As part of this, the HSC recommends that each hospital department should review their autopsy facilities, using local health and safety resources, and potentially the Health and Safety Authority for more formal input. A detailed outline of each mortuary's resource requirements can then be submitted to the HSC. These will be communicated to the HSE and form the basis of a process of improvement nationally. The HSE is eager to work with pathologists, and local authorities to progress and improve the autopsy service nationally.

This is an opportunity to look at new developments. Autopsy work is changing with expanding use of radiological techniques in many centres in the UK, North America, and Australia. If Ireland is to adopt such developments, it makes sense to develop regional services where facilities could be centralised and availed of by collaborating hospitals .

On a regional basis, it would be ideal to have a central unit with laboratory and radiological support. In time, this would evolve into becoming the preferred centre of autopsy practice. Dublin and Cork each have large, dedicated autopsy centres. However, neither have an officially dedicated laboratory facility. This would ideally be a new build or could be contracted in the interim to a local teaching hospital.

Specialist autopsy (paediatric and perinatal)

The Royal College of Pathologists and the Royal College of Paediatrics and Child Health recommend that paediatric pathologist input should be sought in all cases of perinatal and infant deaths, regardless of whether input from a FP (forensic pathologist) is warranted. [18]

A recent audit of paediatrics and perinatal cases referred to the OSP, found that "when a PP was the lead pathologist at autopsy, there appeared to be a better adherence to paediatric autopsy

[17] https://www.rcpi.ie/news/releases/faculty-of-pathology-publishes-guidelines-on-autopsy-practise-during-the-covid-19-pandemic/

[18] The Royal College of Pathologists and The Royal College of Paediatrics and Child Health. Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation (Section 7 + Appendices 1,2,4,5,6). Available from: https://www.rcpath.org/uploads/assets/874ae50e-c754-4933-995a804e0ef728a4/Sudden-unexpected-death-in-infancy-and-childhood-2e.pdf

guidelines".[19] A clear protocol should be developed to avoid inappropriate referrals to the forensic pathology service.

There is a deficit in perinatal and paediatric pathology in general. This has been documented in a number of reports[3, 15] There are at present a number of posts coming on stream, including replacements, which will alleviate this deficit in time. Close attention should be paid to this to make sure that the expected posts are filled.

Governance of the service

A major challenge is that there is no single governmental department with responsibility for the coronial service. This situation means that there will be huge difficulties in effecting nationwide change. The health service bears much of the costs on the ground, from providing facilities, medical, mortuary and ancillary staff such as secretaries, social workers / autopsy liaison officers / bereavement officers all of whom play a large role in the autopsy service in some of our hospitals. The local authorities resource body transportation, the payment for autopsy services and fund the regional coroners. The coroners are independent, and this must be maintained throughout any evolution of the autopsy service. The Department of Justice will also have a role because of their coronial legislation, Dublin District Mortuary and Dublin District coronial responsibilities.

It is difficult to know how long any process underlying changes to the coronial autopsy service will take to achieve and how difficult it will be. Discussions need to take place between all of the stakeholders.

Legal framework

The lack of a Human Tissue Act denies pathologists a legal framework in which to carry out autopsy and diagnostic work. The bill that is currently being drafted, named 'The Human Tissue Bill' only addresses the consented autopsy. This is a poorly named bill as unfortunately it does not deal with any other issue one would expect from such a bill. The HSC, together with the Faculty of Pathology, will continue to engage with the government in order to expand this bill.

[19] S. Eakins1, L. Mulligan2, K. Han Suyin2 - Paediatric cases referred to The Office of the State Pathologist https://imj.ie/irish-medical-journal-april-2021-vol-114-no-4/

8. Recommendations

Make autopsy work more manageable within the hospital pathologist's normal work environment and commitments

1. Development of autopsy as a subspecialty, with appropriate training and staffing.
2. Autopsy to be developed as a 'special interest' within histopathology departments , leading to a pool of interested consultants, thus enabling the development of a regionalised service (main training centre supported by regional hospitals in time (see Appendix D for suggested collaborating hospitals/groups).
3. Protected time for conduct of autopsy and inquest responsibilities.
4. Appropriate levels of dedicated secretarial support.
5. Inclusion of autopsy in consultant histopathologist job descriptions, with specific outlines of the expected commitment in each post

Deliver appropriate and responsive autopsy training and exams

The training of NCHDs in autopsy should continue. The Histopathology Specialty Training Committee of the Faculty of Pathology in RCPI should continue to closely examine the rotations to ensure adequate exposure to autopsies at BST and HST rotations . It should be acknowledged that trainees in centres without an autopsy service should be supported in undertaking their CHAT exam which may require linking with another site. In summary :

6. Ensure training and exams responsive to the needs of the Coronial autopsy system

7. Ensure ongoing feedback to the histopathology Speciality Training Committee (STC) and trainers to monitor issues around training needs including:
    - Approach to CHAT exam
    - Appropriate rostering of autopsy service within trainee rosters
    - Ensure ongoing incorporation of training needs around autopsy into current study day programmes. This training is relevant for all pathologists and should alleviate concerns regarding inquests.

Ensure a robust and sustainable future death investigation system

8. Ensure that autopsy has a formal standing through an Irish Human Tissue Act.

9. Begin evaluation of local mortuary facilities in order to start the process with the HSE which will result in ensuring that infrastructure and facilities nationwide are of good standard, fit for purpose and that all have access to appropriate laboratory, secretarial and social service system support.

10. Consider a change to the current system of death investigation (in line with proposals from the 2000 Review of the Coroner Service and by the 2021 research report published by the Irish Council for Civil Liberties[2]).
    - Initially a hub and spoke model, where a group of collaborating hospitals includes a university teaching hospital. This opens up rotation possibilities for trainees to get more autopsy exposure and allows for possibility of better communication between practicing autopsy pathologists, improved standards and options for peer review and subsequently improved training.
    - Ultimately this could evolve into a regionalised autopsy service where the main hospital base is a centre of excellence and works closely with the forensic pathology service.

- Such collaborative groups would ensure access on a regional basis to specialist expertise in neuropathology, perinatal and paediatric pathology and allow the development of radiology support services.

Ensure availability of specialist autopsy expertise

11. Ensure sufficient perinatal and paediatric pathology expertise/posts so that each region is appropriately resourced, and that appropriate referral of cases can be made.
12. Establish a clear protocol for perinatal and paediatric cases to avoid inappropriate referrals to forensic pathology service.

Implementation of recommendations

We append a suggested grouping of hospitals (see Appendix D). The hubs and the hospitals providing services would have to be agreed with the stakeholders. Each collaborating group should be resourced with access to specialist opinion and laboratory services for paediatric / perinatal and neuropathology autopsies. At the start, this would likely necessitate off-site opinion or body transfer, but appropriate consultant appointments and established guidelines for autopsy would ensure local access and more standardised practice in time. The agreed regionally assigned university/teaching hospital would be the favoured location for specialised services such as radiology and would coordinate training of NCHDs and technicians, with rotations through collaborating hospital departments as part of the training programme. A regionalised forensic service would thus also be enabled .

Additional pathologist appointments with dedicated autopsy sessions will be needed In Dublin South and in Ireland Southwest to ensure continued service in St Columcille's Hospital (SCH) and Cork University Hospital (CUH), neither of whom have a pathologist with a substantial local hospital commitment. In the case of SCH, following reconfiguration of laboratory services, the significant autopsy component did not transfer into St Vincent's University Hospital (SVUH) with the histopathologist post, although full laboratory support is provided to the mortuary by SVUH. These posts should be funded by the HSE as consultant posts with dedicated autopsy sessions. The Department of Justice may potentially be approached to provide part-funding for one or more of these posts, particularly in the Ireland Southwest region.

Next steps towards implementation:

- Circulate this proposal to histopathology consultants nationwide
- Establish a discourse with stakeholders (HSE, Department of Justice , coroners, county councils, Faculty of Pathology) with the aim of :
  - Agreeing collaborating hospital groups and function of each hospital within these groups
  - Appointing additional consultant pathologists with dedicated autopsy sessions
  - Sourcing appropriate funding.

Appendices

Appendix A: Questions for Mortuary Facilities

FACULTY OF PATHOLOGY

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Questions for Mortuary Facilities

Faculty of Pathology- Histopathology Standing Committee

May 2020

Location and catchment area

1. Where is the mortuary located?
2. What is the catchment area?
3. Name the coroner(s) who direct(s) autopsies to be performed at the mortuary.
4. Is there any proposal to regionalize the provision of autopsy services?
   a. In operation already ☐
   b. In planning ☐
   c. No, there are no such plans ☐

Autopsies

5. Type of autopsy performed (tick all that apply)
   a. Adult ☐
   b. Paediatric ☐
   c. Perinatal ☐
   d. Neuropathology ☐

Annual Case Load

6. How many bodies go through the facility?
7. How many of these are Coroner autopsies

8. How many are Consented/Hospital autopsies?

Staff

9. Do you have a mortuary manager?
10. How many Anatomical Pathology Technicians (APTs) work in the mortuary? (Whole time equivalent -WTE)?
    a. Senior APTs?
    b. Junior APTs?
    c. Trainee APTs?
11. Is there an APT available at weekends and out-of-hours to assist with forensic cases?
12. How many consultant histopathologists work in your department? (Whole time equivalent -WTE)
13. Of these, how many perform autopsy examinations?
14. How many histopathology trainees work in the department?
15. What proportion of autopsy examinations are performed by histopathology trainees with consultant supervision?
    a. All ☐
    b. Majority ☐
    c. About half ☐
    d. Minority ☐
16. Do medical students attend cases?
    a. Never ☐
    b. Rarely ☐
    c. Sometimes ☐
    d. Often ☐
    e. Always ☐

Additional services

17. Is there secretarial support at the mortuary?
18. Is there onsite availability for autopsy biochemistry and microbiology?
19. Is there onsite availability for autopsy imaging?
20. Is there a radiologist on site who can report the autopsy imaging?

21. Is the mortuary on NIMIS (National Integrated Medical Imaging System)?

22. Is there a formal arrangement with the radiology department in the hospital (where the mortuary is located) for carrying out the autopsy radiology?

23. Is histology performed on or off-site? If off-site, where?

24. Who finances the histology?

25. Is there a payment for the use of the mortuary/autopsy facility?

Facilities

26. What is the refrigerated body storage capacity of the mortuary?

27. How many tables are there for autopsies?

28. How many tables are actually used on a regular basis?

29. Is there adequate autopsy equipment?

30. Staff facilities

    a. Separate changing area for staff ☐

    b. Shower facilities ☐

    c. Toilet facilities ☐

31. Is there an office facility for paperwork, phone calls, microscopy, etc?

32. Is there a facility for families to view/identify their deceased relatives?

Hazards and protective equipment

33. What protective clothing and equipment is available? Tick all that apply.

    a. Gowns ☐

    b. Gloves ☐

    c. Eye protection (goggles, glasses) ☐

    d. Surgical Masks ☐

    e. Respirator masks ☐

    f. Head covers ☐

g. Shoe covers ☐

34. Are there isolation facilities to perform infectious cases (hazard group 3,4)?

35. What type of ventilation is present?

a. Downdraft tables only ☐

b. Full room downdraft ☐

c. None ☐

Upgrades and future plans

36. Are there any existing proposals to upgrade the facility?

a. Yes, planned and costed and approved and underway ☐

b. Yes, planned and costed and approved but not underway ☐

c. Yes, planned and costed but not approved ☐

d. Yes, planned but not costed ☐

37. Is there any capacity to upgrade the facility within its existing footprint?

38. Is there any capacity to upgrade the facility adjacent to its existing footprint?

39. Is there any space on the hospital campus to construct a new mortuary?

40. Do any of the proposed upgrades include a facility suitable for handling hazardous autopsies?

Additional information

41. Any further information you would like to include?

Appendix B – Survey for Consultants

Autopsy Survey-
Consultants Final Dı

Appendix C – Survey for Trainees

Autopsy
Survey-Trainees fina

Appendix D – Suggested Collaborating Hospitals/Groups

Group	Supporting Hospitals	Paediatric centre	Perinatal centre (including regional SIDS cases)	Neuropatholoy Centre	Main Centre	Associated University Teaching Hospital
Dublin North	Beaumont Hospital Mater Misericordiae University Hospital (MMUH) Our Lady of Lourdes Hospital, Drogheda James Connolly Memorial Hospital (JCMH) / Navan Hospital Cavan Hospital	Children's Health Ireland (CHI)	Rotunda	Beaumont Hospital (BH)	Dublin District Mortuary (DDM)	BH
Dublin South	St. Columcille's Hospital Loughlinstown St Vincent's University Hospital (SVUH) Tallaght University Hospital (TUH) Naas General Hospital St James's Hospital	Children's Health Ireland (CHI)	Coombe Women and Infants University Hospital (CWIUH) National Maternity Hospital (NMH)	BH	TUH	TUH
Ireland North/North West	Letterkenny University Hospital(LUH) Sligo University Hospital	Children's Health Ireland (CHI)	Galway University Hospital (GUH)	BH	LUH	LUH

Ireland West	Galway University Hospital (GUH) Ballinasloe Hospital Mayo General Hospital	Children's Health Ireland (CHI)	GUH	Cork University Hospital (CUH)	GUH	GUH
Ireland South/South West	CUH Mercy Hospital Cork Kerry General Hospital Bantry and Mallow hospitals	Children's Health Ireland (CHI)	CUH	CUH	CUH	CUH
Ireland Southeast	Waterford University Hospital (WUH) Limerick University Hospital Wexford General Hospital South Tipperary General Hospital	Children's Health Ireland (CHI)	CUH	CUH	WUH	WUH
Midlands	Midlands Regional Hospital Tullamore Midlands Regional Hospital Portlaoise Midlands Regional Hospital Mullingar	Children's Health Ireland (CHI)		BH	MRH Tullamore	

CC_03(2)

Executive Summary

Experience qualifications necessary to become a Coroner: Considerations include should the person be legally or medically qualified or both? (In Northern Ireland only legally qualified candidates are considered). Jury Selection: At present it is not in keeping with the principles set out in *De Burca* (1972) because it is not an appropriate cross section of society taken from the Register of Electors. An Inquest is a very circumscribed inquiry which cannot pronounce on issues of civil or criminal liability; the record of evidence given at an Inquest may be of prime importance in subsequent proceedings, but they are incidental by-products of the system and not intrinsic to it. At present Coroners recommendations lack statutory teeth. A comparison should be made with the system in England and Wales where statutory Prevention of Future Death Reports have a legislative footing. Judicial review is available as a remedy in respect of Coroners' decisions but is a difficult remedy to establish. Under Section 24 of the 1962 Act, an avenue of appeal to the Attorney General exists. Under Section 62 of the 1962 Act (as inserted by the 2019 Act), a Coroner can now seek direction of the High Court on a point of law.

CC_03(1)

Submission to Joint Oireachtas Committee on Justice in relation to the Operation of the Coroner's Service

- **What are the qualifications/experience necessary to become a Coroner?**

1. Section 14 of the Coroners Act, 1962 Act stipulates that a Coroner must be a registered medical practitioner, barrister or solicitor with at least five years post qualification experience. Is five years' experience sufficient? Conceivably, you could have somebody who qualifies at 25, presiding over a very detailed Inquest at the age of 30. Is this desirable? In my respectful submission, the period for qualification should be extended to ten years. In respect of application for judicial office, the period generally is ten to twelve years.

2. The next consideration is: Should only lawyers be considered and not medics who are not legally qualified? This is the position which applies in Northern Ireland where only qualified lawyers can apply to be Coroners. In the respectful submission of this author, the Coroner's Court is becoming increasingly formal and hearing matters of evidence. I have just finished one Inquest which sat for 14 days before the Galway West Coroner's Court, making it the longest running medical Inquest in the history of the State. Clearly, the optimum would be if a Coroner could have both medical and legal qualifications: High profile examples include Dr. Myra Cullinane, who presides over the Dublin District Coroner's Court, the recently retired Dr. Ciaran McLaughlin BL, Coroner for Galway West, and the also retired Dr. Brian Farrell BL who presided over the Coroner's Court in Dublin until 2015. The difficulty with having medically qualified Coroners with no legal training is that they are, in the respectful submission of this author, and in my experience, more likely to fall into error when it comes to procedural matters. Of course, any legally qualified person lacks medical training, but this is where witnesses come in: medical knowledge is no substitute for ordinary common sense, an open mind and intellectual curiosity. The current system works well, with many medics equipping themselves with

legal knowledge. Provision also exists under the 2019 Act, for a Coroner to appoint an expert witness on a particular point.

- **How is the Jury for an Inquest selected? Is the process aimed at a Jury which is representative and balanced?**

3. In the respectful submission of this author, the current system for selecting Juries is not consistent with the principles enunciated in *De Burca v Attorney General* [1]. In that case, the Supreme Court stated:

> "*In determining whether a particular method of jury selection will produce a jury that fairly represents a cross-section of the community, it is not enough to show that a particular class or particular classes are not represented or are under-represented. Competence to fulfil the duties of a juror is an individual rather than a class attribute. No group or class can lay claim to have any special qualification to produce representative jurors. Ideally as many identifiable groups and classes as possible should be included by the standard of eligibility employed, so that a jury drawn from the panel will be seen to be a random sample of the whole community of the relevant district.*"

4. At present, the legislation simply says that a Coroner's Jury shall consist of at least six members and not more than twelve. In the respectful submission of the author, seven would be a better number and this is to avoid any situation where there is a three and three split. A foreperson should be selected. The legislation is silent on what a majority verdict is: is it a majority as in a criminal or civil case i.e. 10 versus 2, or is it a simple numerical majority e.g. in a seven member Jury, 4 versus 3?

5. Many international studies have shown that smaller Juries work best. This is because people who are inhibited or may be introverted or more likely to speak up in a small

[1] [1972] IR 38.

group thereby ensuring an absence of groupthink and ensuring that everyone is heard. The main problem with the selection of Juries under the Coroners Act is that the Jury pool is not drawn from the Register of Electors, as is the case in a criminal or civil trial. This lacuna was identified recently in the context of the Stardust Inquiry and a Private Members Bill is before the Houses of the Oireachtas in relation to amending the legislation to ensure that Jury selection is fair and impartial and in compliance with the constitutional principles enunciated above. The difficulty with Jury selection at the moment is that it is entirely left to the discretion of the Guards, and in many cases, the Jury is compromised of people who simply happen to be available, retirees or students. The process needs to be changed so that a Jury is an appropriate cross representation of the entire of society.

- **Does the Inquest process in addition to determining the cause of death, give sufficient consideration to any relatives of the deceased who may look to the Inquest to provide them closure?**

6. The best summary of the parameters of an Inquest can be found in the words of Lord Lane CJ in the case of *R v South London Coroner ex parte Thompson* [2]:

> *"Once again it should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and the rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should not be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the Judge holding the balance or the ring, whichever metaphor one chooses to use".*

[2] [1982] 126 SJ 625 at 627.

7. There is a prohibition in Section 30 and Section 31 of the 1962 Act against any consideration of matters which determine criminal or civil liability. The main problem is the extent to which latitude is allowed by Coroners in relation to exploration of issues which in another forum, may be entirely relevant to these.

8. In *Ex parte Thompson*, the Court held:

> "*A Coroner's investigation can often help to save the legal interests of the person affected by a death. For example, the results of a post-mortem examination can be useful in helping to decide questions of inheritance, where there may have been a question as to which of two relatives died first. Again, a Coroner's inquest can, on occasion, be an extremely valuable method of enabling relatives to assess the chances of a successful civil claim, and sometimes the record of evidence given at an inquest may of prime importance at a subsequent claim for compensation. But these are incidental by-products of the system and not intrinsic to it*". [3]

9. If issues of liability simmer beneath the surface, then there should be guidance given to Coroners in the form of Formal Coroners Rules in relation to the extent to which questions may be asked and avenues explored which may be relevant e.g. in a civil case. There is too significant a variation between the extent to which some Coroners afford latitude in this regard whereas others adopt a more narrow and strict interpretation of Sections 30 and 31, thereby inhibiting the inquiry.

- **Is there a mechanism to follow up on the implementation of recommendations made following an Inquest?**

10. No; this is a major lacuna in the legislation. In the jurisdiction of England and Wales, Prevention of Future Death Reports (PFDs) are available which stipulate that if a Coroner identifies a lacuna or gap or in health and safety which has led to a fatality, he or she has a

[3] [1982] 126 SJ 621 at 627.

statutory obligation to write to the person or entity who has control or responsibility for that state of affairs and stipulate that action should be taken. They are not statutorily able to stipulate what action ought to be taken, other than to direct that some action must be taken. The person or entity to whom they have written must respond within eight weeks with confirmation of the steps they have taken with a view to taking on board the concerns and considerations of the Coroner.

11. In relation to PFDs, the following can be said:

In England and Wales, the Coroner has now a statutory duty to refer matters to an appropriate person to enable action to be taken to prevent similar fatalities in the future.[4] This duty arises where matters have been revealed during the course of the Coroner's investigation which give rise to a concern that circumstances exist which create a risk that other deaths may occur and that in the Coroner's opinion, steps need to be taken to eliminate the existence of such circumstances or to ameliorate the risk of death created by these conditions. If these conditions are met, the Coroner has a statutory obligation to report the matter to the Chief Coroner and to every interested person who in the opinion of the Coroner ought to receive it. The entity or individual to whom it is addressed must respond in writing with 56 days and the response must contain information on details of the action that has been or is intended to be taken and a timeline established, or an explanation as to why, if no action is proposed, the reason for that. The reply must be sent to the Chief Coroner and every interested person, who, in the opinion of the Coroner, ought to receive it. [5]

12. A similar statutory framework is required in this jurisdiction so that the recommendations that a jury or coroner return can have real teeth.

[4] Coroners and Justice Act 2009, Sch 5, para 7.
[5] Coroners (Investigations) Regulations 2013, S.I. 2013/1629, Regulations 24 (a)- (c), 28.5 (a)

13. Guidance should be taken from England and Wales where, under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, where a Coroner's investigation gives rise to concern that future deaths will occur and the investigating coroner is of the opinion that actions should be taken to reduce the risk of death, the Coroner *must* make a report to the entity that he or she believes has the power to take such remedial action. This is called, as we have seen, a Prevention of Future Death report (PFD). [6] What is striking about the power in the jurisdiction of England and Wales is that there is no discretion: a coroner must report. As the guidance for the Chief Coroner sets out:

"*PFDs are vitally important if society is to learn from deaths. Coroners have … a statutory duty (rather than simply a power), where appropriate, to report about deaths with a view to preventing future deaths. And a bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it is less likely to happen to somebody else.' PFDs are not intended as a punishment: they are made for the benefit of the public*". [7]

14. The guidance goes on to make the following observations in relation to PFDs: they are about learning,[8] and they should

"n*ot be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and wherever possible, designed to have practical effect".*

15. In conclusion, recommendations at the moment are statutorily toothless. There is a moral imperative obviously on institutions to follow through in relation to recommendations made by Coroners, but there is no mechanism to check to see if those recommendations have been implemented, and there is no penalty for not doing so.

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[6] See also HH Judge Mark Lucraft QC, Chief Coroner, Reports to Prevent Future of Deaths, Revised Guidance No. 5, last revised 4 November 2020.

[7] See above.

[8] See above.

- **Is appealing the outcome of an Inquest to the High Court too restrictive for ordinary citizens?**

16. The main mechanism for this is judicial review. Judicial review is available as a remedy where any entity exercising judicial or quasi-judicial powers oversteps the boundaries of their inquiry. It has been called "the great remedy of citizens". In relation to judicial review, it is taken in the High Court, and can be a prohibitively expensive affair. In many respects, the potential costs have a chilling effect. Moreover, the bar in terms of challenging a Coroner's decision is set very high: mere want of following procedures in and of itself may not be sufficient to overturn a decision. The case law makes clear that Coroners must behave reasonably with regard to every aspect of their decision making: from considering request for witnesses and documentation, to the manner in which they correspond with the parties, to the manner in which they conduct themselves before the inquiry, in relation to the charge before the Jury and in relation to the verdicts they give. All aspects of the above are capable of being challenged by way of judicial review if it has been found they were exercised in an arbitrary, capricious or unreasonable manner. A Coroner must give reasons for his or her reasons. A Coroner must be balanced. A Coroner must hear both sides of an argument before coming to a conclusion; *Audi alteram partem*. A Coroner must be entirely unbiased and there can't be any perception of bias: *nemo judex in causa sua*. A Coroner's discretion is very wide, and the Courts are very reluctant to interfere with a Coroner's discretion where there is some basis for suggesting that it was exercised reasonably. With regard to the interference or otherwise with a coroner's decision, the Courts will be cautious.

17. In *Bingham v Farrell* [9], the Court cited with approval the decision of *Lowe Taverns (Tallaght) Ltd v South Dublin County Council* [10] in which it was held as follows:

> "*The courts should be slow to interfere with the decisions of such a specialist tribunal and should operate on the basis of curial deference and judicial*

[9] [2010] IEHC 74.
[10] [2006] IEHC 383.

restraint".[8] *The above principles are clearly applicable to the role of Coroner. The Coroner [in this instance] is a medical practitioner and a barrister. He is the clearest possible example of a specialist tribunal. Whilst the courts must always be alert for illegality or want of jurisdiction, it is particularly appropriate to accord to the coroner a curial deference in regard to his role in construing the medical evidence before him*".[11]

18. As things stand, Section 24 of the Coroners Act 1962 gives the Attorney General the power to order that an Inquest be held. For instance, regarding the current upcoming Stardust Inquest, this particular statutory provision is also applicable and is operative where an Inquest has already taken place. It is doubtful, however, whether or not the Attorney General would exercise his or her statutory discretion in this regard in relation to a recently held and reasonably conducted Inquest. A referral to the High Court on a point of law during the currency of an Inquest is now available to sitting Coroners and this may ultimately reduce the number of judicial review cases.

19. This newly introduced mechanism under s 36 of the 2019 Coroners Amendment Act allowing applications to the High Court on point of law might in fact lessen the amount of judicial review applications.

20. The principal Act (1962 Act) was amended by the insertion of a new s 62 as follows:

    62.

    1) A coroner may, whenever he or she considers it appropriate to do so, apply to the High Court for directions on a point of law regarding the performance of his or her functions under this Act in relation to the death of any person.
    2) The High Court shall determine an application under subsection (1) by giving such directions and making such orders as it considers appropriate.
    3) The High Court may, on application to it in that behalf, hear an application under subsection (1) otherwise than in public if satisfied that it is appropriate to do so because of—

[11] [2010] IEHC 74 at para 13.

a) the subject matter in relation to which directions are sought,
b) a risk of prejudice to criminal proceedings, or
c) any other matter relating to the nature of the evidence to be given at the hearing of the application.

4) The High Court shall give such priority as it reasonably can, having regard to all of the circumstances, to the disposal of proceedings in the Court under this section.
5) An appeal shall lie by leave of the High Court to the Court of Appeal from a determination of the High Court of an application under subsection (1).
6) The Superior Court Rules Committee may, with the concurrence of the Minister, make rules of court to facilitate the giving of effect to subsection (4).

21. How this is going to work in practice remains to be seen, but it may very well reduce the circumstances leading to a successful judicial review if a coroner refers, for instance, to the High Court for adjudication a point of law on; whether a particular document is admissible; whether a particular witness expert or otherwise ought to be called; whether there is the existence of bias and so on. What is clear, however, is that Coronial proceedings are likely to be substantially delayed pending that application to the High Court and it might very well be that justice delayed could be justice denied.

22. The provision of specialist Coroners Rules would certainly help in relation to establishing whether or not a Coroner conducted his or her inquiry within the bounds of reasonableness. Such Coroners Rules are extensively available in the jurisdiction of England and Wales and guidance is provided by the Chief Coroner in relation to the adherence and operation of those rules on a regular basis. In 2003, the Coroners Statutory Committee made recommendations in relation to the implementation of Coroner Rules and submitted a detailed report. It is beyond time that these recommendations are followed through on.

- **Is the current Coroner's process effective in establishing the truth and material facts around death?**

23. The Coroner's Inquest has been significantly strengthened under the 2019 Act because now the Coroner has the power to compel witnesses to answer questions, has the power to compel witnesses to attend Court and has the power to compel the production of documents. The process would be much more effective if statutory coroners rules were available and/or if guidance were given in relation to for instance, the extent to which the inquiry can embark upon considerations which may trespass into the area of Section 30 or Section 31 without necessarily transgressing them completely.

- **Should findings and/or evidence heard in Coroner's Court be admissible in any legal action on the same incident?**

24. Yes, it should be the case that any evidence given at an Inquest is admissible in further proceedings such as disciplinary proceedings e.g. before the Medical Council. Increasingly, Coroners are engaging stenographers to keep a very detailed transcript of the proceedings and it might very well be that this will become more common practice. There is of course a statutory prohibition again self-incrimination contained in the 2019 Act and a witness is entitled to the same immunity in relation to giving evidence which may prejudice the outcome of a further inquiry if they are answered.

- **What changes would you recommend to how the Coroner's system works at the moment?**

a) Jury composition to be representative of society as a whole and the Jury drawn from the Register of Electors, to be set at a minimum of 7.

b) Coroners Recommendation to be given statutory teeth similar to the Prevention of Future Death Reports in England and Wales.

c) Appropriate civil legal aid for Inquests. At the moment the system creaks and is very prohibitively expensive for many would be participants at an Inquest to seek legal advice.

d) The adoption of Coroners Rules, see above.

e) The complete overhauling of the Coroner's system as was recommended by the Working Group established in 2000 and as was contained in the 2007 Coroner's Bill which ultimately got shelved. This proposed a root and branch of the Coroner's system, with the adoption, inter-alia, of a Chief Coroner for the Country and a division of appropriate districts and a further division as follows:

25. The blueprint was the product of extensive engagement.[12] In the context of transformational societal changes in the second half of the 20th century, the coronial system was stuck in the permafrost of 1962 and, even prior to that, centuries of common law precedent. As a mission statement, it identified that the coronial service could be described as:

> "*The Coroner's service is a public service for the living, which in recognising the core value of each human life, provides a forensic and medico legal investigation of sudden death having due regard to public safety and health epidemiology issues".*[13]

26. Amongst its key recommendations were the following:

- There should be a statutory requirement on a coroner to order a post-mortem if he/she is of the opinion that a death has not been due to natural causes.[14]

[12] 82 written submissions, contributions from England, Wales and Canada and oral submissions made by a number of families.
[13] Executive Summary, p 3.
[14] Recommendation 44, p 60.

- Concerning verdicts, the report referenced a lack of consistent criteria in reaching verdicts and made a recommendation that guidelines regarding the reaching and wording of verdicts should be the subject of coroners rules.[15]

- Concerning the release of documentation, there was a recommendation that coroners should retain their discretion with regard to the release of documents, but that new legislation should be introduced, and that the coroner's discretion should be "*expressed in favour of release rather than retention*".[16]

- There was also a recommendation that a Jury should have an odd number of Jurors and should range from 7 to 11 and that simple majority verdict should be required.[17]

- Concerning the appeal process, the authors noted that Judicial Review often is the only avenue for families, but it is expensive and not user friendly. The authors went on to note that once decisions are made (in this case quasi-judicial decisions) the question of accountability for decision arises although there is currently no direct review from a Coroner's decision.[18]

- Accordingly, they came back with a recommendation that without prejudice to the role of Judicial Review, there should be a review board capable of being established in conjunction with the Attorney General, a member of the Irish Coroner's Association, a qualified lawyer and they should have the power to make recommendations to include, inter-alia, that a first inquest or enquiry be held and the review granted, the second inquest where enquiry should be held and the review granted.[19] Where no further inquest or enquiry should be held, the coroner should be permitted to make a consultative case stated subject to consult with the Attorney General on any point of

[15] ibid., Recommendation 52, p 63.
[16] ibid., Recommendation 55, p 64.
[17] ibid., Recommendations 69 and 70, p 68.
[18] ibid, Para 3.3.7, p 68.
[19] ibid, Recommendation 75, p 71.

thought that arises and there should be no time bar on application for review to the Attorney General.[20]

- Concerning organisation, the authors pointed out that '*the high number of Coroners in the country is related more to a time of poor communications and transport rather than to analysis of system requirements'*.[21] Accordingly, the authors made recommendations that the number of coroners should be reduced, evolving over time into a regional structure.[22]

- The Group also felt that a new coroner's office or coroner's administrator should be appointed at a regional level to provide logistical support.[23]

- There was also a recommendation that the coronial service should be attached to the Courts Service.[16] It was also recommended that a new statutory agency should be established, to be known as the Central Coronial Service, which would reflect the core concepts of the service and have functions including logistics including salaries; expenses and organisational set up; supporting the implementation of coroners rules; supporting and developing a high quality of service and best practice procedures; training for coroners; information dissemination, supporting and developing a national information system for coroners and producing an annual report or presentation to the government on general coroner activities and progress achieved.[24]

- There was also a recommendation that the new agency should be headed by a director with overall responsibility.[25]

- The report also outlines coroners rules as follows:

[20] ibid, Recommendations 75–80, p 71, 72.
[21] Ibid, 72.
[22] ibid., Recommendations 81–83, p 73.
[23] ibid, 74.
[24] ibid, Recommendations 95 and 96, p 82, 83.
[25] ibid, Recommendation 97, p 83.

27. This outline includes the minimum areas to covered by Coroner's Rules and provides notes for the assistance of the proposed Rules Committee as recommended in Section 3.3.1. The minimum areas to be covered by Coroner's Rules are:

Part 1. General

1. Definition of terms

Part 2. Deaths reported to coroners

2.1 Reportable deaths to a coroner

2.2 Who must report a death?

2.3 When is it necessary to hold a postmortem examination?

Part 3. Post-mortem examinations

3.1 Who may carry out a post-mortem

3.2 When should a pathologist not carry out a post-mortem?

3.3 Preservation of material and records

3.4 Organs and body parts – removal, retention and disposition

3.5 The post-mortem report

Part 4. Special examinations

4.1 Authorisation for a special examination

Part 5. Interim Certificate of Death

5.1 Criteria governing the issuing of a fact of death certificate

Part 6. Inquests

6.1 When should a coroner be disqualified from holding an inquest?

6.2 Circumstances where flexibility of jurisdiction are required.

6.3 Notice of an inquest

6.4 Circumstances when a jury must be used

6.5 Empanelling the jury

6.6 Records to be kept

6.7 Taking documentary evidence at inquest

6 8 Requesting documentary evidence at inquest

6.9 Coroner’s discretion for non release of documents before inquest

6.10 Witness anonymity

6.11 Protocols for examining witnesses

6.12 Inquest adjourned due to criminal proceedings

6.13 Mandatory inquests

Part 7. Verdicts

7.1 What verdicts are available to the coroner?

7.2 Findings

Part 8. Review

8.1 Procedures to be used in the review system

Part 9. Removal from office

9.1 Procedures for removal from office by the minister

Part 10. Procedures for clearance for burial

Part 11. Forms design

Part 12. Revision of Rules.

28. Interestingly, 16 out of the 28 areas for outline coroners rules deal with the ‘judicial aspects of the function including Jury; documentary evidence, witnesses, verdict findings and review’.

29. In large measure, these are similar to the Coroners (Inquests) Rules for England and Wales 2013 (about which more follows).[26]

30. The Coroners Bill 2007, in Part 2, contained provisions dealing with, inter-alia, the establishment of the Coroners Service, the composition of the Coroners Service and the appointment of a Chief Coroner for the Country and a Deputy Chief Coroner.

31. Under head 9 of the Bill, the principal functions of the Coroners Service were to, amongst other things:

a. Provide a national service for coroners' investigations and inquests.
b. Provide the necessary supports to coroners to ensure that every such investigation or Inquest is conducted effectively and efficiently.
c. Liaise efficiently and sympathetically with bereaved families and interested persons involved in an investigation or inquest.
d. Where relevant to a reportable death, liaise with any statutory body involved in the investigation of accidents, incidents or diseases.
e. Provide to the appropriate registrars, a certificate in accordance with Section 41 of the Civil Registration Act 2004.
f. Contribute to the enhancement of public health and safety.
g. Advise the minister on any matter arising in relation to its functions.
h. Carry out any other duties and exercise any other powers assigned to it under this Act.
i. Under the Bill, the coroners service was to consist of a Chief Coroner, a Deputy Chief Coroner and Director of the Coroner Service and subsidiary coroners, assistant coroners and coroners assistant officers.
j. Under the heads of Bill, the Coroners Service was to operate on a regional basis, each region to be determined by the Minister by reference to population, mortality rate, the configuration of towns, cities and hospitals and each coroner region was to have allocated to it, two coroners, one assistant coroner, two coroners officers.

[26] S.I. 2013.

k. The function of the National Chief Coroner was to (Head 14) provide leadership and direction in all coronial matters and, ensure that all necessary training and development was provided to Coroners.

32. The Coroners Bill 2015 repeated these provisions in large measure, but it too never came to fruition. There is significant variation in practice and the lack of uniformity of investigation standards must be addressed.

33. Coroner's Courts need to be properly resourced and given appropriate facilities. In many instances, Coroner's Courts have had to take place in functions rooms, in theatres, and this is unacceptable. They deserve and demand the gravitas of a formal Court setting and formal Court time needs to be put aside to cater for this.

34. There should be appropriate training and certification in respect of medicine for lawyers and law for the medics, and this could be overseen by the Coroner's Association in conjunction with the Royal College of Surgeons and/or the Bar Council of Ireland/Kings Inns and/or the Incorporated Law Society of Ireland.

Signed: ***Roger Murray SC***

CC_04(1)

Submission to Joint Committee on Justice

"An examination of operation of the Coroner's Service"

1. What are the qualifications/experience necessary to become a Coroner?

The coroner service is one of the oldest public services in existence with the earliest references going back to the twelfth century, but it is 2022 and we need to modernise and humanise this vital public service which has come under increasing scrutiny.

While always connected in some way with sudden or unnatural death, the complexity and importance of the modern coroner bears little relationship to his historical predecessor. Today's coroner has a very wide range of duties involving investigatory, administrative, judicial, preventative and educational functions. Contrary to common public perception, the coroner is not permitted to consider civil or criminal liability let alone to determine such matters. He or she must simply establish facts. In other words, the coroners court is inquisitorial rather than adversarial.

In terms of qualifications and experience necessary to be a coroner, one must be an expert in a medical or legal field (or sometimes both) and this should remain the case.

I believe we need a more highly-trained and specialised cadre of coroners however, with opportunities for developing the very specialised nature of their work.

As part of this there should be reciprocal training – that is to say medical training for the coroners who are lawyers and legal training for the coroners who are doctors.

There should be a requirement for coroners to participate in appropriate training as well as continuing professional development on an ongoing basis.

Around Ireland, coroners are appointed by the local authority after selection by the Local Appointments Commission, but in Dublin where they are appointed by the Minister for Justice.

The Department of Justice is responsible for the legislation that governs the role and responsibilities of coroners, while matters such as their expenses are managed by the relevant local authority.

There is however a real and pressing need to reflect high levels of transparency, accountability and fairness and to this end I believe it would be more appropriate if the Minister for Justice took over the formal appointment of coroners nationwide, with formal selection procedures and interviews for posts.

The appointment of coroners by the local authority is a matter of historic precedent based on the fact that the local authority were the paymasters. The question has been asked: "*When was the last time an interview was held for a coroner's post?*"

Also, coroners should be paid a salary rather than being paid fees for work done.

2. How is the jury for an inquest selected? Is the process aimed at a jury which is representative and balanced?

Where there is reason to believe that a death occurred in circumstances, the continuance or a possible recurrence of which would be prejudicial to the health or safety of the public, it is appropriate that a jury be present.

Interested persons (including families) should know whether the jury is to be sworn by or before the coroner, and how its members are to be selected.

It is of course inconsistent with the proper function of a jury for a coroner to regularly empanel the same jurors, and a jury cannot be impartial if it is not randomly selected.

The concept of '*professional jurors*' should be anathema in 21st century Ireland and the same people should not frequently sit on juries in any particular coroner's district.

Where there is need for a jury at a particular inquest then the coroner should ask An Garda Siochana to choose jurors from the electoral register.

3. Does the inquest process, in addition to determining the cause of death, give sufficient consideration to any relatives of the deceased who may look to the inquest to provide them closure?

My experience has led me to believe that what families want above all else is a *professional* medicolegal investigation into the circumstances surrounding the death of their loved one. It is fair to say that the service must become more user-friendly in order for families to feel that they are getting some kind of 'closure'.

They do not seek platitudes, rather they seek a fair and through investigation which leaves no stone unturned. It is - or at least it should be - understood that coroners are not counsellors for families; they are medicolegal death investigators.

The professionalism of the coroner in the lead-up to the inquest will set the tone however, and if a coroner appears to be dismissive, disengaged or disinterested at the pre-inquest stage then it will create unnecessary stress and anxiety for the family.

For example, I am aware of the fact that that some families have sought the attendance of medical consultants under whose care their deceased loved ones were prior to the death, and have been notified that unless a series of questions to be posed for that particular consultant are submitted to the coroner in writing in advance of the inquest, their request will not be facilitated. This is not a widespread practice, but the fact that it happens at all is completely unacceptable. Practices like this are naturally bound to make families feel that they may not get closure.

Coroners in the UK are referred to as 'HM Coroner for [a region]' because of course they act on behalf of the Crown. Here in Ireland, coroners act on behalf of the State. When State institutions (such as the Health Service Executive) are involved there may be a perception that the coroner is overly-protective of the State interests if he or she refuses to accede to reasonable requests from the family in advance of the inquest

hearing and this must be avoided at all costs.

4. Is there a mechanism to follow-up on the implementation of recommendations made following an inquest?

No. The mechanism for follow-up on the implementation of recommendations made following an inquest should be formalised.

Section 19 of the Coroners (Amendment) Act 2019 amended Section 31 of the 1962 Act which now reads:

> *"Recommendations of a general character designed to prevent further fatalities may be appended to the verdict at any inquest*."

There is an issue in relation to these recommendations lacking 'teeth' however, and families being disappointed at the lack of follow-through afterwards.

There is certainly a moral weight to recommendations, especially when they are widely publicised in the media, but at present there is no imperative for the agencies or entities contacted to follow through or report back, and this is not good enough.

Guidance should be taken from the UK where (under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013) if a coroner's inquest gives rise to concern that future deaths will occur and the Coroner is of the opinion that actions should be taken to reduce the risk of such deaths, that coroner *must* make a report to the entity that he or she believes has the power to take such remedial action. This is called a 'Prevention of Death Report.' These are vitally important if society is to learn from deaths. PFDs are not intended as a punishment: they are made for the benefit of the public.

Simply put, coroners in the UK have a statutory duty (rather than simply a power) where appropriate, to report about deaths with a view to preventing future deaths. We should have something similar here in Ireland.

Crucially, the UK legislation stipulates that the person or entity to whom the report is addressed is under a duty to respond within a specified timeframe and the response must contain details of the action taken or proposed to be taken, and setting out the timescale for the action. The report is also sent to the Chief Coroner and the Coroner may publish either the report and/or the response. Here, no such mechanism exists and so the well-intentioned and sensible recommendations made at inquest can be meaningless.

Historically, healthcare institutions here did not routinely collect data on how fatal accidents occurred, which made it difficult to detect meaningful patterns of error and almost impossible to have any meaningful learning from wrongful deaths. One may contrast this with the aviation industry in which education and training has a crucial role to play in preventing harm through greater openness and transparency: failure is used as a learning opportunity as opposed to an opportunity to apportion blame.

In my experience, all any bereaved family want to be able to say at the end of the day

and when all is said and done is that yes, their loved one's death may have been tragic, but *at least* it is less likely to happen to another family because of lessons learned and changes made. And this is why the recommendations are so vitally important.

The verdict returned at an inquest is rarely of any comfort to a family, but the recommendations made can be of immense comfort, provided there is an assurance that they will be implemented in full and without delay. Without that assurance, it is understandable that some families walk away from the Coroner's Court wondering 'what was the point of all that?'

We owe it to those who have to go through the extremely difficult process of an inquest into the sudden and unexplained death of a loved one that one glimmer of hope it can offer – and that is the prospect of important changes that can be brought about through the recommendations.

To effect change we must formalise the mechanism for follow-up of recommendations made at inquest.

5. Is appealing the outcome of an inquest to the High Court too restrictive for ordinary citizens?

Judicial review exists as a remedy to ensure that all inquests are run fairly and without any arbitrary, capricious or unfair elements. One must point out from the outset that successful judicial review proceedings in respect of coroners are rare occurrences.

A coroner exercises a judicial function; consequently the High Court has jurisdiction to review decisions of the coroner during the course of his or her Court hearing in relation to an Inquest, or during an investigation pre-Inquest. The principal relief sought is certiorari whereby a decision by a coroner may be quashed.

The widely-held view is that it is indeed very time-consuming and expensive to appeal the outcome of an inquest to the High Court, and thus families very often feel that they do not 'have it in them' to go down this route. Clearly this is unsatisfactory.

A coroner has significant discretion when making decisions and/or carrying out their inquest and it is fair to say that the review system is not user-friendly, particularly when compared with the review mechanisms in place in other fora including the courts.

A review board or panel should be established (consisting of perhaps a member of the Attorney General's office along with a pathologist, a coroner and an outsider). Matters could then be referred to the review board/panel either before, during or after an inquest, which would save time and costs for families and the State.

6. Is the current Coroner's process effective in establishing the truth and material facts around deaths?

It *has* to be, although it could be much more effective! The point I will return to is the need for professionalism during the process – if an inquest is conducted in a slipshod

or perfunctory manner, it follows that the family will be justifiably upset and angry. They will of course then feel that the process was ineffective in establishing the truth and uncovering all of the material facts surrounding the death.

Simply maintaining high standards through the provision of reciprocal training programmes and continuing professional development for coroners as referenced hereinabove would, I believe, foster much more trust in the service.

Bringing in a formal and published set of Coroners Rules as has previously been recommended would also go a long way towards ensuring consistency right across the country, meaning that a family in Cork is likely to get the same treatment from the coroner there as they would in Dublin or elsewhere. The appointment of a Chief Coroner is also a long overdue move that needs to be made.

7. Should findings and/or evidence heard in a Coroner's court be admissible in any later legal action on same incident?

Arguably, yes. The coroner's service is a service for the living, and human rights must be considered in the context of an inquest.

The Irish State, through the inquest process, is required by Article 2 of the European Convention on Human Rights, to fully investigate the circumstances surrounding any sudden or unexplained death in a public hospital. The European Convention on Human Rights Act 2003 transposed Convention obligations into Irish law.

The essence of the Act, and the decisions of the European Court of Human Rights arising therefrom require a more extensive investigation of the circumstances of death than had previously been obtaining, although some believe Article 2 affords no greater protection than the provisions of the Irish Constitution in Article 40.3.2 which arguably provides an even greater protection to the right to life.

In this context the public policy considerations underlying the holding of an Inquest first enunciated in *Farrell v. Attorney General* [1998] 1 IR 203 are worth repeating:

- To determine the medical cause of death;
- To allay rumours or suspicions;
- To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;
- To advance medical knowledge;
- To preserve the legal interests of the deceased person's family, heirs or other interested parties.

Taking the above public policy considerations into account, there is a strong argument to be made in favour of findings and/or evidence heard in a coroner's court being deemed admissible in any later legal action on same incident.

8. What changes would you recommend to how the Coroner's system works at moment?

A new post of Coroner's Officer should be introduced at regional level to act as a general support to both coroners and relatives. The appointment of coroners officers to provide good quality, compassionate and empathetic direct coroner support. This would permit the standards of service for the bereaved to be raised to an acceptable level for a public service in the 21st century.

Coroners work part-time from busy practices as lawyers or doctors and many of the problems and difficulties with the existing service can be traced to insufficient time and resources to allocate to supporting relatives throughout the full cycle of coroner activity. Focus on this issue, will, perhaps, more than any other area of change, serve to transform the quality of the coroner service in Ireland.

Consistency through the establishment of Coroners rules is also vital. There are no statutory rules supporting the Coroner's Act 1962 or, indeed the Coroner's (Amendment) Act 2019, in relation to procedures or disclosure of documents. Accordingly the Coroner still retains a very wide discretion in this regard.

There remain significant inconsistencies in the administration, application and conduct of all elements of the coronial process across Ireland. There are noticeable inconsistencies between coronial districts nationwide, in relation to: full-time/ part-time coronial appointments; staffing and support; offices and accommodation; location of inquests; jury selection; legal representation; scope and depth of inquests; and information provided to families.

The parties at an inquest should all be working together to create a factual narrative which is as accurate as possible so as to assist the Coroner, and the omission of important documentation (such as, in the case of a hospital death, the HSE Systems Analysis Review report) can be seen to be at complete variance with that aim.

The HSE states that its systems analysis model for investigations focuses on prevention, not blame or punishment. The focus of this type of analysis is on system- level vulnerabilities, as opposed to individual performance. Healthcare services carry out incident investigations using systems analysis to find out what happened, how it happened, why it happened, what the organisation can learn from it and the changes the organisation should make to prevent it happening again. The purpose of such an investigation is to: improve safety, identify the factors that contributed to the incident, identify problems or deficiencies, ensure that lessons are learned and act as early warning mechanisms. It is not to: apportion blame or fault, exonerate individuals or management, or identify legal liability. When a State institution is involved directly in a death, the potential for the Inquest to fully interrogate the circumstances of death must not be compromised.

Sharing of information is vital, so as to assist the coroner, and to maintain trust.

Doireann O'Mahony B.L.
8th April 2022

CC_05

My name is David O'Malley Partner Callan Tansey Solicitors.
I have appeared as chief advocate in numerous inquests across the Country. I welcome opportunity to make submissions on reform and am available for oral submissions etc if required.

My co authors of recent book Medical Inquests (Roger Murray SC, Doireann O'Mahony BL) will also be submitting and we have split up the range of questions between us as separate but all-encompassing submissions.

I have focussed on observations re Juries and couple brief observations re Coronial appointment.

The area is currently in flux and I feel strongly that the Coronial system needs be more representative, more transparent with weight being added to verdicts and recommendations.
We cant keep going round in circles as we are all representing the most tacit value one can protect in the Truth. Families deserve nothing less.

Juries

Section 40 of the Coroners Act 1962 provides:

(1) An inquest shall be held with a jury if, either before or during the inquest, the coroner becomes of opinion-

> *(a) that the deceased came by his death by murder, infanticide or manslaughter, or*
>
> *(b) that the death of the deceased occurred in a place or in circumstances which, under provisions in that behalf contained in any other enactment, require that an inquest should be held, or*
>
> *(c), that the death of the deceased was caused by accident, poisoning or disease of which, under provisions in that behalf contained in any other enactment, notice is required to be given to a Minister or Department of State or to an inspector or other officer of a Minister or Department of State, or*
>
> *(d) that the death of the deceased was caused by an accident arising out of the use of a vehicle in a public place, or*

(e) that the death of the deceased occurred in circumstances the continuance or possible recurrence of which would be prejudicial to the health or safety of the public or any section of the public.

noindent

Section 41 of the Coroners Act 1962 (since consolidated) notes that an inquest Jury must consist of a minimum of six and no more than 12 persons.

Prior to the Coroners (Amendment) Act 1927, an inquest could only be held by a coroner sitting with a Jury. Juries were seen as vital to inquests in the early days.

Inquests have become a lot more non-jury in recent times with coroners becoming very skilled at assessing 'how' death occurred. Coroners are now often trained lawyers themselves. In the early days, coroners were more likely to be doctors and therefore an element of public scrutiny was required with a jury. It is often the case that a jury is more suitable in medical inquests with multifactorial matters and the need for riders and recommendations.

Recent high-profile inquests such as Savita Halappanavar and Dhara Kivlehan have shown the renewed utility of having a Jury to ensure multifactorial inquests have the benefit of true public scrutiny.

Before opening an inquest a coroner will explain to the Jury the function and scope of an inquest. The Jury will have to be satisfied in relation to the circumstances surrounding death and they will need to bring a finding of identification, date and place and cause of death. In addition, the Jury may make certain riders and recommendations to prevent similar deaths occurring.

Jurors can be a lot more empathetic to the extraneous facts surrounding deaths.

Practically if there are public policy issues in an inquest it may well be worthwhile for a coroner to select a jury.

So, who forms the jury? An inquest cannot be seen as impartial or proportionate if the same Jurors are called repeatedly. Before some coroners, a practice has arisen that juries are not randomly selected, and the same Jurors appear in multiple inquests. In some instances, the Jurors were retired people who were known to the coroner. Such customs raise serious constitutional questions and an experienced practitioner should insist on a randomly selected jury. This tenet is enshrined in law.

In *De Burca v Attorney General*,**[1]** the seminal jury case, Henchy J clearly outlined the constitutionally enshrined randomness of jury selection:

—— In determining whether a particular method of jury selection will
produce a jury that fairly represents a cross-section of the
community, it is not enough to show that a particular class or

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[1] [1972] IR 38.

> particular classes are not represented or are under-represented. Competence to fulfil the duties of a juror is an individual rather than a class attribute. No group or class can lay claim to have any special qualification to produce representative jurors. Ideally as many identifiable groups and classes as possible should be included by the standard of eligibility employed, so that a jury drawn from the panel will be seen to be a random sample of the whole community of the relevant district.

noindent

The Law Reform Commission paper 2013 on juries emphasises the need for juries to be representative of the entire community under the Constitution. The case of *De Burca v Attorney General* clearly outlined the need for representatives in society. This is all the more pertinent given the now multicultural nature of 21st-century Ireland.

Developments in human rights law under the European Convention on Human Rights surely strengthen the requirement for Juries to be truly representative.

To concur with Walsh J in the *De Burca* case, Jury service should accurately reflect a cross-section of the population of the State as a whole. That is a constitutional enshrinement that has to chime with the Coroners Act 2019.

A jury simply cannot be impartial if it is not randomly selected.

From a practical perspective, practitioners should, if a jury is indicated at a preliminary stage, insist on random selection with the coroner made by An Garda Síochána.

This protects both the coroner and the inquisitorial process itself.

The recent paper, 'Death Investigation, coroner's inquests and the Rights of the Bereaved',[2] found that selection of Juries can cause distress to families if there is no broad representativeness across the Jury. It recommended that jury selection should be random from the electoral register[3] and that in high profile contested cases lawyers representing properly interested persons should be able to challenge the constitution of the jury.

I would strongly submit on the basis of the foregoing that legislation specifically addresses the odd lacunae that same Jurors appear time and time again at inquests.
A practical analysis of De Burca makes any other scenario unconstitutional in any event.
However, specifically addressing same by legislation would remove any ambiguity.
Inquests are important matters of public policy so must be representative of society as a whole.
The time is now to ensure that the inquisitorial process is enriched with a cross section of society as in all other Judicial forums.

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[2] Scranton and McNaul, Irish Council for Civil Liberties https://www.iccl.ie accessed 24/11/21.

[3] Recommendation 44, p 11.

Selection of Coroners:

The selection of Coroners appears to follow a Public appointment process.

However, it is the writer's experience that it is quite common for Deputy Coroners who invariably are relatives or employees of current Coroners to step into the shoes somewhat.

It is my respectful submission same is wrong as given the importance of the Coroner the best possible candidate should be selected.

It might be worthwhile profiling each district to see the succession statistics of relatives/employees simply taking over.

The age limit appears to be 72 as well in many cases which is too old in this writer's submission as Coroner roles require great energy and vitality.

This writer would suggest capping same at the ordinary retirement age.

I thank you for opportunity of making submission and welcome any questions you may have.

Signed

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David O Malley
Solicitor
Author

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An Examination of the Operation of the Coroner's Service

ICCL Submission to the Joint Oireachtas Committee on Justice

April 2022

Irish Council for Civil Liberties

Introduction

The Irish Council for Civil Liberties published a comprehensive report into the Coronial system in Ireland in April 2021.[1] This submission summarises findings and recommendations from that report in response to an invitation with specific questions from the Oireachtas Joint Commission on Justice.

What are the qualifications/experience necessary to become a Coroner?

1. The Coroner Service is a network of mainly part-time, under-resourced coroners with no standardised set of qualifications or criteria and no standardised system of training or support. Currently coroners are lawyers or medical practitioners who are appointed on a part-time basis by local authorities (with the exception of coroners in Dublin who are appointed on a full-time basis by the Minister for Justice). ICCL's report into the coronial system 'Death Investigation, Coroners' Inquests and the Rights of the Bereaved' published in April 2021 recommends a change to this system so that **all newly appointed coroners would be required to have legal training** and to have practiced for a minimum of five years as a barrister or solicitor.[2]

2. A **national training programme** for existing and newly appointed coroners should be developed and coroners and secretarial staff involved in processing cases should receive appropriate support and counselling on request.[3] The Department of Justice, Equality and Law Reform Review Report published in 2000 also noted that training should be provided to coroners – legal training for coroners who come from the medical profession and medical training for those coming from the legal profession.[4]

3. Further recommendations in the ICCL report regarding the professionalisation of the Coroner Service include the appointment of a Director/Chief Coroner with responsibility for the management and operation of the Coroner Service and the appointment of full-time Senior Coroners, coroner officers and secretarial staff to each regional office.[5] This will require an acceptance by Government of the need to adequately resource the Coroner Service.[6]

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[1] Phil Scraton and Gillian McNaull, 'Death Investigation, Coroners' Inquests and the Rights of the Bereaved' (Irish Council for Civil Liberties 2021) 9, Recommendation 19. Available at: https://www.iccl.ie/iccl-death-investigations-coroners-inquests-the-rights-of-the-bereaved/

[2] Phil Scraton and Gillian McNaull, 'Death Investigation, Coroners' Inquests and the Rights of the Bereaved' (Irish Council for Civil Liberties 2021) 9, Recommendation 19. Available at: https://www.iccl.ie/iccl-death-investigations-coroners-inquests-the-rights-of-the-bereaved/

[3] ibid 9, Recommendations 18 & 20.

[4] The Department of Justice, 'Review of the Coroner Service – Report of the Working Group' (Department of Justice, Equality and Law Reform 2000) 46. Available at: https://www.justice.ie/en/JELR/Pages/Review-of-the-coroner-service-report .

[5] Scraton and McNaull (n 1) 9, Recommendations 14-17.

[6] ibid 8, Recommendation 9.

How is the jury for an inquest selected? Is the process aimed at a jury which is representative and balanced?

4. There is no formal system for selecting an inquest jury at present and no measures are in place to ensure that the jury is representative of the community and balanced in terms of gender or other personal characteristics. The **lack of structured selection of a jury**, compared to the selection process for court cases, was noted in the Department of Justice Review.[7] ICCL's research highlights comments from a solicitor that the discretion allowed in the selection of juries means that it was not fit for purpose, noting that frequently the same local retired people appeared on different jury panels.[8] ICCL recommends that, in line with normal jury selection processes, jurors should be selected randomly from the electoral register.[9] A further ICCL recommendation in relation to juries is that in high profile, contested cases lawyers representing properly-interested persons should be able to challenge the composition of the jury.[10]

Does the inquest process, in addition to determining the cause of death, give sufficient consideration to any relatives of the deceased who may look to the inquest to provide them closure?

5. We do not believe that the inquest process as currently constituted gives sufficient consideration to the relatives of the deceased. The **lack of direct support** to bereaved families necessary to deliver a client-centred service was identified by the Department of Justice in 2000 as '[p]erhaps the most serious deficiency in the Coroner Service'.[11] One coroner interviewed during our research noted that the inquest is part of the journey to serenity but does not provide closure.[12] This view was echoed by some of the bereaved families we interviewed. While some appreciated the level of empathy showed by the coroner, others complained of a failure for the coroner to fully consider the impact of the death on the family and that the whole process did not provide closure, with the grieving process recommencing following the inquest.[13] Our report made a number of recommendations to provide more information and support to relatives of the deceased and to better protect the rights of bereaved families which would help them to feel more empowered throughout the inquest process.[14]

6. **Information** provided to bereaved families by the coroner should include details about appropriate supports such as: **guidance on accessing appropriate legal advice and representation; advice on the purpose, function and objectives of the coroner's court; and access to bereavement counselling**.[15]

7. **Legal Advice and Representation: Legal Aid** should be made available to all bereaved families seeking legal representation at inquests with consideration also given to extending the circumstances in which bereaved families have an automatic

[7] Department of Justice (n 3) 27.
[8] ibid 60
[9] Scraton and McNaull (n 1) 11, Recommendation 44.
[10] ibid 11, Recommendation 45.
[11] Department of Justice (n 3) 5 & 6.
[12] Scraton and McNaull (n 1) 64.
[13] ibid 49.
[14] ibid 9 & 10.
[15] ibid 9, Recommendation 27

right to an inquest.[16] The granting of legal aid is currently on a discretionary basis but is generally granted in cases involving deaths in custody or where the coroner considers a case to be in the public interest. Our research highlights that many bereaved families go through the inquest process without any legal representation.[17] Legal representation is important as evidence presented at the inquest should be subject to examination by interested parties and is particularly important in cases where the circumstances of death are controversial where the 'fine line' of liability becomes most evident, as, in such instances, questioning is often directed at influencing the verdict.[18] Our research notes that in high-profile cases where GSOC is involved, GSOC recommend that bereaved families obtain legal advice.[19] However, the engagement of private legal representation can be costly and may be unaffordable for many bereaved families.

8. Bereaved families should also be advised of the reasons for holding post-mortems and be provided with details, well in advance of the inquest, as to how to access, in full, the findings of post-mortems.[20] In addition, bereaved families and those close to the deceased should be informed that details contained in post-mortem reports will be revealed at the inquest and could be reported by the media.[21]

9. Furthermore, in advance of inquests, bereaved families and those close to the deceased should be provided with **detailed information to ensure that they understand the process, its function, its procedure and its possible outcomes**, while also being provided with **detailed evidence disclosure** to enable them and their lawyers to prepare thoroughly.

10. Those conducting interviews with the bereaved, survivors or witnesses to the death/s should be **trained in trauma-informed practice and bereavement awareness**. Counselling should be made available to bereaved families and to those giving evidence at inquests. Investigators should establish and maintain **regular consultations** with the bereaved, informing them of progress and explaining fully any delays.[22]

11. Bereaved families should be reassured that pathologists' medical examinations and the conclusions they draw are not unduly influenced by accounts of the circumstances of death given by police investigators.[23] Pathologists should also complete their examinations quickly to enable release of the body to the bereaved family without delay, ensuring that they are informed of where their loved one is accommodated.[24]

12. Other recommendations regarding appropriate support to bereaved families at inquests include prioritising the duty of care owed to them and anticipating the vulnerabilities of those giving evidence as witnesses so that appropriate accommodations can be made including by appropriately trained staff.[25] Consideration should

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[16] ibid 9, Recommendations 22 & 23.
[17] ibid 15 & 21.
[18] ibid 21.
[19] ibid 30.
[20] ibid 10, Recommendations 28 & 29.
[21] ibid 10, Recommendation 32.
[22] ibid 9, Recommendations 24-26.
[23] ibid 9, Recommendation 30.
[24] ibid 9, Recommendation 31
[25] ibid 10, Recommendations 32- 36.

also be given to protecting the privacy to bereaved families and witnesses by providing discrete accommodation within the building, refreshments and, if necessary, independent support.[26] This independent support could be delivered by appointing an **independent family liaison** to bereaved families, as currently the Garda Liaison Officer is often the only source of information.[27]

13. A final recommendation is that consideration should be given to enabled bereaved families to present pen portraits of the deceased at the opening of inquests into multiple deaths.[28]

Is there a mechanism to follow-up on the implementation of recommendations made following an inquest?

14. Our research highlights **the failure, identified by solicitors and bereaved families, to put in place a structured process to follow-up jury and coroner recommendations for reform**.[29] We believe that this must be addressed, and is particularly important for riders and recommendations which could **prevent further deaths**.[30] Our report notes that in addition to verdicts, riders provide opportunities to make recommendations arising from the circumstances of deaths to prevent the recurrence of any failings.[31] However, it is clear from the persons surveyed from our report that many bereaved families and legal professionals do not have faith in this process, particularly as recommendations and riders are not legally binding.[32] Without any formal system to follow up the enactment of recommendations, bereaved families and their legal representatives cannot be assured that lessons are being learnt from inquests in the manner necessary to ensure structural, procedural or institutional reform.[33] In this regard, consideration should be given to regular review of narrative verdicts delivered by juries where deaths have occurred in similar circumstances and which identify systemic, recurring deficiencies in institutional practices.[34]

15. We recommend that the **review process be conducted under the direction of the Director/Chief Coroner**, engaging with Government or other agencies as appropriate, to ensure that all the narrative verdict recommendations are fully implemented.[35] Consideration should also be given to introducing 'Special Procedure' inquests in the aftermath of tragedies which involved multiple deaths or when a pattern of systemic failure is identified.[36] ICCL has already engaged with An Garda about the establishment of an appropriate internal system within that organisation to ensure that where an inquest makes recommendations directed at police policy or practice the relevant information is disseminated through the police service.

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[26] ibid 11, Recommendation 49.
[27] ibid 38 & 50.
[28] ibid 10, Recommendation 37
[29] ibid 10, Recommendation 42.
[30] ibid 33.
[31] ibid 60.
[32] ibid.
[33] ibid.
[34] ibid 10, Recommendation 39.
[35] ibid 10, Recommendation 40.
[36] ibid 10, Recommendation 41.

Is appealing the outcome of an inquest to the High Court too restrictive for ordinary citizens?

16. While our research did not specifically address this issue, one of the families interviewed who had initiated judicial review proceedings against a coroner to access investigative documents, noted that the process took a considerable length of time and was very expensive.[37] Given the time that had already elapsed and the extensive costs incurred, when the family did not win the judicial review they decided against appealing the decision as this would have resulted in further financial outlay and further delay.[38]

Is the current Coroner's process effective in establishing the truth and material facts around deaths?

17. For many families, the present system does not provide an effective mechanism to get to the truth about their loved one who died. This is despite the Department of Justice Review in 2000 noting that the system is inquisitorial in nature and is aimed at ascertaining facts as opposed to attributing liability.[39] **The current system fails families of persons who die in contested circumstances.** Despite the intended focus of inquests on establishing the truth surrounding the cause and circumstances of death, many bereaved families interviewed in our research highlighted the failure of the inquest process in establishing the truth and achieving justice.[40] Families are often denied the truth and denied justice for their loved one because of structural failings in how the system operates. These failings also mean that the public interest in getting to the truth of what happened, and in preventing future deaths is not being met.

Should findings and/or evidence heard in a Coroner's court be admissible in any later legal action on same incident?

18. We recommend looking to the current model in England and Wales on this question.

What changes would you recommend to how the Coroner Service works at the moment?

19. **Institutional Independence:** In addition to the recommendations already discussed regarding professionalisation, adequate resourcing; jury empanelling; the need to address delays; improved supports and access to legal representation for bereaved families; and the need to adequately follow up on recommendations; a priority for ICCL is that **the coroner system be made fully independent, including being independent of An Garda Síochána and the State**. The role of An Garda Síochána in the delivery of the Coroner Service should be significantly reviewed to ensure that its role is confined to the investigation of deaths where Gardaí have not been involved.[41] While many families interviewed in our research were grateful for the support received from An Garda Síochána investigators, others questioned the lack of independence in the process and whether investigations were being carried

[37] ibid 48.
[38] ibid.
[39] Department of Justice (n 3) 27.
[40] ibid 48.
[41] Scraton and McNaull (n 1) 8, Recommendation 13.

out in the families' best interests.[42] We also heard that An Garda have been involved in roles beyond investigations such as providing administrative support to Coroners or finding jury members for an inquest.

20. **Institutional Reform and Oversight:** Other important recommendations suggested by ICCL's research are the rationalisation of the thirty-nine Coroner districts to create a region-based, distinct agency reflecting population distribution, demography and case numbers; the realisation of the Department of Justice Review recommendation regarding the establishment of a 'new coroner agency' including its eighteen significant functions; the development of a **code of practice** to establish uniformity in standards, appropriate **accommodation** throughout the regions, **support for the bereaved and detailed information** on the Service; and the **appointment of an Inspectorate** to monitor consistency in practice.[43]

21. **Inquest Procedural Reform:** ICCL's research also makes a number of recommendations regarding the inquest process and procedures. Subject to the privilege regarding self-incrimination**, a duty of candour** should be obtained regarding evidence given by witnesses who had a duty of care for the deceased, including during arrest, in custody or in hospitals/residential homes.[44] All inquest **proceedings should be recorded and made available to properly-interested persons and, if requested, be transcribed**.[45] Finally, all evidence presented at an inquest, with the exception of that derived in statements made by a person since deceased, should be **subject to questioning** by lawyers representing properly-interested persons.[46]

Additional Comments

22. **Charter for the Bereaved:** ICCL has also recommended that consideration be given by the Minister for Justice to establish a Charter for the Bereaved following consultation with bereaved families, advocacy groups and campaign organisations.[47] Our report makes the following recommendations regarding such a Charter which should:

- provide a clear overview of the statutory role and obligations of An Garda Síochána and other State agencies in servicing inquests, distinguishing between lawful obligations and discretionary practices[48]
- commit Government and its agencies to a statement of rights of the bereaved concerning: information; viewing the body; identification; post-mortems; return of the body; return of personal effects; access to the location of death; crisis support[49]
- establish an appropriate timeframe for the coronial investigation of deaths, the gathering of evidence and the holding of inquests[50]
- be published and made available to all who suffer sudden bereavement in contested circumstances, in disasters or related tragedies[51]

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[42] ibid 36.
[43] ibid 8, Recommendations 8, 10–12.
[44] ibid 11, Recommendation 46.
[45] ibid 1, Recommendation 47.
[46] ibid 11, Recommendation 48.
[47] ibid 8, Recommendation 1.
[48] ibid 8, Recommendation 2.
[49] ibid 8, Recommendation 3.
[50] ibid 8, Recommendation 4.
[51] ibid 8, Recommendation 5.

- affirm that those bereaved, injured or affected by disasters have a right to privacy and a right to be protected from further suffering due to intrusive journalism[52]
- ensure that all State agencies and those working with them involved with the reporting, analysis and investigation of deaths have received anti-discrimination awareness training focused on class, race, gender, sexuality, culture, age and ability[53]

23. **Role of the Media:** Regarding the conduct, details and outcome of inquests the media should ensure that they report within the Press Council of Ireland's Code of Practice, specifically within Principle 1 – Truth and Accuracy; Principle 5 – Privacy; Principle 7 – Court Reporting; Principle 10 – Suicide; and the Broadcasting Authority of Ireland Codes and Standards.[54]

24. **Research on Institutionalised Racism:** Within the Coroner Service, its support agencies and An Garda Síochána, further research is required to identify and eliminate all forms of institutionalised discrimination focusing particularly on the experiences of the Irish Traveller Community.[55]

[52] ibid 8, Recommendation 6.
[53] ibid 8, Recommendation 7.
[54] ibid 11, Recommendation 51.
[55] ibid 11, Recommendation 52.

An Examination of the Operation of the Coroner's Service

A Submission to the Oireachtas Joint Committee on Justice

by

Steven C. Smyrl, MAGI, FIGRS, FSG

01 Executive Summary

01.1 The *Registration of Births and Deaths (Ireland) Act 1863* provided that from 1st January 1864 the coroner (rather than the deceased's next-of-kin) would register deaths after inquest. Despite the shortcomings of this system having been long known, and calls having been made for reform, it was carried over into the *Civil Registration Act 2004*.

01.2 The 2004 Act greatly extended the personal details to be recorded about each deceased person in death registrations. Importantly, for the first time the deceased's date and place of birth and parents' names were to be recorded.

01.3 Since the commencement in December 2005 of Section 41 of the 2004 Act (which legislates for deaths registered by coroners), the majority of registrations have not been complete. Too often they do not record the deceased's date of birth and virtually never record the deceased's place of birth and parents' names.

01.4 This is a serious deficiency which, where the coroner is involved, will only be resolved through an amendment to the 2004 Act providing for the involvement of the deceased's next-of-kin in the registration process. Currently, where a coroner is involved the deceased's family are completely excluded from the process of registering the death of their relative. This is the reason why much of the personal information required under the 2004 Act is omitted.

Main Submission

02 1863 Registration Act

02.1 Under the *Registration of Births and Deaths (Ireland) Act 1863* (and subsequent amending legislation), from 1st January 1864 (when civil registration of deaths first began) the following details were recorded in each death registration:

i) date and place of death
ii) the deceased's name and address

iii) sex
iv) civil status
v) age
vi) occupation
vii) cause of death
viii) name, qualification and address of the informant
ix) date of registration

02.2 In ordinary circumstances this information would be provided by the deceased's next-of-kin. However, where a coroner became involved, the onus rested entirely upon them obtaining the information noted above and ensuring that it was accurate. This was done in the form of a certificate, which the coroner submitted to the civil registrar and who then caused an entry to be made in the register of deaths for the relevant Registration District. This had the unfortunate effect of excluding the next-of-kin from the registration process, who might otherwise have ensured the accuracy of the personal information submitted by the coroner.

03 2004 Registration Act

03.1 This unsatisfactory process (which excludes the deceased's next-of-kin) was continued in the *Civil Registration Act 2004*, the legislation which superseded the previous Victorian acts dating to 1863. Section 41 of the 2004 Act provides that in the prescribed circumstances where a coroner exercises authority he/she shall issue a certificate to the civil registrar "*containing the required particulars of the death concerned*" who will then enter the details into the civil register.

03.2 This contrasts with section 42 of the 2004 Act which provides that in deaths which do not involve the coroner a medical practitioner "*shall sign and give to a qualified informant (within the meaning of section 37) a certificate stating to the best of his or her knowledge and belief the cause of the death, and the informant shall give the certificate to any registrar together with the form specified in section 37 (1) containing the required particulars in relation to the death*."

04 Improvement in Personal Information Recorded under the 2004 Act

04.1 Part 5 of the 2004 Act (comprising sections 36 to 44) was commenced on 5th December 2005 under S.I. No. 764/2005 and thus continued the practice that in the registration of deaths which involve a coroner, the deceased's next-of-kin are completely excluded from the registration process.

04.2 Part 5 of the First Schedule to the 2004 Act provides for the details to be entered in the civil register of deaths, and which were greatly expanded from those noted above in paragraph 02.1 under the repealed 1863 Act.

04.3 The new particulars are:

i) Date and place of death.
ii) Place of birth of deceased.
iii) Sex of deceased.
iv) Forename(s), surname, birth surname and address of deceased.
v) Personal public service number of deceased.
vi) Marital status of deceased.
vii) Date of birth or age last birthday of deceased.
viii) Profession or occupation of deceased.
ix) If deceased was married, the profession or occupation of spouse.
x) If deceased was less than 18 years of age on date of death, occupation(s) of his or her parent(s) or guardian(s).
xi) Forename(s) and birth surname of father of deceased.
xii) Forename(s) and birth surname of mother of deceased.
xiii) Certificated cause of death, duration of illness and date of certificate under section 42 .
xiv) Forename, surname, place of business, daytime telephone number and qualification of registered medical practitioner who signed certificate under section 42 .
xv) Forename(s), surname, qualification, address and signature of informant.
xvi) If an inquest in relation to the death or a post-mortem examination of the body of deceased was held, the forename, surname and place of business of coroner concerned.
xvii) Date of registration.
xviii) Signature of registrar.

04.4 Among the particulars (noted above) is the new provision that (where known to the informant) the deceased's date and place of birth be registered along with the name of his/her parents.

04.5 This was an important and vital improvement for which genealogists had successfully lobbied for more than a decade. In a submission to government in 2004 written by me for the Council of Irish Genealogical Organisations (CIGO) (Appendix A), I highlighted that such a move would bring Ireland into line with Article 115 of the United Nation's 'model civil registration law' (published by the UN in the 1990s).

04.6 The said Article notes twelve pieces of information that should be recorded in all death registrations. Of these twelve items listed, in relation to each death registered the second item provides for the "names of his or her mother and father" and the ninth item for the deceased's "*date and place of birth*"

04.7 Of the fifteen member states that then comprised the European Union in 2004, all but Ireland and Greece recorded a deceased person's date and place of birth and parents' names in death registrations. In the case of Greece, only the parents' names are recorded: father's forename(s) and surname and mother's forename(s) and maiden surname.

EU Member States in 2004

Death Registrations:	Date & Place of birth?	Parents' Names?
Austria	Yes	Yes
Belgium	Yes	Yes
Denmark	Yes	Yes
Finland	Yes	Yes
France	Yes	Yes
Germany	Yes	Yes
Greece	No	Yes
Ireland	**No**	**No**
Italy	Yes	Yes
Luxembourg	Yes	Yes
Netherlands	Yes	Yes
Portugal	Yes	Yes
Spain	Yes	Yes
Sweden	Yes	Yes
United Kingdom	Yes	Only Scotland

04.8 CIGO's lobbying was successful, as noted above. Since then, on foot of further lobbying by CIGO, similar provisions were included in the *Civil Registration Act (Northern Ireland) 2011* (commenced on 17 December 2012). Thus, where known, each deceased person's date and place of birth and parents' names are now recorded. In Britain and Ireland, this leaves only England & Wales not recording the names of deceased person's parents (though these two jurisdictions have recorded the date and place of birth for each deceased person since 1st June 1969).

05 Shortcomings of Section 41 of Civil Registration Act 2004

05.1 However, returning to the jurisdiction of coroners in Ireland, the application of section 41 of the 2004 Act has had the unfortunate effect of rendering defective many deaths registered by coroners. Too often they fail to record the deceased's date of birth, and in my own experience, in almost every instance the deceased's place of birth and parents' names are never recorded.

05.2 The problem is that coroners' courts have few enough staff and my own investigations a decade ago established that many coroners had taken the decision not to contact a deceased persons' next-of-kin to obtain the additional information required under the 2004 Act. Given that under section 41 the next-of-kin are excluded from the registration

process where a coroner is involved, then this has led to the vast majority of deaths registered by coroners since 2005 omitting vital biographical details. In most instances the next-of-kin are not even aware of this and even if they should become aware and want to amend or correct the entry in the death register, then per section 41 (3) they have to do so by involving the coroner.

06 Solution to Registration Deficiencies

06.1 The solution is simple and one which I am aware has also long been the preferred option of the Coroners Society of Ireland.

06.2 Section 41 (1) & (2) provide that a death be registered by the coroner issuing a certificate to the civil registrar. I propose that these sections (along with any sections affected by such a change) should, in broad terms, be brought in line with section 42 of the 2004 Act. Section 42 provides that a medical "*practitioner shall sign and give to a qualified informant (within the meaning of section 37) a certificate stating to the best of his or her knowledge and belief the cause of the death, and the informant shall give the certificate to any registrar together with the form specified in section 37 (1) containing the required particulars in relation to the death*."

06.3 Such a change would have the result that in future coroners would issue a certificate noting the finding regarding the cause or circumstances of the death to the deceased's next-of-kin or other party acting as a qualified informant as provided for in section 37 of the 2004 Act.

06.4 I am aware that as part of the Working Group on Review of the Coroners Service (1998-2000) the Coroners Society of Ireland raised the issue of the difficulties inherent in obliging coroners to obtain and submit to the civil registrar personal details about the deceased individuals whose deaths they had investigated. The Working Group went on to recommend that the certificate issued by coroners should in future be divided in two. The first part recording the finding of the coroner and the second part providing for the next-of-kin / qualified informant to enter the deceased's personal information. Despite at the time the proposal of the Coroners Society of Ireland receiving the support of the General Register Office, for whatever reason when the Bill was published it was not included.

06.5 I submit that it is now beyond doubt that the only way to resolve the matter of deaths registered by coroners failing to include key pieces of personal information (as required under Part 5 of the First Schedule to the 2004 Act) is to amend the 2004 Act to provide for, in all circumstances, input in the registration process by the deceased's next-of-kin / or a qualified informant.

8th April 2022

APPENDIX A

COUNCIL OF IRISH GENEALOGICAL ORGANISATIONS

THE IMPORTANCE OF INCLUDING 'PLACE OF BIRTH' & 'PARENTS' NAMES' IN IRISH DEATH REGISTRATIONS

A SUBMISSIONS TO GOVERNMENT

FEBRUARY 2004

NEW CIVIL REGISTRATION BILL

01 In July the Department of Social and Family Affairs published the long anticipated Civil Registration Bill. Such a Bill has been awaited since An Taoiseach, Albert Reynolds, announced in 1993 that the General Register Office (GRO) was to be decentralised to Roscommon town. The new Bill includes provision for much needed and long overdue modernisation of Ireland's civil registration system. That which is most exciting relates to the digitisation of its paper-based records, which form an unbroken series from 1845.

BACKGROUND TO THE GENERAL REGISTER OFFICE

02 Although all non-Catholic marriages have been centrally registered from April 1845, it was not until January 1864 that all of life's vital events (births, deaths and all marriages) were first civilly recorded in Ireland.[1] The data captured upon the registration of each event has remained unaltered until fairly recent times.[2]

BIRTHS

03 For the period 1864 through to 1996 the detail recorded in birth registrations was as follows:

Date & place of birth;
First Name(s);
Sex;

[1] Marriage (Ireland) Act 1844, 7&8 Vic. C. 81; Registration of Marriages (Ireland) Act 1863, 26&27 Vic. C. 90; Births & Death (Ireland) Registration Act 1863, 26 Vic. C. 11.
[2] The history of the General Register Office and its records is comprehensively covered in *Irish Civil Registration – Where Do I Start?* comp. Eileen Ó Duill and Steven C. ffeary-Smyrl (Dublin, 2000).

Name, surname & dwelling place of father;
Name, surname & maiden surname of mother;
Father's occupation;
Name, qualification and residence of informant;
Date of registration;

04 Since 1997 the following additional information has been recorded:

Surname of child;
Mother's occupation;

04 The new Civil Registration Bill (2003) proposes that the following data should be recorded in all future birth registrations:[3]

Date and place of birth;
Time of birth;
Sex;
Name(s) and surname;
Personal Public Service Number (PPSN);
Name(s), surname, birth surname, address and occupation of mother;
Former surname(s) of (if any) of mother;
Date of birth of mother;
Marital status of mother;
PPSN of mother;
Birth surname of mother's mother;
Name(s), surname, birth surname, address and occupation of father;
Former surname(s) of father (if any);
Date of birth of father;
PPSN of father;
Birth surname of father's mother;
Name(s), surname, qualification, signature of informant;
Date of registration;

05 The gathering of so much information in birth registrations represents an almost complete reversal in the State's civil registration policy to date. Until now it had been the norm to gather a minimal amount of data in order simply to establish the facts of an event of birth, death or marriage that had taken place. In fact, this long established policy was referred to by Mary Hanifan TD, then Minister for Children at the Department of Social and Family Affairs, on the 26th March 2002 during the Seanad debate relating to the Social Welfare (Miscellaneous Provisions) Bill 2002 in which she stated (in a rebuttal to the suggestion that place of birth and maiden surnames should be added along with date of birth in death registrations) that "*the primary purpose of the registration of a death is to record accurately the facts pertaining to a death…*"

[3] Section 19 and First Schedule, Civil Registration Bill, 2003.

Marriages

06 For the period 1845 through to 1955 the detail recorded in marriage registrations was as follows:

The address of the church (and religious denomination) or, if a civil ceremony, the registration office;
Date marriage took place;
Full name(s) of bride and groom;
Ages
Marital status;
Occupations;
Home address;
Fathers' name(s) and occupations;
The name(s) of two witnesses;
Date of registration;

07 Since 1956 the following additional information has been recorded:[4]

Bride & groom's dates of birth;
Bride & groom's fathers' name(s) and surname and mothers' name(s) and maiden surname;
Bride & groom's intended place of residence after marriage;

Deaths

08 Unchanged since 1864, the detail currently recorded in death registrations is as follows:

Date and place of death;
Name(s) & surname of deceased;
Sex;
Marital status;
Age;
Occupation;
Cause of death;
Name, qualification and residence of informant;
Date of registration;

Use of certificates as legal documents

09 The UN states that "*civil registration is a major foundation for a legal system for establishing the rights and privileges of individuals in a country*" and in doing so acknowledges that beyond a country's authorities, its citizens also have rights of access to, and use of, data recorded in civil registration records.[5] Civil registration

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[4] Since the commencement of the Vital Statistics and Births, Deaths and Marriages Registration Act 1952, 1952 No.8, the occupation of the bride and groom's fathers has not been recorded.
[5] United Nations, *Principles and Recommendations for a Vital Statistics System, Revision 2*, (New York, 2002),p. iii.

data is a primary source for the public and private sector in the creation of statistics for use in social and public policy and in business. However, this is of course not the only use of civil registration data. The general public, through the obtaining of civil registration certificates, uses the data for a wide variety of purposes connected to the establishment and the exercise of legal rights, both within Ireland and outside of it.[6] This very point is made in the introductory remarks to the new Bill when reference is made to the fact that "*apart from providing a record of vital events in relation to persons living in the State, these records also: satisfy the need for evidence which has a bearing on rights, entitlements, liabilities, status and nationality*".

10 Regarding citizens using registration data in a personal capacity, the UN acknowledges that when setting up a civil registration service "*vital registration document[s] will contain data used for legal purposes*".[7] With the creation of the Department of Social and Family Affairs' 'Through-Life-Register'[8] it might be thought by some that the days of the paper certificates were numbered. This is far from true. Of course, once the 'Through-Life-Register' is eventually completed and on-line, it will certainly reduce the number of times an individual will need to obtain a paper certificate from the General Register Office. However, particularly in relation to death registrations, for those occasions when such a document is required it is of vital importance that the certificate issued includes data that is sufficient and precise enough to prove the identity of the deceased beyond doubt.

11 Further, in *Principles and Recommendations for a Vital Statistics System, Revision 2* the United Nations' Statistics Division notes a civil registration system as having a dual purpose – legal and administrative. It states, that for legal purposes, for the "*individual, …civil registration records of death provide legal evidence of the fact and circumstances of death and the demographic characteristics of the decedent* [including amongst other details the deceased's date and place of birth and parents' names] *for the purposes of inheritance, insurance claims, …for demonstrating the right of the surviving spouse to remarry and for the support of claims for other benefits which may be predicated on the death of an individual.*"[9]

THE CASE FOR IMPROVING THE DATA RECORDED IN IRISH DEATH REGISTRATIONS

12 As can be seen above, since 1864 (when registration of deaths in Ireland first commenced) the information recorded has remained unchanged. Other than through emigration, during the period from the mid-nineteenth to the mid-twentieth century, population movement within Ireland has been relatively low when compared with the United Kingdom or European countries. When it did occur those involved tended to move to Ireland's two main centres of growing population, Dublin and Belfast. When the system was first created, personal data captured in

[6] United Nations, *Principles and Recommendations for a Vital Statistics System, Revision 2*, pp.4 -6
[7] United Nations *Handbook on Training in Civil Registration and Vital Statistics Systems*, p.40.
[8] The 'Through-Life-Register' will be created by use of the Personal Public Service Number (PPSN) the use of which will allow data about an individual to be identified from across the public service.
[9] United Nations, *Principles and Recommendations for a Vital Statistics System, Revision 2*, p. 5.

death registrations was relevant to that period of our history. However, almost one hundred and sixty years later it is far from adequate. To cite a simple example, Mary McDaid was born 1st April 1901 in Ramelton, Co. Donegal. She died in Dublin in May 1989, aged 88, as Mary Collins, widow. Immediately, it can be seen that if the information in both her birth and death certificates is compared then it is not possible, without recourse to secondary or other sources, to draw the conclusion that they relate to one and the same person.

13 One argument that has been put forward to address this problem is that in future civil registration will also capture an individual's 'Personal Public Service Number' (PPSN)[10]. However, careful examination of the facts shows that there are two reasons why the PPSN will not solve the problem. The first is that for reasons of practicality and cost (acknowledged and accepted by both the Department of Social and Family Affairs and the GRO) only those events registered in future can include the PPSN. This means that not until about seventy years hence will it occur that most people who die will have been born after the beginning of the inclusion of the PPSN in birth registrations. The second point is that even if it were possible to retrospectively add the PPSN to the birth and marriage registrations of all people now living in Ireland, as the PPSN will not be within the public domain[11] it will be of no use in assisting the public to link records together. In practise, this means that as the PPSN will not be shown on paper certificates, using the other data recorded in such documents will remain the only way to prove 'legal' family-links through certificates of birth, death and marriage.

14 Over the past number of years, various groups have lobbied the General Register Office and the Department of Health & Children (in writing, through direct dialogue and through the press) to improve the detail recorded in Irish death registrations. Amongst others, such groups have included the Council of Irish Genealogical Organisations (CIGO), the Law Society of Ireland, Cherish, PACT, the Genealogical Society of Ireland (GSI), and the Association of Professional Genealogists in Ireland (APGI). During the debate on the *Social Welfare (Miscellaneous Provisions) Bill 2002*, CIGO lobbied widely for inclusion of a deceased person's place of birth and the maiden surname of married, divorced or widowed women in all future death registrations.[12] Unfortunately, the Bill was passed without fully addressing this issue.

15 In the later part of 2002, further lobbying about this issue was undertaken and about the same time a fairly lively debate took place through the letters page of *The Irish Times*. It is pleasing to see that the new Bill provides for future death registrations to include a deceased's surname at birth (if different at death).

[10] The Personal Public Service Number (PPSN) is a unique number ascribed to every citizen and replaces the Revenue and Social Insurance number (RSI). Its use allows the holder to access State services.
[11] Section 53 (4), Civil Registration Bill, 2003.
[12] The Bill already included the proposal to record a deceased person's date of birth.

A DECEASED PERSON'S PLACE OF BIRTH & PARENTS' NAMES

16 Given what is said immediately above, the issue of including a deceased person's place of birth and parents' names therefore now remains the only outstanding issue to be addressed. Such a small piece of information might seem very trivial indeed, but in the context of 'linking' life's events together it is one of the three basic interlinking pieces of information internationally recognised as of prime importance in establishing a person's identity. The three pieces of information are: (i) a name, (ii) a date & place of birth and (iii) parents' names. It is interesting to note that of these three pieces of information, in the context of an individual's identity, the date and place of birth have been recorded on British and Irish passports since 1921.[13]

17 A 1970s UN survey found that of the countries included, approximately 50% recorded a deceased person's date and place of birth and parents' names in death registrations.[14] Since then, over twenty-five years later, in a 2002 UN publication citing typical examples of death certificates from around the world, approximately 85% include the type of detail vital to clearly establish a deceased person's identity in relation to their birth details.[15] Further, current data obtained directly from DESA[16] shows that of 19 sample states (of diverse economic status) surveyed with regard to civil registration practices, 17 recorded a deceased person's date of birth and 14 their place of birth.[17]

18 In the 1990s the UN produced a 'model civil registration law' to assist under-developed countries in setting up modern civil registration systems. Article 115 of the model law records twelve pieces of information that should be recorded in all death registrations. Of these twelve items listed, the second provides for the "names of his or her mother and father" and the ninth fort the deceased's "*date and place of birth*" . The same UN publication states that in the context of marriage and death registrations it is "*recommended that place of birth be asked for all persons*" and that when registering a death the person attending should be able to "*supply accurate information about the full name of the deceased person, the date and place of birth, the last domicile, the names of the mother and father, and if the deceased was married – the spouse's name*".[18]

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[13] *The Passport – The History of Man's Most Travelled Document*, Martin Lloyd (Stroud, UK, 2003) p.128.
[14] United Nations, *Handbook of Vital Statistics Systems and Methods, Vol. II, Review of National Practices*, (New York, 1985) p. 38.
[15] Such detail included the date and place of birth and/or the names of the deceased's parents. United Nations, *Handbook on Training in Civil Registration and Vital Statistics Systems*, (New York, 2002), p.p.139-251.
[16] Department of Economic & Social Affairs (UN).
[17] Recording place of birth: Burkina Faso, Cameroon, Canada, Egypt, United Kingdom, Italy, Jordan, Kuwait, Russia, Senegal, Singapore, Spain, Togo, Unites States. Not recording place of birth: Bahrain, Chile, Costa Rica, Mexico, Philippines.
[18] United Nations, *Handbook on Training in Civil Registration and Vital Statistics Systems*, (New York, 2002), p.p.37, 122, 264-265.

DATE OF BIRTH IS NOT ENOUGH

19 Of course, there is also the concern that by recording only a deceased person's date of birth and not their place of birth and parents' names, in instances involving prolific surnames it could all too easy be found that several namesakes had been born on the same day. Problems would also arise in instances where, through error or mistaken recollection, an inaccurate date of birth is recorded for a deceased person. Put simply, for example, the death occurs of a John Murphy and on his death certificate it is recorded that he was born at Oldtown, Callan, Co. Kilkenny, on 4th July 1920. The fact that both his date and place of birth and parents' names have been recorded establishes his identity beyond reasonable doubt. Importantly, having recorded not only the deceased person's date of birth, but also their place of birth and parents' names, allows for his identity to be discernable despite two possibilities: i) more than one person named John Murphy having being born on the same date; ii) or for the date of birth to have been (through error of recollection) inaccurately recorded at the time the death was registered. In such instances, recording the place of birth and parents' names (rather than just the date of birth) in death registrations would provide other vital distinguishing characteristic about the deceased, of use in establishing an identity.

20 In death registrations, recording three items of fact particular to a deceased person allows, that while one of the facts might contain an error, the deceased's identity will remain discernable - whether, for some legal or other purpose, the fact of the death requires to be established as little as a year or as long as a century after the event.

BRITISH AND EUROPEAN COMPARISONS & THE NAPOLEONIC CODE

21 With regard to the United Kingdom, date and place of birth has been recorded in death registrations in England & Wales since 1969, in Scotland since 1971 and in Northern Ireland since 1973**.** The purpose was three fold: to assist in the provision and application of Social Security policy and benefits; to assist the Department of Health in ensuring that payments to National Health doctors ceased upon a patients death; and to be able to provide death certificates which the general public could use in legal and other official matters. To be successful in this there was the need to remove ambiguity about the identity of deceased persons named in death certificates. To refer again here to Mary Collins (see above), if she had died in 1989 in Northern Ireland (rather than the Republic of Ireland) then her death certificate would have recorded that she was born as Mary McDaid, 1st April 1901 at Ramelton, Co. Donegal. Instantly, it can be seen that the data recorded at her death links directly to that recorded at her birth and therefore it is patently clear which Mary Collins she is from amongst any others bearing that name. Thus, for the first time ever, all British death registrations clearly establish the identity of a deceased person by recording not just details pertaining to their death but also to their birth. However, recording the deceased's parents' names too would immeasurably improve the quality of the data recorded.

22 Of the current fifteen member states that comprise the European Union all but Ireland and Greece record a deceased person's place of birth and parents' names in death registrations. In the case of Greece the only the parents' names are recorded: father's forename(s) and surname and mother's forename(s) and maiden surname.

EU Member States

Death Registrations:	**Place of birth?**	**Parents' Names?**
Austria	Yes	Yes
Belgium	Yes	Yes
Denmark	Yes	Yes
Finland	Yes	Yes
France	Yes	Yes
Germany	Yes	Yes
Greece	No	Yes
Ireland	**No**	**No**
Italy	Yes	Yes
Luxembourg	Yes	Yes
Netherlands	Yes	Yes
Portugal	Yes	Yes
Spain	Yes	Yes
Sweden	Yes	Yes
United Kingdom	Yes	Only Scotland

23 Most continental European countries base their civil registration system on the 1804 Napoleonic Code. What this means in practice is that all civil records are linked together by two points of reference. The first is that the details of an individual's subsequent marriage(s) and death are noted in the record of their birth. The second is that all records of marriage and death include the particulars relating to the individual's birth, usually the place of registration and the reference number to the record.

CIVIL REGISTRATION AS A MATTER OF FAMILY RECORD

24 The introduction to the new Civil Registration Bill remarks that civil registration records "*provide a rich source of information for people tracing their family history and compiling 'family trees'* ". While it is true that civil records are an invaluable source for Irish genealogy (particularly as so much destruction befell Irish genealogical records when the Public Record Office was consumed by fire in 1922), unfortunately they cannot be truly regarded as a rich source of information as the detail recorded up to relatively recent times has been all too brief. As can be seen above, the detail recorded in Irish marriage registrations was markedly improved from 1956 when recording began of both parties' dates of birth and full parents'

names, and the new Bill will also provide for far greater detail in Irish birth registrations. However, if Irish death records are ever to be described as a rich source for genealogists, then provision must be made to include such basic detail as that prescribed in the UN's 'Model Civil Registration Law' – not just the deceased's date of birth and surname at birth, but the place of birth and parents' names too. In recent years, with Ireland's new found prosperity, we have witnessed the arrival into Ireland of immigrants from around the world. Is it not the State's duty to record for its future generations the place of origin of those of its citizen's who began life outside of Ireland?

CONCLUSION

25 The issue of improving the data recorded in Irish death certificates is one that is held as vitally important by CIGO. As can be seen above, as long ago as 1985 the UN published recommendations about 24 items of data which should be recorded in death registrations. Of these 24, two related to the collection of data pertaining to a deceased person's date & place of birth and parents' names.

26 In an Irish context, all that is actually required to comply with the United Nations' 'model civil registration law' and its other published key recommendations is the insertion of the words "*Place of birth (if known to informant)*" "Parents' forenames and birth surnames" between lines 37 and 38 on page 55 of the *Civil Registration Bill, 2003*.

27 POINTS IN BRIEF

- **THE** information recorded in Irish death registrations has remained unchanged since registration first began in 1864. Other than the age, no information is recorded relating to the deceased person's date and place of birth.

- **SINCE** 1973, all deaths registered in Northern Ireland have included the deceased's date and place of birth and the maiden surname of married women.

- **IN** a 1970s survey, the United Nation's found that of the countries included approximately 50% registered deceased people's parents' names in death registrations.

- **IN** a 2002 survey, the United Nation's had found that of the countries included 85% registered deceased people's parents' names in death registrations.

- **IN** the early 1990s, the United Nations produced a 'Model Civil Registration Law' that included provision for the registration of deceased people's place of birth and parents' names.

- **CURRENTLY,** parents' names are recorded in death registrations in all fifteen member-states of the European Union, apart from Ireland and the United Kingdom.[19]

- **FUTURE** use of the 'PPSN' in Irish civil registrations will **not** allow for birth and death records to be 'linked' in a computerised manner as there is no way to go back over births already registered and add the 'PPSN' to them.

- **INCLUDING** only the date of birth in future Irish death registrations will be the cause of much confusion as Ireland has only a small pool of surnames. Consequently, it is all too easy to find examples of namesakes born on the same day (although in different parts of Ireland). Including the place of birth [now agreed to by the Minister] and parents' names in death records will remove such confusion.

- **INCLUDING** the place of birth (along with the proposal in the Bill to include the date of birth and surname at birth) and the parents' names will mean that in future it will be virtually impossible to use civil registration certificates in the perpetration of fraud.

- **All that is required for Ireland to comply with the United Nation's 'model civil registration law' (and the UN's other published key recommendations) is the insertion of the words "*Forename(s) and birth surname of father" "Forename(s) and birth surname of mother*" between lines 36 and 37 on page 65 of the *Civil Registration Bill, 2003 (No. 35b)*.**

[19] Even in the UK, although England & Wales and Northern Ireland no not record parents' names, Scotland does.

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AN TSEIRBHÍS CHRÓINÉARA
CORONER SERVICE
Senior Coroner for the District of Kildare

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7th April 2022.

Mr. Alan Guidon,
Clerk,
Joint Oireachtas Committee on Justice,
Leinster House,
Dublin 2.

Dear Mr. Guidon,

I refer to your letter of 21st March 2022 to the President of the Council of the Coroners Society of Ireland inviting written submission to the Joint Oireachtas Committee on Justice on the topic of **"An examination of operation of the Coroner's Service"**.

At our Council meeting on Saturday last, 2nd April 2022 we discussed the invitation in detail and Mr. O'Connell is submitting his reply on behalf of the Coroner Service. In addition, I informed the President that I would be making an individual submission on the topic with further information relevant to the Committee's considerations and also in the context of recent Oireachtas debates on the Coroner Service, including forensic standards and medico-legal and forensic death investigation nationally and internationally.

I attach a copy of the letter I wrote to the Minister for Justice on 2nd November 2021 to which she kindly replied on 7th February 2022.

I served on the Department of Justice's Review of the Coroner Service Working Group which produced the Report of 2000. I also served as President of the Coroners Society in 2008-2010.

I am including information on forensic death investigation pertinent to the Committee's current considerations of the Coroner Service as I have some international forensic background as current President of the European Council of Legal Medicine and a current member of the Scientific Advisory Committee to the Office of the Prosecutor at the International Criminal Court in the Hague and hope that I may have some additional information to help.

Firstly, in relation to reforms which would enhance the Coroner Service, I refer to my letter to the Minister for Justice and summarise those reforms as follows with a brief illustrative (but not exhaustive) list of broad areas of needed reform which include:

1. The re-organisation of the Coroners' Districts within a larger Regional structure with shared operational, office, administrative and investigative framework and support;

2. Support service arrangements for pathology *post mortem* examination, toxicology and histopathology;

3. The appointment system and conditions for Coroners with more full-time Coroners as Districts are amalgamated and caseloads increase;

4. The appointment of Coroner's Investigation Officers on a regional and shared basis;

5. The appointment of a Chief Coroner and Deputy Chief Coroner;

6. The establishment of a structured Coroner Service Agency with an Agency Director; and

7. The establishment of a Coroner Service Advisory Committee.

There are three broad areas of forensic and coronial death to which I will now make reference: the underlying system and standards set out internationally for such investigation in the context of coroner's investigations in Ireland; the forensic identification of human remains (in the context of the current debate on exhumation and examination of remains in the mother and baby home inquiries and proposed legislation); and an example of the oversight function of the Coroner Service of certain categories of deaths which do not proceed to post mortem examination or inquest hearing but which remain an important safeguard of the vulnerable within our society and important to Public Health measures and epidemiology (and the Covid-19 Pandemic mortality is a stark and tragic example of this).

The reference information documents I attach (publicly available) include:

1. Death Investigation System (peer-reviewed international ECLM papers 2014-2022):

A. European Council of Legal Medicine: Harmonisation of Medico-Legal Autopsy Rules ECLM update of the principles and rules relating to medico-legal autopsy procedures (IJLM 2014)

B. European Council of Legal Medicine (ECLM) accreditation of forensic pathology services in Europe (IJLM 2015)

C. European Council of Legal Medicine (ECLM) principles for on-site forensic and medico-legal scene and corpse investigation (IJLM 2017)

D. European Council of Legal Medicine (ECLM) on-site inspection forms for forensic pathology, anthropology, odontology, genetics, entomology and toxicology for forensic and medico-legal scene and corpse investigation: the Parma form (IJLM 2022)

2. Forensic Identification of Human Remains (report of 2022):

International Committee of the Red Cross (ICRC) - The Forensic Human Identification Process: an Integrated Approach (ICRC 2022).

3. Coroner's Investigation and Oversight of Deaths not resulting in post mortem or inquest hearing (paper and report 2020-2021):

A. COVID-19 pandemic: Coroner's database of death inquiries with clinical epidemiology and total and excess mortality analyses in the District of Kildare March to June 2020 (JFLM 2020)

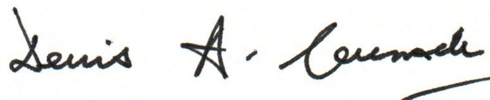
B. Coroner's District of Kildare - Covid-19 Pandemic Report on Coroner's Inquiries into Deaths in the Community, Hospital and Nursing Home and Residential Care: Epidemiology and Total and Excess Mortality in the District of Kildare for the Year March 2020 through February 2021 (Kildare Coroner's Website, Second Report).

From my experience nationally and internationally in the field, I am familiar with much of the independent international expertise within the Forensic Medicine and Pathology community and indeed a number of experts serve on committees or organisations on which I also serve. These experts have been involved in the publication of the forensic procedures and standards in the papers I attach and are actively involved in forensic investigations worldwide. I am including this information in this letter as I noted references to the need for international forensic expertise in the Oireachtas debates on specialised death investigation in Ireland as well as reference to our existing coroner's system. We are also very fortunate in having the excellent and recognised expertise of the Chief State Pathologist and her colleagues in Forensic Pathology and Anthropology in this jurisdiction.

I do hope that the members of the Committee may find some helpful information in this brief submission and in the attached forensic papers on the topic as part of their consideration.

If I can be of any assistance, please do let me know.

Yours Sincerely.



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Ms. Helen McEntee T.D.,
Minister for Justice,
Department of Justice and Equality,
51 St. Stephen's Green,
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2nd November 2021.

Dear Minister,

Re: The Coroner Service: Reforms 2000-2021

May I first of all welcome you back to your Ministerial role and thank you for your support given to the Coroner Service (the Coroners) to date.

I was a member of the Review of the Coroner Service Working Group 1999-2000 (and also headed the researchers for the group and chaired the service issues subgroup) arising from which the Government published the Review Report of December 2000. I have also served on the Coroners' Council for some decades and was President of the Coroners Society 2008-2010 working closely with previous Ministers, Secretaries-General and Department Officials.

There have been many very significant legislative reforms of the coroner's role in the intervening period through the great efforts of all concerned: Ministers, Coroners and Department Officials with tremendous positive input from the Public, relevant Stakeholders and TDs. Minister of State Hildegard Naughton summarised these very well in the Dáil on a number of occasions in the past few months in response to Parliamentary Questions on the Coroners Service and Coroners Act 1962-2020. The reforms in investigation of maternal deaths and in civil legal aid are two examples of worthy reform now in place (the latter still needing some further work).

Notwithstanding these positive legislative reforms, little or no progress has been made in the area of structural and organisational reform of the Service. In Part 2 of the Coroners Bill 2007

very significant reforms and restructuring were proposed, many in line with the recommendations of the Working Group Report of 2000 (but now needing some updating). Part 3 and other very critical legislative provisions were also in the Bill. For various reasons, none of these provisions has been followed through in any meaningful way or at all since the Bill lapsed with the dissolution of the then Dáil and Seanad.

The Coroner Service continues to provide great service to the citizens of our State. I say this with knowledge of many international death investigation systems, being on governing councils of a number of international forensic and medico-legal organisations and having published papers with international colleagues in this area. Our death investigation service is also very much a service for the living (the bereaved and others affected by deaths) as well as upholding the human rights and dignity of the deceased. But this is being achieved through the individual and collective efforts of the Coroners supported by your Departmental Officials and staff in the Local Authorities, an Garda Síochána, medical doctors and others (truly seen and tested during this Covid-19 pandemic emergency as with so many services). The structure, organisation and financing of the Coroner Service no longer meet the needs of a modern forensic and medico-legal death investigation service and have not done so for some time.

I will mention only a brief illustrative (not exhaustive) list of broad areas of need which include:

- organisation of the Coroners' Districts into a larger Regional structure with shared operational, office, administrative and investigative framework and support;
- the appointment system and conditions for Coroners with more full-time Coroners as Districts are amalgamated and caseloads increase;
- the appointment of Coroner's Investigation Officers on a regional and shared basis;
- the appointment of a Chief Coroner and Deputy Chief Coroner;
- the establishment of a structured Coroner Service Agency with an Agency Director; and
- the establishment of a Coroner Service Advisory Committee.

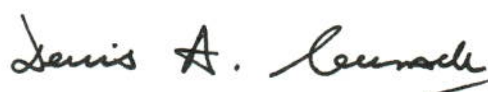
For example, the establishment of the Office of Chief Coroner would provide leadership and support for the Service to provide the service our citizens need and deserve. A Chief Coroner would drive reform, consistency, oversight and harmonisation of death investigation by our Coroners as Judicial Officers of the State and has been proven as an effective driver in other jurisdictions.

There is much detail needed to flesh out my brief summary above further but I urge you as the Minster with responsibility in this area to embrace this reform project in a critical service for our society as part of your vision and potential achievement in the immediate to short term.

This correspondence and the views expressed in it are my own. The Coroners' Council, Coroners Society and many other interested persons will also have views and opinions on the matter but it behoves me to write to you urging active consideration of the necessary reforms which I and others have been advocating for more than 20 years.

With Kind Regards.

Yours Sincerely.



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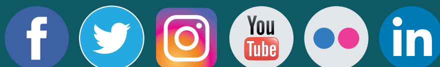

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