

Review of the Coroner Service



Report of the Working Group



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CORONER SERVICE

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DEPARTMENT OF JUSTICE, EQUALITY AND LAW REFORM
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Preamble

There are perhaps few public services as poorly understood or indeed as poorly appreciated as the coroner service. Its association with what are often tragic circumstances does not encourage the general public to look behind the process of death investigation of which the public inquest is an important but not the sole aspect of coroner work.

The role of the coroner has evolved over hundreds of years and its present shape and organisation is very similar to that which existed before the turn of the last century. Apart from the Coroners Act 1962 which updated some legislative aspects of coroner work, there has never been a comprehensive review of the Irish coroner service in terms of assessing its adequacy for societal needs.

In making such an assessment for the needs of society in the twenty-century, it is inevitable that some radical reforms are indicated and that unattended historical evolution must now give way to more modern organisation structures, a focussed management perspective and a dedicated funding programme to achieve specified objectives in the short and long term. Piecemeal evolution and improvements under the current organisational arrangements will not achieve the standards of public service which have now become part of the legitimate expectations of today's society.

In making a choice to develop and fund a modern coroner system, it is critical to focus on the fact that the coroner system is a service for the living. It serves and reassures society as a whole by public investigation of sudden or unexplained death. It informs and supports the bereaved by establishing the cause of death – a service often critical to the process of mourning and adaptation especially where the circumstances of the death may have been unusual or tragic.

This Report seeks to provide a blueprint for the coroner service for the foreseeable future and provides specific recommendations critical to achieving specific legislative, organisational, financial and service objectives in the short, medium and long term. While the way forward poses challenges for all those involved in supporting and delivering all aspects of the service, coroners themselves face change and adaptation in a part time profession which has remained relatively undisturbed for a very long period of time. Their desire for high standards and their proven commitment to public service will, no doubt, ensure that these challenges are met.

Acknowledgments

The Group wish to acknowledge the considerable assistance given to it by a wide variety of persons and organisations. The total of 82 written submissions reflected a significant willingness to assist the Group in its deliberations on what was a far-ranging and complex topic. We were particularly grateful for the oral submissions made to the Group by a number of families who recounted their general experiences with the coroner service.

The workshop with coroners from England, Wales and Canada was particularly useful to the Group and the attendance of the State Pathologist and his Deputy on that occasion was much appreciated.

Much of the basic research material for the Group was provided by a specially commissioned research group, directed by Professor Denis Cusack, from the Division of Legal Medicine, Department of Forensic Medicine, National University of Ireland, UCD. Ms Maria Colbert, B.C.L.(NUI); LL.M.(Heidelberg); Barrister-at-law. and Ms Cliona Mc Govern, B.A.(hons) (NUI), M.A.(NUI) the research fellows on the team, made an invaluable contribution both to the core knowledge of the Group and to our ongoing deliberations. A selection of the material which they prepared is available on the Internet at www.irlgov.ie/justice

In the context of preparing this Report it became very evident that a number of people involved in the coronial service had, over many years, carried out their duties in a very dedicated manner. Our acknowledgments would not, therefore, be complete without a reference to those many coroners who have, during their lifetime, given such high quality service to their community. In this context we would like to refer particularly to the recent death of Dr Bartley Sheehan who, apart from his contributions to the work of the Group, represented not only a standard of excellence as a coroner and a doctor but also epitomised the standard of care, service and compassion which best describes the aspirations of the coroner service of the twenty first century which this Report seeks to set in motion.

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Terms of Reference

To carry out a review of all aspects of the coroner service in Ireland and equivalent services in appropriate comparable jurisdictions.

Arising from such a review, and on the basis of broad consultation with interested parties, to identify the issues which must be addressed to ensure that the coroner service represents an appropriate response to the needs of society.

To make specific recommendations in relation to these issues, including:

- the most appropriate financial arrangements for the funding of the coroner service
- the organisational structure within which the service is to be delivered
- the nature of the core service to be delivered
- the implications for other ancillary services
- the legislative provisions required to implement such recommendations

To identify the specific steps which need to be taken in the short, medium and long term in order to implement the proposed recommendations.

To furnish an interim report on the Group's deliberations within a period of one year.

Téarmaí Tagartha

Athbhreithniú a dhéanamh ar gach gné den tseirbhís chróinéara in Éirinn agus ar sheirbhísí den tsamhail chéanna i ndlínsí cuí inchomparáide.

Ag éirí as an athbhreithniú sin, agus ar bhonn comhchomhairliúcháin fhorleathan le páirtithe leasmhara, na nithe a shainaithint nach mór aghaidh a thabhairt orthu lena chinntiú go mbíonn an tseirbhís chróinéara ag freastal go cuí ar riachtanais na sochaí.

Moltaí sonracha a dhéanamh i ndáil leis na nithe sin, lena náirítear:

- na socruithe airgeadais is oiriúnaí a dhéanamh chun an tseirbhís chróinéara a mhaoiniú
- an struchtúr eagrúcháin ar laistigh de a sholáthrófar an tseirbhís
- cinéal na seirbhíse bunúsaí atá le soláthar
- na himpleachtaí atá ann do sheirbhísí coimhdeacha eile
- na forálacha reachtaíochta atá ag teastáil chun moltaí den sórt sin a chur i bhfeidhm

Na bearta sonracha a shainaithint nach mór a ghlacadh sa ghearrthéarma, sa mhéantéarma agus san fhadtéarma d'fhonn na moltaí a dhéanfaidh siad a chur i bhfeidhm.

Turascáil eatramhach a chur ar fáil, laistigh de bhliain, ar bhreithniú an Ghasra.

EXECUTIVE SUMMARY

BACKGROUND

Basic duties of a modern coroner

The coroner service is one of the oldest public services in existence with the earliest references going back to the twelfth century. 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. Operating as an independent judicial officer, he¹ must establish the 'who, when, where and how' of unexplained death. Contrary to common public perception, the coroner is not permitted to consider civil or criminal liability let alone to determine such matters. He must simply establish facts. In other words, his court is inquisitorial rather than adversarial – a critical distinction when examining many of the issues in this Report.

Ethos of the Irish coroner service

Investigation of sudden and unexplained death takes many forms throughout the world and the Irish system with its emphasis on investigating a relatively wide range of unexplained deaths, reflects the essential value placed by our constitution on life itself. No death should be left uninvestigated unless there is a clear and certifiable reason for that death. In its independence from the medical profession, the Gardaí, other agencies of the State or any parties who might have an interest in the outcome of death investigation, the coroner service reassures society through a process of public hearing which can establish that nothing underhand has taken place.

The coroner cycle

There is a cycle which starts with any reportable death, an understanding of which is critical to assessing the recommendations in the Report. It starts with the reporting of the death to a coroner and finishes with the issue of a certificate to the Registrar of Births and Deaths. The totality of activities within these events represents the principal subject matter of this Report. The coroners enquiry may simply involve confirmation with medical authorities that the death was, in fact, natural or it may extend to the formal court process of an inquest.

When reported, if the death is not immediately explicable, the coroner may order a post mortem to help establish the cause of death. This is carried out by a pathologist who, although usually attached to a hospital, acts independently of the hospital as the "coroner's agent" for the purpose of the post mortem. This process can involve retention of organs for special analysis which means that a post mortem report may not be completed for a number of weeks. It must be remembered that a post mortem ordered by a coroner is carried out solely for the purpose of establishing the cause of death. If the coroner is still unable to establish the cause of death, he may proceed to an inquest. (Where obvious violent death is involved such as homicide, a special post mortem is carried out by the State Pathologist. These Post-mortems, which constitute less than 2% of all post-mortems, require the approval of the Minister for Justice, Equality and Law Reform and are requested by the coroner usually at the instigation of the Gardaí.)

In general, he **must** hold an inquest if he believes that the death was violent or unnatural or happened suddenly and from unknown causes.

¹ The masculine pronoun is used for convenience throughout the Report

The inquest sees the coroner moving to what is primarily a judicial phase which focuses exclusively on the 'who, when, where and how' of death. Being an inquisitorial process, documentation is not automatically made available before the inquest although the coroner has discretion in this area. The emphasis is on fact-finding and not liability assignment. Some of the procedures for conducting the inquest are based on legislation while others have evolved over the years. Juries may be used but are limited to a number of statutorily-defined situations.

Verdicts on the 'who, when, where, and how' of the death are returned on completion of proceedings and general recommendations designed to prevent similar deaths may be made by the coroner or the jury. A certificate is issued to the Registrar of Births and Deaths, thus completing the coroner cycle.

In terms of a general mission statement the service can therefore be described as follows:

The coroner 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.

INTERNATIONAL EXPERIENCE

Coroner systems vary substantially between countries for a wide variety of reasons. These include differences in legal systems, a focus on either legal or medical aspects of death investigation, varying relationships with the criminal justice system and differences in historical evolution. An examination of this diversity has, however, been useful for the Group and points of particular interest included:

- the need for good communication with relatives
- the need for a unified coroner structure to allow integrated and planned evolution of the service over time

- the usefulness of rules-based legislation to address the detailed, complex and changing requirements of the coroner system
- the advantages to be gained from an integrated support system for the coroner service.

ISSUES AND RESPONSES

Coroner legislation has remained unchanged for almost forty years and the organisational and administrative arrangements for the coroner service itself have not been examined for an even longer period. This contrasts with what can only be described as transformational societal changes throughout the second half of the twentieth century.

Radical change

Against this background, the Group found itself contemplating radical reform and a major reconfiguration of the coroner service at a very early stage of its deliberations. While an evolutionary process will be needed to implement all the Group's proposals, there must be a clear strategy for change leading to the achievement of defined objectives. There must be an equally clear understanding and ownership of such change both from those engaged in managing and contributing to the change process and those involved in the direct provision of coroner services.

Funding

Critically, there must be a commitment to the resourcing of such change, without which the overall strategic objectives of the service will not be secured. In the allocation of scarce resources, society perhaps has not always fully appreciated that the coroner service is a service for the living and indeed for a very precious segment of the living – those traumatised by sudden and unexpected death. The Group was clear in its view that all the prerequisites of funding and ownership must be satisfied if we are to build a

coroner service which is geared towards the demands of a modern society into the new century.

Key areas of reform

The reconfiguration of the Irish coroner service pivots on three key areas:

Legal: redesigning and updating the legislative environment

Support services: ensuring that all necessary support services are available as of right to the coroner system and introducing funding arrangements for such services which are exclusively ring-fenced so as to achieve agreed objectives

Restructuring: reshaping the arrangements for delivering the services and establishing appropriate management structures to install, develop and monitor the new service

LEGAL

ISSUES

It is inevitable that in a rapidly changing society, strains are placed on legislation which has been in existence for almost forty years. Difficulties with the current legislation have included:

- lack of codification of statutory and common law governing the coroner service
- inadequacies in the Act in relation to the specification of coroner procedures
- difficulties with provisions regarding jurisdictional powers which impinge on the core task of the coroner
- the lack of a user-friendly review system
- constitutional issues relating to compellability of witnesses and citation to the High Court in relation to contempt.

RESPONSES

The core recommendations of the Group in this area is the drafting of a new Act to incorporate:

- the introduction of Coroner's Rules based on statutory regulations with coroners themselves developing "best practice" guidelines in areas where coroner discretion is indicated
- changes to provision on jurisdiction to ensure that coroners will be able to investigate the circumstances surrounding a death rather than being confined to establishing the proximal or medical cause of death
- the introduction of a new review system where the Attorney General will retain the power to order an inquest but will do so with the benefit of recommendations from a specially-constituted Review Board
- the availability to the coroner of a consultative case-stated procedure.

Some measures relating to compellability of witnesses may have to be introduced in advance of the new legislation.

SUPPORT SERVICES

ISSUES

Coroners are part of a multi-faceted system involving pathologist services, mortuary and post mortem facilities, histology (tissue) and toxicology (fluid) testing, hospital administration, Garda support and many other related services including general practitioner and funeral undertaker services. The coroner service is unable to function effectively (and indeed sometimes not at all) in the absence of many of these core support services such as pathologists, tissue and fluid analysis and post mortem facilities.

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 development and modernisation of **mortuary facilities** has been sporadic and given the funding links between general post-mortem facilities and health budgets, it is not surprising that despite the best intentions, resources are distributed with an ante-mortem bias. While understandable, this bias will continually frustrate any attempt to bring the coroner service to the standard envisaged by the Group.

Fluid and tissue analysis also present difficulties. Fluid analysis is carried out by the State Laboratory and resource problems have led to serious delays for coroners awaiting results of Post-mortems. Tissue analysis takes place at hospital laboratories and as with pathologist services, is done on the basis of informal arrangements where the coroner has no right to the service and delays can occur.

Perhaps the most serious deficiency in the

RESPONSES

The range of responses to the service support issues identified in the report include:

- Pathologist services should be made available as of right to coroners. In view of the industrial relations implications which might be involved, the Group did not have a mandate to prescribe specifically how this guarantee of **services** might be achieved. It appears clear, however, that some form of formal, perhaps contractual arrangements, either with pathologists or with hospitals will be needed.
- Funding for post mortem and mortuary facilities should be ring-fenced to ensure that a planned programme of improvements and upgrading is implemented and not affected by continuing resource pressures on general health expenditure. The Group wish to emphasise again that the coroner service is a service for the living and resource allocation must be evaluated in that context.
- Arrangements for tissue analysis will also benefit from formal arrangements for delivery and should be included in whatever guarantee arrangements are devised in respect of pathologist services. Long delays in fluid analysis is a serious problem in the coroner system often leading to unnecessary suffering for bereaved persons. Appropriate resourcing of the State Laboratory to provide an acceptable level of service should be undertaken as a matter of urgency.
- In relation to the kind of direct coroner support needed to raise the overall quality of service to relatives, the introduction of coroners officers at a regional level (see subsequent paragraph on structural reform) is crucial. These officers, in addition to carrying out a wide range of support and coordination

ISSUES (CONT.)

coroner service lies in the absence of the kind of direct coroner support which would permit the standards of **service for the bereaved** to be raised to the levels compatible with the kind of client-centred service now emerging in the Irish public service. 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.

RESPONSES (CONT.)

functions (see Section 3.42 of main report) will be at the heart of implementing and developing the long-term strategy for the new service and will be ideally positioned to ensure that the service maintains the high standards of care envisaged by the group for those traumatised by sudden death.

STRUCTURAL

ISSUES

The high number of coroners in the country dates back to a time of poor communications and transport rather than to any analysis of service requirement. There is currently no link between the existing organisational structure and the most appropriate and effective way of delivering the service.

Coroner districts (there is one coroner per district) are roughly equivalent to local authority areas although in some cases there are a number of coroners in the same county. Coroner salaries and expenses (estimated at approximately £2M per annum) are paid by local authorities who appoint coroners, although coroner legislation is under the aegis of the Minister for Justice, Equality and Law Reform. The Department of Health and Children provides funding for many of the post mortem support services. Responsibility for the management and resourcing of the service is, therefore, at the very least, fragmented.

The wide extent of part-time coroners tends to dilute the levels of coronial expertise and the

RESPONSES

- Considerable rationalisation of the number of coroners is needed in the interest of securing an efficient and cost-effective coroner service. Benefits to be gained will include:
 - better use of resources
 - a more highly-trained and specialised cadre of coroners with opportunities for developing the specialised nature of their work
 - greater teamwork and improved communications.
- Using vacancies in the coroner service, such rationalisation should proceed to a regional structure with one or more coroners in each region. As already described, appropriate support should be provided from coroners officers located in such regions. While the Group carefully examined a number of options as to how the regions should be configured and was very attracted to the court regions, further work will be needed to optimise the regional arrangements to

ISSUES (CONT.)

core professions of those involved are very much those of medicine and law rather than coronial. Dublin City is still the only area where, although still part time, the city coroner post approximates to a full professional career.

Economies of scale are difficult to achieve and coroner workloads vary significantly from one district to the other. Different levels of coronial expertise can also produce uneven sets of procedures when such procedures are at the discretion of individual coroners.

At an overall service management level, it is clear that there is no specific management of the strategic direction of the coroner service. Both the Department of the Environment and Local Government and the Department of Justice, Equality and Law Reform carry out certain operational functions but these do not touch on overall strategy for the service. Separate briefs for different parts of the service have resulted in sporadic and reactive change and only then in the face of impending crisis.

RESPONSES (CONT.)

include caseloads, demographic factors, population densities, availability of facilities and physical distances involved.

- Fundamental to the feasibility of the new arrangements is the choice of the organisational engine needed to drive the proposed new vision of the coroner service of the twenty first century. The Group, in recognition of its importance, gave considerable thought to this issue and examined a number of options as detailed in the report. The criteria for choosing an organisation included a requirement to:
 - have a strong management focus concentrated exclusively on the coroner service
 - have its own budget for administration and have an appropriate input into ring-fenced funding arrangements for critical support service
 - have an inbuilt capacity for change management and organisational restructuring of the service
 - constitute a viable organisation in terms of its ability to staff and maintain the appropriate levels of expertise needed to carry out its mission
- While the Group felt that two options were feasible, i.e., establish a separate coroner agency or attach a coroner division to the existing Courts Service, the strong consensus of the Group favoured the establishment of a separate agency dedicated to the coroner service. The Department of Finance were of the view, however, that the coroner service was not sufficiently large to warrant agency status because of the costs involved and that the Courts Service was a better option. This view was not supported by any member of the Group who felt that the level of dedication needed and the extensive and

ISSUES (CONT.)

RESPONSES (CONT.)

prolonged change management process required, favoured a separate agency which would not be subject to competing priorities of attention and resources from such a basic and important service as the courts. The creation of a separate agency was not seen as a barrier to ongoing and productive co-operation with the new Courts Service on a wide range of courts-related issues.

- The new agency would be under the aegis of the Department of Justice, Equality and Law Reform and headed by a Director working to a Board of Management representative of the various interests involved in the coroner service. Agency staff could be seconded from that Department in accordance with the usual practice for small agencies. While the Group acknowledged that it was difficult at this stage to estimate the number of staff needed for the new agency, it anticipated that, in addition to the position of the Director, eight members of staff would be required to enable it to carry out its range of functions as identified in the report.

IMPLEMENTATION

Implementation of the Report's recommendations will take place over an extended period. The speed of evolution of the service towards a regional structure will be a function of the rate at which vacancies occur among coroners.

Notwithstanding this evolutionary change, and indeed perhaps because of it, the importance of a definite, articulated and sequenced implementation strategy is critical. In this regard, the Report sets out the activities which should be pursued immediately and in the short, medium and long term. One of the most important recommendations in this area relates to the appointment of a Director Designate of the coroner service whose task would be to initiate, lead and develop a vision of the new coroner service as outlined in the Report.

ORGAN RETENTION

In view of emerging controversy during the currency of the Group's deliberations relating to the retention of organs and body parts, the Group opted to extend its timescales to permit a more detailed evaluation of this difficult and sensitive issue. Essentially, we point out the importance of differentiating between Post-mortems carried out on the instruction of the coroner and those carried out for other reasons. Consent is not required for coroner Post-mortems but there is an absolute requirement to give the bereaved the right to make choices regarding how, when, and if they wish to be informed about the retention of organs and body parts.

The core recommendations of the Group focus only on Post-mortems ordered by the coroner but we do suggest that coroner and non-coroner cases should be components of the same central dialogue with the bereaved. We recommend the establishment of a designated person by the hospital authorities. Such a person would be specially trained to engage in a structured dialogue with relatives to minimise the distress involved in Post-mortems. At the same time relatives would be given clear choices in relation

to the options involved in the retention of organ and body parts. While it is inevitable that such dialogue may cause additional pain for some families, the right to know and to exercise options at a pre-burial stage, is, the Group believes, sacrosanct.

In addition, the group believes that the circumstances and procedures for the removal, retention and disposition of organs and body parts in post-mortems directed by the coroner should be put on a statutory basis.

LIST OF RECOMMENDATIONS

3.2 THE POSITION OF THE CORONER

3.2.1 Appointment

1. Coroners should be appointed by the Minister for Justice, Equality and Law Reform and should be selected in accordance with arrangements to be devised by the new Coroner Agency with the current entry age to the service of 30 years old being dropped.

3.2.2 Retirement

2. There should be no change in the retirement age for coroners currently set at 70.

3.2.3 Residence

3. The present restriction that coroners should be resident in their districts should be removed.

3.2.4 Deputies

4. Training programme to be devised for coroners should include provision for deputy coroners.

3.2.5 Qualifications

5. While the initial qualification requirements for coroners should not be changed, cessation of practice either as a lawyer or as a medical practitioner should not be a bar to working as a coroner.
6. Reciprocal coroner training programmes should be introduced – legal training for doctors, medical training for lawyers.

3.2.6 Removal from office

7. The existing legal provisions for the

removal of a coroner from office should be retained and extended to include disbarment from practice by a professional body. The full list of situations in which a coroner can be removed from office should be established by the proposed Rules Committee.

8. Procedures governing the right of reply by a coroner in accordance with the rules of natural justice should be put in place.

3.2.7 Flexibility of jurisdiction

9. Concurrent jurisdiction should be introduced for coroners and their deputies for all aspects of coroner work.
10. Where deaths from the one incident occur in different coroner districts, coroners should be empowered to arrange jurisdiction between themselves without having recourse to the Minister. Failure to agree jurisdiction should result in direction from the Minister.
11. The full set of situations where jurisdiction can be transferred should be developed in the proposed Coroners Rules.

3.3 THE CYCLE OF CORONER WORK

3.3.1 General coroner procedures and rules

12. A Rules Committee should be immediately established on acceptance of the report by Government.
13. The Committee should devise Coroners Rules in accordance with the recommendations in this report and on the basis of the Outline Coroners Rules set out in Appendix J.

14. The Committee should be representative of the interests affected by the Rules and should include representatives from:

- The Coroners Association
- The Department of Justice, Equality and Law Reform
- The Faculty of Pathology of the Royal College of Physicians of Ireland
- The Department of Health and Children
- The Office of the Attorney General
- A representative of bereaved persons, such as a bereavement group.

Given the detailed task to be performed by the Committee, the Group felt that the membership should not exceed eight persons.

15. A detailed list of parties to be consulted in drawing up the Rules should be compiled by the Committee.
16. Those drafting and re-writing a new Coroner Act, which will incorporate the introduction of Coroners Rules, should take full advantage to consolidate existing legislation.
17. In the interest of codifying good coroner practice, Best Practice Notes should be devised by coroners with assistance from the proposed new Coroner Agency.

3.3.2 Information provision by the coroner

GENERAL INFORMATION PROVISION

18. A generic information leaflet should be developed as a matter of urgency to clearly explain the coroner service, to identify the rights of relatives and to point to any restrictions placed on them in the course of their contact with the coroner service. The same leaflet should be used to supplement the dialogue recommended in the context

of the arrangement for a designated person. The new leaflet could be modelled on that currently made available by the Dublin City Coroner and should be made available, in the initial phase at least, in coroners offices, hospitals and Garda stations.

19. The generic information leaflet as described above should provide an appropriate insert at coroner district level to identify local support and bereavement groups.
20. The minimum information to be given to relatives at the time of a death, should include the following:
- that the coroner is involved and the reasons for that involvement
 - where a post mortem is to be carried out, the possibility of organ/body part retention to establish the cause of death.
21. A protocol should be developed in consultation and in agreement with all the parties involved in coroner cases, in relation to how, by whom, and when, the leaflet, preference document and other information is to be given to relatives.
22. Relatives should have an automatic right to receive a copy of the post mortem report in cases where no inquest is to be held. The preferred method of issue of such reports would be through a general practitioner.
23. Coroners and their offices should be listed along with other public and State bodies in the telephone book.
24. A coroners' web site should be developed containing a range of information about the coroner service and with appropriate links to other related organisations such as the Department of Justice, Equality and Law Reform and the new Courts Service.

25. As far as is practical the service should be available to people whose first or preferred language is Irish.

CERTIFICATES

26. A revised Coroner's certificate based on the sample suggested by the Office of the Registrar of Births, Deaths and Marriages should be introduced as soon as possible. (A proposed draft form is included at Appendix L)
27. Interim death certificates may be issued by coroners with the backing of statute, as soon as death has been established.

RETENTION OF ORGANS AND BODY PARTS

28. The minimum information to be given to relatives at the time of a death, should also include the following:
- an option to indicate whether or not, before the burial, the relatives wish to be informed in the event that organs have, in fact, been removed
 - the options available for return or disposal of the body parts or organs when the coroner's jurisdiction is ended
 - a reminder to the relatives that coroner law and the need to establish the cause of death governs the retention of organs only until the cause of death has been established
 - advice that any further retention of the organs beyond the coroner jurisdiction for any non-coroner purposes (such as education or research) is a matter to be determined between the relatives and the medical authorities.
29. A formal document for signature by a relative should be designed along the lines of that set out in Appendix K and implemented as part of the proposed structured dialogue.

30. The physical retention of organs and tissues for coroner cases should continue to be carried out by the medical authorities in accordance with any national revised practices currently being worked out by those authorities.

3.3.3 Reporting of deaths

31. Existing categories of reportable death should be extended to include maternal deaths and deaths of "vulnerable persons" as detailed above.
32. The question of further extending reportable deaths should be considered by the Rules Committee.
33. Any obligation to report a death to a coroner which is fulfilled by reporting to the Gardaí should place an equivalent obligation on the Gardaí to proceed to notify the coroner.
34. The reference to the word "anaesthetic" in section 18.4 of the Act should be replaced by the term "any medical or surgical procedure".
35. Liaison between coroners and those responsible for reporting deaths should be improved through training for all relevant parties and the development of best practice procedures.

3.3.4 Issues related to the body of a deceased person

36. Coroners should not be obliged to view the body of the deceased – this should be the duty of the Gardaí, although evidence of viewing can be presented in documentary form unless challenged at an inquest.
37. For bodies within the coroners jurisdiction there should be a statutory requirement for identification of the body by an appropriate person. The coroner must be satisfied in relation to such an identification.

38. The current role of the jury in viewing the body of the deceased should be removed.
39. In circumstances where a coroner permits a doctor to certify a death even when they have not treated them within one month of the death, there should be a statutory requirement on the doctor to carry out an external examination of the body.
40. A duty should be placed on funeral directors to ensure that a certificate of death is procurable or that clearance has been obtained from the coroner to bury the body. Such clearance procedures should be part of the proposed Coroner Rules.
41. New enforcement powers should be given to the Gardaí: (a) to enter a premises in which a body lies and to make investigations in support of the coroners inquiry; (b) to secure possession of a body where they are being prevented from so doing and; (c) to recover possession of a body where it has been removed from a mortuary or morgue without the permission of the coroner.
42. The existing legal provisions regarding the removal of a body from the State should be reworded so as to positively direct that no body should be removed from the State unless approval to do so has been obtained from the coroner in whose district it lies.
43. A coroner should be empowered to request an exhumation from the Minister on his own initiative without first having to be requested to do so by the Gardaí.
- 3.3.5 Post-mortems**
44. There should be a statutory requirement on a coroner to order a post mortem if he is of the opinion that a death has not been due to natural causes.
45. A statutory basis in relation to circumstances and procedures for the removal, retention and disposition of tissues and organs in coroner directed post-mortems should be set out in Coroners Rules.
46. Coroners should be given the power to order a post mortem from the State Pathologist without prior approval by the Minister. The procedures and circumstances governing these special Post-mortems should be established in Coroners Rules as set out in the Outline Coroner's Rules in Appendix J.
47. The Gardaí should also be permitted to request directly the services of the State Pathologist on authorisation by the coroner, who would be obliged to give such authorisation on request of a Garda, not below the rank of Inspector.
48. A post mortem should not be carried out by a pathologist where the coroner considers the pathologists association with the hospital is likely to be called into question at the inquest or is inappropriate. Coroners Rules should be developed to specify the appropriate procedures.
- 3.3.6 Inquests**
- COURTROOM FACILITIES, JURISDICTION OF THE CORONER, VERDICTS, POWER TO MAKE RECOMMENDATIONS**
49. The jurisdiction of the coroner should include the investigation not only of the medical cause of death but also the investigation of the circumstances surrounding the death. This should be expressed in positive terms in the new Coroners Act.
50. Coroners should continue to be disallowed from considering matters for the purpose of apportioning civil or criminal liability.
51. Given clarification on coroner jurisdiction, suicide verdicts should be returned

whenever it has been established beyond a reasonable doubt that a person has taken their own life.

52. Verdicts should reflect both the results of the investigations as to the medical cause of death and the circumstances surrounding a death. Guidelines regarding the reaching and wording of verdicts in general, should be the subject of Coroners Rules.
53. The practice whereby coroners or juries can make general recommendations to prevent further fatalities should be continued.

OBLIGATORY AND DISCRETIONARY ASPECTS

54. Mandatory inquests should be extended to include, at a minimum, situations where the death occurs in Garda custody, prison or workplace and the Rules Committee should review the issue to assess if further extensions are required.

PRE-RELEASE OF DOCUMENTATION

55. Coroners should have discretion with regard to the release of documents prior to an inquest. New legislation, however, should be worded to reflect the idea that documents should be released, save for a number of specifically defined situations to be set out in Coroners Rules. In any refusal of documents, the grounds for refusal should be given to the applicant.

INQUEST WITHOUT POST MORTEM

56. A coroner should be allowed, without the prior approval of the Minister, to hold an inquest on a person whose body has been destroyed and whose death is verified.

INQUEST ADJOURNMENT

57. The criteria for deciding whether or not to resume an inquest which has been

postponed due to criminal proceedings should be specified in Coroners Rules.

58. The current legal arrangements whereby details of the outcome of criminal proceedings are conveyed by the courts to the coroner should be implemented in practice and should include the names of deceased and where they died.
59. The appropriate systems should be in place to ensure that the Courts inform the coroner when criminal proceedings are concluded.

WITNESSES

60. There should be no restriction on the extent to which coroners can call medical witnesses.

DISQUALIFICATION FROM CARRYING OUT

INQUEST

61. The range of circumstances under which a coroner can be disqualified from holding an inquest should be set out in Coroners Rules.

ENSURING ATTENDANCE AND PRODUCTION OF

DOCUMENTS

62. Fines for failing to respond to coroner summons to attend should be increased substantially to at least £1,000.
63. A summons to attend should be capable of being delivered by registered post in addition to delivery by the Gardaí.
64. Powers, including witness attendance and document production, should be given to the coroner to apply to the High Court to seek compliance with their directions. These powers should be based on the Tribunal of Enquiries (Amendment) Act, 1979 and the Committees of the Houses of

the Oireachtas (Compellability, Privileges and Immunities of Witness) Act, 1997.

ANONYMITY OF WITNESSES

65. Anonymity of witnesses should be confined to two specific cases where state or personal security is involved. The coroner should be given this limited statutory authority which should be exercised in accordance with the rules of natural and constitutional justice.

IMMUNITY OF CORONERS

66. General statutory immunity in line with other judicial persons should be given to coroners provided they are acting bone fide and within jurisdiction.

JURIES – OBLIGATORY USE

67. The current provisions regarding obligatory juries should be retained, with the exception of routine traffic accidents which should be at the coroner's discretion.
68. Other obligatory uses of juries should be developed under the proposed new Coroner's Rules.

JURIES – GENERAL

69. A jury should have an odd number of jurors and should range from 7 to 11.
70. A simple majority verdict should continue to be acceptable in all cases.
71. The coroner should be given access to the list of empanelled jurors required to attend the circuit court.
72. A different jury should be capable of being used where an inquest has been adjourned at which only evidence of identification has been taken and medical evidence has been given.

MEDIA REPORTING

73. An appropriate code of practice should be adopted by the media to govern inquest reporting.

RECORDING

74. Full recording of complex inquests should be facilitated on the certification of the coroner.

3.3.7 Review of coroner decisions

75. Without prejudice to the role of judicial review for all parties in all aspects of the coroner system, an application for a review should be provided to the Attorney General in relation to a specified range of situations arising from a decision by a coroner. These situations should include:
- where a coroner concluded that death was due to natural causes and issues a certificate to the Registrar of Births and Deaths following the reporting of a death
 - where a coroner decided not to proceed with a post mortem
 - where a coroner decided not to proceed with an inquest
 - where new evidence likely to change the original verdict has emerged
 - where disagreement exists over a coroner's procedural handling of a first inquest
 - where relatives or other interested parties were not satisfied with the verdict at a first inquest
 - where a coroner himself wishes to initiate a review.
76. The Attorney General, having carried out an initial assessment of whether or not any of the above applications for review is

frivolous or vexatious, should refer the application for review to a Review Board who, using procedures to be set out in the proposed Coroner's Rules, will advise the Attorney General in relation to whether or not a first or second inquest or enquiry is to take place. The final decision on the holding of such an inquest or enquiry would be a matter solely for the Attorney General.

77. The proposed Review Board should consist of three members as follows:
- a member of the Bar of Ireland or Law Society of Ireland
 - a member of the staff of the Attorney General
 - a member of the Irish Coroners Association.
78. The range of recommendations which can be made to the Attorney General should include the following:
- that a first inquest or inquiry be held and the review granted
 - that a second inquest or inquiry should be held and the review granted
 - that no further inquest or enquiry should be held and the review refused.
79. Coroners should be permitted to make a consultative case stated subject to consultation with the Attorney General and subject to any constraints specified in the Coroner's Rules.
80. There should be no time bar on any application for review to the Attorney General subject to any statute limitations set by legislation.

3.4 ORGANISATION AND MANAGEMENT

3.4.1 Organisation and numbers

81. The number of coroners should be reduced over time evolving to a regional structure with one or more coroners in each region.
82. A programme of rationalisation should be commenced with vacancies being used to progress to such regional structure as early as possible.
83. The issue of existing acting posts should be addressed as soon as possible in the context of evolution to the new arrangements.

3.4.2 Personnel Infrastructure

84. A new post of coroner's officer should be introduced at regional level to act as a general support to both coroners and relatives.
85. Detailed functions should be determined by the introduction of the post on a pilot basis but should be generally based on the parameters as set out in Section 3.4.2. of the report.
86. There should be one post per region at around higher executive level (civil service) with appropriate administrative support. Recruitment should be from the wider public service.

3.4.3 Critical support services

87. The present informal system for providing pathology services to coroners should be discontinued and such services should be made available as of right to coroners.
88. Support for regional coroners' officers should be provided in conjunction with facilities emerging from the development and improvement of the new Courts Service.

3.4.4 Histology and toxicology

89. The turnaround time for toxicology reports must be significantly improved by an appropriate and immediate investment in the provision of these services.
90. The turnaround time for histology reports should be improved by the inclusion of this aspect in new revised guaranteed arrangements for delivery of pathology services.
91. While the Group do not wish to interfere with the market forces supplying such services, the most pragmatic and immediate response to this issue is, at least in the short term, and in the absence of other providers, best served by additional funding for the State Laboratory service.
92. A centre of excellence should be maintained in this area and is best provided by the State Laboratory.

3.4.5 Post mortem facilities

93. Existing mortuary and post mortem facilities should be urgently upgraded on a planned basis having regard to the need for the distribution of such facilities throughout the country.
94. Upgrades should be carried out to the appropriate standards applying to the various types of facilities involved.

3.4.6 A new coroner agency

95. A new agency should be established to be known as Central Coroner Services (CCS) to reflect the core concept of service to both coroners and the public and its central role in relation to the future shaping of the new service.
96. The range of functions of the new body should include:

- routine processing of coroner salaries and expenses
- devising an optimum regional structure for the new coroner service
- arranging and implementing pilot projects to establish the best way of implementing the various staffing and structural recommendations of the Group
- providing an appropriate input into guaranteed arrangements for core coroner services
- developing co-operative measures with the Courts Service
- supporting the implementation of Coroner's Rules
- supporting and developing a high quality of service
- encouraging and facilitating best practice procedures
- preparation and implementation of training programmes for coroners
- information dissemination
- coroner liaison with other relevant statutory and non-statutory groups
- liaison with Department of Health and Children on general hospital refurbishment programme
- processing of industrial relations issues
- budget negotiation and management
- developing and co-ordinating role of coroners in disaster planning
- supporting and encouraging the use of information technology
- supporting and developing a national information system for coroners

- producing an annual report for presentation to Government on general coroner activities and progress achieved in restructuring the service.

97. The new agency should be headed by a Director who would have statutory responsibility for the operation of the entire coroner service. Staff would be seconded from the Department of Justice, Equality and Law Reform in accordance with the usual arrangements for this kind of agency. The level of the Director designate should be sufficiently high to reflect the importance of the post. The number of staff required for the Agency should be commensurate with its range of functions and is estimated at nine as set out in the Report.

98. The Director would report to a Management Board consisting of representatives from the following:

- Coroners Association of Ireland
- Department of Justice, Equality and Law Reform
- Department of Health and Children
- Courts Service
- Faculty of Pathology, R.C.P.I.
- An Garda Síochána
- The general public

3.4.7 Industrial relations issues

99. The implementation of the Group's recommendations should go hand in hand with addressing any consequent industrial relations implications.

3.4.8 Financing the new service

100. Funding relating to the administration of the coroner service supplied currently by the local authorities should be moved into

the control of the proposed new central coroner agency in accordance with the outcome of discussions between the relevant Departments.

101. Dedicated funding to upgrade mortuary and post mortem facilities should be provided and ring-fenced so as to remove such funding from other demands relating to health-related services.
102. Close liaison should be maintained with the Department of Health and Children to ensure compatibility between the activities of the central coroner agency and that Department's general hospital programme.
103. The new coroner agency should be allocated the function of providing an appropriate input into the guaranteed arrangements for all core coroner services.

3.5 MISCELLANEOUS

3.5.1 Treasure trove

104. Reference to the coroner's function in relation to treasure trove should be deleted from any future coroner legislation.

3.5.2 Definitions

105. Current references to the Medical Practitioner Act should be updated.
106. Post mortem examinations should be defined as three cavity examinations carried out by qualified pathologists or a trainee under their direction.
107. Interested parties should be defined.

4. IMPLEMENTATION

Some of the measures recommended for the implementation phase have already been identified elsewhere in the report. Those not mentioned include the following:

- 108. To facilitate the early implementation of the Group's recommendation, it is suggested that the Director designate be appointed to oversee preparation for the new service in advance of the introduction of the legislation to establish the new agency.**
- 109. In conjunction with the appointment of the Director designate, an Implementation Committee with the same representation as suggested for the Management Board should be appointed to assist the Director in preparing for the new agency.**
- 110. Advance legislation should be prepared to:**
 - (a) revise the existing section 38 in particularly in so far as it relates to the compelling of witnesses to attend at inquests and;**
 - (b) provide for the amalgamation of districts beyond county level.**

1	Background and History	22
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1. BACKGROUND AND HISTORY

1.1 ESTABLISHMENT OF GROUP

The coroner service is one of the oldest public services in existence with the earliest references to the position going back to the twelfth century. The main duty of the coroner was to protect the interests of the Crown in criminal cases and thus the name coroner. Its evolution over time is obviously outside the scope of this brief introduction but the position of coroners as last determined in the Coroners Act 1962, now stands as one of significant importance in today's society. The passage of almost forty years has, however, involved societal changes which have transformed almost every aspect of life and, indeed, death to the point where a comprehensive review of this important aspect of public life is warranted.

Apart from the real requirement to review the coroner service as a whole, the Government's commitment to regulatory reform also identified the 1962 Act as in need of review and in accordance with the commitment contained in the Department of Justice, Equality and Law Reform's Strategy Statement 1998 – 2000, a Working Group was established by the Minister to examine the role of the service, its needs and the appropriate framework for its development. The inaugural meeting of the Group took place on 17 December, 1998 and the deliberations of the Group extended over a period of 19 months. A total of 20 plenary sessions involving 115 hours of deliberations were held. Four sub-groups had a total of 37 meetings accounting for a further 103 hours of deliberation. A full membership list of both plenary and subgroups is given in Appendix A.

1.2 METHODOLOGY

The full range of coroner issues were categorised and listed under the three headings of 'legal', 'organisational' and 'service'. A subgroup was

then formed under each category to study the specific issues. Separate Chairpersons were appointed by each group and individual group reports were drafted, discussed and ultimately agreed by the plenary group. A further subgroup was established to consider the issues related to organ and body part retention and disposal. This subgroup was chaired by the Chairman of the plenary group and reported back to the main group.

Invitations for submissions to the Working Group were publicly advertised in February, 1999 and a total of 82 submissions were received. The Group also heard a further 6 detailed oral presentations. A full list of those who made submissions is shown in Appendix C.

The Group held a one-day workshop with visiting coroners from England, Wales and Canada along with the State Pathologist, his Deputy and some invited guests from the Coroners Association of Ireland.

1.3 HISTORY

Given the coroner's historic interest in protecting the property of the "Crown" and given that violent deaths would often bring revenue to the Crown, one of the coroner's most important duties was to inquire into unnatural deaths. Since the disposal of the deceased's property could well be affected by the status of the deceased and the precise conditions surrounding the death, the coroner's office became intimately concerned with the overall investigation of suspicious deaths. The identity of the deceased was always fundamental. The coroner had to view the body at the place of death, if possible. Inquests were held with juries in the presence of the body. Although the coroner had no authority to act as a judge, it appears that he did often try criminal cases.

As the financial connotations of sudden death gradually relaxed, or were diverted to other offices, the position of coroner declined until it was revived in the middle ages. At that time the coroner's attention was specifically directed to the establishment or exclusion of criminality, a principle that persisted until the 19th century. Gradually, with changing conditions, the importance of the coroner's fiscal duties declined and the holding of inquests on unnatural deaths became for all practical purposes his only function. Stemming from the Coroner's mediaeval duty in protecting the financial interest of the Crown he had also a range of other obscure functions, one of which – determining treasure trove – has lasted to present day legislation.

1.4 DEVELOPMENT TO MODERN TIMES

The modern coroner came into being with the Coroners (Ireland) Act, 1846, which consolidated the law relating to the Coroner and his duties in Ireland. It provided for the division of each county into coroners' districts and for the election and appointment of coroners and their payment by means of a fee. At this time, the only qualification for appointment was that of property. The Coroners Act, 1881 took a more scientific approach and insisted on the qualification of being either a duly qualified medical practitioner, barrister or solicitor.

As the history of the coroners evolved, their executive functions – including their duties to have regard to the financial interests of the Crown – became steadily less important and their judicial functions steadily more important. Today, the role of the coroner has developed to the point where he may be considered to have a range of duties involving investigatory, administrative, judicial, preventative and educational functions, it may be worth pointing out even at this early stage of the report that the coroner does not investigate criminal or civil responsibility, a fact much misunderstood by the public.

In essence, today's coroner provides a service for the benefit of the community as a whole which focuses on establishing in the case of sudden and unexpected death, the identity of the deceased, where death took place, and the cause of death. As we shall see later in this report, the element of determining the cause of death has been a major issue in the evolution of the role of the coroner in modern times. It is a difficult job carried out mostly on a part time basis by people who are either doctors or lawyers. Job pressures are growing and with increasing education and awareness, coroners find their work is subject to greater scrutiny by a public that is becoming more conscious of its legal rights and entitlements. As with all aspects of the public service, high standards are being demanded and the coroner service has come to a critical cross-roads in terms of separating from its past and facing the challenge of taking its place in the modern public service of the twenty-first century.

1.5 CURRENT STRUCTURES

Responsibility for the various services of coroners is spread across a number of organisations: the Department of Justice, Equality and Law Reform is responsible for the legislation and policy; the Department of the Environment and Local Government through the local authorities has responsibilities for appointment, salaries and fees; and the Department of Health and Children fund the pathology services and post mortem facilities provided through the health agencies, which are used by the coroners. In the major urban centres, local authorities also have responsibility for the provision of municipal mortuary facilities.

Currently, there are 48 coroner's districts. Each of these districts has a coroner and a deputy coroner who acts for the coroner during the formers' absence or illness. All coroners must either be registerable medical practitioners or practising solicitors or barristers for five years. Approximately half of the present coroners are doctors and the remainder are solicitors or barristers. All coroners work part-time and their

case loads vary considerably. Coroners are paid a basic fee based on the size category of their district and then earn fees for different aspects of their coroner work. There are approximately 32,000 deaths annually in Ireland of which approximately 7,250 are reported to coroners. The coroner's jurisdiction is limited to the district to which he was originally appointed and within which he must reside. Districts are contained within a local authority area. (see Appendix H)

With the exception of the Dublin City Coroner and to some extent the Cork City Coroner, coroners do not have dedicated premises or staff and usually work out of their practice office. Courthouse facilities are used for the holding of inquests. This is not always possible, however, and anything from local halls to hotels are sometimes used. Pathology services are provided by the hospital authorities but coroners are in competition with other demands on this service.

The High Court is the body which judicially review the acts of coroners. Coroner immunity is set by precedent. In line with this, a decision in a recent case (see case D, Appendix G) found that a coroner enjoys the same 'absolute privilege' as a judge would, where he is performing the duties of his office. This is to enable the coroner to administer the law freed from the concern that he would be answerable for his actions, yet not impinging on the individual's constitutional rights.

Although not anchored in statute, there is currently a *de facto* indemnity arrangement in operation by which a coroner is indemnified by the State in respect of an order of costs or an award of damages made against him, subject to provisos in relation to his acting within his legal powers. Coroners are represented as a body by the Coroners Association of Ireland.

1.6 THE OFFICE OF THE CORONER

The Coroner performs a public service by making enquiries into sudden and unexplained deaths independently of the medical profession, the Gardaí, the State or any parties who might for whatever reason have an interest in the outcome of death investigation. In essence, this reflects not only the reassurance given to society by such independent action but also mirrors the great value placed on life itself by our Constitution. In other words, society is demanding that no death be left uninvestigated unless there is a clear and certifiable reason for that death. The office of coroner recognises that formal investigation should not be confined to homicides, manslaughter and the more obvious ways in which sudden death occurs but that a whole range of circumstances exist where unexplained death needs a process of public recording in the general interest of society.

The coroner is, therefore, an independent office holder who operates in the public interest in a judicial capacity co-ordinating the medico-legal investigations into certain deaths. A coroner must inquire into the circumstances of sudden, unexplained, violent and unnatural deaths. This may require a post-mortem examination, sometimes followed by an inquest. The coroner's inquiry is concerned with establishing whether or not death was due to natural or unnatural causes. If a death was due to **unnatural** causes then an inquest must be held. If the coroner's inquiries ultimately end up with the holding of an inquest, then it must be remembered that a coroner's court is an inquisitorial court rather than an adversarial one. There are no "parties" in the coroner's court and all depositions, post-mortem reports and verdict records are preserved by the coroner and are available to the public. The coroner may summon a jury and may call witnesses but all these court-like aspects still focus on the establishment of the facts and not on apportioning guilt or blame. As Lord Lane pointed out:

"..... an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are not suitable 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 the facts. It is an inquisitorial process, a process of investigation quite unlike a trial...."

(Lord Lane C.J in R v South London Coroner, ex parte Thompson (1982), 126 S.J. 625)

1.7 THE CORONER CYCLE

Notification

The reporting of a death triggers the coroner's involvement. Although at common law anyone can report a death to a coroner, (or indeed to the Gardaí, which has the same effect) the legislation sets out who should report a death and what kinds of death should be reported, for example, doctors, funeral undertakers, people in charge of premises or institutions in which someone dies should report a death. Sudden and unexpected deaths, homicides, suicides, death from unknown causes, death during an operation are all examples of reportable deaths.

A coroner will generally not be involved where a person died from some natural illness or disease for which he was being treated by a doctor within one month prior to death. In such a case the doctor will issue the medical certificate of the cause of death, and the death will be registered accordingly.

Once a death has been reported a cycle starts from which an exit can be made at different points. In the simplest case a coroner's inquiries confirm that the death was in fact natural and he issues a certificate to the Registrar of Births and Deaths who in turn issues a death certificate. In carrying out his investigation the coroner is

assisted by the Gardaí who act as coroner's officers. This accounts for the appearance of the Gardaí in situation where no blame or suspicion arises such as sudden infant death. Garda assistance can vary from arranging a formal identification of the body and outlining the circumstances of the death to much more detailed support if an investigation goes all the way to a formal inquest.

The post-mortem

If the death is not immediately explicable, the coroner may order a post-mortem to help establish the cause of death. The post mortem examination (sometimes referred to as an autopsy and referred to in this report as 'the post mortem') is a procedure almost always carried out by a specially trained doctor, a pathologist. When performing a coroner's post-mortem, the pathologist is acting independently of the hospital as an officer of the coroner. post-mortem examinations are carried out in hospital facilities and although the examination typically requires only two to three hours to complete, it usually involves retention of tissue and may involve retention of organs for detailed laboratory examination. It is usually therefore be some weeks or months before a post-mortem report can be completed.

If the results of the post-mortem disclose the cause of death to be of natural causes, a coroner's certificate will issue at that stage. It should be noted that the final output from the coroner system is the issue of a final coroner's certificate so that a death certificate can issue. Since the cycle of investigation can take some time, interim certificates are issued at any time after death has been established.

If a coroner is still unable to establish the cause of death he may decide to proceed to an inquest. It is important to note that he **must** hold an inquest if he believes that the death occurred in a violent or unnatural manner or suddenly and from unknown causes. However, in the case of death

occurring suddenly and from unknown causes a post-mortem may suffice in lieu of an inquest.

In the case of obvious violent death, say through homicide, a special post-mortem may be carried out by the State Pathologist. These Post-mortems require the approval of the Minister for Justice, Equality and Law Reform and are requested by the coroner, usually at the instigation of the Gardaí.

The body of the deceased is normally released to the spouse or next of kin immediately after the post-mortem examination has been completed. Funeral arrangements can then be made, but cremations cannot take place until the appropriate coroner's certificate has been issued.

The inquest

When the investigation of a death goes to a formal inquest, the process moves to a primarily judicial phase. The inquest is concerned with establishing the facts of a death, namely when where and how death occurred. No one is found guilty or innocent. No criminal or civil liability is determined. There are no "parties" and only the coroner can call witnesses. Documentation is not automatically made available before the inquest hearing although the coroner has discretion to provide same, if circumstances warrant it. In other words, the emphasis is on an inquisitorial process rather than an adversarial one, on fact-finding as opposed to liability assignment.

In other ways the coroner's court can resemble a traditional court. A jury is empanelled in some but not all cases, (although the process is less structured than in the adversarial courts) witnesses are summoned, the coroner enjoys certain levels of immunity and is indemnified from costs awarded against him, he can cite for contempt, and witnesses can be compelled to attend and those attending can have their own legal representatives. But for all its similarities, it is fundamentally an inquisitorial court of public record and any insight into the coroner system

must be based on this core understanding.

As with any system of proceedings various procedures come into play when an inquest is to be held. Notice must be given, depositions may be prepared and arrangements made to have all the necessary parties attend. The inquest can be adjourned for a number of reasons principally when criminal proceedings are pending. Over the years, based on practice and in some cases legislation, detailed procedures have been used to determine a very wide range of practices covering every aspect of conducting inquests and some of these procedures are, in fact, the subject of discussion in this report.

When the proceedings have been completed a verdict is returned in relation to the identity of the deceased and how, when and where the death occurred. The range of verdicts open to the coroner or jury (in jury cases it is the jury which returns the verdict) include accidental death, misadventure, suicide, open verdict, natural causes, and in certain circumstances, unlawful killing. A general recommendation designed to prevent similar deaths occurring may be made by the coroner or jury. When the inquest is completed the coroner issues a certificate so that the death can be properly registered and thus the coroner cycle is at an end, although the coroner often continues to be involved in other related administrative matters. A diagram illustrating the coroner cycle is shown in fig A over.

2	International Practice and Experience
2.1	INTRODUCTION
2.2	ENGLAND AND WALES
2.3	NORTHERN IRELAND
2.4	SCOTLAND
2.5	AUSTRALIA
2.6	NEW ZEALAND
2.7	HONG KONG
2.8	CANADA
2.9	USA
2.10	GERMANY
2.11	SWITZERLAND
2.12	THE IRISH PERSPECTIVE

2. INTERNATIONAL PRACTICE AND EXPERIENCE

2.1 INTRODUCTION

In accordance with its terms of reference, the Working Group examined coroner services, or their equivalent, in other jurisdictions.

Although not always referred to as coroner systems, most countries have some form of system which investigates sudden or unnatural death. Some countries are quite comparable to the Irish system while others differ greatly in their procedures and practices. Comparisons are therefore difficult and care is needed in examining and evaluating experience in other jurisdictions. Even within the United Kingdom systems vary greatly although the common law base is useful in examining different approaches. The Group examined the systems in place in the following jurisdictions:

- England and Wales
- Northern Ireland
- Scotland
- Australia
- New Zealand
- Hong Kong
- Canada
- USA
- Germany
- Switzerland.

The following is a brief overview of the coroner system, or its equivalent, in these jurisdictions identifying particular points of interest in relation to comparison with the Irish system. More detailed material is available on www.irlgov.ie/justice

The Working Group were very pleased to meet with, and be informed by, visiting coroners from the Coroners Association of England and Wales and the Ontario Coroners Association, Canada, at its workshop of 14 May, 1999.

2.2 ENGLAND AND WALES

Coroner law in England and Wales is derived from: (a) common law, i.e. decisions of the High Court and Court of Appeal and; (b) statute, i.e., the 1988 Coroners Act and the 1984 Coroner's Rules.

The service is provided on a local basis (although coroners are appointed for the whole area of Wales rather than on a specific district basis) and the size and composition of coroners' districts and caseloads vary greatly. There are approximately 140 different coroners' districts in England and Wales. At present, there are 26 whole-time coroners who are paid an annual salary. The remainder are part-time with pay based on the number of cases they handle. Responsibility for the running of the coroner service is shared between the Home Office, the Lord Chancellor's Department and local authorities.

In England and Wales, a coroner is not an employee but an independent judicial officer. As in the Irish system, a coroner is either a barrister, solicitor or medical practitioner of not less than five years standing. A coroner must appoint a deputy to act in his place if he is out of the district or otherwise unable to act. Deputies need to have the same professional qualifications as the coroner.

System of review

While in the exercise of his duties and powers, the Coroner is subject to judicial review, there is no appeal from the verdict of an inquest. However,

should a coroner refuse or neglect to hold an inquest which ought to be held, a person with sufficient interest in the refusal of a coroner to hold an inquest may apply for judicial review of that decision. In addition, the Attorney General, or any other interested person authorised by him, may apply to the High Court, which, if satisfied that the coroner is refusing or neglecting to hold an inquest which should be held, may order an inquest to be held, either by that coroner, or by another. The High Court may also order the coroner to pay such costs of and incidental to the application as seem just. Section. 13(1) of the Act of 1988 states:

“where on an application by or under the authority of the Attorney-General, the High Court is satisfied as respects a coroner...either –

- (a) that he refuses or neglects to hold an inquest which ought to be held; or*
- (b) where an inquest has been held by him, that (whether by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new facts or evidence or otherwise) it is necessary or desirable in the interest of justice that another inquest should be held.”*

Accordingly, under the circumstances set out in section 13(1)(b), the High Court may order another inquest to be held.

Jurisdiction

The British Committee on Death Certification and Coroners (the Brodrick Committee), in its Report of November 1971, identified that the purposes of the coroner’s inquest are:

- to determine the medical cause of death
- to allay rumour or suspicion
- 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.

The English Court of Appeal has referred to a passage of the Brodrick Report as follows:

“...the function of an inquest should be simply to seek out and record as many of the facts concerning the death as the public interest requires, without deducing from these facts any determination of blame”.

The coroner’s jurisdiction to consider questions bearing on civil or criminal liability has not been the subject of litigation in England and Wales to the same extent as in Ireland. The chief reason for this probably is the wording of rules 36 and 42 of the Coroner’s Rules, 1984. Rule 36 provides that the proceedings and evidence at an inquest shall be directed solely to ascertaining who the deceased was, how, when and where he came by his death, and the particulars required for registration. Rule 42 provides that no “verdict shall be framed in such a way as to appear to determine any question” of criminal liability on the part of a named person, or civil liability. This can be contrasted with the wording of section 30 of the Irish Act of 1962, which states that questions of civil or criminal liability shall not be considered or investigated at an inquest. The focus in the English statutory provision is the prohibition of verdicts which determine questions of civil or criminal liability while in Ireland a much higher standard of prohibition of consideration or investigation of such questions exists.

It should not be assumed that the English legislation has been unproblematic. The focus of judicial review in the English coroner system has shifted to the examination of verdicts attributing death to lack of care or unlawful killing, and carrying an imputation of blame. It has been established that a verdict of death due to lack of care or neglect cannot be returned within the confines of the Act of 1988. By contrast, in the

Irish system, section 56 of the Irish Safety, Health and Welfare at Work Act, 1989, empowers the coroner to consider whether neglect has caused or contributed to the death.

Coroner's Rules and Best Practice Notes

Coroner's Rules and Practice Notes form part of the English and Welsh systems. They are useful in assisting the coroner in carrying out his duties and they help to standardise and bring uniformity to the office. No such rules or guidelines for best practice exist in the Irish system.

Coroners' Officers

Another interesting feature of the system in England and Wales is the role played by coroners' officers in each district. These officers support the coroner in his work by acting as a liaison between the coroner and other interested parties in each coroner case. In most districts, coroners' officers are provided by the local police authority and their work includes an investigatory function into the death.

2.3 NORTHERN IRELAND

The coroner system in Northern Ireland is part of the court system and is regulated by the 1959 Coroners Act, the 1963 Coroners Practice and Procedure Rules (Northern Ireland) and by common law.

Northern Ireland is divided into seven coroners' districts, each with a coroner and a deputy coroner. Coroners in Northern Ireland are appointed by the Lord Chancellor, who also has the power to appoint a coroner's officer. There are no statutory disqualifications to appointment to the office of coroner. However, the terms of appointment for the Greater Belfast district provide, *inter alia*, that he may not practice either directly or indirectly as a barrister or solicitor. Only solicitors and barristers are eligible to become coroners and in practice, all of the coroners appointed in Northern Ireland since 1959 have been solicitors.

Support services/coroners' officers

Only the full-time coroner for Greater Belfast is provided with clerical staff and office accommodation, part-time coroners must make their own arrangements.

Although the Lord Chancellor is empowered by the 1959 Act to appoint coroners' officers to assist coroners, no such appointment has been made in recent years. This has resulted in the police in Northern Ireland carrying out many of the functions undertaken by the coroners' officers in England and Wales.

Discretionary inquests

An interesting feature of the Coroner system in Northern Ireland relates to the holding of inquests. Unlike the system in the Republic of Ireland and in England and Wales, where a coroner is obliged to hold an inquest in certain circumstances of death, the coroner retains a discretion to do so in the Northern Ireland. Because a decision not to hold an inquest may be judicially reviewed, the coroner should be able to demonstrate that his discretion has been exercised reasonably.

Juries

Under the Coroners Act of 1959, a coroner must hold an inquest with a jury only where it appears to him that there is reason to suspect that the death occurred in prison, or that the death was caused by an accident, poisoning, or disease which must, under statute, be notified to certain officials, or that the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public. Otherwise the coroner has a discretionary power to require a jury at inquest. Jurors are selected according to the provisions of the Juries (Northern Ireland) Order 1996.

Verdicts

Unlike in the Republic, it is interesting to note

that in Northern Ireland there is no provision for a coroner to accept a majority verdict and all members of the jury must agree upon their verdict. Failure to reach a unanimous verdict will lead to the discharge of the jury. The requirements relating to the inquest verdict are provided for in Rule 22(1) of the 1963 Rules, according to which the coroner or the jury, after hearing the evidence, shall give a verdict in writing, which shall be confined to a statement of the matters set out in Rule 15, namely, who the deceased was, how, when and where he came by his death, and the particulars required for the formal registration of death. Most specific verdicts, e.g. death from natural causes, open verdict, were abolished by the Coroners (Practice and Procedure) (Amendment) Rules (Northern Ireland), 1980, and were replaced by “findings”. No guidance was provided as to the nature of the “findings”. Since 1980, the jury at an inquest in Northern Ireland is no longer entitled in law to make any recommendations with its findings.

Power of the Attorney General to order an inquest

Section 14 of the 1959 Coroners Act empowers the Attorney General to direct a coroner to hold an inquest where the Attorney General has reason to believe that a death has occurred in circumstances which make the holding of an inquest advisable. It appears that this decision has been rarely exercised.

Organs and tissues

The Human Tissue Act (Northern Ireland), 1962 makes provision for the use of a body, or parts thereof, for therapeutic purposes and for medical education and research. Section 1(1) provides:

“If any person, either in writing at any time or orally in the presence of two or more witnesses during his last illness, has expressed a request that his body or any specified part of his body be used after his death for therapeutic purposes or for purposes of

medical education or research, the person lawfully in possession of his body after his death may, unless he has reason to believe that the request was subsequently withdrawn, authorise the removal from the body of any part or, as the case may be, the specified part, for use in accordance with the request.”

If the deceased has expressed no such request, section 1(2) permits the person lawfully in possession of the body to authorise the removal of any part thereof provided, having made such reasonable enquiry as is practicable, he has no reason to believe either that the deceased had expressed an objection to his body being dealt with after his death, and had not withdrawn it, or that the surviving spouse or any surviving relative of the deceased objects to the body being so dealt with.

The Anatomy (Northern Ireland) Order, 1992 makes similar provision for the use of bodies of deceased persons, or parts thereof, for anatomical examination. Where the death has been reported to the coroner, the body may not be interfered with in any way without his consent. The removal of organs or other tissues from the body of a deceased person under these provisions is therefore subject to the consent of the coroner. Indicative of the circumstances which may prompt a coroner to refuse consent to organ donation are the following:

- the coroner is aware that there may be later criminal proceedings in which the organ may be required as evidence
- he believes that the removal of an organ might impede his own further enquiries
- he has reason to believe that a defect in the organ itself was the cause, or contributory cause, of death.

2.4 SCOTLAND

In Scotland, the Procurator Fiscal’s role is comparable to the coroner as the investigator, in the public interest, of certain deaths. However he

does not preside over the court hearings which are conducted by the Sheriff in whose district the death took place.

A report of a relevant death is made to the Procurator Fiscal (PF), who investigates and, if necessary, reports to the Crown Office, which decides whether an inquiry should be held. These are known as fatal accident inquiries.

In practice, the police do the initial detailed investigation of the death on behalf of the PF. In cases which require pathology tests, pathologists report to the PF. Where the results of these tests show that the death was from natural causes, the pathologists issue a death certificate. Where any doubts remain, a fatal accident inquiry is held.

Fatal accident inquiry

The circumstances in which such an inquiry may be held and the procedures to be followed are regulated in the Fatal Accidents and Sudden Deaths inquiry (Scotland) Act, 1976 and the Fatal Accidents and Sudden Deaths Inquiry Procedure (Scotland) Rules, 1977. The fatal accident inquiry is conducted before a Sheriff, whose status is equivalent to that of an Irish Circuit Court judge. It is held in public with no jury and all interested parties can give evidence and have the right to question witnesses. An inquiry is seldom held if there is a likelihood of criminal proceedings arising from the death. The Sheriff's deliberations cannot be used in evidence in any future actions.

Fatal accident inquiries are mandatory where the death has resulted from an accident at work, or has occurred while the deceased was in legal custody. Otherwise, an inquiry will only be held if the death is sudden, suspicious or unexplained and deemed to be in the public interest. Fatal inquiries are not held in suicide cases and only in road traffic accidents in very limited Circumstances

2.5 AUSTRALIA

Australia is a federation of six States and several Territories. Each State or Territory has its own

Constitution as well as its own set of statutes and common law. For coroner purposes, the smaller Territories are linked to the appropriate State jurisdiction, or where size and population warrant it, have their own coroner's court and associated offices. The various State coroner statutes vary in detail, but follow a common form inherited from English coroner law. Some jurisdictions have State coroners who are senior judicial officers, with subordinate coroners reporting to them from the geographic periphery. All State coroners are required to have formal qualifications in law.

Jurisdiction

The Western Australian Coroners Act, 1996, the most recent Coroner Act in Australia, provides that a coroner investigating a death must establish, if possible, the identity of the deceased, how death occurred, the cause of death, and the particulars needed for death registration. The Act of 1996 specifically empowers a coroner to comment on any matter connected with the death, including public health, safety, or the administration of justice. However, a coroner "must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence" (section 25).

The Victorian Coroners Act, 1985, similarly states that a coroner investigating a death must find, if possible, the identity of the deceased, how death occurred, the cause of death, the particulars necessary for registration of the death and the identity of any person who contributed to the death. The Act of 1985 further prohibits a coroner and /or jury from including in a finding or comment a statement that a person is, or may be, guilty of an offence, but the Act is silent on imputations of civil liability (sections 19 and 55).

Appeal to a Superior Court

The Victorian Coroners Act, 1985, provides that the Supreme Court may declare some or all of the findings of the inquest void and may order a new

inquest or the reopening of the original inquest (section 59.2). The Western Australian Coroners Act, 1996, provides that any person may apply to the Supreme Court for an order that some or all of the findings of an inquest are void. The Supreme Court may make such an order and may order a new inquest or the reopening of the inquest, if satisfied that it is necessary or desirable because of fraud, considerations of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry, that it is desirable because of new facts or evidence, or that the findings are against the weight of the evidence (section 52).

2.6 NEW ZEALAND

The Coroner system in New Zealand is regulated in statute by the Coroners Act, 1988, which was subsequently amended by the Coroners Amendment Act, 1996.

The Coroners Act, 1988, provides that a coroner holds an inquest for the purpose of establishing, so far as is possible, that a person has died, that person's identity, when and where s/he died, the causes of the death and the circumstances of the death (section 15). If the coroner to whom a death should be reported is unavailable to act, or the office of coroner is vacant, the death must be reported to a Justice.

Review of Coroner's decisions

Section 38 of the New Zealand Coroners Act, 1988, provides that the Solicitor General may order an inquest (or another inquest) to be held, if satisfied that since the inquest (or the decision not to hold an inquest), new facts have been discovered which make such an order desirable.

Appeal to a Superior Court

Under section 39 of the same Act, the Solicitor General may apply to the High Court for an order for a post-mortem examination of a body to be performed, where a coroner has failed or refused to authorise its performance. The 1988 Act also

allows the Solicitor General to apply to the High Court for an order for an inquest to be held into any death, which shall order one if satisfied that an inquest is necessary or desirable and the coroner has failed or refused to hold one, or that an inquest has been held but that by reasons of fraud, rejection of evidence, irregularity of proceedings, or discovery of new facts, or for any other sufficient reason, another inquest is to be held. This provision, in section 40, gives wide powers to the High Court to order an inquest, on application by the Solicitor General.

2.7 HONG KONG

The coroners system in Hong Kong is based in common law and the Coroners Ordinance of 1997. This legislation provides that the purpose of an inquest into the death of a person is to "inquire into the cause of and the circumstances connected with the death" (section 27). The coroner and jury are prohibited from framing a finding such a way as to appear to determine any question of civil liability (section 44).

2.8 CANADA

The Canadian system is based on English Common Law and tends to be a mixture of coroner and medical examiner systems in the ten provinces and territories. For example, Quebec is modelled along the lines of the Ontario Coroners Act while Newfoundland, Manitoba and Alberta have variations on the medical examiner's system. Saskatchewan and British Columbia have coroners systems which are composed of medical, legal and lay investigators.

The Group were very appreciative of the visit of the Ontario Coroners Association and were able to discuss some detailed aspects of that system.

- The Ontario Coroners Act 1972 introduced major changes in the purpose and conduct of inquests and clarified coroners duties and authority.
- General supervision of the coroner system is

under the direction of the Chief Coroner assisted by two Deputy Chief Coroners and eight Regional Coroners who are directly responsible for all coroner activities within designated geographical areas. Initial investigations are done by one of the approximately 400 investigating coroners. In most cases the inquests are conducted by selected coroners who receive special training. Most of the more lengthy inquests are conducted by the Regional Coroners or the Chief Coroner or one of the Deputy Chief Coroners.

- Ontario's local investigating coroners are all licensed physicians working part time in this role on a fee-for-service basis.
- The services of most of Ontario's local hospital pathologists are available to coroners. In some areas, certain pathologists have demonstrated a special interest in forensic cases and perform a large number of the forensic autopsies, especially the more problematic cases. Also based in Toronto, the Forensic Pathology Unit is responsible for all the medico-legal autopsies in Metropolitan Toronto, as well as some of the more difficult cases from across the province and the Unit is also available for consultation.
- There are approximately 27,000 death investigations per year and 100 inquests per year in Ontario.
- Regular training courses are run by the Chief Coroner for new coroners, and coroners and pathologists are expected to attend a three day continuing education course every three years.
- The Coroners Act requires that the police provide assistance to the coroner in carrying out investigations and they do so on behalf of the coroner. Police also prepare briefs for inquests.

General focus of coroner system

A coroner in Ontario must establish five findings in a death investigation – the who, where, when, how questions and also establish by what means death occurred. Inquests are held;

(i) when they are mandatory e.g. deaths in custody or arising from work in construction or a mine; (ii) when the coroner feels an inquest is necessary to assist in making these findings or to satisfy the public need to have an open and full hearing of a particular case and; (iii) where the coroner wishes to focus public attention on preventable deaths and to stimulate responses by public or private organisations. It was extremely rare for anyone to challenge a coroner's verdict in Ontario although it is more common for judicial review to be requested of a ruling made by a coroner at an inquest.

The whole emphasis of the Ontario system is towards public safety. The number of inquests has dropped markedly in the past twenty years as routine inquests have been stopped. However, current inquests now tend to be longer and more involved. Many of the inquests held, apart from the mandatory ones, now tend to be ones where the investigations would take place in a very broad framework, e.g. they would be concerned with issues of public safety or general health care more than with the specifics of individual cases.

Coroners in Ontario are not permitted to consider any matters of liability and the jury is not allowed to assign blame to anyone in their verdict. However, at most inquests, the jury make recommendations which are intended to prevent similar deaths in the future. After each inquest the coroner sends the verdict and recommendations to the Chief Coroner for distribution to a number of agencies of government, industry and public safety who are either expected or invited to respond.

Decision review and mechanisms used

In the circumstances that an investigating coroner

decides not to order an inquest, there is an appeal mechanism in place. The family or group who request an inquest can write and meet with the investigating or Regional Coroner, who at his discretion can undertake a further investigation and make a decision as to whether an inquest is in order. Should this request be turned down and the person is still unhappy about the decision, a request can be made in writing to the Chief Coroner to reconsider. He will review the case and make a formal decision. Final appeal may be made to the Minister responsible for the coroner system.

Coroner support mechanisms

A number of mechanisms are used by the Coroner to assist in certain investigations where death occurs in particular settings. A number of advisory committees have been set up by the Chief Coroner to provide expert assessment and advice to coroners in some specialised areas of medicine. There are four such committees at present:

- Anaesthetic Advisory Committee
- Paediatric Review Committee
- Geriatric and Long Term Care Review Committee
- Obstetrical Care Review Committee.

These committees review particular cases and the conclusions they reach are forwarded to the referring coroner who is expected to bring them to those involved in the care of persons in these areas. These reports are also made available to interested health care agencies

Regional Coroner's review

Another mechanism which has been developed in recent times is the Regional Coroner's Review which is often used as a means to allay the concerns of families in particular cases without the need to hold lengthy and costly inquests. An informal meeting is held between all parties to explain and clarify the circumstances of death and to try and resolve any grievances that families

may have. It is the Canadian experience that in many cases, this personal and informal contact between the family, the coroner and others involved in the case has proven to be an effective way of resolving conflicts. This point has been well taken by the Group in its recommendations regarding the establishment of coroners officers.

Other aspects of the system

In the Ontario system, families have the right to be kept fully informed of their cases and to obtain copies of records, such as post-mortem reports – the exceptions to this is when only limited information is provided e.g. in cases where there is ongoing police investigations or where the release of material may prejudice an inquest e.g. a possible negligence case. Juries at inquest are selected at random from jury lists and the coroner's constable summonses five jurors to attend.

Witnesses are served with subpoena and are entitled to bring legal counsel but such counsel may take no other part in the inquest without leave of the coroner. Persons who have substantial and direct interest in the inquest may apply for standing before or during an inquest and if given standing are entitled to present witnesses, make arguments and submissions.

Pre-inquest disclosure meetings are held and persons granted standing are provided with copies of the brief. Witnesses are examined in chief by the coroner's legal counsel and cross-examined by parties with standing. Jurors may also ask questions.

2.9 U.S.A.

In the USA, each State has its own system of death investigation. In some States there is a coroner, in others a medical examiner and others have both. In certain areas, a person can be elected or appointed to be a coroner without any qualification required under statute, while in others a coroner must be a qualified medical doctor or lawyer.

There are 52 jurisdictions in the USA, including the Armed Forces which have a specific procedure for dealing with death investigation. There are considerable differences between death investigation/coroner systems between states and even though there are rules governing the system in each state, they allow for flexibility in the individual counties within each state.

In view of the size and diversity of the US coroner system, further information may be obtained from website – www.irlgov.ie/justice

2.10 GERMANY

In most of the German states, causes of death are classified as natural, unnatural, and unascertained. A death is allocated to one of these classifications on medico-scientific grounds only. Suicides, accidents, homicides and deaths in the course of medical treatment are classified as unnatural deaths. Only unnatural or unascertained deaths must be reported to the authorities. Reportable deaths account for approximately 5-10% of all deaths, a much lower figure than the comparative one in other European countries. Only 2% of all deaths are the subject of an autopsy.

An assumption that death was not due to natural causes may be grounded on particular indicators which may even be vague in nature, for example; the circumstances in which death occurred, the place in which the body was discovered, or signs that force was used, any marks on the body, or even, particularly where the deceased was a young person, the mere absence of circumstances indicating that death was due to natural causes. A death which is medically certified as due to unknown causes indicates an unnatural death and obliges the state attorney to investigate.

Because the objectivity of the doctors is paramount, a doctor who has attended the deceased in his last illness is ineligible to carry out the post-mortem, not least because he may have to adjudge the accuracy of his own diagnosis.

Where it is suspected that the death of a person in hospital has been due to a crime, the post-mortem must not be carried out by doctors from that hospital, although, given their scientific interest, they are usually allowed to be present.

The State Attorney will only participate in an post-mortem when he is of the opinion that this is necessary for the proper investigation of the case, in particular with regard to felonies, for the purposes of reconstructing fatal accidents, or in cases of medical negligence. After the post-mortem, the State Prosecutor (who may attend it in order to take into custody any samples or body parts required as evidence in criminal proceedings) decides whether to release the body for burial.

2.11 SWITZERLAND

In Switzerland, death investigation is regulated by health legislation and by the rules of civil procedure. The death of a person must be notified publicly as soon as possible, but in any case within 48 hours. Everyone, in particular family members, is obliged to report the death.

A death certificate, issued by a medical doctor after an examination of the body, must be presented. If the doctor is unable to certify that death has occurred due to natural causes, or he suspects that the death was due to suicide, accident, homicide, or unknown causes and in suspicious circumstances, he must report the case to the relevant police authority.

In cases where death has occurred in unusual circumstances, the police initiate an investigation and call in a medico-legal expert, who is sometimes the district physician. In areas where there is an Institute of Legal Medicine, the medical doctors of these institutes are charged with the duty of performing a "legal inspection".

The aim of the investigation is to define the manner of death, the time of death, the cause of death and the identity of the deceased. If it transpires that death was due to natural causes,

the State Attorney closes the file and the body is released for burial. Otherwise, further investigation will be ordered, comprising a medico-legal post-mortem and investigations of a toxicological or haemogenetic nature. The medico-legal expert then issues a final report with a detailed description of the body (clothes, outer appearance, wounds etc) and presents his conclusions regarding the manner of death, the cause of death and the time of death.

Post-mortems

Where required, medico-legal autopsies are performed in the Institutes of Legal Medicine, of which there are six in Switzerland. The post-mortem has to be performed by a medico-legal doctor, assisted by another medico-legal doctor. Photographs and additional documentation are appended. The medico-legal post-mortem is usually complemented by histological and toxicological tests. The work of the medico-legal expert is completed by a written report. In cases of homicide or severe injury, where the criminal prosecution necessitates a jury, the medico-legal expert is usually required to present his findings before the jury.

2.12 THE IRISH PERSPECTIVE

It is to be expected that coroner systems or their equivalents vary substantially between countries for a very wide variety of reasons. Different legal systems, a focus on medical or legal aspects, varying relationships with the criminal justice systems, differences in historical evolution - all account for the contrasting shapes and structures which make up coroner systems. Examination of this diversity has, however, been useful for the Group. Specifically, it has been reassuring to note that the principal issues identified in other jurisdictions are broadly similar to those identified by the Group and that approaches to organising and developing this critical public service, other than those inherited by historical evolution in Ireland, were not only possible, but working in practice in other countries.

For all the differences, however, some of the basic tenets of the coroner system remain intact. Examples include; the judicial independence of the coroner; the inappropriateness of assigning civil or criminal liability; the need to allow the coroner to fully establish the circumstances of death; and the inquisitorial nature of the inquest. Such bedrock is reflected in the final recommendations of the Group's Report while at the same time international experience suggests ideas and concepts from which any revised coroner arrangement will benefit.

Of particular interest to the Group in this regard were:

- the need to foster and develop good communication with relatives at times of crisis
- the power of such good communications in any form of conflict resolution or review process
- the requirement for a drawing together of coroner structures which allow the service to develop in an integrated and planned manner consistent with the service demands of a modern society
- the usefulness of Rules-based legislation to address the detailed, complex and changing requirements of the coroner system
- the advantages to be gained from an integrated support system for coroner practice.

While the coroner system in some countries seems to be more confined in terms of the kinds of deaths brought into the system, the Group feels that the Irish system of death investigation as a whole, properly reflects the values which the Irish Constitution places on human life. While different systems place greater emphasis on different aspects of a coroner service (e.g., the Canadian emphasis on public safety) any death which cannot be explained is, the Group believes, sufficient grounds for the invocation of a public inquisition-based measure as characterised by the Irish coroner system.

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3. ISSUES AND RESPONSES

3.1 INTRODUCTION

This section of the Report will analyse the issues faced by the coroner system both now and in the future. Some of these issues arise from inadequacies in existing legislation which is now almost forty years old. This is hardly surprising when one reflects on the significant changes in society itself over this period and in the expectations which society now has for the performance of the public service generally, including the coroner service.

Other coroner-related issues arise from a consideration of how the structures of the coroner system have continued relatively unchanged over an even longer period, despite major parallel developments in administrative and organisational reform across the public sector. No area of public endeavour can remain unchanged for such a long period and expect to perform efficiently and effectively to the high levels of service expected in today's public sector.

Against this background, the Group took the view from an early stage that its general approach should: (a) constructively question all aspects of the service as currently organised and practised and; (b) focus on securing high levels of public service as an essential constituent of any new coroner service. Whereas in some areas of public service reform, change will need to be incremental, the Group felt that the coroner service requires a bold reorientation which sets a course for the first half of the new century. Accordingly, in addition to addressing the specific issues which currently arise, we also geared our work to providing new structures which will be capable of developing and sustaining the new directions needed if the coroner service is to fulfil its mandate as a high-quality public service carrying out a critical role in a modern society.

No matter what reforms are introduced into the coroner system, little will be achieved if critical support services are not, at the same time, geared to accommodate a new coroner system.

Reorganisation, regrouping, improved training and communication systems, all have a major role to play, but without adequate funding and investment in the service, they alone can not achieve the key objectives set out by the Group.

In particular, current problems affecting the provision of critical core support services such as pathology and toxicology will require resolution both in the short and long term if the service is to establish a basic delivery platform for services to the relatives of the deceased. The coroner system does not work in isolation. It has a series of major dependencies and those dependencies must be actively managed and anticipated. This active management of critical resources may well involve new ways of contracting for services and different relationships with those who currently provide these services.

Apart from the need for other related services requiring delivery in the context of a revised coroner system, there is the general question of the cost-effectiveness of the new service. As with all public services, the Group, in making its recommendations was conscious of the need to make the specific case for the investment which will be required. The core parameters used by the Group in setting out its proposals were:

- the need for a high-quality service to the relatives of the deceased in line with Government policy on customer services
- the need for optimising the use of existing resources
- the need for providing sufficient infrastructure both in personnel and other resources to

ensure that core coroner activities can meet service demands for the foreseeable future

- the need to reflect high levels of transparency, accountability and fairness.

Using these parameters, the Group considered that adequate future funding of the service requires an investment strategy focusing primarily on:

- adequate pathology and toxicology services
- a new approach to administrative support for coroners
- establishing and funding the structures which will implement, lead, monitor and shape the new directions for the coroner service.

While the Group was conscious that new funding will be required to implement many of its recommendations, it has also sought to ensure that any new investment in related areas such as hospital and pathology services goes hand in hand with specific recommendations for the coroner area. The Group's objective is that the overall package being put forward by the Group will result in an overall cost-effective and efficient coroner service. Apart from pay issues (and these have only been resolved in very recent times), there has been a low level of investment in the coroner system since the establishment of the State. The service has served the community well since that time but as we turn into the new century an investment and commitment to this important service must now be made.

The issues in the coroner service and the Group's responses to them are set out under a number of broad headings and immediately followed by the relevant recommendation.

3.2 THE POSITION OF THE CORONER

3.2.1 Appointment

Coroners are currently appointed by the local authorities after selection by the Local Appointments Commission. Under the new structural arrangements proposed in Section 3.4.6, and in view of the proposed establishment of a separate Coroner Agency to administer and manage the coroner service, it would be more appropriate if the Minister for Justice, Equality and Law Reform took over the formal appointment of coroners with selection procedures and rules being arranged by the new Coroner Agency. The appointment by the local authority is a matter of historic precedent based on the fact that the local authority were the paymasters. Under proposed new funding arrangements, this will no longer be the case and revised arrangements are appropriate. Any new arrangements are of course without prejudice to the independence of the coroner in the performance of his functions.

RECOMMENDATION

1. Coroners should be appointed by the Minister for Justice, Equality and Law Reform and should be selected in accordance with arrangements to be devised by the new Coroner Agency with the current entry age to the service of 30 years old being dropped.

3.2.2 Retirement

The Group considered whether or not specific recommendations should be made on the question of the age at which coroners should retire. In the absence of any strong views being expressed by the group on this issue, it is suggested that any new arrangements in this area be worked out in an appropriate industrial relations context.

RECOMMENDATION

2. There should be no change in the retirement age for coroners currently set at 70.

3.2.3 Residence

There is an existing requirement that a coroner live within his district unless he obtains the permission of the Minister to do otherwise. It was felt that this is an outmoded restriction and that the obligation should be removed. From a logistical and service point of view it would, of course, be desirable for a coroner to live within an appropriate distance from his area of work but given:

- transport improvements
- the proposed increased flexibility of coroner jurisdiction between coroners themselves and between coroners and their deputies the proposed general evolution towards regional structures

It was considered that the present restrictions should be removed and that there should be no specific legislative requirement governing the place of residence of a coroner.

RECOMMENDATION

3. The present restriction that coroners should be resident in their districts should be removed.

3.2.4 Deputies

A deputy coroner must exist at all times and is appointed by the coroner. There is a large variation between districts in the extent to which deputy coroners have any real involvement in coroner work. Nevertheless, they are a critical part of the coroner system and the coroner cannot possibly be available at all times.

A number of general issues arise in this area as follows:

- the lack of training and consistency of standards given the low levels of access to coroner practice by deputies
- the future role of deputies in the new structures envisaged for the coroner service.

Deputies may not have sufficient opportunities to gain experience in coroner practice and irrespective of the long-term evolution of this position, there are real training issues to be addressed. Given the view of the Group that coroner training in general should be strengthened and developed, deputy training should be no exception.

It must be clearly stated (and indeed the concept will be developed in detail later in the report) that in the longer term, the service will be rationalised in terms of the number of coroners providing the service. As the service evolves towards a regional structure and the number of coroners reduces in line with natural wastage and the preferences of individual coroners to continue in this aspect of their careers, it is inevitable that the number of deputies will also decrease. Overall greater flexibility in jurisdictional competencies will help to ease the problems of coroners not being available for whatever reason.

It will not be possible to carry out parallel investment in the deputy coroner area to the extent of creating an extra layer of coroners (another 48 in fact) which, in turn, would have to be integrated separately into a more focused and rationalised environment. Accordingly, the Group does not wish to make any recommendation in the area of consolidating the position of deputy coroner other than to signal the need for appropriate training in the short term and to liberalise the jurisdictional aspects of their work.

RECOMMENDATION

4. Training programme to be devised for coroners should include provision for deputy coroners.

3.2.5 Qualifications

The question of whether a radical change was needed in the qualifications of coroners was discussed. The current position is that a coroner must, at time of appointment, be either a practising solicitor or barrister, or a registered medical practitioner. The reasons for this go back to early in the last century when the office of coroner was being upgraded, having fallen somewhat in status. The drive to “professionalising” the office was reflected in the introduction of these kinds of qualifications. The argument might be made today that if the carrying out of coroner functions requires a particular set of detailed skills and professional knowledge, how can coroners be either a doctor or a lawyer?

It can certainly be argued that both legal and medical knowledge is required. Lawyers need to be able to understand and interpret medical and post-mortem reports and doctors need to understand the judicial aspects of the coroner system. It may further be argued that as we move towards regionalisation and ultimately full-time coroners, the aptitudes and skills required may well belong neither to doctors nor solicitors but reflect a special amalgam of medical, legal, social, interpersonal, management and counselling skills constituting the modern office of the coroner.

The Group felt, however, that its responsibility lay in addressing issues which fall to be resolved along the path to such ultimate specialisation and focused on the need to ensure that the service could evolve and grow successfully towards its final objective. Against this background, it opted for stressing the need for reciprocal training for all coroners in both medical and legal fields

without introducing fundamental change in qualification arrangements. Such reciprocal training is critical to the delivery of an effective coroner service and should be embarked upon as a matter of immediate priority.

The Group drew attention to the fact that a coroner may cease to practice at either profession even under existing law and saw no reason to change this arrangement. Indeed, in terms of opting for a more full-time approach to coroner work, cessation of practice might well be part of an overall development towards the long-term structures envisaged by the Group.

RECOMMENDATIONS

5. While the initial qualification requirements for coroners should not be changed, cessation of practice either as a lawyer or as a medical practitioner should not be a bar to working as a coroner.
6. Reciprocal coroner training programmes should be introduced – legal training for doctors, medical training for lawyers.

3.2.6 Removal from office

A coroner may currently be removed from office by the Minister for Justice, Equality and Law Reform. The reasons for removal have to be serious and involve issues such as misconduct, neglect of duty or unfitness for office because of mental or physical infirmity. Effectively, the existing law requires a link between a coroner’s wrongdoing and his duties as a coroner. Having considered the matter, the Group felt that in general, these kinds of grounds should be retained but extended to include situations such as disbarment by a governing body. Other situations should be considered and identified in due course by the proposed Rules Committee, see Appendix J.

In order to meet the requirements of natural justice, explicit procedures should also be put in place whereby a coroner, who is informed of a complaint against him, is given the opportunity to defend himself. "Fast-track" procedures for removal of a coroner may, however, be needed in particularly urgent circumstances.

RECOMMENDATIONS

7. The existing legal provisions for the removal of a coroner from office should be retained and extended to include disbarment from practice by a professional body. The full list of situations in which a coroner can be removed from office should be established by the proposed Rules Committee.
8. Procedures governing the right of reply by a coroner in accordance with the rules of natural justice should be put in place.

3.2.7 Flexibility of jurisdiction

Apart from the issue of defining the coroner's jurisdiction at inquest in a particular case, the Group looked at the whole question of the flexibility of transferring coroner jurisdiction between coroners and between coroners and their deputies. The existing provisions provide poor flexibility in this area and the Group felt that improvements were needed particularly in the light of the new regional structures being recommended.

There are a number of situations where flexible transfer of jurisdiction would be useful. The absence of concurrent jurisdiction between coroners and their deputies is a recurring problem in that absence or illness is required in order to address normal logistical problems which arise on a day-to-day basis. More, rather than less, flexibility will be needed as the service moves

towards a more integrated and supported structure. The current legal provisions which limit this jurisdictional flexibility should be removed as we move towards the new structures over the coming years.

Another jurisdictional problem surfaces in cases of serious accidents which may involve the injured being taken to different hospitals in different districts. Subsequent deaths may then result in different coroners investigating the same basic cause of death. Currently, application must be made to the Minister to allow a single coroner to take overall jurisdiction. It is considered that this is unnecessary and should take place at the initiative of the coroners. If agreement is not forthcoming then the Minister could be asked to direct a particular coroner to take over the case.

RECOMMENDATIONS

9. Concurrent jurisdiction should be introduced for coroners and their deputies for all aspects of coroner work.
10. Where deaths from the one incident occur in different coroner districts, coroners should be empowered to arrange jurisdiction between themselves without having recourse to the Minister. Failure to agree jurisdiction should result in direction from the Minister.
11. The full set of situations where jurisdiction can be transferred should be developed in the proposed Coroner's Rules

3.3 THE CYCLE OF CORONER WORK

3.3.1 General coroner procedures and rules

One of the major tasks undertaken by the Group was to carry out a detailed review of the Coroners Act 1962. This took place over several months and was the focus of a special sub-group established for this purpose. In terms of general conclusions in this area, the Group took the view that the 1962 Act suffered from a range of anomalies accumulated since its introduction and needed updating to reflect modern practices and thinking. It was further considered that it needed redesign in more logical order and would need further amendment to reflect the new structures being recommended by the Group. The Group considered that any new legislation should bring together all other enactments which impact on coronial practice, in accordance with Government policy on regulatory reform.

One fundamental feature of the Act was that it had not provided for Coroner's Rules. Instead, the designers had opted for building a wide range of procedures into the primary legislation which has now been overtaken by the passage of forty years and the ever-increasing complexity of modern life. In fairness to the original Act, its design reflected a high level of independence for coroners insofar as it provided scope for detailed procedures to be introduced by individual coroners. The downside of this approach is, however, that it can lead to inconsistencies in practice throughout the coroner service in areas which may not be in the overall interest of the service as a whole. This lack of consistency coupled with the high number of coroners and deputy coroners distributed around the country and the lack of structured training programmes, all leads to potential problems both for coroners themselves and the public that they serve.

In the overall interest of shaping a coroner service that will survive well into the twenty-first century, the Group felt that the concept of regulation-based Coroner's Rules should be an essential part of any new legislative scheme proposed. The task

of drawing up such a detailed set of rules was, however, considered to be beyond the remit of the Review Group and should be drawn up by a specially established Rules Committee with the necessary focus and concentrated expertise required by such a detailed task. The committee should adopt appropriate consultative procedures in developing the Rules which should include appropriate representatives from the relevant parties involved. A full list of such parties should be formally identified by the Committee and would include the Registrar of Births, Deaths and Marriages, mortuary technicians, undertakers etc..

Rules should be established by statutory regulation and be capable of being amended. They should cover the various procedures and options available to coroners throughout the cycle of their functions from death reporting right through to the carrying out of formal inquests. While not attempting the detailed task of rules composition, the Group did establish the general parameters within which the new Rules should be developed.

The minimum areas to be covered by the new Rules are set out in Appendix J which also contains some specific recommendations described in the main body of the report. A set of "notes" which reflect much of the detailed discussions of the Group are also included to assist in the deliberations of the proposed Rules Committee.

"Best Practice Notes"

Apart from the need for statutory-based procedures as set out in Rules, the group also felt that some areas of coroner procedure could benefit from the development of codes of best practice. These would cover areas where consistency of approach rather than statutory obligation would benefit the service as a whole. Such procedures could be set out as "Best Practice Notes" and would best be devised by coroners themselves with assistance from the proposed new Coroner Agency.

RECOMMENDATIONS

12. A statutory Rules Committee should be immediately established on acceptance of the report by Government.
13. The Committee should devise Coroner's Rules in accordance with the recommendations in this report and on the basis of the Outline Coroner's Rules set out in Appendix J.
14. The Committee should be representative of the interests affected by the Rules and should include representatives from:
 - The Coroners Association
 - The Department of Justice, Equality and Law Reform
 - The Faculty of Pathology of the Royal College of Physicians of Ireland
 - The Department of Health and Children
 - The Office of the Attorney General
 - A representative of bereaved persons, such as a bereavement group.

Given the detailed task to be performed by the Committee, the Group felt that the membership should not exceed eight persons.
15. A detailed list of parties to be consulted in drawing up the Rules should be compiled by the Committee.
16. Those drafting and re-writing a new Coroner Act, which will incorporate the introduction of Coroner's Rules, should take full advantage to consolidate existing legislation.

17. In the interest of codifying good coroner practice, Best Practice Notes should be devised by coroners with assistance from the proposed new Coroner Agency.

3.3.2 Information provision by the coroner**GENERAL****Knowledge of coroner service**

The Group felt that there was a general deficit in the public's knowledge of the coroner service. The reality is that few members of the public know, or indeed would wish to know, about the service until they find themselves face to face with it in tragic circumstances. For those not in direct contact, the source of most information is confined to media reporting. Understandably, this is not always the best way to appreciate the system and may indeed cause confusion, particularly when the public come to discover that the central role of the coroner lies in establishing the cause of death and not in determining either civil or criminal liability.

This general lack of knowledge of the service, coupled with a lack of uniformity in conveying information to relatives at the time of death, means that misunderstandings and needless trauma can occur which could be remedied through adequate information provision. Initiatives are required both at a general level, where the public are made aware of what coroners do, and at a specific level, where the public are involved in a particular case.

The proposed coroners officer would play a critical role as the primary source of information for all the parties involved in the coroner system. Initiatives at a general level could involve the inclusion of the coroner service in the range of public information facilities currently being developed. Using conventional (leaflets) and high

tech (citizen's information kiosks and the Internet) approaches, information about the coroner service could be integrated into existing or planned public information schemes, thereby including the coroner service in the general public perception of services available. The Group noted that an initiative has already been taken in this regard with the inclusion of coroner information in the Victim Charter published by the Department of Justice, Equality and Law Reform in 1999.

In line with modern legislative provisions, in other areas, the Group felt that as far as is practical the service should be available to people whose first or preferred language is Irish.

Specific information at time of a death

At such times, considerable stress and trauma will usually be involved and there is a requirement to thoroughly review the information practices and procedures involved. The availability of easily-interpreted information is paramount, particularly where, as is mostly the case, relatives will be dealing with a wide variety of other parties involved in coroner cases such as the Gardaí, general practitioners, medical consultants, pathologists, nursing staff, mortuary technicians and undertakers. There are points in the coroner cycle where contact is required between the relatives of the deceased and the coroner system. These are shown diagrammatically in fig. B of the coroner cycle chart. While the new structures proposed by the Group will assist in improving communications generally, an improvement in the quality of information made available to relatives at the time of death will help in the short term. It is a stressful time for relatives and in developing a strategy for conveying coroner information, great attention should be given not only to the type of information to be provided but also to the choice of person to provide that information and the timing of its provision. This is particularly so in situations where organs or body parts must be retained in the context of establishing the cause of death.

The post-mortem report

The question of the availability to the relatives of formal documentation generated in the coroner cycle is related to, but distinct from, the need for high quality communication with the relatives. Some of this paperwork such as burial certificates, temporary death certificates, final death certificates, notices of inquest, will all automatically come from the routine progress of the system. There are some exceptions however.

Where an inquest is not being held, relatives should be informed of their right to receive a copy of the post-mortem report. In view of the fact that such reports may often contain information which could be harrowing to families, the Group felt that, where possible, such reports should be routed through the family doctor who are trained to present such information in a sensitive and clear fashion to the relatives. Where a death investigation is, however, proceeding to inquest, the situation is not so clear-cut and the coroner must retain discretion about the release of documentation prior to inquest. This will be further discussed in Section 3.3.6.

CERTIFICATES

Coroners certificate

As the Registrar of Births, Deaths and Marriages Office has a considerable amount of dealings with the Coroners Office there is a need for a close working relationship. Difficulties sometimes arise from errors in relation to personal details of the deceased on death certificates. In their submission to the Working Group the office of the Registrar suggested a revised Coroners certificate which could alleviate many of the problems and this form should be introduced as soon as possible (a proposed draft form is included at Appendix L).

Interim certificate of death

From the relatives' perspective, there is a practical requirement for a certificate of death to be issued as soon as possible after death. While many

Fig. B* Points of Contact for Relatives with the Coroner System

coroners do, in practice, issue such certificates, the Group felt that the issue of interim certificates should be on a statutory basis and may be issued at any time after death has been established. This does not prejudice the ultimate issue of final death certificates which may issue at different times in the coroner cycle depending on the route taken through that cycle.

RETENTION OF ORGANS AND BODY PARTS

Background

The Group initiated discussions on this sensitive topic at an early stage of their deliberations and commissioned a legal study from the UCD research support group. That Report was discussed a number of times in plenary session. As the discussion progressed, the Group became aware of the emerging issue of the retention of children's organs and body parts as reported in the media. This merely confirmed their view of the need to adopt a sensitive, structured and consistent approach to the whole question.

Considerable confusion has existed in relation to the role of the coroner in organ and body part retention and the Group is anxious to ensure that this confusion is addressed in the interest of the coroner service and more, importantly, of relatives. As explained earlier in the Report, the main function of the coroner is to investigate violent or unnatural death and to establish its cause. "coroner cases" can vary from what appears to be the most straight forward of cases involving, say, the death of an old person living alone at home, to the death of someone who has been the victim of a violent murder. There is a very wide range of cases within this continuum and it is inevitable that sometimes people can be confused about precisely why a coroner is involved in the first place.

An understanding of these matters will, the Group feels, help relatives to understand their overall experience of the coroner system and accept the various coroner procedures with which

they may be involved. That understanding can only be achieved by introducing a well defined, structured, and bereaved-centred dialogue between relatives and a designated person who would be available around the time of death. It was against this background and criteria that the Group formulated its overall proposals in this matter.

While the Group were in the process of finalising its views in this matter, the Faculty of Pathology asked for comment on the paper which it had prepared on this topic. In view of the urgency of the situation and the need to put new arrangements in place as quickly as possible, a special subgroup was formed to examine the particular draft put forward by the Faculty. The special group reported to the plenary group in March 2000 and an agreed view was transmitted to the Faculty at that time. This consensus view represents the conclusions of the Group and is reflected in the following paragraphs. While the Group made a number of comments about "hospital cases" in the Faculty document, it focused primarily on "coroner cases", making a very strong recommendation that one should be clearly distinguished from the other.

It should be further noted that the announcement by the Government of an inquiry into post-mortem practices has coincided with the writing of this Report and the Group notes that the terms of reference include the making of recommendations regarding future procedures to avoid past problems. To the extent that such procedures may involve dialogue with relatives, the Group would wish to highlight the need for close integration with its own proposals in this area. The Group also noted that the Minister for Health and Children is currently establishing a consultative group in respect of a Human Tissue Act which would influence future procedures.

Need to differentiate coroner cases

At the outset, it is important to differentiate between: (a) the retention of organs and tissues

in the context of establishing the cause of death by the coroner and; (b) the retention of organs in the context of furthering medical education and research. In the case of (a) i.e. "coroner cases", the organs and body parts are being retained in accordance with coroner law and solely for the purposes of establishing the cause of death. Once this has been established by the coroner, the organs/body parts are no longer within the jurisdiction of the coroner and are available to the relatives for them to exercise their options in having them returned or disposed of in a manner to which they will already have agreed.

In other words, if organs/body parts are retained in coroner cases, under coroner law, consent is not required from the relatives to the post-mortem or to any retention of organs or body parts. They do, however, need to be fully informed about the basis of the coroner's involvement and to be given the choice as to what happens to the organs/body parts when the coroner's jurisdiction has ended.

The position in relation to (b), retention of organs for medical education and research, is quite different. While the Group do not wish to anticipate the ultimate arrangements of the relevant authorities in this area, the issue would appear to centre around:

- consent prior to any organ/body parts retention;
- the giving of appropriate options to relatives for their disposal or return, to the extent that organs/body parts are retained.

The coroner service view

A number of practical issues were discussed by the Group in this regard. The first relates to what is meant by the terms "organs", "body parts" and "tissues". While the Group had expert medical advice available to it, the view was taken that a pragmatic lay person's perspective on these terms should be paramount when discussing the issue. There are very small (4cm by 4cm) tissue samples

held on blocks or slides which are retained as part of the ongoing medical records of any post-mortem and the Group felt that these should not be at issue when talking about the retention problems. Such retention, can, in addition to ensuring appropriate standards of pathologist practice, be used also to protect family rights to future re-examination of specific cases. Preservation of such microscopic slides and blocks is in fact part of standard practice by the various international bodies that regulate pathology practice, such as the Royal College of Pathologists in the UK and the College of American Pathologists², a standard supported by the coroner service. When one moves from such small items to larger "tissue samples" the problem of differentiation gets more complex as some larger tissue samples can approximate to whole organs.

Having considered the matter in some detail, the Group felt that consideration of retention issues such as disposal, return, exercising preferences, etc. should be confined to whole organs and larger tissue samples which the Group propose to refer to as "parts of the body or "body parts". This is, accordingly, the terminology which we use in discussing this issue.

The second practical issue arose in relation to when and how the relatives should be told that organs have, in fact, been retained in a particular case under coroner law. This matter was discussed at length and the consensus was that the right to be told before the time of burial was paramount. However, it was accepted that individual reactions and feelings in this area might differ from person to person and that where a relative had indicated that they did not wish to know prior to burial that organs were being retained, then that wish should be respected. This view did, of course, presuppose that the relatives were advised and asked about their particular preference in the first place. Accordingly, the design of any forms or procedure should reflect this view of the Group.

² *Autopsy Performance and Reporting*, GM Hutchins MD, Ed., *College of American Pathologists*, 1990.
Handbook of Forensic Pathology, RC Froede MD, Ed., *College of American Pathologists*, 1990.

The final practical point relates to the juxtaposition of: (a) providing information about organ retention in coroner cases and; (b) requesting consent for organ retention for medical research and education. The fact that these two separate items may be presented to a relative at a time of great trauma poses significant challenges in the area of clear and concise communication with relatives. This potential confusion and the absolute need to be clear about the issues involved for the relatives indicated to the Group that a very discrete, planned and structured dialogue was needed.

Specifically, the Group felt that a panel of “designated persons” should be appointed for each hospital who would receive training in a predefined package containing all the dialogue and documentation needed to successfully and sensibly engage with relatives. This package would reflect the need to distinguish between coroner cases and hospital cases and incorporate separate instructions and documentation for each stream. Coroners, pathologists, hospital staff and counselling experts should be encouraged to assist in the development of the training package.

In essence, the Group felt that the situation at time of death was too traumatised and too confusing for relatives to be dealt with other than by a combination of both dialogue and documentation presented by trained people in a structured fashion. Having this procedure in place would ensure that relatives would have a single informed point of contact available to discuss and explain the issues involved in a clear and sensitive manner.

While every effort should be made to introduce revised arrangements so as to minimise delay to the process of burial, the Group felt that the early burial culture in Irish society will, in some cases, have to yield, at least a little, to the greater need for transparency and clarity in the whole area of organ and body parts retention.

In summary, from the point of view of the coroner service, the Group felt that the relatives should:

- be informed clearly that the coroner is to be involved and be given the reasons for his involvement
- be advised of the differences between retaining: (i) small tissue samples held as part of the medical records of an post-mortem and; (ii) retention of organs and other parts of the body
- be informed that the analysis of organs parts will inevitably extend beyond the time of burial and that preferences will have to be exercised in relation to how they are to be disposed of
- be clearly given those options which should include a preference on whether or not they wish to know, before burial, if organs or parts have, in fact, been retained
- be advised of the options available for return or disposal of the tissues/organs when the coroners jurisdiction has ended
- be further advised that any further retention of the organs for any non-coroner purposes (such as research or education) beyond the coroners jurisdiction is a matter to be determined between the relatives and the non-coroner authorities through a separate dialogue and separate documentation.

Some pragmatic variations on this approach would need to be considered in practice. For example, where it was difficult or impractical for relatives to meet designated persons, arrangements should be introduced seeking preferences by telephone. Paperwork could be forwarded in due course.

These proposals are based on the primary right of a bereaved person to make a choice in relation to the content and timing of information about retained organs and body parts. The Group were aware that the mere exercise of these rights may result in additional suffering for some families. The decision to choose, however, lay with the families and was not in the hands of any of the authorities involved.

Responsibility for disposal

It must be remembered that the position of coroner is a quasi-judicial one and the coroner's interest in organs or tissues, lies only in establishing the cause of death. The question of the arrangements and facilities for retaining and disposing of organs/tissues, is, the Group feels, is a matter for the medical authorities, having due regard to health and safety legislation. At the time of writing this Report, those authorities are refining and developing these facilities and the Group feels that whatever practices are adopted should apply to the return or disposal of organs/tissues which have been the subject of coroner jurisdiction. In any event, in many cases, medical authorities will have obtained consent for the retention of organs/tissues which have also been the subject of coroner inquiries.

RECOMMENDATIONS

1. Coroners should be appointed by the Minister for Justice, Equality and Law Reform and should be selected in accordance with arrangements to be devised by the new Coroner Agency with the current entry age to the service of 30 years old being dropped.

General information provision

18. A generic information leaflet should be developed as a matter of urgency to clearly explain the coroner service, to identify the rights of relatives and to point to any restrictions placed on them in the course of their contact with the coroner service. The same leaflet should be used to supplement the dialogue recommended in the context of the arrangement for a designated person. The new leaflet could be modelled on that currently made available by the Dublin City Coroner and should be made available, in the initial phase at least, in coroners' offices, hospitals and Garda stations.

19. The generic information leaflet as described above should provide an appropriate insert at coroner district level to identify local support and bereavement groups.
20. The minimum information to be given to relatives at the time of a death, should include:
 - that the coroner is involved and the reasons for that involvement
 - where a post-mortem is to be carried out, the possibility of organ/body part retention to establish the cause of death.
21. A protocol should be developed in consultation and in agreement with all the parties involved in coroner cases, in relation to how, by whom, and when, the leaflet, preference document and other information is to be given to relatives.
22. Relatives should have an automatic right to receive a copy of the post-mortem report in cases where no inquest is to be held. The preferred method of issue of such reports would be through a general practitioner.
23. Coroners and their offices should be listed along with other public and State bodies in the telephone book.
24. A coroners' web site should be developed containing a range of information about the coroner service and with appropriate links to other related organisations such as the Department of Justice, Equality and Law Reform and the new Courts Service.

25. As far as is practical the service should be available to people whose first or preferred language is Irish.

Certificates

26. A revised Coroners certificate based on the sample suggested by the Office of the Registrar of Births, Deaths and Marriages should be introduced as soon as possible. (A proposed draft form is included at Appendix L)
27. Interim death certificates may be issued by coroners with the backing of statute, as soon as death has been established.

Retention of organs and body parts

28. The minimum information to be given to relatives at the time of a death, should also include the following:
- an option to indicate whether or not, before the burial, the relatives wish to be informed in the event that organs have, in fact, been removed
 - the options available for return or disposal of the body parts or organs when the coroner's jurisdiction is ended
 - a reminder to the relatives that coroner law and the need to establish the cause of death governs the retention of organs only until the cause of death has been established
 - advice that any further retention of the organs beyond the coroner jurisdiction for any non-coroner purposes (such as education or research) is a matter to be determined between the relatives and the medical authorities.

29. A formal document for signature by a relative should be designed along the lines of that set out in Appendix K and implemented as part of the proposed structured dialogue.
30. The physical retention of organs and tissues for coroner cases should continue to be carried out by the medical authorities in accordance with any national revised practices currently being worked out by those authorities.

3.3.3 Reporting of deaths

There are two main aspects to this issue. The first relates to who can, or must, report a death and the second relates to the kinds of death which must be reported. At common law, any person can report a death to a coroner but the important point relates to the kinds of legal obligations placed on certain kinds of people in certain kinds of circumstances. For example, if the Gardaí become aware of a death for which no certificate is available, then they must report it to the coroner. Primary legislation in this area then goes on to identify various situations which must be reported and various persons who must do the reporting. While such reporting obligations can be discharged by informing the Gardaí, the Group feels that there should then be an equivalent duty on the Gardaí to then report that death to the coroner. Apart from this specific point the lists need to be extended in the proposed Rules and removed from the primary legislation. Particular situations identified by the Group as requiring compulsory notification should include maternal deaths and deaths in "vulnerable" groups.

In relation to the latter group, it was acknowledged that there may be some difficulty in identifying and categorising such people. A balance needs to be struck between providing

protection to vulnerable people on the one hand and stigmatising particular groups on the other. While the Group were prepared to allow the Rules Committee to consider these questions in more detail, it felt that the criteria to be adopted should focus on those who were in some category of formal care rather than those who were merely being supported by the community care concept underpinning current approaches in this area.

It was further noted that there was some tension between one of the categories of reportable death (death due to misconduct, malpractice or negligence on the part of others) and the fact that coroners are specifically barred from considering criminal or civil liability. On balance, it was felt that omitting this category would be incompatible with the reasoning which underpins coroner death investigation, i.e. unexplained death, and that the revised proposals of the group in relation to coroner jurisdiction would allow such deaths to be investigated and the potential tension to be resolved.

The Group felt that improved liaison was needed between coroners and all those who had responsibilities for death reporting. Training would have an important role to play in this area but best practice guidelines would also need to be developed in this area.

RECOMMENDATIONS

31. Existing categories of reportable death should be extended to include maternal deaths and deaths of “vulnerable persons” as detailed above.
32. The question of further extending reportable deaths should be considered by the Rules Committee.

33. Any obligation to report a death to a coroner which is fulfilled by reporting to the Gardaí should place an equivalent obligation on the Gardaí to proceed to notify the coroner.
34. The reference to the word “anaesthetic” in section 18.4 of the Act should be replaced by the term “any medical or surgical procedure”.
35. Liaison between coroners and those responsible for reporting deaths should be improved through training for all relevant parties and the development of best practice procedures.

3.3.4 Issues related to the body of a deceased person

Viewing

Under current provisions, a coroner must view the body of a deceased (if available) unless the Gardaí have done so. The Group felt that this should be changed to a situation where the obligation to view the body is on the Gardaí and not on the coroner. It is generally impractical for the coroner to physically view bodies as part of their general duties. At inquest documentary evidence to this effect should, therefore, be acceptable unless the evidence is challenged in court, in which circumstances the Gardaí would have to attend. In practice, the viewing of the body by the Gardaí usually serves to fulfil the purpose of identification – one of the central investigatory duties of the coroner. The Group noted, however, that despite this primary duty, there is no specific obligation on the coroner to have the body identified. In some cases identification may not be provided by the Gardaí but by the hospital who may (despite informally established practice to the contrary) notify the coroner directly since they are not legally obliged to notify the Gardaí. Against this background, the Group felt that there should

be a statutory requirement for the formal identification of the body by an appropriate party. The present role of the jury in viewing a body is rooted in antiquity and should also be removed.

Special issues arise in relation to cases where a coroner permits a doctor to certify on a death even when they have not treated them within one month of the death. The Group felt that in such circumstances, there should be a statutory requirement on the doctor to carry out an external examination of the body.

Authorisation for burial

Within the coroner system, it is critical that a burial does not take place without the coroner's permission. Concerns have arisen regarding the practical measures to be taken in this area and the Group feel that a positive onus should be put on funeral directors not to proceed with burial until clarification has been obtained that a medical certificate of death will be available. Where a certificate is not available, it will be necessary to put in place a formal clearance procedure by the coroner to certify that burial can proceed. The detail of this procedure should be dealt with in Coroner's Rules.

In this general context the Group noted the submission made by the Irish Association of Funeral Directors and suggest that "best practice notes", covering procedures and communication lines with the bereaved, should be developed by coroners in association with the Irish Association of Funeral Directors.

Removal and custody

In order to exercise his duties under coroner legislation, a coroner may need to have physical possession of the body. The Group understands that there have been some situations where the body has not, in fact, been yielded to the coroner and that the Gardaí were prevented from removing a body for post-mortem. It would be inappropriate to place duties on coroners if

corresponding powers were not given to the Gardaí to enable those coroners duties to be exercised. Accordingly, the Group took the view that enforcement powers be given to the Gardaí to: (a) to enter a premises in which a body lies and to make investigations in support of the coroners inquiry; (b) secure possession of the body where they are being prevented from so doing and; (c) recover possession of a body where it had been removed from a mortuary or morgue without the approval of the coroner.

Removal outside the State

The provision which requires a coroner to give clearance for the removal of a body outside the State should be retained but the Group felt that it should be worded in a more positive manner directing that no body should be removed from the State unless approval to do so has been obtained from the coroner in whose district it lies.

Exhumations

Under current legislation requests for exhumations, in the context of coroner investigations, can only be made through the Minister. A coroner cannot himself initiate this process. Indeed he must first receive a request from the Gardaí (at Inspector rank at least) before he can lodge a request for exhumation to the Minister. This mandatory requirement that the Gardaí initiate a request by the coroner for an exhumation was considered by the Group who felt that some change was indicated. The Gardaí should, of course, be empowered to continue to seek exhumations, through the coroner, but the coroner in the course of his death investigation duties should also be able to take the initiative in this area. In practical terms, any request for an exhumation by a coroner will also involve consultation with the Gardaí and vice versa.

RECOMMENDATIONS

36. Coroners should not be obliged to view the body of the deceased – this should be the duty of the Gardaí, although evidence of viewing can be presented in documentary form unless challenged at an inquest.
37. For bodies within the coroners jurisdiction there should be a statutory requirement for identification of the body by an appropriate person. The coroner must be satisfied in relation to such an identification.
38. The current role of the jury in viewing the body of the deceased should be removed.
39. In circumstances where a coroner permits a doctor to certify a death even when they have not treated them within one month of the death, there should be a statutory requirement on the doctor to carry out an external examination of the body.
40. A duty should be placed on funeral directors to ensure that a certificate of death is procurable or that clearance has been obtained from the coroner to bury the body. Such clearance procedures should be part of the proposed Coroner's Rules.
41. New enforcement powers should be given to the Gardaí: (a) to enter a premises in which a body lies and to make investigations in support of the coroners inquiry; (b) to secure possession of a body where they are being prevented from so doing and; (c) to recover possession of a body where it has been removed from a mortuary or morgue without the permission of the coroner.

42. The existing legal provisions regarding the removal of a body from the State should be reworded so as to positively direct that no body should be removed from the State unless approval to do so has been obtained from the coroner in whose district it lies.
43. A coroner should be empowered to request an exhumation from the Minister on his own initiative without first having to be requested to do so by the Gardaí.

3.3.5 Post-mortems**Discretion and obligation to hold**

Under existing provisions, a coroner has a discretion to order a post-mortem where an inquest is to be held but does not have to proceed with the inquest if the post-mortem indicates that the death was due to natural causes. There is, however, no statutory requirement for a coroner to order a post-mortem even though he may be of the opinion that a death was not, in fact, due to natural causes. It seemed to the Group that there should be such a requirement, given that no natural cause of death could be established. The obvious exception to this rule would be where a body had already been buried without a post-mortem, and an exhumation was not deemed necessary for the inquest to proceed. Similarly, if the body has already been destroyed or irrecoverable, a post-mortem could not be mandatory.

In addition, a statutory basis in relation to circumstances and procedures for the removal, retention and disposition of tissues and organs in coroner directed post-mortems should be set out in Coroner's Rules.

State Pathologist

The role of the coroner in the procedures whereby Post-mortems are carried out by the State Pathologist was reviewed by the Group. Currently, the coroner is legally obliged to request the services of the State Pathologist and to secure ministerial approval for doing so. The cycle of requests and notifications which involve the Gardaí, the coroner and the Minister should be streamlined to exclude this need for prior approval by the Minister. The Gardaí would accordingly directly request the services of the State Pathologist on authorisation by the coroner, who would be obliged to give such authorisation on request of a Garda, not below the rank of Inspector. The procedures governing these special Post-mortems should be established in Coroner's Rules as set out in the Outline Coroner's Rules in Appendix J.

Qualified persons

It must be remembered that it is the coroner who directs that a post-mortem be carried out. It has already been pointed out that the post-mortem itself should be fully defined in terms of a three-cavity procedure and the Group feel that it is now opportune to clearly establish that it should be carried out by a qualified pathologist. It is important to provide however that in asking a particular pathologist to carry out a post-mortem, a judgement will have to be made in relation to whether or not the pathologist's association with a particular hospital would be likely to be called into question. Specifically, the Group expressed the view that any new legislative wording in this area should reflect the following:

A post-mortem shall not be made by a pathologist where the coroner considers the pathologist's association with the hospital is likely to be called into question at the inquest or is inappropriate.

Coroners' Rules should be used to help a coroner to decide in what circumstances a particular pathologist should not be requested by him to undertake a post-mortem.

RECOMMENDATIONS

44. There should be a statutory requirement on a coroner to order a post-mortem if he is of the opinion that a death has not been due to natural causes.
45. A statutory basis in relation to circumstances and procedures for the removal, retention and disposition of tissues and organs in coroner directed post-mortems should be set out in Coroner's Rules.
46. Coroners should be given the power to order a post-mortem from the State Pathologist without prior approval by the Minister. The procedures and circumstances governing these special post-mortems should be established in Coroner's Rules as set out in the Outline Coroner's Rules in Appendix J.
47. The Gardaí should also be permitted to request directly the services of the State Pathologist on authorisation by the coroner, who would be obliged to give such authorisation on request of a Garda, not below the rank of Inspector.
48. A Post-mortem should not be carried out by a pathologist where the coroner considers the pathologists' association with the hospital is likely to be called into question at the inquest or is inappropriate. Coroner's Rules should be developed to specify the appropriate procedures.

3.3.6 Inquests

The inquest is often viewed as the centrepiece of the coroner task and is certainly the one which is most familiar to the general public. It is of course, only part, albeit an important part of the full

cycle of coroner activities. A wide range of issues arise in relation to inquests and will now be considered. These include:

- courtroom facilities
- jurisdiction of the coroner
- verdicts
- recommendations
- discretionary and obligatory inquests
- inquests without a post-mortem
- disclosure of documentation in relation to an inquest
- adjournments
- disqualification from holding
- ensuring attendance
- immunity
- juries.

Courtroom facilities

In terms of the Group's commitment to a renewed focus on service to relatives, it was felt that physical facilities in the form of waiting rooms, toilet facilities and other basic infrastructure should be available at inquests. This is best achieved by an active and focused engagement with the Courts Service on how best to integrate developments in court facilities with the special requirement of those who must take part in an inquest process, which can often be a source of great trauma and upset.

Jurisdiction of the coroner

One of the most important issues addressed by the Group related to the question of coroner jurisdiction. In simple terms, this is often expressed in the form of a question as to how far the coroner can or should go in investigating the cause of death. Section 30 of the Coroners Act states:

"Questions of civil or criminal liability shall not be considered or investigated at an inquest and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when and where the death occurred."

A number of important legal cases have arisen over this issue and these are outlined in Cases A, B and C in Appendix G. Essentially, the argument focuses on the interpretation of "how" the death occurred. Should the interpretation be confined to the proximate medical cause of death, e.g. "asphyxia" or should the coroner look behind the medical cause and explain the death in terms of "asphyxia due to accidental hanging" or "asphyxia due to self-inflicted hanging." Should the interpretation of "how" be confined to "heart failure" or "heart failure due to an accidental overdose of a drug"?

The Group debated this issue at length and agreed that its resolution lay at the heart of the very reason for the coroner's existence. It must be remembered that the role of the coroner is activated by circumstances where a death has occurred in a violent or unfair manner or through negligence, malpractice misconduct, or unnaturally. There is an assumption of the possibility, given the particular circumstances, that an investigation is warranted in the public interest. The system reflects the value placed by our society on the preciousness of life and is part of the checks and balances used to account for sudden and unexpected death in whatever form. These public interest functions which point to allaying suspicion and making recommendations in the public interest are clearly set out in Case C, Appendix G.

Against this background, if the interpretation of "how" someone died is confined to the proximate cause of death (as some would argue) then the role of the coroner is confined to merely admitting the pathologist's post-mortem report at the inquest.

Since the coroner is disallowed from establishing criminal or civil liability, it has to be said that there are some dangers in prolonging or extending the brief in relation to establishing the cause of death. There is a balance needed between the continuum where at one extreme, a coroner may only register the proximate medical cause of death and at the other, carries out what amounts to a full judicial investigation as if liability were to be determined. In securing that balance, the Group are unanimous in their view that it is not appropriate to confine the investigation to the proximate medical cause of death as some interpretation of the legislation has indicated (see Cases A and B, Appendix G). This view does not, the Group believes, take into sufficient account the core reason for having a coroner system in the first place. Coroner jurisdiction should extend not only to establishing the medical cause of death but also to investigating the surrounding circumstances of death. The Group also felt that unlike the present wording in the Act, the duties and powers of a coroner at an inquest should be stated in positive terms along the following lines:

The inquest has a duty to establish the following: the identity of the deceased, when and where the death took place, the medical cause of death and the surrounding circumstances of death: in establishing this, the coroner is not permitted to allow any consideration of these matters which apportion civil or criminal liability.

Verdicts

The uncertainty about the jurisdiction of the coroner has, in turn, led to considerable confusion over the verdicts which can be returned at inquest. If the coroner must be confined to the proximate cause of death, verdicts such as suicide are problematic in that they can be considered to go beyond the proximate cause of death. Clarity about jurisdiction will go a long way towards resolving the verdicts issue but a number of points need to be discussed in relation to the general question of verdicts.

The suicide verdict

There was general agreement in the Group that if it was proved beyond reasonable doubt that a person took their own life, then a verdict of suicide should be recorded. Suicide verdicts should be returned as appropriate and the Group believe that this is in the interests of society generally, including relatives. Of paramount importance, however, was the sensitive handling of such cases by coroners and the need for support services to deal with bereaved families.

Verdicts in general

The Group observed a lack of consistent criteria for reaching verdicts and suggested that guidelines in this area be part of the Coroners' Rules as outlined in Appendix J. The general relationship between verdicts and jurisdiction should be positively stated along the following lines:

The verdict reached at inquest shall be the findings in relation to the matters established in accordance with (the new section 30 as detailed in the previous paragraph) together with conclusions as to death.

Power to make recommendations

The final point which is linked to the question of jurisdiction and verdicts relates to the power of the coroner to make "recommendations of a general character designed to prevent further fatalities". The Group felt that this function was consistent with the view of the coroner function taken by the Group in relation to the public service aspect of coroner work and should be continued in new legislation. It was noted that the coroner or jury only has the power to make "recommendations". While every effort should be made by other relevant authorities to follow up on such recommendations, the Group did not consider it appropriate to extend the strength of the coroner's input in this area. The proposed Coroner Agency could, it was felt, take a particular interest in ensuring that coroner recommendations were, in fact, appropriately

considered by the relevant authorities. The phrasing of recommendations could be very important and could be the basis of a “Best Practice” set of notes.

It was noted that other jurisdictions take different approaches and place great emphasis on the recommendations arising from inquests and the public safety aspect of their work. The Canadian system is a case in point.

RECOMMENDATIONS

49. The jurisdiction of the coroner should include the investigation not only of the medical cause of death but also the investigation of the circumstances surrounding the death. This should be expressed in positive terms in the new Coroners Act.
50. Coroners should continue to be disallowed from considering matters for the purpose of apportioning civil or criminal liability.
51. Given clarification on coroner jurisdiction, suicide verdicts should be returned whenever it has been established beyond a reasonable doubt that a person has taken their own life.
52. Verdicts should reflect both the results of the investigations as to the medical cause of death and the circumstances surrounding a death. Guidelines regarding the reaching and wording of verdicts in general, should be the subject of Coroner’s Rules.
53. The practice whereby coroners or juries can make general recommendations to prevent further fatalities should be continued.

Obligatory and discretionary aspects

There are situations where a coroner has discretion to hold an inquest and other situations where he has no choice in the matter. The present legal provisions in this regard are presented in a somewhat tortuous way in that some mandatory inquests are subject to the opinion of the coroner that an post-mortem will suffice in terms of carrying out an effective death investigation. Essentially, the position is as follows:

OBLIGATORY INQUESTS

He must hold an inquest if:

- he believes that the death may have occurred in a violent or unnatural manner
- he believes that the death may have occurred suddenly or from unknown causes (unless he thinks an post-mortem might establish the cause)
- the death occurred in a place or circumstance where another piece of legislation requires an inquest.

DISCRETIONARY INQUESTS

The coroner has a discretion to hold an inquest if a medical certificate is not available and he is unable to establish the cause of death.

Having discussed the issue, the Group felt that obligatory inquests should be extended to cover such situations as death in Garda custody, prison or workplace. Indeed the Group do not propose these extended situations as a conclusive list but recommend that any further mandatory inquests be considered by the Rules Committee in accordance with the Outline Coroners Rules in Appendix J.

The position with regard to optional inquests should be maintained in any general situation where the coroner believes the cause of death has not, for whatever reason, been satisfactorily established.

RECOMMENDATION

54. Mandatory inquests should be extended to include, at a minimum, situations where the death occurs in Garda custody, prison or workplace and the Rules Committee should review the issue to assess if further extensions are required.

Pre-release of documentation

The right of relatives to receive a copy of the post-mortem report has already been established in Section 3.3.2. **Difficulties arise, however, in relation to the release of documents once the coroner has decided to hold an inquest.** (The release of documents after the inquest does not, of course, raise any issue and all documents are available to all interested parties.) On the one hand there is a need to ensure that fair procedures are in place so that those attending the inquest will not be disadvantaged by not having sight of the documentation to be presented. On the other hand, it must be remembered that the coroner's court is not an adversarial one and is merely an investigation of the facts of a situation, i.e., an inquisitorial procedure. There are no adversaries and consequences of guilt or innocence. Consequently, the case for all parties having access to all documents is weakened. It may very well transpire, for example, that post-mortem reports at an inquest may prove to be inadmissible as evidence or even incorrect.

Having discussed the issue at length, the Group concluded that some element of discretion was needed by the coroner in the release of documents prior to an inquest. The problem was to secure a balance between the need for some coroner discretion on the one hand and the need for fair procedures on the other. In the final analysis, the Group decided that some discretion should be retained by the coroner but that it should be expressed in favour of release rather

than retention. Specifically, we recommend that new legislation should be worded to reflect the idea that documents should be released save for a number of specifically defined situations to be set out in Coroner's Rules.

RECOMMENDATION

55. Coroners should have discretion with regard to the release of documents prior to an inquest. New legislation, however, should be worded to reflect the idea that documents should be released, save for a number of specifically defined situations to be set out in Coroner's Rules. In any refusal of documents, the grounds for refusal should be given to the applicant.

Inquest without post-mortem

In general a post-mortem will precede an inquest. There are some situations, however, where this will not occur. If a body is already buried and an exhumation is not considered to be needed, the inquest can proceed.

If a body is irrecoverable, then the Minister has a role on directing an inquest. This situation was considered to be appropriate for Ministerial approval in that death may not be taken to be certain. If on the other hand, a body has been destroyed and death is certain, then it was felt that the Minister's intervention was not necessary and the coroner himself could proceed to inquest.

RECOMMENDATION

56. A coroner should be allowed, without the prior approval of the Minister, to hold an inquest on a person whose body has been destroyed and whose death is verified.

Inquest adjournment

Inquests must be adjourned for a specific time if the Gardaí indicate that criminal proceedings are being taken in relation to a death. The decision on whether or not to proceed with such an inquest is one for the coroner and the Group felt that the particular circumstances where such an inquest would, in fact proceed, should be spelled out in the proposed Coroner's Rules as outlined in the Group's notes on this topic. On a specific practical point, the Courts Service should ensure that when cases have been completed, details, including the name of the deceased and where they died, should be transmitted as a matter of obligation to the coroner. Furthermore, applications for adjournments of this kind should always be on points which refer to the cause of death – an issue not always addressed under current practice.

RECOMMENDATIONS

57. The criteria for deciding whether or not to resume an inquest which has been postponed due to criminal proceedings should be specified in Coroner's Rules.
58. The current legal arrangements whereby details of the outcome of criminal proceedings are conveyed by the courts to the coroner should be implemented in practice and should include the name of the deceased and where the death took place.
59. The appropriate systems should be in place to ensure that the Courts inform the coroner when criminal proceedings are concluded.

Witnesses

A number of specific points in this context were examined by the Group. While a coroner can call

witnesses, including medical witnesses, at an inquest, he is restricted from calling a second medical witness unless a majority of jurors ask him to do so. The Group feel that this is an unnecessary restriction in the context of (a) experience over the years (b) the realities of the subject matter of most inquests, and (c) the fact that coroners should not be confined to the proximate causes of death in their investigation.

RECOMMENDATION

60. There should be no restriction on the extent to which coroners can call medical witnesses.

Disqualification from holding an inquest

Given that a coroner can be either a solicitor/barrister or a doctor, it sometimes happens that he may have been involved in the medical or legal affairs of the deceased. The question of disqualification arises therefore. Under present arrangements a small number of these situations are set out in the primary legislation. The Group felt that these should be developed by the Rules Committee and included in Coroner's Rules.

RECOMMENDATION

61. The range of circumstances under which a coroner can be disqualified from holding an inquest should be set out in Coroner's Rules.

Ensuring attendance and production of documents

A coroner can issue a summons for any person to attend his court. While the Act currently provides that this be delivered to the person's address by the Gardaí, it would be more appropriate if the summons could also be delivered by registered

post. Failure to attend is only punishable by a five pound fine and the Group felt that this should be updated to at least £1,000. Having paid the fine, the person is still not obliged to attend court and the Group noted at a very early stage in their deliberations that the current provision in the Act which allows the coroner to cite for contempt is defective and contains a constitutional difficulty.

The problems revolve around the current powers of each coroner to certify the offence of contempt to the High Court. Judgements in other cases related to the actual certification of contempt have highlighted this issue and there is an urgent need to alter the contempt provision in line with constitutional imperatives. The Group recommend that the Tribunals of Enquiry (Amendment) Act, 1979 be used as a precedent in addressing this issue.

It should be noted that the powers of the coroner to help him to conduct court proceedings are not confined to the compelling of witnesses and may cover other aspects of court conduct such as production of documents and the obtaining of evidence. It is essential, however, that the powers relating to contempt envisaged by the original legal provisions are construed in such a way so as to render them constitutional. In practice, coroners need to be able to compel the attendance of witnesses and to insist on the production of documents. The Group felt that provisions based on the Tribunal of Enquiries (Amendment) Act, 1979 and the Committees of the Houses of the Oireachtas (Compellability, Privileges and Immunities of Witness) Act, 1997 would be appropriate legal precedents in this regard.

RECOMMENDATIONS

62. Fines for failing to respond to coroner summons to attend should be increased substantially to at least £1,000.
63. A summons to attend should be capable of being delivered by registered post in addition to delivery by the Gardaí.
64. Powers, including witness attendance and document production, should be given to the coroner to apply to the High Court to seek compliance with their directions. These powers should be based on the Tribunal of Enquiries (Amendment) Act, 1979 and the Committees of the Houses of the Oireachtas (Compellability, Privileges and Immunities of Witness) Act, 1997.

Anonymity of witnesses

The Group believed that anonymity of witnesses at the Coroner's Court was inappropriate except under highly warranted and unusual circumstances. On examining the issue, the Group could only make a case for two particular instances; State security and personal security. It would be up to each coroner to consider a particular application and keeping in mind the requirements of natural and constitutional justice, make a finding on the individual facts. Coroners would need specific training in this area. It should be noted that consequential amendments will be required to section 29 of the 1962 Coroners Act to ensure that anonymity in these cases is preserved.

RECOMMENDATION

65. Anonymity of witnesses should be confined to two specific cases where state or personal security is involved. The coroner should be given this limited statutory authority which should be exercised in accordance with the rules of natural and constitutional justice.

Immunity of coroners

The Group noted that while a level of immunity in relation to proceedings taken against coroners had been confirmed in recent years there was no reason why coroners should not be given general statutory immunity in line with other judicial persons. In giving such immunity it would, of course, have to be proved that the coroner was acting bona fide within his jurisdiction particularly in relation to statements made in the context of his coroner functions. As in other judicial aspects of coroner work, the particular approaches needed for ensuring compliance with this aspect of immunity would have to be part of the proposed coroner training programme (see Case D, Appendix G).

RECOMMENDATION

66. General statutory immunity in line with other judicial persons should be given to coroners provided they are acting bona fide and within jurisdiction.

Juries – obligatory use

As with inquests coroners have both discretionary powers and obligations when it comes to having juries at inquests. Currently a jury is obligatory where:

- someone came to his death through murder, infanticide or manslaughter (although the

Group recommend that “came to his death” be replaced by “may have come to his death”)

- some other non-coroner legislation requires juries at an inquest
- an accident, poisoning or disease was involved which required reporting to the authorities
- the circumstances of the death could recur and would be prejudicial to public safety or health
- death was caused by the use of a vehicle in a public place.

In general, the Group felt that these requirements should be retained with one exception relating to deaths caused by traffic accidents which should be discretionary rather than obligatory. Experience has shown that the coroner himself is in the best position to assess the implications of a particular traffic accident and to decide if a jury is necessary or whether a “routine” accident was involved. As with many detailed aspects of the legal provisions, the obligatory use of juries should be recast under Coroners Rules. The finalisation of these rules will need detailed research into the various pieces of legislation which currently require juries at inquests.

RECOMMENDATIONS

67. The current provisions regarding obligatory juries should be retained, with the exception of routine traffic accidents which should be at the coroner’s discretion.
68. Other obligatory uses of juries should be developed under the proposed new Coroner’s Rules.

Juries – general

Specific suggestions were made by the group in relation to some other aspects relating to juries at inquests. These are included in the recommendations set out on following page.

RECOMMENDATIONS

69. A jury should have an odd number of jurors and should range from 7 to 11.
70. A simple majority verdict should continue to be acceptable in all cases.
71. The coroner should be given access to the list of empanelled jurors required to attend the Circuit Court.
72. A different jury should be capable of being used where an inquest has been adjourned at which only evidence of identification has been taken and medical evidence has been given.

Media reporting

Since the hearing of an inquest is a public forum and a verdict of the coroner's court is one of public record, it is impossible to put restriction on what can and cannot be reported by the media. However, in consideration of the often distressful circumstances surrounding inquests there is a need for sensitivity to be shown to those involved. The Group were in general agreement with the recommendation of the National Task Force on Suicide and favour the adoption of a media code of practice which would apply to the reporting of inquests. This is considered to be the most appropriate way to respond to the sensitivity and respect due to the bereaved. It is noted that some media have already taken initiatives in this regard.

RECOMMENDATION

73. An appropriate code of practice should be adopted by the media to govern inquest reporting.

Recording

It was considered by the Group that the recording of all inquests through tape recording or stenographer would be excessively expensive and indeed, unnecessary. It was accepted, however, that some very complex cases may merit the use of some recording method, which could be used on the certification of the coroner.

RECOMMENDATION

74. Full recording of complex inquests should be facilitated on the certification of the coroner.

3.3.7 Review of coroner decisions

It must be said that a coroner makes crucial decisions which may have a significant effect on the relatives, both at the time of death investigation and for some time afterwards. Apart from the obvious decision regarding the actual verdict, a coroner may decide not to hold an inquest or in the course of an inquest, he may decide to take or not to take a particular course of action with which relatives may not be satisfied. Once decisions are made (in this case quasi-judicial decisions) the question of accountability for decisions arises, although there is currently no direct review from a coroner's decision. This general accountability may be expressed in a number of ways and not through any one particular avenue. A coroner can be the subject of judicial review but this review is usually confined to matters of procedure only. Furthermore, judicial review can be expensive from the relative's point of view and is not particularly user-friendly for reviews not pertaining to a point of law.

The existing 1962 Act provides for the Attorney General to direct a coroner to hold an inquest if, in his opinion, he considers it advisable, even if an inquest has already been held. This is the nearest

the system comes to providing an “appeal” mechanism but this recourse has also required clarification both by the Supreme and High Courts. (see case C, Appendix G). In spite of the Courts deciding in favour of the Attorney General’s powers to order a second inquest, there are still issues surrounding the best way of allowing for a review which is “friendly” to the applicant on the one hand and maintains public confidence in the coroner system on the other.

The Group spent considerable time analysing this issue and examined a range of options before recommending a particular approach. An appropriate review process should cover a number of different situations including:

- where a coroner has concluded that death was due to natural causes and issues a certificate to the Registrar of Births and Deaths following the reporting of a death
- where a coroner decides not to proceed with a post-mortem
- where a coroner decides not to proceed with an inquest
- where new evidence which is likely to change the original verdict has emerged
- where disagreement exists over a coroner’s handling of a first inquest
- where interested parties/relatives were not satisfied with the verdict at a first inquest
- where a coroner himself wishes to initiate a review.

In considering an appropriate review system, the Group were very aware of, and took into account, a number of points which apply no matter what review system is chosen. These included:

- irrespective of any formal review arrangement, judicial review would always be available to any aggrieved party including the coroner.
- grievances often arise from misunderstandings

and poor communications. The recommendations of the Group for improvements in these areas, particularly in the area of the proposed coroner’s officer, would, it was felt, go a long way towards resolving difficulties without having to resort to a review mechanism.

A wide range of options were considered by the Group and the following set of parameters were agreed. The review system should:

- be confined as far as possible to a residual situation where other avenues have already been exhausted
- such avenues should include direct discussion with the coroner and/or with the proposed coroner’s officers
- include a method of screening out vexatious or trivial complaints
- be inexpensive, accessible and user friendly from the bereaved’s point of view
- recognise the requirement that the principles of natural justice must not be confined to the interested parties, but should also apply to coroners – this involves allowing coroners to have their case fully stated in any new system
- capitalise, where possible, on the strengths of the existing public interest authority, i.e. the Attorney General
- be confined, in decision terms, as to whether or not a first or second coroner inquest should take place, i.e., the review must not involve a consideration of the substantive matters to be decided at inquest
- be capable of taking into account all available expert advice, particularly medical advice
- be non-adversarial in the sense of avoiding an adversarial judicial process.

Based on these parameters, the Group adopted an approach which attempts to build on existing

structures but which satisfies the criteria set out by the Group. It is proposed to retain the application for review to the Attorney General as guardian of the public interest but under a new arrangement where, before taking a decision on whether to order a coroner inquest, the Attorney General would be advised by an independent Review Board. This Board would consist of a member of the Bar of Ireland, a member of the staff of the Attorney General and a member nominated by the Coroner's Association. The Board would be appointed on a standing basis and a panel of suitable members would be maintained.

The Board would be responsible for:

- observing the rules of natural justice in all its dealings with the parties involved
- examining the written submissions of the various parties
- consulting, if requested, or on their own initiative, the relevant coroner involved in the review
- consulting, if requested, or on their own initiative, the person(s) making the complaint
- consulting medical evidence as appropriate including the view of the pathologist involved
- making recommendations to the Attorney General regarding whether or not, as appropriate, a first or a second inquest needs to be held.

The final decision on whether or not to hold a second inquest would be made by the Attorney General in his role as guardian of the public interest. The Group stresses that such a review arrangement is positioned firmly on the expectation that recourse to the Board will not occur in a significant number of cases and that the new structures being recommended by the Group will play an active part in clarifying misunderstandings and generally helping those affected to understand the coroner system and

how it works. In addition, the Attorney General should not forward a review for consideration by the Board unless he is satisfied that the application for review is neither vexatious nor frivolous.

It should be noted that this review process cannot, for logistical reasons, apply to situations where an immediate time-critical remedy or action is required such as where a family might wish to challenge a coroner's decision to hold a post-mortem. In such cases, judicial review will apply.

Development of coroner law

While the Group were firmly of the view that a review system on the lines of the above is a critical part of any revised coroner system, it must be pointed out that the proposed review mechanism is only one of a number of ways in which aspects of the coroner system can be examined and reviewed. As already pointed out, judicial review must continue to be a critical part of the coroner system and is not prejudiced by the above mentioned review system. Indeed, judicial review is of particular value when a point of law is to be reviewed. Without it the development of coroner law would be impeded and the service as whole would lack the ongoing input of legislative adjustment and reform needed in such a complex area of law.

In recognition of this requirement to ensure the development of coronial law, the Group took the view that the use of the consultative case-stated procedure should be available to the coroner in certain circumstances. Legal advice from the Attorney General would of course be available on an ongoing basis to coroners but the case-stated procedure would also have a useful role. In order to prevent any unproductive overuse of the procedure, the Group felt that: (a) coroners should first seek legal advice from the Attorney General before proceeding to state a case and ; (b) appropriate circumstances in which the procedure may be used should be set out in Coroner's Rules.

In summary, therefore, the process of review in the coroner system should be characterised by a variety of approaches to include both a user-friendly facility focused on client service and an equally important legislatively-based system which facilitates the essential development of coroner law. In the context of the various review options available, it will be important to identify and to point out to relatives any time constraints which apply in the exercise of any particular option. The Group feels that its recommendations in the area of coroner's officers will lead to a correspondingly enhanced facility for internal review which will also add to the thoroughness of the review process.

RECOMMENDATIONS

75. Without prejudice to the role of judicial review for all parties in all aspects of the coroner system, an application for a review should be provided to the Attorney General in relation to a specified range of situations arising from a decision by a coroner. These situations should include:
- where a coroner concluded that death was due to natural causes and issues a certificate to the Registrar of Births and Deaths following the reporting of a death
 - where a coroner decided not to proceed with a post-mortem
 - where a coroner decided not to proceed with a inquest
 - where new evidence likely to change the original verdict has emerged
 - where disagreement exists over a coroner's procedural handling of a first inquest

- where relatives or other interested parties were not satisfied with the verdict at a first inquest
 - where a coroner himself wishes to initiate a review
76. The Attorney General, having carried out an initial assessment of whether or not any of the above applications for review is frivolous or vexatious, should refer the application for review to a Review Board who, using procedures to be set out in the proposed Coroner's Rules, will advise the Attorney General in relation to whether or not a first or second inquest or enquiry is to take place. The final decision on the holding of such an inquest or inquiry would be a matter solely for the Attorney General.
77. The proposed Review Board should consist of three members as follows:
- a member of the Bar of Ireland or Law Society of Ireland
 - a member of the staff of the Attorney General
 - a member of the Irish Coroners Association.
78. The range of recommendations which can be made to the Attorney General should include:
- that a first inquest or enquiry be held and the review granted
 - that a second inquest or enquiry should be held and the review granted

- that no further inquest or inquiry should be held and the review refused.

79. Coroners should be permitted to make a consultative case-stated subject to consultation with the Attorney General and subject to any constraints specified in the Coroner's Rules.

80. There should be no time bar on any application for review to the Attorney General subject to any statute limitations set by legislation.

3.4 ORGANISATION AND MANAGEMENT

3.4.1 Organisation and numbers

As already outlined, coroners are organised on a district basis and come in contact with a range of State Departments and Agencies. All coroners are part time. There are 48 coroners, approximately half of which have medical qualifications with the other half having legal qualifications. Districts are roughly equivalent to local authority county areas although as shown in Appendix H, in some cases there are a number of coroners in the same county. Local authorities fund salaries and expenses and are responsible for the appointment of coroners on the recommendation of the Local Appointments Commission. Around £2mn is spent annually by local authorities on salary and expenses for coroners and this does not include the administration expenses of the local authorities themselves.

The high number of coroners in the country is related more to a time of poor communications and transport rather than to an analysis of service requirements. Like many aspects of any service which has evolved over time without serious review, arrangements have continued based on

nothing more than tradition. There is currently no link between the organisational structure and the most appropriate and effective means of delivering the service. In the interests of securing an efficient and well-resourced modern coroner service, the Group felt that considerable rationalisation of the number of coroners was needed. This would provide for:

- a more cost-effective coroner service
- improvement in services related to
 - better use of resources in terms of economies of scale and a reduction in overheads
 - overall improved funding arising from the more focused objectives associated with a streamlined service
- a more highly trained and specialised cadre of coroners with opportunities for deepening the "professional" aspect of coroner work
- a small team of coroners where teamwork, close communication and growing professional skills would best reflect the requirement of the service well into the new century.

In specific terms, the Group considered that, over time, such rationalisation should proceed to a regional arrangement. In progressing to this vision of a new coroner service, the Group felt that any rationalisation of existing arrangements should be on the following basis:

- that vacancies in coroner posts would be used to evolve towards the regionalised structure with one or more coroners in each region
- that no sub-county vacancies would henceforth be filled with the exception of the larger county boroughs.
- that amalgamations be used wherever possible to significantly reduce the number of coroner posts where suitable vacancies occur

- that the issue of existing acting posts be resolved as soon as possible in the context of evolution to the new arrangements.

In opting for a regionalised structure for coroners, the Group examined a number of options in this area. An exercise was carried out which mapped levels of coroner activity onto both health boards and court circuit regions. On balance, the courts regional system seemed more appropriate but the Group recommends that while the courts circuits could be the general basis of a regional structure, a detailed assessment of other considerations would have to be undertaken before an optimised regional structure could be established.

Other factors to be taken into account would include:

- demographic factors
- caseloads
- population densities
- availability of coroner-related facilities within a region
- physical distances involved.

This task would be one of the first duties of any new Coroner Agency and should be carried out in consultation with all interested parties. It cannot be sufficiently emphasised that reducing the number of coroners and moving towards a regional structure are but single elements of the overall package needed to create the new service envisaged by the Group. Some of these other elements are matters of administrative detail and others are critical to the overall feasibility of the approach recommended by the Group. Included in these critical elements are:

- the personnel infrastructure needed to underpin the new arrangements, particularly the arrangements for coroners officers.
- the absolute requirement to ensure that adequate and appropriate pathology,

toxicology, histology and mortuary facilities are in place

- the assignment of clear responsibility for managing and implementing the levels of change proposed.

RECOMMENDATIONS

81. The number of coroners should be reduced over time evolving to a regional structure with one or more coroners in each region.
82. A programme of rationalisation should be commenced with vacancies being used to progress to such regional structure as early as possible.
83. The issue of existing acting posts should be addressed as soon as possible in the context of evolution to the new arrangements.

3.4.2 Personnel Infrastructure

One of the weaknesses in the existing service lies in the lack of administrative support required to deliver optimal services to relatives. Ongoing support of relatives during the whole cycle involved in a coroner's investigation is critical and often beyond the capacity of individual coroners as presently organised. Indeed, support should not be confined to relatives but extended to all those who have been traumatised by sudden death. Train drivers who are innocent parties to suicide attempts, are a particular case in point and deserve the highest levels of support by all. Part-time coroners depend on the secretarial staff available from their doctors or solicitors practice and such support, while representing the best that can be provided under the circumstances, is often unable to meet the demands of a modern coroner service to provide a high quality service to relatives at times of crisis for them. The Group noted that current problems with many aspects of

the coroner service often revolved around misunderstandings and poor communications often due to the lack of resources to engage with the relatives at particularly important times.

In order to address these issues and as part of the overall new structures, the Group felt that a new “coroner’s officer” or “coroner’s administrator” should be introduced at regional level to provide a range of support services for the coroner. In view of the nature of the work, it is recommended that the position be open to the wider public service (local authorities, health boards etc.) so that the opportunity to secure the appropriate levels of skills and experience is maximised. The posts should be set at around higher executive officer (civil service) level and should be introduced on a pilot basis to assess the full range of functions and duties which might be involved. Administrative support for the coroners’ officers will also be required and while it is difficult to estimate precisely in advance of the pilot schemes, such support should be in the order of two staff per region, at around Executive Officer and Clerical Officer level. In general, the Group felt that the duties of the coroner’s officer which might be included would be as follows:

- assisting the coroner in arranging Post-mortems and handling liaison with the pathology service
- arranging for the identification of the body in conjunction with the Gardaí
- maintaining liaison with relatives throughout the cycle of coroner involvement and ensuring that they are kept as fully informed as possible about the current position and the procedures involved
- arranging inquests, including liaison with all parties involved
- ensuring appropriate support for relatives by developing and maintaining contacts and relationships with appropriate voluntary and statutory organisations

- assisting in the practicalities of holding the inquest and following up on post-inquest procedures
- processing enquiries from relatives, the public and the press
- managing the information systems of the coroner’s office including the application of information technology and interfacing to national systems of coroner information
- managing the interface between all the significant players in the coroner system including mortuary staff, the Gardaí, undertakers etc.
- ensuring that a comprehensive information pack is available both to the general public and to relatives of the deceased
- liaison with the proposed “designated person” suggested in Section 3.3.2.

The Group wished to restate that it sees the coroner’s officer as an essential element in their overall proposals for the new coroner service. As with many aspects of evolving towards a regional structure, the ongoing introduction of coroner’s officers will have to take place on a planned co-ordinated basis in order to maximise the contribution of this new level of support to both coroners and the public. Such evolution is further discussed in Section 3.4.6. It should be noted that the introduction of coroner’s officers will also have the benefit of releasing Gardaí from many of the administrative tasks involved in their dealings with the coroner service.

The planned introduction of coroners’ officers at regional level should take place against a backdrop of co-operation and support from the Courts Service. The Group felt that such co-operative measures should seek to maximise the general co-operation between the Courts Service and the new coroner service.

RECOMMENDATIONS

84. A new post of coroners officer should be introduced at regional level to act as a general support to both coroners and relatives.
85. Detailed functions should be determined by the introduction of the post on a pilot basis but should be generally based on the parameters as set out in Section 3.4.2. of the report.
86. There should be one post per region at around higher executive level (civil service) with appropriate administrative support. Recruitment should be from the wider public service.

3.4.3 Critical support services

One of the other essential elements in any coroner service relates to the availability of pathology services. A coroner service simply cannot operate without good and timely pathology services. Problems and issues in the availability of a pathology service are, by definition, problems and issues in the coroner service. The Group noted with concern that the present arrangements for pathology services for the coroner are relatively unstructured and can vary from adequate in some areas to a total lack of service in other areas. One of the reasons for this situation is that the service to the coroner is not based on any form of contract or formal arrangement but appears to arise from practice over the years.

In the absence of a right to pathology services, situations can arise where the general goodwill between coroners and pathologists fails and service is endangered. The Group is strongly of the opinion that this situation cannot form part of any new coroner system. There is an absolute need for pathology services to be guaranteed on

a formal basis as of right to a coroner. Any other kind of arrangement cannot meet this basic requirement. A regional register of "on-call pathologists" would also be an essential element of any new arrangements.

The Working Group also recognises the need for the availability of doctors trained in forensic medicine who could visit and make a preliminary examination at the scene of death. This would facilitate early and full assessment of deaths reportable to the coroner.

RECOMMENDATIONS

87. The present informal system for providing pathology services to coroners should be discontinued and such services should be made available as of right to coroners.
88. Support for regional coroners' officers should be provided in conjunction with facilities emerging from the development and improvement of the new Courts Service.

3.4.4 Histology and toxicology

The second element in the trilogy of critical services needed for coroners lies in the area of toxicology and histology. Even though the pathologist will have carried out the post-mortem, the samples still have to be analysed before the coroner can begin to draw conclusions. While histology reports (tissue testing) are a matter for the hospital laboratories, these services are also made available to coroners on an informal basis in the context of the relationship between the coroner and the pathologist performing the post-mortem, thus producing the same kinds of problems with pathology services as a whole. The Group noted that considerable delays can be experienced in histology reporting and feels that the timeliness of the service should be part of guaranteed arrangements to be

negotiated in relation to pathology services as a whole.

There are serious delays in producing toxicology reports (body fluids testing for drugs, alcohol etc.) which must be sent to the State Laboratory for quantitative analysis. Delays on the State Laboratory side can run into months and add considerably to the poor levels of service within the coroner system not to speak of causing additional stress and trauma for the relatives.

While toxicology testing is carried out through a mix of private and public sector bodies, the State Laboratory remains the main centre of excellence in this field. The Group understands, however, that other sources of toxicology testing are being considered by various other organisations. While the Group do not wish to make specific recommendations which would interfere with the market forces involved in the provision of toxicology services, there is a clear requirement for an improved turnaround period for such services. This is not a criticism of the State Laboratory who provide a very professional high quality service within the resources allocated to them for coroner work. Indeed the Group considers that the State Laboratory is in a unique position to develop and maintain the kind of "centre of excellence" required in this area for the country as a whole. The problem lies in the resources required to ensure an acceptable turnaround time for toxicology reports for the coroner system. These are at present unacceptable for meeting the kinds of minimum standards envisaged by the Group and expected as of right by relatives of the deceased.

RECOMMENDATIONS

89. The turnaround time for toxicology reports must be significantly improved by an appropriate and immediate investment in the provision of these services.
90. The turnaround time for histology reports should be improved by the inclusion of this aspect in new revised guaranteed arrangements for delivery of pathology services.
91. While the Group do not wish to interfere with the market forces supplying such services, the most pragmatic and immediate response to this issue is, at least in the short term, and in the absence of other providers, best served by additional funding for the State Laboratory service.
92. A centre of excellence should be maintained in this area and is best provided by the State Laboratory.

3.4.5 Post-mortem facilities

The final element in the area of critical services available to the coroner is the availability of appropriate post-mortem facilities. A survey carried out by the Faculty of Pathology and the Department of Health and Children established that around a total of 4,000 post-mortems are carried out each year at hospital facilities. Given the high proportion of post-mortems which are, in fact, coroner's post-mortems, (approx. 80% to 90%) the improvements needed in this area are central to the improvement of the coroner service. At present, the standard of these facilities available to the coroner service vary considerably from adequate in some cases to seriously deficient in others. The Group appreciates that the standard of post-mortem facilities cannot be held

at the same level throughout the country and that in addressing the issue of providing adequate post-mortem and mortuary facilities, grouping and regionalisation of services will be required. For example, where dedicated mortuary facilities are not available, post-mortems might appropriately be undertaken at acute general hospitals which meet the required standard and where there is ready access to the expertise of a pathologist and suitable laboratory facilities.

Standards for post-mortem facilities should be developed as part of the upgrading programme. In relation to post-mortem facilities in hospitals, considerations should include:

- facilities being approximate to the operating theatre
- camera recording features
- maintenance of the highest levels of health and safety standards.

There is also a need for a small number of facilities to deal with high-risk infectious cases - these could be located at the larger academic teaching hospitals. There are, of course, issues of equity of access to such facilities and the effect which the lack of such will have on relatives. All initiatives in this area will need to be co-ordinated with any other developments focused on improving the hospital service in general, particularly the Department of Health and Children's capital programme and the activities of the Health and Safety Authority. The funding aspect is discussed at Section 3.4.8.

Finally, the Group are very conscious of the critical role played by mortuary employees and their overall contribution to a high quality coroner service. The importance of their role would need to be reflected in any new arrangements for the coroner service.

RECOMMENDATIONS

93. Existing mortuary and post-mortem facilities should be urgently upgraded on a planned basis having regard to the need for the distribution of such facilities throughout the country.
94. Upgrades should be carried out to the appropriate standards applying to the various types of facilities involved.

3.4.6 Structural changes

One of the major obstacles to the development of the coroner service has been the lack of any overall single focus of responsibility for the maintenance and development of the service. It is clear to the Group that meeting the challenges faced by the service into the new century will not only require a single dedicated management framework but also a positive commitment to guiding and directing the high levels of change reflected in the recommendations in this Report.

Against this background the choice of an appropriate structure for the new service is critical and the Group spent a considerable amount of time discussing this issue. The broad options considered by the Group included:

- building on existing arrangements and fine-tuning the management and other processes involved
- establishing the new coroner service as part of the Department of Justice Equality and Law Reform
- attaching the coroner service to the Courts Service
- establishing totally new structures (a Coroner Agency) with a definite and separate brief to establish and develop a new coroner service.

Building on existing arrangements

It was clear to the Group that the existing arrangements were not addressing and could not fully address current service needs. They were more an accident of history rather than an arrangement with any particular focus on an integrated coroner service let alone possessing a capacity for change management. Over many years a special relationship has existed between local authorities and the coroner service. As already noted, local authorities pay the salary, fees and expenses relating to coroner activities and also make the formal coroner appointments based on recommendations from the Local Appointments Commission. Given the important role of local authorities in relation to local development and provision of a wide range of services there was initially a clear rationale for the linking of the coroner service with local government. This was particularly the case when local authorities were also the health authorities. However in this regard since the 1970's in particular the health functions generally have transferred to new regional boards. Additionally, given the quasi-judicial nature of the coroner service it is clearly appropriate that courthouse accommodation, which in general was owned and maintained by local authorities should be made available for the carrying out of coroner activities. Again in this latter regard, with the establishment of the Courts Service, the local authorities will no longer have responsibility for maintenance and improvement of courthouses.

It is clearly appropriate that revised arrangements need to be put in train. There is now little rationale for a continuing link between the coroner service and local authorities generally. While acknowledging the very important role which local authorities have played for many decades and the excellent relationship which has generally existed at local level between local authorities and coroner staff, the time has now come to move forward on the basis of new arrangements.

A separate brief for separate parts of the service had resulted in sporadic and reactive change and only then in the face of impending crisis. Apart from Dublin City which has attracted funding and public interest because of the sheer scale of the operation, the service had, for many years, relied on a public sense of duty on the part of individuals who were, in the main, part-time public office holders. These core conclusions were stressed in both the Organisation and Service subgroup Reports.

While much was achieved and the service evolved in its own fashion, standards of procedures and consistency of operation varied throughout the country. Support services in the form of pathology and mortuary services also varied considerably from satisfactory in some cases to almost non-existent in others. While dedicated contributions from individuals working in the various parts of State and local authority organisations currently involved in the coroner service have helped the service to keep pace with societal demands, such individual effort will not be adequate in the future. A more integrated approach is, therefore, critical to any proposals to implement the level of change and development needed. The Group feels that such integration will not be provided by the present arrangements. In assessing structural options, the advantages and disadvantages of each option were fully evaluated and discussed at great length.

New Structures

In moving beyond current arrangements, the Group set out the criteria to be used in choosing an appropriate structure. It was felt that any new organisation should:

- have a strong management focus concentrated exclusively on the coroner service
- consist of an organisation exclusively devoted either to the coroner service or contained within to a closely-related service.

- be in a position to provide an appropriate input into for all core coroner services
 - have a inbuilt capacity for change management
 - be capable of carrying out the full range of organisational and personnel restructuring
- involved in moving to the vision of the new service as set out by the Group
 - constitute a viable organisation in itself in terms of its ability to staff and maintain the appropriate levels of expertise needed to carry out its mission.

Locating a new coroner service in the Department of Justice, Equality and Law Reform (with liaison to Courts Service)

Advantages

- single Department focus
- existing management set-up, competence and expertise
- well-positioned to ensure full staffing of coroner dimension
- set-up costs probably less than alternatives
- organisational viability guaranteed

Disadvantages

- inconsistent with Strategic Management Initiative (SMI) policy which delegate operational functions to agency bodies
- competing with other prime focus of Department in terms of resources and attention
- new vision for coroner service best achieved by organisation solely dedicated to that purpose

It was considered that while the Department has a critical role to play in the future evolution of the service, the location of the new service in that Department at this point in time was in direct opposition to the strategy already put in place to devolve the operation aspects of the Department's activities to other agencies and to focus on policy issues. With the devolution of the Courts Service, the Prisons Service and with plans well-advanced to reconstitute the Land Registries as an independent commercial semi-State body, that policy was well under way and the absorption of the coroners service would not be consistent with these major Departmental objectives.

Quite apart from policy considerations, it was felt that an arrangement more dedicated to the single objective of implementing a vision for the coroner service of the future was more appropriate to other arrangements. As regards the links to the Courts Service, it was considered that these links were not dependent on the location of the service in the Department and could be used no matter what structural arrangement was finally chosen.

Attaching the coroner service to the Courts Service

Advantages

- avoids duplication of organisational structural arrangements
- strong management structure already in place
- well-positioned to ensure full staffing of coroner dimension
- set-up costs probably less than alternatives
- economies of scale possible when considered as part of Courts Service
- organisational viability guaranteed
- builds on existing links with courts system e.g. use of existing court facilities, role of County Registrar in maintaining coroner records, notification of completion of criminal proceedings etc.

Disadvantages

- coroner service may not be seen by existing court stakeholders as central to core service to be delivered by the Courts Service
- coroner funding may be affected by priority in courts service provision i.e. the coroner service may become the "poor relation" of the Courts Service
- the absence of a single change management focus for the coroner service may prejudice success in installing the new service
- the new vision for the coroner service set out by the Group is best achieved by an organisation solely dedicated to that service
- difficulty of establishing an inquisitorial service within an adversarial service.

The Group were, from an early stage, very aware that the newly-established Courts Service might well represent an appropriate home for the new coroner service. The arrangement is not without precedent and indeed, the Northern Ireland coroner service is contained within the courts service. The office of coroner is, of course, a quasi-judicial one and while its functions cover an investigative and administrative dimension, the heart of the coroner's inquiries lies in the inquest, a judicial process which, while not adversarial, has many of the hallmarks of what might be termed a "traditional" court procedure.

Establishing a separate Coroner Agency

Advantages

- single focus on achieving coroner service objectives
- no deflection of management endeavour
- no contention between potentially conflicting priorities
- guaranteed application of available funds in the interests of the coroner service
- dedicated capacity for generating and implementing the visions needed for successful implementation of the Group's recommendations

Disadvantages

- small agency may find staff turnover a problem
- set up costs will be greater than for an established organisation

The final structural model considered by the Group was the establishment of a separate dedicated agency, associated with the Department of Justice, Equality and Law Reform but with independent functions in relation to the wide range of activities required to operate the service. While the argument for and against this proposal may well be considered in conjunction with the arguments relating to the Courts Service, the Group felt nevertheless that a separate analysis was warranted and that this option had distinct characteristics which clearly separated it from the Courts Service model.

Analysis and conclusions

In balancing and analysing the pros and cons of the main structural options, the Group felt that the choice lay essentially between the Courts Service and the Coroner Agency. Either option was viable and both had particular strengths and weaknesses as outlined above. However, in the final analysis, and in all the circumstances, the strong consensus in the Group favoured the establishment of a separate agency dedicated to the new coroner service. Three factors influenced the final decision on this recommendation. These involved:

- the level of dedication needed to actively pursue and deliver on the objectives set out in the Group's Report
- the extensive change management needed by the new service to bridge the gap between the

present structures and services and the vision of the service as set out in the Report

- the belief that a separate dedicated agency unrestricted by priorities in the courts area, would represent the best organisational form to generate and maintain the wide variety of positive and active relationships needed with all those involved with the coroner service, whether health Boards, the Gardaí, hospitals, pathologists, undertakers, safety authorities, local authorities, relatives of the deceased or others who have been traumatised by sudden or tragic death.

It is not, the Group felt, simply a question of confining the evaluation to the relative financial costs of both main options, although a cost effective service has always been an objective of the Group. An important dimension is the ability

of the new structure to deliver the kind of dedicated and focussed change needed for the level of reform reflected in the Group's recommendations.

In this context the group wishes to acknowledge that the Department of Finance were of the view that the coroner service does not have a critical mass sufficient to warrant a new agency status with the attendant overheads involved. They felt that the functions outlined in recommendation 96 would be most effectively and economically managed by the Courts Service having regard to the quasi-judicial nature of the office and the proposed regional arrangements.

This view was not supported by any member of the Group.

In terms of how the agency would be organised, it is suggested that it be headed by a Director, who would, in turn, report to a Board of Management representing the critical constituent members of the coroner system. These would include the following:

- Department of Justice, Equality and Law Reform – given their lead role in the service as a whole
- Department of Health and Children – given their role in funding many of the critical services needed to run the coroner system
- Coroners Association of Ireland – given that they are in the front line of service delivery
- Faculty of Pathology, R.C.P.I. – given the ongoing input needed in this critical area
- Courts Service – given the strong links and scope for co-operation between the two services
- An Garda Síochána – given their investigative and support role in the coroner service
- Advocate for the general public.

While it is difficult to estimate the numbers of staff required for the new agency functions, the

Group felt that indicative measures should be included in the report. On the basis of the functions set out in recommendation 96, it is estimated that one Principal (Head of Agency) one Assistant Principal, one Higher Executive Officer, two Executive Officers and four Clerical Officers would be required to discharge the agency functions.

RECOMMENDATIONS

95. A new statutory agency should be established to be known as Central Coroner Services (CCS) to reflect the core concept of service to both coroners and the public and its central role in relation to the future shaping of the new service.
96. The range of functions of the new body should include:
 - routine processing of coroner salaries and expenses
 - devising an optimum regional structure for the new coroner service
 - establish the best way of implementing the various staffing and structural recommendations of the Group
 - providing an appropriate input into guaranteed arrangements for core coroner services.
 - developing co-operative measures with the Courts Service
 - supporting the implementation of Coroners' Rules.
 - supporting and developing a high quality of service
 - encouraging and facilitating "best practice procedures"

- preparation and implementation of training programmes for coroners
 - information dissemination
 - coroner liaison with other relevant statutory and non-statutory groups
 - liaison with Department of Health and Children on general hospital refurbishment programme
 - processing of industrial relations issues
 - budget negotiation and management
 - developing and co-ordinating role of coroners in disaster planning
 - supporting and encouraging the use of information technology
 - supporting and developing a national information system for coroners
 - producing an annual report for presentation to Government on general coroner activities and progress achieved in restructuring the service.
97. The new agency should be headed by a Director who would have statutory responsibility for the operation of the entire coroner service. Staff would be seconded from the Department of Justice, Equality and Law Reform in accordance with the usual arrangements for this kind of agency. The level of the Director designate should be sufficiently high to reflect the importance of the post. The number of staff required for the Agency should be commensurate with its range of functions and is estimated at nine as set out in the Report.

98. The Director would report to a Management Board consisting of representatives from the following:
- Coroners Association of Ireland
 - Department of Justice, Equality and Law Reform
 - Department of Health and Children
 - Courts Service
 - Faculty of Pathology, R.C.P.I.
 - An Gardaí Síochána
 - The general public.

3.4.7 Industrial relations issues

The level of change contemplated in this Report will not be possible without many changes in the general conditions and remuneration arrangements applying to many of the principal parties involved, especially coroners. It has not been possible nor would it indeed have been appropriate, to examine the industrial relations aspects of all the changes recommended. One characteristic of such changes is that they will evolve over time and permit the kind of detailed negotiations needed to ensure a successful transition to the ultimate vision of a regional and full-time coroner system. One of the primary functions of the new agency will be to ensure a successful industrial relations engagement with all parties in conjunction with the relevant public service partners. The Group can only identify the need to positively address this issue and to take the appropriate steps to ensure success in the industrial relations aspect of the move to a new coroner service.

RECOMMENDATION

99. The implementation of the Group's recommendations should go hand-in-hand with addressing any consequent industrial relations implications.

3.4.8 Financing the new service

The point has already been made in this Report that the coroner service has lacked any form of structured investment and that new structural and staffing arrangement will prove ineffective unless they are accompanied by a funding commitment to bring the service into the twenty-first century. The Group found it difficult to assign specific costings to the range of changes being recommended but were of the view that the new structures and arrangement would, in their implementation, result in a highly cost-effective coroner service fulfilling its mandate to provide a high quality service to the community. Some of the investment involved will fall to be incurred in any event to maintain basic services such as pathology services, toxicology and histology testing, better training facilities for coroners, improved support arrangements for coroners and relatives and all the other ingredients which are part of the modern public service becoming more and more evident in Irish society.

There are, however, some specific financial aspects to the new arrangements which deserve comment. Apart from the funding arising from the administration of the new service, the issue of the approach to all other coroner related funding was a matter of great concern to the Group. The question of the funding for upgrading mortuary services and post-mortem facilities is a case in point. There is an obvious connection between funding such facilities and funding general hospital expenditure. The Group feels that continuing pressure on hospital's budgets will mean that any "post-mortem" service will give way to services which focus on the living. This is a reality which must be faced now if one of the

mainstays of the new coroner service is to be put in place.

That reality, the Group feels, is best addressed by the unequivocal ring-fencing of such funding in such a manner as to remove the competition between it and other health related programmes and services. Failure to provide such ring-fencing will, the Group feels, result in "the post-mortem" service continuing to play 'catch up' with other health service and a failure to implement the core focus on improved coroner service as a whole in the interests of the bereaved. It is not a question of leaving the issue for resolution of priorities in the provision of health services. It is a question of a policy decision to recognise the coroner service as a service to the living and to dedicate funds accordingly so as to provide a degree of ring-fencing which amounts to the same thing as having a dedicated budget.

Expenditure undertaken by local authorities in relation to the Coroners service, which amounts to about £2mn. per annum, as with other current local authority expenditure is financed generally from a combination of commercial rates levied by local authorities, other fees and charges levied by local authorities and government grants from the Local Government Fund. The Group understands that the financial implications arising from the transfer of functions from local authorities to the new coroners service will be taken into account in discussions between the relevant Departments on finalising future funding arrangements for the new coroner service and local authorities.

For example, at current costs, the cost of upgrading mortuary services as necessary would be in the order of £5mn. Appropriate capital provision would have to be made for the development of such facilities in hospitals over a designated period of time. In order to ensure that funding is appropriately focused on coroner-related activities, whatever that amount might be, the Group felt that the new coroner service should have an appropriate input in the application of these funds and for achieving the

objectives set by Government in this area Any net extra costs arising from the introduction of coroners' officers and the establishment of a small agency to organise and lead the new coroner service, does, the Group feels, represent the minimum investment needed to fill the service gaps left by neglect of the service over many years and to re-position the service to its rightful place as a provider of high quality services in today's public service.

RECOMMENDATIONS

100. Funding relating to the administration of the coroner service supplied currently by the local authorities should be moved into the control of the proposed new central coroner agency in accordance with the outcome of discussions between the relevant Departments.
101. Dedicated funding to upgrade mortuary and post-mortem facilities should be provided and ring-fenced so as to remove such funding from other demands relating to health-related services.
102. Close liaison should be maintained with the Department of Health and Children to ensure compatibility between the activities of the central coroner agency and that Department's general hospital programme.
103. The new Coroner Agency should be allocated the function of providing an appropriate input into the guaranteed arrangements for all core coroner services.

3.5 MISCELLANEOUS

3.5.1 Treasure trove

This provision has no relevance to the work of the modern coroner. In fact, the Director of the National Museum has assumed the coroners jurisdiction in treasure trove under the National Monuments (Amendment) Act, 1994.

RECOMMENDATION

104. Reference to the coroners function in relation to treasure trove should be deleted from any future coroner legislation.

3.5.2 Definitions

A variety of definitions are needed in coroner legislation and these should be incorporated into the Coroner's Rules as set out in Appendix J. Particular attention should be given to the definition of "interested parties" in the context of the availability of information and documents throughout the coroner cycle.

RECOMMENDATIONS

105. Current references to the Medical Practitioner Act should be updated.
106. Post-mortem examinations should be defined as three cavity examinations carried out by qualified pathologists or a trainee under their direction.
107. "Interested parties" should be defined.

4. IMPLEMENTATION

One of the primary tasks of the new agency will be to develop a programme of implementation of these recommendations for the new coroner service. Given the amount of change involved, this will represent challenges for all those associated with the coroner service to change and to develop a vision of the new era of coroner activity set out in the Report. The period of change is, for some aspects of the service, unusually long in that the ultimate structure envisaged for the service is a function of the rate at which vacancies of all kinds will occur among coroners. Successful implementation will depend on commitment over a period of some twenty years.

Notwithstanding this evolutionary aspect, and indeed perhaps because of it, the importance of a definite, articulated and sequenced implementation strategy is critical. While it is virtually impossible to anticipate all aspects of a structure which involves a delivery schedule spanning twenty years, there are a wide range of deliverables which can be quantified in the short, medium and longer term which will contribute significantly to updating and reforming the coroner service. Against this background, the Group opted to identify the various implementation milestones involved in reaching the objective of a modern coroner service as envisaged by the Group.

For the purposes of describing these objectives, the following timescales will be identified:

immediate

What can be done following the publication and approval of the Report pending the preparation of legislation to establish the new agency?

short term

What objectives can be achieved as the final preparations are being made for the establishment of the new agency?

medium term

What should be the priorities of the new agency?

long term

What is the long term focus of the new coroner system?

IMMEDIATE STEPS

- There is no reason to delay the establishment of the Coroner's Rules Committee. A very definitive view has been given by the Group as to the focus and composition of the Committee.
- Some urgency surrounds the development of a coroner's pamphlet to address (a) the public information needs of the coroner system and (b) the need for documentation for use in the Group's suggestions about the issue of organ retention.
- To the extent that any follow up action is required in the wake of the Government decision on the Report, such action should be immediately undertaken.
- Basic training programmes for coroners should be initiated without delay in conjunction with the Department of Justice, Equality and Law Reform. These programmes could be extended to include reciprocal training concepts as recommended by the Group. Coroner training requirements related to people with special needs should be included.
- Initial work on preparing the new legislation could also commence during this phase.
- Advance legislation should be prepared to:
 - (a) revise the existing section 38 in particularly in so far as it relates to the compelling of witnesses to attend at inquests and;
 - (b) provide for the amalgamation of districts beyond county level.

- The availability of the services of a pathologist in all coroner districts should be ensured.
 - Liaise with Courts Service for use of courts facilities.
 - Investigate the issue of delays in the State Laboratory Service – funding, staff and equipment.
 - Introduce a revised Coroners Certificate as suggested by the Office of the Registrar of Births, Deaths and Marriages. (see Appendix L).
 - Ensure that the issue of an interim coroners certificate becomes standard procedure among coroners, to improve its level of acceptability as a certificate of fact of death.
 - In order to maximise progress and to prepare for the establishment of the new agency, it is recommended that a “Director Designate” be appointed to oversee all preparations for the new service. The immediate advantage would lie in the level of experience being gained by the Director and his or her ability to set in motion the various negotiations and systems required. Discussions with the Department of Finance in this regard should be initiated as soon as possible.
- carrying out a study of the optimal regional restructuring
 - providing appropriate input regarding guaranteed delivery of all core coroner services
 - developing an IT strategy for the coroner service, to include the development of dissemination of information and statistics etc.
 - initiation of industrial relations negotiations
 - examining the best arrangements for the delivery of services in Dublin City and County.

SHORT TERM STEPS

- Pending the establishment of the proposed Management Board, an informal implementation steering group consisting of the same membership could be established to assist in general preparations.
- Evaluation of pilot projects for a coroner’s officer with a view to confirming the role and functions of the post, estimating the extent of administrative backup required and evaluating the differences arising between the larger and smaller districts.
- Other activities relevant to this stage would include:
 - finalising all legislative proposals including Coroner’s Rules

MEDIUM TERM STEPS

The establishment of the new agency and the introduction of the new legislation will inevitably dominate this phase of development which will also involve bringing to fruition the various projects initiated in the short term phase

The main activities will include:

- establishment of Central Coroner Services and recruitment of staff
 - establishment of Management Board
 - development and strengthening of reciprocal training services
 - introduction of national IT strategy
 - appropriate contribution to ongoing industrial relations negotiation against a backdrop of emerging clarity about best structural
 - provide a statutory basis for the interim certificate so as to guarantee its acceptability as a certificate of fact of death by all public and private bodies.
- Introduction of new legislation.

LONG TERM STEPS

In the longer term, opportunities for creating pilot regions will arise and the basic nucleus of a regional structure will be emerging. Service contracts or equivalent arrangements will have been agreed and implemented and the full-time professional coroner will be in the process of evolution.

Critical activities at this point will include:

- installing procedures for maintaining consistent and high standards in every aspect of coroner work
- maximising the use of information technology in the delivery of services
- maintaining an impetus towards the full realisation of a complete regionalisation of all coroner services.

RECOMMENDATIONS

Some of the measures recommended for the implementation phase have already been identified elsewhere in the report. Those not mentioned include the following:

108. To facilitate the early implementation of the Group's recommendation, it is suggested that the Director designate be appointed to oversee preparation for the new service in advance of the introduction of the legislation to establish the new agency.
109. In conjunction with the appointment of the Director designate, an Implementation Committee with the same representation as suggested for the Management Board should be appointed to assist the Director in preparing for the new agency.
110.
 - Advance legislation should be prepared to:
 - (a) revise the existing section 38 in particular in so far as it relates to the compelling of witnesses to attend at inquests and;
 - (b) provide for the amalgamation of districts beyond county level.

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D	GUIDE TO THE 1962 CORONERS ACT
E	CORONERS ACT, 1962
F	LIST OF OTHER RELEVANT LEGISLATION
G	SUMMARIES OF RELEVANT LEGAL CASES
H	LIST OF CORONER DISTRICTS
I	CORONERS' ANNUAL RETURNS FOR 1999
J	OUTLINE CORONERS' RULES
K	DRAFT FORM FOR INCLUSION IN DIALOGUE WITH DESIGNATED PERSON
L	PROPOSED FORM FOR REGISTRATION OF A DEATH
	Selected Bibliography

APPENDIX A

GROUP AND SUBGROUP MEMBERSHIP

Main group

Haskins, John	Chairperson, Department of Justice, Equality and Law Reform
Barron, Anne	Office of the Attorney General
Bradley, Niall	County and City Managers Association
Cusack Prof. Denis	Coroners Association of Ireland
Farrell, Dr Brian	Coroners Association of Ireland
Fitzgerald, John	Department of Environment and Local Government
Fitzpatrick, John	Department of Finance
Howard, Supt. John	An Garda Síochána
Hurley, Patrick	General Solicitor
Keane, Michael P	Coroners Association of Ireland
Lawless, Breda	Eastern Region Health Authority
O'Brien Counihan, Dr. Ursula	Irish College of General Practitioners
O'Floinn, Angela	Department of Health and Children
O'Keane, Dr. Conor	Faculty of Pathology, RCPI
Thomas, Rosaleen	The Samaritans
Sweeney, Prof. Eamon	Faculty of Pathology, RCPI
Synnott, Noel	Department of Justice, Equality and Law Reform
Walsh, Elizabeth	Department of Justice, Equality and Law Reform

Replacements, substitutes and specialist contributors

Barry, Eugene	Department of Finance
Colbert, Maria	Division of Legal Medicine, UCD
Howard, Brian	Department of Health and Children
Kearney, Deirdre	Department of Environment and Local Government
McGovern, Cliona	Division of Legal Medicine, UCD
Moran, Dr. Desmond	Coroners Association of Ireland (President)
Morris, Paul	Coroners Association of Ireland
Murphy, Aileen	Department of Environment and Local Government
O' Niagh, Terry	(On behalf of Mr. Niall Bradley, County and City Managers Association)
O'Sullivan, Paul	Department of Health and Children
Sheehan, Dr. Bartley	Coroners Association of Ireland
Smith, Shay	Eastern Region Health Authority
Talbot, Charlie	(On behalf of Niall Bradley, County and City Managers Association)

Secretariat

Cullen, Niall	Department of Justice, Equality and Law Reform
Mc Cabe, Ann	Department of Justice, Equality and Law Reform

Subgroups

SERVICE ISSUES

Cusack, Prof. Denis (Chair)

Howard, Supt. John

Lawless, Breda

Mc Cabe, Ann

O'Brien Counihan, Dr. Ursula

Thomas, Rosaleen

ORGANISATION

Synnott, Noel (Chair)

Bradley, Niall

Fitzgerald, John

Fitzpatrick, John

Keane, Michael

O'Keane, Dr. Conor

O'Sullivan, Paul

Sweeney, Prof. Eamon

Walsh, Elizabeth

LEGAL

Barron, Anne (Chair)

Colbert, Maria

Cullen, Niall

Farrell, Dr. Brian

Hurley, Patrick

O'Floinn, Angela

ORGAN AND BODY PART RETENTION

Haskins, John (Chair)

Barron, Anne

Farrell, Dr. Brian

O'Flionn, Angela

O'Keane, Dr. Conor

Thomas, Rosaleen

APPENDIX B

PUBLIC ADVERTISEMENT FOR SUBMISSIONS

PUBLIC ADVERTISEMENT FOR SUBMISSIONS ON REVIEW OF THE CORONER SERVICE

The Minister for Justice, Equality and Law Reform, Mr John O'Donoghue, T.D., has established a Working Group to review the Coroner Service. The Working Group which consists of representatives from both the private and public sector, has advisory and recommendatory functions. Its terms of reference are as follows:

- to carry out a review of all aspects of the coroner service in Ireland and equivalent services in appropriate comparable jurisdictions
- arising from such a review, and on the basis of broad consultation with interested parties, to identify the issues which must be addressed to ensure that the coroner service represents an appropriate response to the needs of society
- to make specific recommendations in relation to these issues, including:
 - the most appropriate financial arrangements for the funding of the coroner service
 - the organisational structure within which the service is to be delivered
 - the nature of the core service to be delivered
 - the implications for other ancillary services
 - the legislative provisions required to implement such recommendations
- to identify the specific steps which need to be taken in the short, medium and long term in order to implement the proposed recommendations
- to furnish an interim report on the Group's deliberations within a period of one year

The Working Group invites submissions from interested groups and individuals on issues relevant to the above terms of reference.

Submissions should not arrive later than 16th April, 1999.

**Submissions, in writing,
should be sent to:**

**Secretary to the Working Group,
Room 127,
Department of Justice, Equality
and Law Reform,
72-76 St Stephen's Green,
Dublin 2**

**Submissions can also be made
by e-mail to:**

**submissions@justice.ie
or
by visiting the Department of
Justice, Equality and Law Reform
site at:
www.irlgov.ie/justice/**

The coroner is an independent officer who inquires into the circumstances of sudden, unexplained, violent or unnatural deaths. Such enquiries may require a post-mortem examination to be held sometimes followed by an inquest. If a death is due to unnatural causes, then, by law, an inquest must be held.

FÓGRA POIBLÍ I dTAOBH AIGHNEACHTAÍ MAIDIR LE hATHBHREITHNIÚ AR AN tSEIBHÍS CHRÓINÉARA

Tá Gasra Oibre curtha ar bun ag an Aire Dlí agus Cirt, Comhionannais agus Athchóirithe Dlí, Seán Ó Donnchú, chun athbhreithniú a dhéanamh ar an tSeirbhís Chróinéara. Tá feidhmeanna comhairleacha agus feidhmeanna déanta moltaí ag an nGasra Oibre agus tá ionadaithe ón earnáil phríobháideach agus ón earnáil phoiblí air. Is mar a leanas a théarmaí tagartha:

- athbhreithniú a dhéanamh ar gach gné den tseirbhís chróinéara in Éirinn agus ar sheirbhísí den tsamhail chéanna i ndlínsí cuí incomparáide
- ag éirí as an athbhreithniú sin, agus ar bhonn comhchomhairliúcháin fhorleathan le páirtithe leasmhara, na nithe a shainithint nach mór aghaidh a thabhairt orthu lena chinntiú go mbíonn an tseirbhís chróinéara ag freastal go cuí ar riachtanais na sochaí
- moltaí sonracha a dhéanamh i ndáil leis na nithe sin, lena náirítear:
 - na socruithe airgeadais is oiriúnaí a dhéanamh chun an tseirbhís chróinéara a mhaoiniú
 - an struchtúr eagrúcháin ar laistigh de a sholáthrófar an tseirbhís
 - cinéal na seirbhíse bunúsaí atá le soláthar
 - na himpleachtaí atá ann do sheirbhísí coimhdeacha eile
 - na forálacha reachtaíochta atá ag teastáil chun moltaí den sórt sin a chur i bhfeidhm
- na bearta sonracha a shainithint nach mór a ghlacadh sa ghearrthearma, sa mhéantearma agus san fhadtearma d'fhonn na moltaí a dhéanfaidh siad a chur i bhfeidhm
- turascáil eastramhach a chur ar fáil, laistigh de bhliain, ar bhreithniú an Ghasra

Iarann an Gasra Oibre aighneachtaí ó ghrúpaí agus ó dhaoine leasmhara faoi nithe a bhaineann leis na téarmaí tagartha thuas.

**Is ceart go bhfaighfead na haighneachtaí tráth nach déanaí
ná an 16 Aibreán 1999.**

**Is ceart aighneachtaí a chur
i Scríbhinn chuig:**

**Rúnaí an Ghasra Oibre,
Seomra 127,
An Roinn Dlí agus Cirt,
Comhionannais agus Athchóirithe Dlí,
72-76 Faiche Stiabhna,
Baile Átha Cliath 2**

**Is féidir aighneachtaí a sheoladh le
ríomhphost freisin chuig:**

**submissions@justice.ie
nó
trí chuairt a thabhairt ar shuíomh
na Roinne Dlí agus Cirt, Comhionannais
agus Athchóirithe Dlí ag:
www.irlgov.ie/justice/**

Is oifigeach neamhspleách an cróinéir a dhéanann fiosrú i dtaobh na n-imthosca a ghabhann le básanna tobanna, básanna gan mhíniú, básanna foréigneacha nó básanna mí-nádúrtha. D'fhéadfadh sé go mbeadh gá le scrúdú iarbáis a dhéanamh mar gheall ar na fiosrúcháin sin agus ionchoisne a sheoladh ina dhiaidh sin. Más cúiseanna mí-nádúrtha is cúis le bás, ceanglaítear le dlí ionchoisne a bheith ann.

APPENDIX C

LIST OF SUBMISSIONS

Written submissions

An Garda Síochána, Garda Headquarters,
Phoenix Park, Dublin 8.

Association of Health Boards in Ireland,
Dr Steevens' Hospital, Dublin 8.

Bereavement Care Group, Family Life Service,
12 Roche's Road, Wexford.

Bluett, Gerard, 28 Knockfree Avenue, Fairhill,
Cork.

Bolster, Dr. Margot A., Dept of Pathology, (U.C.C.),
Cork University Hospital, Wilton, Cork.

Brady, Dr. Bridin, State Laboratory, Abbotstown,
Dublin 15.

Brocklebank, Patrick, 45 Rose Park, Kill Avenue,
Dun Laoghaire, Co. Dublin

Callaghan, Dr. John, Consultant Pathologist, Dept
of Histopathology & Cytology,
University College Hospital, Galway.

Casey, Mary, 27 Woodview, Cahir, Co. Tipperary.

Cassidy, Dr. Marie Therese, Deputy State
Pathologist, Office of the State Pathologist,
Trinity College, 188 Pearse Street, Dublin 2.

Central Statistics Office, Skehard Road, Cork.

Collins, Daniel F., Commissioner for Oaths,
94 Westcourt Heights, Ballincollig, Co. Cork.

Corcoran, Rosaleen, Director of Public Health &
Planning, Secretary to the DsPH Group,
c/o North Eastern Health Board, Kells, Co Meath

Coroners Association of Ireland,
c/o Dr. Desmond Moran and Paul Morris,
63 Fitzwilliam Sq., Dublin 2

County and City Managers' Association,
Olaf House, 35-37 Ushers Quay, Dublin 8.

Desmond, Jim, Knock House, Rochestown, Cork.

Docherty, Anne,
2 Kilcross Grove, Sandford, Dublin 18.

Donegal County Council,
County House, Lifford, Co. Donegal.

Doyle, Dr. C.T., Dept of Pathology,
Cork University Hospital, Wilton, Cork.

Doyle Family,
Blanchfields Park, Clifden, Co. Kilkenny.

Drug Misuse Research Division,
The Health Research Board,
73 Lower Baggot Street, Dublin 2.

Eastern Health Board,
c/o Roger Greene & Sons, Solicitors,
14 City Gate, Lower Bridge Street, Dublin 8.

Eustace, Dr. Paul W., Consultant Surgeon,
Mayo General Hospital, Castlebar, Co Mayo

Fitzgerald, Sean, Superintendent Registrar,
Joyce House, 8/11 Lombard St East, Dublin 2.

Gaffney, Paul, Clinical Psychology Programme,
Department of Psychology, Trinity College,
Dublin 2.

Prison Governor's Group, c/o Governor's Office,
Loughan House, Blacklion, Co Cavan.

Guild of Anatomical Pathology Technicians of
Ireland (Joint submission with S.I.P.T.U.,
Health Services)

Harbison, Dr. J.F.A, State Pathologist,
Royal College of Surgeons in Ireland,
Department of Forensic Medicine,
188 Pearse St, Trinity College, Dublin 2.

Health and Safety Authority,
10 Hogan Place, Dublin 2.

Irish Association for Counselling and Therapy, 8 Cumberland Street, Dun Laoghaire, Co. Dublin.	Mc Nulty, Eamonn, Anatomical Pathology Technician, Letterkenny General Hospital, Letterkenny, Co. Donegal.
Irish Association for Suicidology, c/o St Mary's Hospital, Castlebar, Co. Mayo.	Medical Defence Union Limited, 192 Altrincham Road, Manchester M22 4RZ, UK.
Irish Association of Funeral Directors, 54 Aungier Street, Dublin 2.	Medical Protection Society, 33 Cavendish Square, London W 1 M OPS, UK.
Irish Medical Organisation, 10 Fitzwilliam Place, Dublin 2.	Mental Health Association of Ireland, Mensana House, 6 Adelaide Street, Dun Laoghaire, Co. Dublin.
Irish Mountain Rescue Association, 130 Glenageary Avenue, Dun Laoghaire.	Midland Health Board, Dept. of Public Health, Central Office, Arden Road, Tullamore, Co. Offaly.
Irish Patients' Association, 78 Seafield Court, Killiney, Co. Dublin.	Mid-Western Health Board, Central Offices, 31/33 Catherine Street, Limerick. (two submissions received)
Irish Sudden Infant Death Association, Carmichael House, 4 North Brunswick Street, Dublin 7.	Mohan, Dr. Angela, on behalf of Consultant staff, St. Brendan's Hospital, Rathdown Road, Dublin 7.
Kealy, Dr. W.F., Consultant Histopathologist (on behalf of histopathologists), Cork University Hospital, Wilton, Cork.	National Association for the Mentally Handicapped of Ireland, 5 Fitzwilliam Place, Dublin 2.
Kelly, Paul V., Acting Coroner for Co. Cavan, c/o John V. Kelly & Co, Solicitors, Church Street, Cavan.	National Bus and Rail Union, 54 Parnell Square, Dublin 1.
Kilkenny County Council, County Hall, John Street, Kilkenny.	National Suicide Bereavement Support Network, P.O. Box 1, Youghal, Co. Cork.
Laffoy, Dr. Marie, Specialist in Public Health Medicine, Dr. Steevens' Hospital, Dublin 8.	National Newspapers of Ireland, Clyde Lodge, 15 Clyde Road, Dublin 4.
Law Society of Ireland, Blackhall Place, Dublin 7.	Nicholson, Dr Alf, Consultant Paediatrician, Our Lady of Lourdes Hospital, Drogheda, Co. Louth.
MacMahon, Dr., Consultant Paediatrician, Waterford Regional Hospital, Dunmore Road, Waterford.	Nolan, Dr Niamh, Consultant Pathologist, St. Columcille's Hospital, Co. Dublin.
Magee, John, Histology Department, General Hospital, Letterkenny, Co. Donegal.	North Eastern Health Board, Kells, Co. Meath.
McGartoll, Eleanor, 2 Knapton Lawn, Monkstown, Dun Laoghaire, Co. Dublin.	O'Brien, Seamus, Programme Manager, Acute Hospital and Services for the Elderly, Eastern Health Board, Dr. Steevens' Hospital, Dublin 8.
McGauran, Vincent, 21 Ramleh Close, Dublin 6.	O'Connor, Patrick, Coroner Mayo East, The Old House, Market Street, Swinford, Co. Mayo.
McGinley, Dinny, T.D., Bunbeg, Co. Donegal.	O'Doherty, Eddie, 62 Bohermuire, Carrick-on-Suir, Co. Tipperary.
Mc Namara, Inspector G.J., An Garda Síochána, Superintendent's Office, Roxboro Road, Limerick City (South), Division of Limerick.	

O'Flaherty, Noel & Rosemarie,
30 Glebemount, Wicklow Town, Co. Wicklow.

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APPENDIX D

GUIDE TO THE 1962 CORONERS ACT

Summary of the Act

The role of the coroner in Ireland is regulated by the 1962 Coroners Act, by common law and by a number of provisions contained in separate legislation. The 1962 Act is the principal legislation governing the service. The Act came into operation on 1 July 1962 and it is entitled “an Act to amend and consolidate the law relating to coroners and Coroners Inquests”

This Act repealed several of the Acts passed between the reign of Edward I in the 13th century and 1947, as well as several items of legislation which, in other legislation, had previously regulated the conduct of Coroners’ Courts.

The Act contains 59 sections and is divided into the following five parts:

- Part I Preliminary and General**
- Part II Coroners and Coroners’ Districts**
- Part III Inquests**
- Part IV Juries at Inquests**
- Part V Miscellaneous**

The following is an outline of the provisions of the 1962 Act on a section by section basis.

Part I – Sections 1 to 5: Preliminary and General

This part of the Act has 5 sections which deal with the title, definitions, regulations, expenses and repeals.

Section	Heading	Sub-section (if any)	Notes on Provision
1	Short title & commencement	(1)&(2)	Name of the Act and when it comes into being.
2	Definitions contained in the Act		Defines certain terms used in the Act e.g. the references to “the Minister” refer to the Minister for Justice.
3	Regulations	(1)&(2)	The Minister for Justice has the power to introduce regulations under the Act. This section sets out the procedures to be followed when regulations are introduced.
4	Expenses		Expenses for the administration of the Act need to be sanctioned by the Minister for Finance out of funding provided by the Oireachtas.
5	Repeals		The schedule at the end of the Act repeals ten Acts and substantially repeals or amends fifteen Acts.

Part II – Sections 6 to 16: Coroners and Coroners’ Districts

This part of the Act deals with matters such as coroners’ districts, the office of coroner, salaries, tenure of office, place of residence, restriction on appointment and the role of deputy coroners.

A coroner is appointed for a particular district within a local authority area by that local Authority on the recommendation of the Local Appointments Commissioners. The salary and expenses of the coroner are paid by the local authority on the basis of scales previously approved of by the Minister for Justice.

A retirement age of 70 years, is introduced for the first time for coroners, as previously they were appointed for life. They must live within the

district for which they are appointed, unless they receive permission from the Minister to do otherwise. A coroner appoints a deputy coroner to carry out his duties in his absence. Only persons who have been a practising barrister, solicitor or registered medical practitioner for “at least five years” may be appointed as a coroner. The Minister for Justice has the power to remove a coroner or deputy coroner from office if he finds a coroner guilty of misconduct or neglect of duty or in cases where he decides that the coroner is unfit for office or is incapable of carrying out his duties by reason of physical or mental infirmity.

Section	Heading	Sub-section	Notes on Provision
6	Coroners’ districts	(1) & (2)	Deals with changes in coroners’ districts.
		(3)	The Minister for Justice can redraw the boundaries of adjoining coroner districts between districts whose coroners were appointed by the same local authority.
		(4)	Amalgamation of coroners’ districts within a county borough is allowed.
		(5)	Cross references with the arrangements for reviewing coroners’ salaries under Section 10 of the Act.
7	Amalgamation of districts	(1) & (2)	Districts can be amalgamated in certain circumstances.

Section	Heading	Sub-section	Notes on Provision
8	Office of coroner	(1)	There must be a coroner for each coroner district
		(2)	Coroners are appointed to a district by the Local Authority in whose area that district is situated.
		(3)	This deals with the selection procedure of coroners by the Local Appointment Commission.
		(4)	Coroners who were appointed after the introduction of this Act under qualification criteria in place before the Act, are deemed to be appointed under the previously existing terms of appointment.
		(5)	The Local Appointments Commissioners must, before recommending a person for appointment as a coroner, be satisfied that the person possesses the skill and knowledge necessary for the position.
9	Salary of coroner	(1)	Coroners are paid by their appointing local authority
		(2)	The Minister for Justice must consult with the Minister for Local Government before approving coroner salaries.
		(3)	Salaries of coroners are inclusive of any travelling, subsistence and other out of pocket expenses incurred by them in the course of their duties as coroners.
10	Review of salary	(1) to (10)	Covers all the procedural aspects of coroner salary reviews.
11	Tenure of office of coroner	(1) & (2)	A retirement age of 70 years is introduced for all coroners appointed after the introduction of the Act, this excludes coroners, who while actually appointed after the Act, were appointed on qualification criteria in place before the Act.
12	Place of residence of coroner	(1) & (2)	A coroner must live within his district unless he obtains the permission of the Minister for Justice to do otherwise.

Section	Heading	Sub-section	Notes on Provision
13	Deputy coroners	(1)	Coroners must appoint a deputy coroner for the district. The person appointed as a deputy must meet the same requirements required of a coroner by the Local Authority.
		(2)	A coroner can cancel any deputy appointment made by him but only until after he has appointed a new Deputy.
		(3)	A Deputy can act for the coroner, who appointed him, when the coroner is ill or absent. The deputy can also act at inquests which the coroner is disqualified from holding under Section 35 of the Act.
		(4)	Where the office of coroner is vacant within a district, the deputy assumes all the powers and duties, with the same salary arrangements which applied to the coroner. This applies until the vacancy is filled.
		(5)	In certain circumstances, the Minister can authorise a deputy coroner to act as a coroner. The Minister can cancel such an authorisation.
		(6)	While acting as the coroner, a Deputy has all the powers and duties of a coroner.
		(7) & (8)	A Deputy, while acting as the coroner, must live within his district unless he obtains the permission of the Minister to do otherwise.
14	Restriction on appointment as coroner or deputy coroner	(1) & (2)	Coroners and deputy coroners, at their time of appointment, must be either a practising barrister or a practising solicitor of five years standing or be a registered medical practitioner who has been registered or is entitled to be registered, for at least five years in the Register of Medical Practitioners for Ireland.
15	Removal from office of coroner and deputy coroner	(1) & (2)	The Minister for Justice can remove a coroner or deputy coroner from office, when the Minister believes that the coroner/deputy has been guilty of misconduct or neglect of duty or is unfit for office or incapable of carrying out his duties due to physical or mental infirmity.

Section	Heading	Sub-section	Notes on Provision
16	First coroners under the Act	(1a&b)	Deals with coroners previously appointed before the Act commenced and ensures that they will have no decrease in salary in the new arrangements.
		(2)	Coroners offices in the boroughs of Kilkenny, Clonmel, Drogheda and Sligo are now integrated into their respective new districts created under Section 6 of this Act.
		(3)	Sitting deputy coroners under the old legislation are deemed to be the deputy coroners under the new Act.

Part III – Sections 17 to 38: Inquests

This part of the Act sets out the law relating to post-mortems and inquests. It determines where there is a legal requirement on a coroner to hold an inquest while also indicating circumstances where the coroner may exercise his optional power to do so. It also determines when a mandatory requirement is placed on various parties to inform the coroner of certain kinds of deaths, with penalties for non-compliance included. Provisions are made for circumstances where a coroner or his deputy would be disqualified from holding a particular inquest.

This part of the Act also legislates for a coroner's handling of certain kinds of inquests and points out when he must adjourn an inquest. Under section 24, the Attorney General is given a power, in his public interest role, to order an inquest in certain circumstances. Certain procedural matters for the coroner's handling of inquests are set out in a number of these sections.

Two particularly important sections, 30 & 31 are contained in this part of the Act. Section 30 prohibits the consideration or investigation of any questions of civil or criminal liability at an inquest and limits the coroners' jurisdiction at the inquest to establishing the identity of the deceased and how, when and where the death occurred. Section 31 of the Act, while it allows that recommendations of a general nature, designed to prevent further fatalities, can be added on to an inquest verdict, prohibits any censure or exoneration of any person in that verdict or rider to the verdict.

Section 33 deals with the handling of post-mortem and special examinations and sections 36, 37 and 38 deal respectively with the issues of, the summoning of juries and witnesses to attend inquest, the non attendance of jurors and witnesses and the coroners powers with respect to the taking of evidence at inquest.

Section	Heading	Sub-section	Notes on Provision
17	General duty to hold inquest		<p>Once a coroner is informed of a body in his jurisdiction and believes that the death may have occurred in a violent and unnatural manner, or suddenly and from unknown causes, or in a place or circumstances which under other legislation an inquest is mandatory, he must hold an inquest.. However, this is subject to the provisions in section 19 where in certain circumstances the holding of a post-mortem eliminates any need to hold an inquest.</p> <p>It is the coroner in whose district the body lies, or comes to lie, who has jurisdiction for investigating the death – unless a coroner sends a body to a mortuary outside his district.</p> <p>Sections 21 & 23 of the Act deal with the issue of jurisdiction in other circumstances such as when a body is irrecoverable or where bodies of two or more persons whose deaths have, or appear to have, taken place due to the same occurrence.</p>

Section	Heading	Sub-section	Notes on Provision
18	Optional power to hold inquest and duty to notify coroner	(1) & (2)	The coroner has an optional power to investigate and, if necessary, hold an inquest into any deaths, within his jurisdiction, where no medical certificate of the cause of death can be obtained. This excludes the mandatory holding of inquests placed on him under section 17.
		(3)	When he is informed of a death, where a medical certificate of its cause cannot be obtained, an inspector or officer of the Garda Síochána must notify the coroner of the relevant district.
		(4)	<p>The following parties must immediately notify the coroner of deaths which they believe were from any other causes other than natural causes.</p> <ul style="list-style-type: none"> • medical practitioners • registrars of deaths • funeral undertakers • occupiers of a house or a mobile home • every person in charge of any institution or premises, in which the deceased person was living at the time of death. <p>However, this obligation to report to the coroner also extends to cases where the deceased, while they may very well have died from natural causes, has not been seen and treated by a registered medical practitioner within one month of their death. Even in circumstances where they may have been seen within that month by a doctor, if there is any suggestion that the death may have been as a result of something other than natural causes, the death must be reported. It also applies to any deaths the circumstances of which may require investigation, including death as a result of the administration of an anesthetic.</p>
		(5)	The people obliged to report such deaths to the coroner under this sub-section 4 satisfy this requirement if they immediately notify the facts and circumstances of the death to a member of the Garda Síochána not below the rank of sergeant.
		(6)	This deals with the fines for not complying with sub-section 4.

Section	Heading	Sub-section	Notes on Provision
19	Post-mortem examination in lieu of inquest	(1)	In cases within his jurisdiction, a coroner can order a post-mortem in lieu of an inquest, where he believes that the death may have occurred suddenly and from unknown causes, on the basis that the post-mortem may show that an inquest is unnecessary.
		(2)	Regardless of sub-section 1 above, a coroner always has to hold an inquest in cases which he believes may involve violent or unnatural deaths or in any places or circumstances where he is obliged under other legislation to do so.
20	Provisions where coroner and deputy coroner are prevented from holding an inquest	(1) & (2)	In situations where both the coroner and his deputy or the relevant district are either absent, ill, incapacitated or disqualified under the Act for holding an inquest, any member of the Garda Síochána not below the rank of inspector may request that the coroner for an adjoining district hold the inquest. In such circumstances, the coroner carrying out the inquest is deemed to be the coroner for the relevant district and the local authority for that district must pay his salary and expenses.
21	Inquest where several deaths arise from one occurrence		In certain cases where the bodies of two or more persons, whose deaths appear to have been caused by the same occurrence, are lying within different coroner districts, the Minister for Justice, may direct that one coroner should hold an inquest in relation to all of the deaths.
22	Inquest without exhuming body		Where it is necessary to hold an inquest in cases where the body may already have been buried, the coroner can proceed with the inquest without any exhumation, if he feels that such an exhumation is unwarranted.
23	Inquest where body destroyed or irrecoverable		Where a coroner believes that a death requiring an inquest has occurred in or near his district, yet the body is either destroyed or irrecoverable, the Minister for Justice has the power to direct either that coroner or another coroner proceed with an inquest, as if the body was lying in his district.

Section	Heading	Sub-section	Notes on Provision
24	Inquests on order of Attorney General	(1)	In this Section, the Attorney General, acting in his public interest role, is given the power to order an inquest where he believes that the circumstances of death make the holding of an inquest advisable. He can direct any coroner to hold this inquest in accordance with this Act. He can invoke this power whether or not this or another coroner has viewed the body, made any inquiry, held any inquest in relation to or done any other action in connection with the death.
		(2)	Sub-section 2 deals with the salary and expenses due to coroners who carry out such inquests.
25	Adjournment of inquest where criminal proceedings are being considered or have been instituted	(1)	A coroner must adjourn an inquest when requested to do so by a member of the Garda Síochána, not below the rank of Inspector, on the basis that criminal proceedings in relation to the death are being considered. In such cases the coroner shall adjourn the inquest for as long as he thinks is appropriate. He shall further adjourn the inquest for similar periods as often as requested to do so by a member of the Gardaí not below the rank inspector.
		(2)	A coroner must adjourn an inquest when requested to do so by a member of the Gardaí, not below the rank of inspector, on the basis that criminal proceedings in relation to the death have been instituted . In such cases the coroner shall adjourn the inquest until such matters are finalised and he is not obliged to resume such an inquest unless he believes that there are any special reasons for so doing.
		(3)	The clerk or registrar of any court must inform the coroner of the outcome of criminal proceedings held within their court, in relation to adjourned coroner cases.
		(4)	When a coroner adjourns an inquest under this section of the Act, he may discharge the jury (if any). In these cases, where a coroner resumes an adjourned inquest and the jury had, in fact, been discharged, he proceeds in all respects as if the inquest had not already begun.

Section	Heading	Sub-section	Notes on Provision
26	Summoning of witnesses	(1) & (2)	A coroner can summon any person to attend and give evidence as a witness at an inquest.
27	View of the body	(1)	In the holding of inquests, a coroner must view the body involved, except in the following circumstances. <ul style="list-style-type: none"> • in cases covered under section 22 & 23 of the Act • where the body has already been viewed by a member of the Gardaí who gives evidence to that effect at the inquest • in cases where the body has already been viewed by a coroner or a deputy coroner.
		(2)	At jury inquests, the jury shall view the body only if the coroner so directs or where a majority of the jury so wishes.
28	Note of names, addresses of witnesses		In inquest cases, where a coroner does not take depositions, he must take a note of the name and address of every person who gives evidence at the inquest.
29	Preservation of certain documents	(1)	A coroner has to keep a record of the following documentation. <ul style="list-style-type: none"> • every deposition or note of the names and addresses taken at inquest • every report of a post-mortem examination • every verdict returned at inquest
		(2)	When a coroner ceases to hold office, he must pass such documentation to his County registrar for preservation
		(3) &(4)	A coroner and a County Registrar shall give a copy of any documentation preserved under this section to every applicant.
		(5)	This deals with the fees payable to a County Registrar in relation to this section.
30	Prohibition of consideration of civil and criminal liability		This prohibits the consideration and investigation of any questions of civil and criminal liability at an inquest. Therefore, every inquest must be confined to ascertaining the identity of the deceased and how, when and where the death occurred.

Section	Heading	Sub-section	Notes on Provision
31	Prohibition of censure and exoneration	(1) & (2)	Any verdict or rider to a verdict at inquest cannot contain a censure or exoneration of any person. However, recommendations of a general nature designed to prevent further deaths can be added on to a verdict.
32	Record of verdict returned at an inquest		Verdict records must be signed by the coroner and, in jury cases, by the jury foreman.
33	Post-mortem and special examinations	(1)	At any time before or during an inquest, the coroner can order a post-mortem examination of the deceased to be carried out.
		(2) & (3)	A coroner either of his own will, or at the request of a member of the Gardaí, not below the rank of inspector, can request the Minister for Justice to appoint a person to perform a post-mortem or a special examination in a particular case
		(4)	This deals with procedures to be followed in these cases.
		(5)	The Minister retains a discretion to approve or refuse these requests for such examinations
34	Holding of adjourned inquest by different coroner		Adjourned inquests at which only identification evidence has been given may be resumed by a different coroner.
35	Disqualification of certain coroners for holding certain inquests	(1) & (2)	A coroner or deputy coroner is disqualified from holding an inquest in certain circumstances e.g. when the coroner, either, acting as a doctor, treated the deceased within one month of death or in acting as a solicitor, drew up or assisted in the drawing up of a will of the deceased.
36	Service of summons		This deals with the serving of summons to attend at inquest as a juror or witness.
37	Non-attendance of jurors and witnesses		If a person who has been served with a summons to attend an inquest, either as a juror or a witness, does not attend, that person will be guilty of an offence.

Section	Heading	Sub-section	Notes on Provision
38	Powers with respect to the taking of evidence etc. at inquest	(1)	A coroner has a discretionary power to examine the witnesses at an inquest on oath.
		(2)	<i>At inquests, any witness who refuses to take an oath or refuses to answer any question to which a coroner may legally require an answer, or any person who does anything which would "if the coroner had been a court having the power to commit for contempt, can be deemed to be in contempt of the coroner court" is guilty of an offence.</i> In those circumstances, the coroner certifies the offence to the High Court and it may then enquire into and deal with the matter.
		(3)	This provision guarantees a witness at inquest the same immunities and privileges as if they were a witness before the High Court

Part IV -Sections 39 to 45: Juries at Inquests

This part of the Act deals with matters relating to juries at inquest. A coroner has a general discretion to hold an inquest with or without a jury except in the following circumstances where juries are mandatory,

- in cases where a coroner believes that the death of the person was caused by murder, infanticide or manslaughter.
- where the death was caused by accident, poisoning or disease at work or by a road traffic accident.

- where the death occurred in a place or in circumstances which under other legislation requires that an inquest must be held e.g.a death in prison.
- where the death occurred in circumstances of which the possible recurrence would jeopardise public health and safety.

Juries must consist of not less than six and not more than twelve people. If a jury fail to agree on a verdict, the coroner shall accept a majority verdict and if this cannot be reached, the coroner can discharge the jury and hold a new inquest.

Section	Heading	Sub-section	Notes on Provision
39	General power to sit with or without jury		A coroner has a general power to hold an inquest with or without a jury, subject to section 40 of the Act which identifies the circumstances where there must be a jury at inquest.
40	Obligation on coroner to sit with or without a jury	(1)	This determines that a coroner must sit with a jury in the following cases; <ul style="list-style-type: none"> • where a coroner believes that the death of the person was caused by murder, infanticide or manslaughter • where the death occurred in a place or in circumstances which under other legislation, an inquest is required e.g. a death in prison • where the death was caused by accident, poisoning or disease at work • where the death was caused by a road traffic accident • where the death occurred in circumstances the possible recurrence of which would jeopardise public health and safety.
		(2)	A jury at inquest is sworn by or before the coroner.

Section	Heading	Sub-section	Notes on Provision
40 contd		(3)	When a Garda, not below the rank of inspector, requests a coroner to adjourn an inquest on the grounds that criminal proceedings in relation to the death are being considered or have been instituted. any obligation on a coroner to hold an inquest with a jury is deemed to be suspended unless and until the full hearing of the inquest takes place.
41	Number of coroner's jury		A jury at inquest must consist of not less than six and not more than twelve persons.
42	Liability to serve on coroner's jury		Everyone over the age of twenty-one living in a coroner's district was liable to serve on an inquest jury within that district unless they were disqualified or exempted under the 1927 Juries Act. This provision was amended by the Juries Act 1976.
43	Summoning of jury		Procedural matters for the Gardaí summoning a jury.
44	Failure of jury to agree		If a jury fail to reach agreement on an inquest verdict, the coroner shall accept a majority verdict. If a majority verdict cannot be reached, the coroner is obliged to discharge the jury and hold a new inquest.
45	Holding of adjourned inquest with different jury		An inquest which has been adjourned and which only identification evidence has been given, may be resumed with a different jury

Part V - Sections 46 to 59: Miscellaneous

This part of the Act contains a range of miscellaneous provisions. It deals with matters such as the removal and custody of bodies pending inquest, exhumation, removal of bodies from the State, the prohibition on coroners and deputy coroners who are solicitors from acting in criminal proceedings related to any cases they

dealt with as coroners. Provisions are also made in this part of the Act for the registration of deaths following inquest, for dealing with treasure trove, for the prescribing of certain fees and expenses and for dealing with other administrative functions of the coroner.

Section	Heading	Sub-section	Notes on Provision
46	Removal and custody of body pending inquest etc.	(1)	A coroner has custody of a body pending post-mortem and/or inquest.
		(2)	A person in charge of the premises where the coroner has directed the body to be kept, is obliged to keep the body in that premises until the coroner directs otherwise.
		(3)	It is an offence to obstruct the removal of a body to a mortuary as directed by the coroner.
		(4)	It is an offence, punishable by a fine, for a person in charge of any premises where a body is kept under the coroner's direction, not to comply with sub-section 2 of this section.
		(5)	The coroners powers remain the same regardless of where the body is kept and this location does not confer any jurisdiction on any other coroner.
47	Exhumation	(1)	The coroner can request the Minister to order an exhumation on a body buried within his district, in cases where he has been informed by a member of the Gardaí, not below the rank of inspector, that the death may have occurred in a violent or unnatural manner.
		(2)	The Minister has a discretion to direct or refuse to make an exhumation order
		(3)	Procedural aspects of exhumation orders
		(4)	When a body is exhumed under this section, the coroners' powers remain as if the body had not been buried.

Section	Heading	Sub-section	Notes on Provision
48	Removal of body outside the State		Where a coroner is advised that it is intended to remove out of the State, the body of a deceased person which is within his jurisdiction, he may issue a certificate permitting such removal.
49	Inquest on treasure trove		This empowers a coroner to enquire into the finding of treasure trove in his District.
50	Furnishing of particulars to registrars of births and deaths	(1)&(2)&(3)	In cases under his jurisdiction, a coroner is normally obliged to issue a certificate to the appropriate registrar of births and deaths in his district with all the details necessary for the registration of the death. This section also enables a coroner to give such details to the registrar, in cases where an inquest has been adjourned after evidence of identification and medical evidence as to the cause of death has been given. A coroner can issue an amending certificate when an original is found to be incorrect.
51	Extension of power of coroner to authorise burial		The existing powers of the coroner under section 17 of the 1880 Births and Deaths Registration (Ireland) Act regarding authorising the burial of bodies are extended here. Under that legislation, the coroner is given the power to authorise the release of a body for burial after inquest. This provision extends this power as it enables a coroner, if he is satisfied that no good purpose will be served by retaining the body, to authorise such a release where he has decided that an inquest is to be held, or where he is considering that an inquest may be held.
52	Provisions governing post-mortem examination caused to be made by coroner	(1)	When a coroner orders a post-mortem, this examination should be carried out by one registered practitioner only, unless the coroner believes a second registered practitioner is needed. When this is the case, the coroner must report his reasons for needing two practitioners to the Minister.
		(2)	Coroner post-mortems cannot be undertaken by a registered medical practitioner who had attended the deceased within one month of their death. This exclusion does not apply to a pathologist, who is on the staff or associated with a hospital, except in cases where the coroner feels that the association of that pathologist in relation to the care of the deceased person is likely to be called into question at the inquest.

Section	Heading	Sub-section	Notes on Provision
53	Prohibition on certain coroners from acting in certain proceedings		A coroner or a deputy coroner cannot act as a barrister or solicitor in any criminal proceedings which relate to any of their coroner cases.
54	Supply of forms to coroner		Local authorities must provide the coroners under their jurisdiction with stationery supplies including all necessary forms.
55	Returns to be made by coroner	(1)&(2)&(3)	All coroners must provide a yearly written return of their cases to the Minister and they may from time to time, be directed by the Minister to provide other written reports.
56	Prescribing of forms of oaths, etc in respect of inquests		This deals with the introduction of coroner forms to formally deal with matters such as oaths to be taken by jurors and witnesses, summons to be served, witness depositions and records of verdicts.
57	Prescribing of certain fees and expenses		This deals with the introduction of fees and expenses in respect of; fees paid to persons performing, or assisting at, post-mortem and special examinations, witness expenses and expenses in connection with the removal and custody of a body under coroner direction.
58	Certification and payment of certain sums		Procedural matters relating to the payment of fees and expenses in coroner cases. Essentially, each coroner issues a certificate for payment to the payee who reclaims payment from the relevant local authority. Certain registered medical practitioners are excluded from any payment under section 57 of the Act.
59	Amendment of Juries Act, 1927		Coroners and deputy coroners are exempt from jury service by the extension of the 1927 Juries Act. This provision was amended by the 1976 Juries Act.

APPENDIX E

CORONERS ACT, 1962

ARRANGEMENT OF SECTIONS

PART I

PRELIMINARY AND GENERAL

- Section
1. Short title and commencement.
 2. Definitions.
 3. Regulations.
 4. Expenses.
 5. Repeals.

PART II

CORONERS AND CORONERS' DISTRICTS

6. Coroners' districts.
7. Amalgamation of districts.
8. Office of coroner.
9. Salary of coroner.
10. Review of salary.
11. Tenure of office of coroner.
12. Place of residence of coroner.
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SCHEDULE**ENACTMENTS REPEALED**

Number 9 of 1962.

CORONERS ACT, 1962.

**AN ACT TO AMEND AND CONSOLIDATE THE
LAW RELATING TO CORONERS AND TO
CORONERS' INQUESTS. [11TH APRIL, 1962.]**

**BE IT ENACTED BY THE OIREACHTAS AS
FOLLOWS:**

PART I

PRELIMINARY AND GENERAL

1.-(1) This Act may be cited as the Coroners Act, 1962.

Short title and
commencement.

(2) This Act shall come into operation on such day as the
Minister shall by order appoint for that purpose.

2.-In this Act-

"coroner", except in sections 6, 7, 8, 10, 11, 16 and 59, includes
a person appointed under subsection (2) of section 5 of the
Local Authorities (Officers and Employees) Act, 1926, as
applied by section 8 of this Act, to fill the office of coroner
temporarily;

Definitions.
1926, No. 39.

"deputy coroner" has the meaning given to it by section 13 of
this Act;

"local authority" means the council of a county or the
corporation of a county borough;

"the Minister" means the Minister for Justice;

"prescribed", save where the context otherwise requires,
means prescribed by regulations made by the Minister under
this Act;

"registered medical practitioner" means a person who is
registered, other than provisionally or temporarily, under the
Medical Practitioners Acts, 1927 to 1961, in the Register of
Medical Practitioners for Ireland.

3.-(1) The Minister may make regulations in relation to any
matter referred to in this Act as prescribed or to be prescribed.

Regulations.

(2) Every regulation made by the Minister under this Act shall

be laid before each House of the Oireachtas as soon as may be after it is made and, if a resolution annulling the regulation is passed by either such House within the next subsequent twenty-one days on which that House has sat after the regulation is laid before it, the regulation shall be annulled accordingly but without prejudice to anything previously done thereunder.

4.-The expenses incurred by the Minister in the administration of this Act shall to such extent as may be sanctioned by the Minister for Finance be paid out of moneys provided by the Oireachtas.

Expenses.

5.-The enactments specified in the Schedule to this Act are hereby repealed to the extent mentioned in the third column of the Schedule.

Repeals.

PART II

CORONERS AND CORONERS' DISTRICTS

6.-(1) The coroners' districts of the State shall, subject to subsection (2) of this section, the provisions of any order under subsection (3) of this section and section 7 of this Act be the same as the coroners' districts immediately before the commencement of this Act.

Coroners' districts.

(2) The boroughs of Kilkenny, Clonmel, Drogheda and Sligo shall be included, respectively, with the areas which, heretofore, constituted the coroners' districts of County Kilkenny, County Tipperary South Riding, County Louth and North County Sligo to form new coroners' districts.

(3) The boundary between two adjoining coroners' districts the coroners for which were appointed by the same local authority may be altered by the Minister by order made after consultation with the Minister for Local Government and with the consent of the coroners for such districts.

(4) Where a vacancy occurs in a coroner's district portion of which is within a county borough, that portion shall thereupon cease to be part of that district and shall be amalgamated with the district comprising the remainder of the county borough,

the coroner of which shall become coroner for the district thereby created and comprising the whole of the county borough.

(5) Section 10 of this Act shall have effect in the case of the creation of a coroner's district under subsection (4) of this

section in like manner as if such creation were an amalgamation under a scheme under section 7 of this Act and, for that purpose, the references in subsections (1) and (9) of the said section 10 to the coming into force of a scheme under the said section 7 shall be construed as references to the creation of a district under subsection (4) of this section.

7.-(1) When a coroner ceases to hold office, the local authority by whom he was appointed, in lieu of appointing a successor, may, and if required by the Minister shall, submit to the Minister a scheme for the amalgamation of his district or part of his district with the district or districts of any other coroner or coroners appointed by that local authority.

Amalgamation of districts.

(2) A scheme under this section, if approved of by the Minister after consultation with the Minister for Local Government, shall come into force on such day as the Minister determines.

8.-(1) There shall be a coroner for every coroner's district.

Office of coroner.

(2) The coroner for a coroner's district shall be appointed by the local authority in whose area the district is situate.

(3) The office of coroner shall be an office to which the Local Authorities (Officers and Employees) Act, 1926, applies and that Act shall apply accordingly but with the following modifications:

1926, No. 39.

(a) "the Minister" in the said Act shall, in relation to the office of coroner, mean the Minister for Justice,

(b) subsection (1) of section 5, subsections (1) and (2) of section 7 and section 11 of that Act shall not apply to the office of coroner,

(c) the Minister shall, after consultation with the Local Appointments Commissioners, declare, either generally or for a particular appointment, the qualifications as to age, health and character for appointment to the office of coroner,

(d) the reference in subsection (3) of section 7 of that Act to qualifications prescribed under that section shall be construed as a reference to qualifications declared under paragraph (c) of this subsection, and

(e) every person to be recommended for appointment to the office of coroner shall be selected by such means and in such manner as the Local Appointments Commissioners think proper.

(4) The modifications effected by subsection (3) of this section shall not apply in the case of the appointment of a coroner after the commencement of this Act where the qualifications

for the appointment were prescribed before such commencement, and the appointment shall be made as if this Act had not been passed.

(5) The Local Appointments Commissioners shall, before recommending a person for appointment to the office of coroner, satisfy themselves that the person possesses the requisite knowledge and ability for the proper discharge of the duties of that office.

9.-(1) Every coroner shall be paid by the local authority by whom he is appointed such salary as shall from time to time be fixed, with the approval of the Minister, by that local authority.

Salary of coroner.

(2) The Minister shall not give any approval under this section save after consultation with the Minister for Local Government.

(3) The salary of a coroner shall be inclusive of any travelling, subsistence and other out-of-pocket expenses incurred by him in the course of his duties as coroner.

10.-(1) Within six months after a scheme under section 7 of this Act has come into force, the salary of a coroner whose district has been enlarged under the scheme shall be reviewed by the local authority who pay the salary.

Review of salary.

(2) On a review under this section of a salary, the local authority shall, subject to the approval of the Minister, make a determination (in this section referred to as a provisional determination) that the salary shall be increased in a specified manner or that it shall be confirmed.

(3) A local authority who make a provisional determination shall inform the coroner to whom the determination relates of the terms of the determination within one month after it is made.

(4) Where a coroner is dissatisfied with a provisional determination, he may, within three months after being informed of the terms of the determination, appeal against it to the Minister.

(5) Where an appeal is taken against a provisional determination, the Minister shall either dismiss the appeal or determine that the salary in question shall be increased in a specified manner.

(6) Where a provisional determination is made and an appeal against it is not taken or, if taken, is dismissed, the salary in question shall stand confirmed or increased in accordance with the determination.

(7) Where an appeal is taken against a provisional determination and on the appeal the Minister determines that the salary in question shall be increased in a specified manner, the salary shall stand so increased.

(8) Where a local authority who are required by this section to review the salary of a coroner refuse to review it or, on the expiration of one month after the expiration of the period during which they are required to review the salary, have failed to inform the coroner of the terms of a provisional determination made by them in respect of the salary-

(a) the coroner may request the Minister to review the salary,

(b) the Minister shall review the salary and on such review shall determine either that the salary shall be increased in a specified manner or that it shall be confirmed,

(c) the salary shall thereupon stand increased or confirmed in accordance with the determination of the Minister.

(9) An increase of salary under this section shall have effect as from the coming into force of the relevant scheme.

(10) The Minister shall not under this section give an approval, dismiss an appeal or review, or make a determination in relation to, a salary save after consultation with the Minister for Local Government.

11.-(1) Every coroner appointed after the commencement of this Act shall, unless he sooner dies, resigns or is removed from office, hold office until he reaches the age of seventy years.

Tenure of office of coroner.

(2) Subsection (1) of this section shall not apply to a coroner appointed after the commencement of this Act where the qualifications for his appointment were prescribed before such commencement.

12.-(1) A coroner shall have his ordinary residence in his district.

Place of residence of coroner.

(2) Where a coroner has the permission of the Minister (which permission may at any time be withdrawn by the Minister) to have his ordinary residence at a particular place outside his district, he shall be deemed to be fulfilling the requirement of subsection (1) of this section so long as he has his ordinary residence at that place.

13.-(1) Every coroner shall appoint a person approved of for the purpose by the local authority by which the coroner was appointed to be his deputy and the deputy shall be known, and is in this Act referred to, as a deputy coroner.

Deputy coroners.

(2) A coroner may at any time revoke an appointment made by him under this section, but the revocation shall not have effect unless and until he makes a new appointment of a deputy coroner.

(3) A deputy coroner may act for the coroner by whom he was appointed during the illness or absence of the coroner and may also act for the coroner at any inquest which the coroner is disqualified under this Act for holding unless he is himself disqualified under this Act for holding the inquest.

(4) Whenever the office of coroner for a coroner's district is vacant, the following provisions shall have effect:

(a) the person (if any) who was the deputy coroner for that district immediately before the occurrence of the vacancy shall, unless he sooner dies, resigns or is removed from office, continue in office as deputy coroner for that district until the termination of the vacancy;

(b) during the continuance of the vacancy, the deputy coroner for that district shall have all the powers and duties of the coroner for that district and shall be paid by the local

authority in whose area the district is situate the same salary as would have been payable by such local authority to the coroner for that district if he had continued in office.

(5) (a) Where a coroner is absent from his duties with the permission of the Minister, the Minister may authorise the deputy coroner for the district of that coroner to perform all the duties of that coroner's office and, while the authorisation is in force, the deputy coroner shall, for the purposes of this Act except section 9, be deemed to be the coroner for that district.

(b) The Minister may revoke an authorisation given under this subsection.

(6) A deputy coroner shall, while acting as coroner in the place of the coroner by whom he was appointed, have all the duties and powers of a coroner.

(7) A deputy coroner shall have his ordinary residence in the coroner's district for which he is deputy coroner.

(8) Where a deputy coroner has the permission of the Minister (which permission may at any time be withdrawn by the Minister) to have his ordinary residence at a particular place outside that coroner's district, he shall be deemed to be fulfilling the requirement of subsection (7) of this section so long as he has his ordinary residence at that place.

14.-(1) No person shall be appointed to be a coroner or a deputy coroner unless he is a practising barrister of at least five years' standing, a practising solicitor of at least five years' standing or a registered medical practitioner who has been registered, other than provisionally or temporarily, under the Medical Practitioners Acts, 1927 to 1961, in the Register of Medical Practitioners for Ireland, or who has been entitled to be so registered, for at least five years.

Restriction on appointment as coroner or deputy coroner.

(2) In reckoning the number of years' standing of a barrister who during a previous period was a solicitor, or of a solicitor who during a previous period was a barrister, such period shall be taken into account.

15.-(1) Whenever the Minister is of opinion that any coroner or deputy coroner has been guilty of misconduct or neglect of duty or is unfit for office or incapable of the due discharge of his duties by reason of physical or mental infirmity, the Minister may send by registered post to such coroner or deputy coroner at his ordinary residence a notice in writing

Removal from office of coroner and deputy coroner.

stating the said opinion and, if the Minister, after the expiration of seven days from the sending of the notice and after consideration of the representations (if any) made to him by such coroner or deputy coroner, remains of the said opinion, he may by order remove such coroner or deputy coroner from office.

(2) Every order removing a coroner or deputy coroner from office shall specify the reason for the removal.

16.-(1) Notwithstanding anything contained in this Act-

First coroners under this Act.

(a) every person who, immediately before the commencement of this Act, was a coroner under the law then relating to coroners shall (save as otherwise provided by this section) be deemed immediately upon such commencement to have been appointed under and in accordance with this Act to be the first coroner for the coroner's district corresponding to the district for which he was coroner immediately before such commencement; and

(b) the salary of every such first coroner shall not be less than that which he was paid as coroner immediately before the commencement of this Act.

(2) The respective offices of coroner for the several boroughs of Kilkenny, Clonmel, Drogheda and Sligo shall, upon the commencement of this Act, cease to exist, and every coroner's district which, by virtue of section 6 of this Act, contains one of those boroughs shall be deemed for the purposes of subsection (1) of this section to correspond to the district, as

existing immediately before such commencement, to which the borough was added to form that coroner's district.

(3) Every person who is deemed under this section to have been appointed to be a coroner shall furnish to the Minister the name and address of the person (if any) who immediately before the commencement of this Act was, under the law then relating to coroners, deputy coroner for the district of that coroner and thereupon, notwithstanding anything contained in this Act, the last mentioned person shall be deemed to have been appointed under and in accordance with this Act to be the deputy coroner for the district of that coroner.

PART III

INQUESTS

17.-Subject to the provisions of this Act, where a coroner is informed that the body of a deceased person is lying within his district, it shall be the duty of the coroner to hold an inquest in relation to the death of that person if he is of opinion that the death may have occurred in a violent or unnatural manner, or suddenly and from unknown causes or in a place or in circumstances which, under provisions in that behalf contained in any other enactment, require that an inquest should be held.

General duty to hold inquest.

18.-(1) Where a coroner is informed that the body of a deceased person is lying within his district and that a medical certificate of the cause of death is not procurable, he may inquire into the circumstances of the death of that person and, if he is unable to ascertain the cause of death, may, if he so thinks proper, hold an inquest in relation to the death.

Optional power to hold inquest and duty to notify coroner.

(2) Subsection (1) of this section shall not apply to any case to which section 17 of this Act applies.

(3) It shall be the duty of an inspector or officer of the Garda Síochána, if he becomes aware of the death within the district of a coroner of any person in whose case a medical certificate of the cause of death is not procurable, to inform the coroner of such death.

(4) Every medical practitioner, registrar of deaths or funeral undertaker and every occupier of a house or mobile dwelling, and every person in charge of any institution or premises, in which a deceased person was residing at the time of his death, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence

or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within one month before his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of the deceased person is lying of the facts and circumstances relating to the death.

(5) The obligation imposed on a person by subsection (4) of this section shall be deemed to be discharged if he immediately notifies a member of the Garda Síochána not below the rank of sergeant of the facts and circumstances required to be notified under that subsection.

(6) Every person who contravenes subsection (4) of this section shall be guilty of an offence under this section and shall be liable on summary conviction thereof to a fine not exceeding twenty pounds.

19.-(1) Where a coroner-

(a) is informed that the body of a deceased person is lying within his district, and

(b) is of opinion that that person's death may have occurred suddenly and from unknown causes, and

(c) is of opinion that a post-mortem examination of the body of that person may show that an inquest in relation to the death is unnecessary, he may cause the examination to be made and if, in his opinion, the report of the examination shows that an inquest in relation to the death is unnecessary it shall not be obligatory upon him to hold an inquest.

(2) Nothing in this section shall authorise a coroner to dispense with holding an inquest in relation to a death if he is of opinion that the death may have occurred in a violent or unnatural manner or in a place or in circumstances which, under provisions in that behalf contained in any other enactment, require that an inquest should be held.

20.-(1) Whenever an inquest cannot be held save by virtue of this section on account of-

(a) the coroner for the relevant district being absent, ill, incapacitated or disqualified under this Act for holding the inquest or there being a vacancy in the office of coroner for the district, and

(b) the deputy coroner for the district being at the same time absent, ill, incapacitated or disqualified under this Act for

Post-mortem examination in lieu of inquest.

Provisions where coroner and deputy coroner are prevented from holding inquest.

holding the inquest, any member of the Garda Síochána not below the rank of inspector may request the coroner for an adjoining district to hold the inquest, and thereupon such coroner shall hold the inquest accordingly and for that purpose shall be deemed to be the coroner for the first-mentioned district.

(2) Whenever an inquest is held by virtue of this section, the local authority liable to pay the salary, of the coroner who would ordinarily hold the inquest shall pay the coroner who holds the inquest such fee as may be prescribed together with such sum to cover his travelling and other expenses as shall be agreed upon between him and the local authority or, in default of agreement, as shall be fixed by the Minister.

21.-Where the bodies of two or more persons whose deaths appear to have been caused by the same occurrence are lying within the districts of different coroners, the Minister may, if he so thinks proper, direct that one of those coroners shall hold an inquest in relation to all of the deaths, and thereupon the coroner so directed shall hold the inquest in like manner if all of the bodies were lying within his district.

Inquests where several deaths arise from one occurrence.

22.-Where the body of any person upon which it is necessary to hold an inquest has been buried and it is known to the coroner that no good purpose will be effected by exhuming the body for the purposes of an inquest, he may proceed to hold an inquest without having exhumed the body.

Inquest without exhuming body.

23.-Whenever a coroner has reason to believe that a death has occurred in or near his district in such circumstances that an inquest is appropriate and that, owing to the destruction of the body or its being irrecoverable, an inquest cannot be held except by virtue of this section, the Minister may, if he so thinks proper, direct an inquest in relation to the death to be held by that coroner or another coroner, and thereupon the coroner so directed shall hold an inquest in relation to the death in like manner as if the body were lying within his district and had been viewed by him.

Inquest where body destroyed or irrecoverable.

24.-(1) Where the Attorney General has reason to believe that a person has died in circumstances which in his opinion make the holding of an inquest advisable he may direct any coroner (whether or not he is the coroner who would ordinarily hold the inquest) to hold an inquest in relation to the death of that person, and that coroner shall proceed to hold an inquest in accordance with the provisions of this Act (and as if, not being the coroner who would ordinarily hold the inquest, he were such coroner) whether or not he or any other coroner has viewed the body, made any inquiry, held any inquest in relation to or done any other act in connection with the death.

Inquest on order of Attorney General.

(2) Whenever an inquest is held by virtue of this section by a coroner other than the coroner who would ordinarily hold the inquest, the local authority liable to pay the salary of the coroner who would ordinarily hold the inquest shall pay the coroner who holds the inquest such fee as may be prescribed together with such sum to cover his travelling and other expenses as shall be agreed upon between him and that local authority or, in default of agreement, as shall be fixed by the Minister.

25.-(1) Where, at an inquest in relation to any death, a member of the Garda Síochána not below the rank of inspector requests the coroner to adjourn the inquest on the ground that proceedings in relation to the death are being considered, coroner shall adjourn the inquest for such period as he thinks proper and shall further adjourn the inquest for similar periods so often as a member of the Garda Síochána not below the rank of inspector requests him on the ground aforesaid so to do.

Adjournment of inquest where criminal proceedings are being considered or have been instituted.

(2) Where, at an inquest in relation to any death, a member of the Garda Síochána not below the rank of inspector requests the coroner to adjourn the inquest on the ground that criminal proceedings in relation to the death have been instituted, the coroner shall adjourn the inquest until such proceedings have been finally determined, but it shall not then be obligatory on the coroner to resume the inquest unless he thinks there are special reasons for so doing.

(3) It shall be the duty of the clerk or registrar of any court, at the conclusion of criminal proceedings in that court in relation to the death of a person, to inform the coroner holding an inquest in relation to the death of the result of such proceedings.

(4) When adjourning under this section an inquest a coroner may discharge the jury (if any) summoned therefor.

(5) Where a coroner resumes an inquest which was adjourned under this section and the jury for which has been discharged, he shall proceed in all respects as if the inquest had not been begun.

26.-(1) A coroner may, at any time before the conclusion of an inquest held by him, cause a summons in the prescribed form to attend and give evidence at the inquest to be served on any person (including in particular any registered medical practitioner) whose evidence would, in the opinion of the coroner, be of assistance at the inquest.

Summoning of witnesses.

(2) A coroner shall not exercise, in relation to the attendance

at an inquest of a second registered medical practitioner, the power conferred on him by subsection (1) of this section unless-

(a) a majority of the jurors at the inquest, it having appeared to them that the cause of death has not been satisfactorily explained by the medical practitioner giving evidence thereof at the inquest, have by a requisition in writing called upon the coroner to cause a summons under that subsection to be served on another registered medical practitioner, or

(b) that practitioner had assisted at a post-mortem examination upon the person in relation to whose death the inquest is being held.

27.-(1) A coroner holding an inquest in relation to the death of any person shall, except in a case to which section 22 or section 23 of this Act relates, view the body unless-

View of the body.

(a) it has been viewed by a member of the Garda Síochána who gives evidence to that effect at the inquest, or

(b) it has previously been viewed by a coroner or deputy coroner.

(2) Where a coroner is holding an inquest with a jury in relation to the death of any person, the jury shall view the body only if the coroner so directs or a majority of the jury so desires.

28.-Where a coroner holding an inquest does not take depositions, he shall take a note of the name and address of every person who gives evidence at the inquest.

Note of names, addresses of witnesses.

29.-(1) Every deposition or note of the names and addresses of witnesses taken at an inquest, every report of a post-mortem examination made in pursuance of this Act and every record of the verdict returned at an inquest shall be preserved by the coroner.

Preservation of certain documents.

(2) When a coroner ceases to hold office, all documents preserved by him under this section shall be handed over to the county registrar for the county or county borough in which his district is situate and the county registrar shall preserve the documents.

(3) A coroner shall furnish a copy of any document preserved by him under this section to every applicant therefor and, except where the application is made on behalf of a Minister of State or the Garda Síochána, may charge for a copy such fee as may be prescribed.

(4) A county registrar shall furnish a copy of any document

preserved by him under this section to every applicant therefor and, except where the application is made on behalf of a Minister of State or the Garda Síochána, shall charge for a copy such fee as may be prescribed.

(5) The following provisions shall have effect in relation to all fees payable to a county registrar under this section:

(a) they shall be collected and taken in such manner as the Minister for Finance shall from time to time direct and shall be paid into or disposed of for the benefit of the Exchequer in accordance with the directions of the said Minister,

(b) the Public Offices (Fees) Act, 1879, shall not apply in respect of them.

1879, c. 58.

30.-Questions of civil or criminal liability shall not be considered or investigated at an inquest and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when and where the death occurred.

Prohibition of consideration of civil and criminal liability.

31.-(1) Neither the verdict nor any rider to the verdict at an inquest shall contain a censure or exoneration of any person.

Prohibition of censure and exoneration.

(2) Notwithstanding anything contained in subsection (1) of this section, recommendations of a general character designed to prevent further fatalities may be appended to the verdict at any inquest.

32.-The record of the verdict returned at an inquest shall be signed by the coroner holding the inquest and, where he is sitting with a jury, by the foreman of the jury.

Record of verdict returned at an inquest.

33.-(1) A coroner may at any time before or during an inquest cause to be made a post-mortem examination of the body of any person in relation to whose death an inquest is to be or is being held.

Post-mortem and special examinations.

(2) A coroner may request the Minister to arrange-

(a) a post-mortem examination by a person appointed by the Minister of the body of any person in relation to whose death the coroner is holding or proposes to hold an inquest, or

(b) a special examination by way of analysis, test or otherwise by a person appointed by the Minister of particular parts or contents of the body or of any other relevant substances or things, or

(c) both such post-mortem examination and special examination,

and he may make such request whether or not he has

exercised any other power conferred on him by this Act of causing a post-mortem examination of the body to be made.

(3) It shall be the duty of a coroner to exercise his powers of request to the Minister under subsection (2) of this section in every case in which a member of the Garda Síochána not below the rank of inspector applies to him so to do and states his reasons for so applying.

(4) Every request to the Minister under subsection (2) of this section shall be accompanied by the reasons therefor of the coroner or member of the Garda Síochána at whose instance the request is made.

(5) The Minister on receiving a request under subsection (2) of this section may, as he thinks proper, either comply or decline to comply with the request.

34.-An inquest which has been adjourned and at which only evidence of identification has been given may be resumed by a different coroner.

Holding of adjourned inquest by different coroner.

35.-(1) A coroner or deputy coroner who is a registered medical practitioner shall not hold an inquest on the body of, or inquire into the death of, any person who was attended by him within one month before the person's death.

Disqualification of certain coroners for holding certain inquests.

(2) (a) A coroner or deputy coroner shall not hold an inquest on the body of, or inquire into the death of, any person if he has drawn up, or assisted in the drawing up of, and benefits under, any testamentary disposition made by that person.

(b) For the purpose of paragraph (a) of this subsection, a coroner or deputy coroner who is a solicitor and an executor of the deceased shall not be taken to benefit under a testamentary disposition merely because he is authorised to charge fees in respect of the administration of the estate.

36.-Every summons to attend an inquest as a juror or witness shall be served by a member of the Garda Síochána either by delivering it to the person to whom it is addressed or by leaving it for him at the address at which he ordinarily resides with a person of the age of sixteen years or upwards.

Service of summons.

37.-Every person who, having been duly served with a summons to attend an inquest as a juror or witness, fails to attend at the time and place specified in the summons shall be guilty of an offence under this section and shall be liable on summary conviction thereof to a fine not exceeding five pounds.

Non-attendance of jurors and witnesses.

38.-(1) A coroner may examine the witnesses at an inquest on oath.

(2) Any person who-

(a) being in attendance as a witness at an inquest refuses to take an oath legally required by the coroner holding the inquest to be taken or to answer any question to which the coroner may legally require an answer, or

(b) does any other thing which would, if the coroner had been a court having power to commit for contempt, have been contempt of that court, shall be guilty of an offence and the coroner may certify the offence under his hand to the High Court, and that Court may thereupon inquire into the alleged offence and after hearing any witnesses who may be produced against or on behalf of the person charged with the offence, and after hearing any

statement that may be offered in defence, punish or take steps for the punishment of that person in like manner as if he had been guilty of contempt of that Court.

(3) A witness at an inquest shall be entitled to the same immunities and privileges as if he were a witness before the High Court.

Powers with respect to the taking of evidence, etc, at inquest.

PART IV

JURIES AT INQUESTS

39.-Save as otherwise provided by this Part, a coroner may hold any inquest either, as he thinks proper, with or without a jury.

General power to sit with or without jury.

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

Obligation on coroner to sit with or without jury.

(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.

(2) The jury at an inquest shall be sworn by or before the coroner.

(3) Where a coroner, before commencing or resuming an inquest in relation to any death, is informed by a member of the Garda Síochána not below the rank of inspector that he will request an adjournment of the inquest on the ground either that criminal proceedings in relation to the death are being considered or have been instituted, every (if any) obligation under subsection (1) of this section to hold the inquest with a jury shall be deemed to be suspended unless and until the full hearing of the inquest takes place.

41.-A coroner's jury shall consist of not less than six and not more than twelve persons.

Number of coroner's jury.

42.-Every person over the age of twenty-one years residing within a coroner's district shall be liable to serve on the jury at any inquest held within that district unless-

Liability to serve on coroner's jury.

(a) he is disqualified for serving as a juror under section 4 of the Juries Act, 1927;

(b) he is exempted from serving as a juror under section 5 of that Act, and is not included, under section 16 of that Act, in a jurors list.

43.-Whenever a jury is required for an inquest at any time and place, the coroner shall so inform a member of the Garda Síochána and the member shall assemble not less than six and not more than twelve persons qualified to be jurors at the inquest at such time and place and may, if he thinks it necessary, serve summonses in the prescribed form to ensure their attendance.

Summoning of jury.

44.-If the jury at an inquest fail to agree on a verdict, the following provisions shall have effect:

Failure of jury to agree.

(a) if a majority of the jury agree on a verdict, the verdict shall be accepted by the coroner, and

(b) in any other case, the coroner shall discharge the jury and hold a new inquest.

45.-An inquest which has been adjourned and at which only evidence of identification has been given may be resumed with a different jury.

Holding of adjourned inquest with different jury.

PART V

MISCELLANEOUS

46.-(1) Where a coroner considers it necessary to hold an inquest on, or a post-mortem examination of, the body of a deceased person, he may direct that the body be removed into a convenient mortuary or morgue or other suitable place (whether inside or outside his district) and kept therein until he otherwise directs, and he may make such arrangements for the removal of the body as he considers necessary or desirable.

Removal and custody of body pending inquest, etc.

(2) The person in charge of a mortuary, morgue or other place to which the body of a deceased person is directed to be removed under subsection (1) of this section shall allow the body to be deposited in such mortuary, morgue or other place and shall be the body therein until the coroner otherwise directs.

(3) Any person who obstructs the removal of a body pursuant to a direction under subsection (1) of this section shall be guilty of an offence under this subsection and shall be liable on summary conviction thereof to a fine not exceeding ten pounds.

(4) Any person in charge of a mortuary, morgue or other place who fails to comply with subsection (2) of this section shall be guilty of an offence under this subsection and shall be liable on summary conviction thereof to a fine not exceeding ten pounds.

(5) The removal of a body in pursuance of a direction by a coroner under subsection (1) of this section to any place outside his district shall not affect his powers and duties in relation to the body or the inquest thereon, nor shall it confer or impose any rights, powers or duties upon any other coroner.

47.-(1) Where a coroner is informed by a member of the Garda Síochána not below the rank of inspector that, in his opinion, the death of any person whose body has been buried in the coroner's district may have occurred in a violent or unnatural manner, the coroner may request the Minister to order the exhumation of the body by the Garda Síochána.

Exhumation.

(2) On being requested under this section to authorise by

order the exhumation of any body, the Minister may, as he thinks proper, either make or refuse to make the order.

(3) Every order made under this section for the exhumation of a body shall operate to authorise the exhumation in accordance with the terms of the order.

(4) Where the body of a deceased person is exhumed in pursuance of an order made under this section, the coroner concerned shall have the like powers and duties as if the body had not been buried.

48.-Where it is brought to the notice of a coroner that it is intended to remove out of the State the body of a deceased person which is within his jurisdiction he may certify, in such form as may be prescribed, that he has been satisfied as to the cause of death and that no circumstances exist necessitating the retention of the body, or any part thereof, in the State.

Removal of body outside the State.

49.-A coroner shall have jurisdiction to inquire into the finding of treasure trove in his district and the provisions of this Act (other than those relating to post-mortem examinations or to the removal of bodies) shall, so far as is consistent with the tenor thereof, apply to every such inquest.

Inquest on treasure trove.

50.-(1) Where, in pursuance of this Act, a coroner-

Furnishing of particulars to registrars of births and deaths.

(a) holds an inquest, or

(b) adjourns an inquest at which evidence of identification and medical evidence as to the cause of death has been given, or

(c) decides, as a result of a post-mortem examination, not to hold an inquest,

he shall furnish the appropriate registrar of births and deaths with a certificate containing such particulars for the registration of the death as may be prescribed after consultation with the Minister for Health and the death shall be registered accordingly.

(2) Where, in pursuance of this Act, a coroner inquires into the circumstances of a death without holding an inquest or causing a post-mortem examination to be made, he shall furnish the appropriate registrar of births and deaths with a certificate containing, such particulars as may be prescribed after consultation with the Minister for Health.

(3) Where there is an error in a certificate furnished by a coroner under subsection (1) of this section, he may issue an amending certificate to the registrar and the error shall thereupon be corrected by the registrar in the register of deaths.

51.-The power conferred by section 17 of the Births and Deaths Registration Act (Ireland), 1880, on a coroner, upon holding an inquest on a body, of authorising by order the burial of the body shall be construed as including a power so to authorise the burial of a body, whether it is lying for the time being inside or outside his district, in relation to which he has decided that an inquest to be held by him is or may become necessary, and that section shall have extended operation accordingly.

Extension of power of coroner to authorise burial.

1880, c. 13.

52.-(1) Where a coroner causes under this Act a post-mortem examination of a body to be made, the following provisions shall have effect:

Provisions governing post-mortem examination caused to be made by coroner.

(a) save as provided by the next following paragraph of this subsection, the coroner shall cause such examination to be made by one (and not more than one) registered medical practitioner,

(b) if the coroner considers that that practitioner will require the assistance of another registered medical practitioner in making the examination, he may cause such assistance to be given by one other (but not more than one other) registered medical practitioner,

(c) where the coroner causes such assistance to be given, he shall furnish the Minister with a statement of his reasons for considering it to be necessary, and

(d) if the coroner summons or requests such other practitioner to give evidence at an inquest on the body, he shall furnish the Minister with a statement of his reasons for considering that evidence to be necessary.

(2) (a) A post-mortem examination under this Act shall not be made by a registered medical practitioner who had attended the person in relation to whose death an inquest is to be or is being held within one month before the person's death.

(b) Paragraph (a) of this subsection shall not apply to a registered medical practitioner who is a pathologist on the staff of, or associated with, a hospital save where the coroner considers that the conduct of such practitioner in relation to his attendance on the deceased person is likely to be called in question at the inquest.

53.-A coroner or deputy coroner who is a solicitor or barrister shall not act as solicitor or barrister in criminal proceedings arising out of any matter which may have come before him as coroner or deputy coroner.

Prohibition on certain coroners from acting in certain proceedings.

54.-The local authority by whom a coroner was appointed shall supply him with such supplies of stationery and of prescribed forms as shall be reasonably required by him for the discharge of his duties.

Supply of forms to coroner.

55.-(1) Every coroner shall, on or before the 1st day of February in each year, furnish to the Minister a written return of the inquests held and deaths inquired into in his district during the year ended on the immediately preceding 31st day of December.

Returns to be made by coroner.

(2) In addition to the yearly return specified in subsection (1) of this section, every coroner shall furnish to the Minister or to such other Minister as the Minister may direct such written returns in relation to inquests held and deaths inquired into in his district as the Minister may from time to time require.

(3) Every return furnished under this section shall be in such form and contain such particulars as the Minister may from time to time direct.

56.-(1) The following forms may be prescribed in respect of inquests, namely, the form of-

Prescribing of forms of oaths, etc., in respect of inquests.

(a) oath to be taken by jurors and to be taken by witnesses,

(b) summons to be served on jurors and to be served on witnesses,

(c) deposition, and

(d) record of verdict.

(2) Until forms have been prescribed under this section, the forms of oaths, summonses, depositions and inquisitions in use in respect of inquests immediately before the commencement of this Act may continue to be used and may, where necessary, be modified so as to conform with the provisions of this Act.

57.-The following fees and expenses shall be prescribed, after consultation with the Minister for Local Government, namely-

Prescribing of certain fees and expenses.

(a) the fees payable to persons performing, or assisting at, post-mortem and special examinations,

(b) the expenses payable to witnesses at inquests, and

(c) the expenses payable in connection with removal or custody, in accordance with the direction of a coroner, of a body.

58.-(1) A coroner may, in respect of any matter for which a fee or expenses is or are prescribed under section 57 of this Act, issue his certificate for the payment by a specified local authority to the person concerned of a sum not greater than the sum prescribed in that behalf.

Certification and payment of certain sums.

(2) Every person to whom a certificate has been issued under this section may present the certificate to the local authority specified in the certificate and thereupon the local authority shall pay the sum mentioned in the certificate to the person.

(3) The local authority to be specified in a certificate issued under this section shall be-

(a) in a case where the certificate is issued after an inquest by a coroner who would not ordinarily hold the inquest, the local authority by whom the coroner who would ordinarily hold the inquest was appointed,

(b) in case the certificate is issued by a deputy coroner acting in place of a coroner, the local authority by whom the coroner was appointed,

(c) in every other case, the local authority by whom the coroner issuing the certificate was appointed.

(4) No certificate for the payment of any fee shall be issued under this section to a registered medical practitioner who is on the staff of a health institution, within the meaning of the Health Act, 1947, or a hospital in connection with an inquest on the body of a person who died in the institution, if it was his duty to attend the person.

1947, No. 28

59.-Section 5 (which relates to exemption from jury service) of the Juries Act, 1927, shall have effect as if there were added to Part I of the First Schedule thereto "coroners, deputy coroners and persons appointed under subsection (2) of section 5 of the Local Authorities (Officers and Employees) Act, 1926, to fill the office of coroner temporarily".

Amendment of Juries Act, 1927.

1927, No. 23,

1926, No. 39.

SCHEDULE
ENACTMENTS REPEALED

Session and Chapter or Number and Year (1)	Short Title (2)	Extent of Repeal (3)
4 Edw. I.	The Office of the coroner.	The whole Act.
6 Geo. IV, c. 51.	The Assizes (Ireland) Act, 1825.	So much of section 4 as relates to any inquisition taken before a coroner; in section 6, the words from "and by order" to "his or their jurisdictions;".
9 Geo. IV, c. 54.	Criminal Law (Ireland) Act, 1828.	Section 4; sections 5 and 6 in so far as they relate to coroners.
10 Geo. IV, c. 37.	Coroners (Ireland) Act, 1829.	The whole Act.
6 & 7 Will. IV, c. 89.	Coroners (Ireland) Act, 1836.	The whole Act.
3 & 4 Vic., c. 108.	Municipal Corporations (Ireland) Act, 1840.	Sections 153, 154, 155 and 156.
6 & 7 Vic., c. 12.	Coroners Act, 1843.	The whole Act.
8 & 9 Vic., c. 18.	Lands Clauses Consolidation Act, 1845.	Sections 39 and 40, in so far as they relate to coroners.
9 & 10 Vic., c. 37.	Coroners (Ireland) Act, 1846.	The whole Act.
23 & 24 Vic., c. 74.	Borough Coroners (Ireland) Act, 1860.	The whole Act.
36 & 37 Vic., c. 76.	Railways Regulation Act (Returns of Signal Arrangements, Workings, etc.), 1873	Section 5.
39 & 40 Vic., c. xciii.	Coroners (Dublin) Act, 1876.	The whole Act except section 6.
41 & 42 Vic., c. 69.	Petty Sessions Clerks and Fines (Ireland) Act, 1878.	In section 9, the words "or coroner" wherever they occur.
43 & 44 Vic., c. 13.	Births and Deaths Registration Act (Ireland) 1880.	In section 16, from the beginning of the section to the words "from the coroner".
44 & 45 Vic., c. 35.	Coroners (Ireland) Act, 1881.	The whole Act.
55 & 56 Vic., c 56.	Coroners Act, 1892.	Subsections (1), (2), (3), (4), 1 (5) and (8) of section 1.
61 & 62 Vic., c. 37	Local Government (Ireland) Act, 1898	Subsections (1), (2) and (5) of section 14; subsection (3) of section 40; in sub section (1) of section 69, the word "coroner".
8 Edw. VII, c. 37.	Coroners (Ireland) Act, 1908.	The whole Act.
No. 4 of 1924.	Coroners (Qualification) Act, 1924.	The whole Act.
No. 1 of 1927.	Coroners (Amendment) Act, 1927.	The whole Act.
No. 27 of 1930.	Local Government (Dublin) Act, 1930.	Subsection (2) of section 23
No. 3 (Private) of 1937.	Local Government (Galway) Act, 1937.	Section 36.
No. 21 of 1940.	Local Government (Dublin) (Amendment) Act, 1940.	Subsection (1) of section 9.
No. 50 of 1947.	Coroners (Amendment) Act, 1947.	The whole Act.
No. 1 (Private) of 1950.	Local Government Provisional Orders Confirmation Act, 1950.	Paragraph 1 of Article 9 of the Order set out in the First Schedule.
No. 10 of 1953.	Local Government (Dublin) (Amendment) Act, 1953.	Section 2.
No. 1 (Private) of 1955.	Local Government Provisional Orders Confirmation Act, 1955.	Article 11 of the Order set out in the First Schedule; Article 11 of the Order set out in the Third Schedule.

APPENDIX F

LIST OF OTHER RELEVANT LEGISLATION

The following is a list of the main Statutes and Statutory Instruments relevant to the coroners service.

Statutes

Safety, Health and Welfare at Work Act, 1989
(and appended schedules)

Stillbirths Registration Act, 1994

Juries Act, 1976 (and appended schedules)

Births and Deaths Registration Acts (Ireland),
1863-1994

Criminal Law (Suicide), Act 1993

Other references

Defence Act, 1954.

Mental Treatment Act, 1945.

Prisons (Ireland) Act, 1877

Criminal Justice (Location of Victims' Remains)
Act, 1999

Statutory Instruments

S.I. No. 151/1996: Coroners Act, 1962
(Fees and Expenses) Regulations, 1996.

S.I. No. 94/1962: Coroners Act, 1962
(Forms) Regulations, 1962.

S.I. No. 95/1962: Coroners Act, 1962 (Particulars
for Registration of Death) Regulations, 1962.

S.I. No. 138/1972: Prisons Act, 1972
(Military Custody) Regulations, 1973.

S.I. No.320/1947, Rules for the Government of
Prisons (Rules and Orders), 1947

APPENDIX G

SUMMARIES OF RELEVANT LEGAL CASES

(A)

**Mrs. Angela McKeown v
Dr. Thomas E. Scully,
Coroner for Co.Louth.**

The State (at the prosecution of Mrs. Angela McKeown) v Dr. Thomas E. Scully, Coroner for Co. Louth, High Court 1984 No. 646 SS, (O'Hanlon J) 29 April 1985

On 14 May 1984 the prosecutor's husband was killed when he was struck by a train. On 2 August 1984 an inquest was held in order to inquire into circumstances surrounding the death. At the inquest, the respondent, as Coroner for County Louth, sat along with a jury. The verdict of the inquest, as recorded, identified the deceased as Mr. Kevin McKeown, the date and place of death were given as "14 May 1984 - Lourdes Hospital, Drogheda" and the cause of death was recorded as "(a) Multiple Injuries (b) Accident on Railway Line (c) Suicide". Prior to the enactment of the Criminal Law (Suicide) Act, 1993, suicide was unlawful. The prosecutor sought to have the record of the verdict quashed insofar as it included a verdict of suicide on two grounds. First of all, she claimed that as section 30 of the Coroners Act, 1962, provides that questions of civil and criminal liability shall not be considered or investigated at an inquest and that an inquest shall be confined to ascertaining the identity of the deceased and how, when and where death occurred, the Coroner and the jury exceeded the jurisdiction conferred on them. Secondly, she argued that the deceased's next of kin should have been given notice as to the holding of the inquest so that they could be represented and make evidence available which might have a bearing on the jury's verdict.

Held

O'Hanlon J in granting an order of certiorari quashing the finding of suicide:

(1) The intention behind section.30 of the 1962 Act was that it should not be open to a Coroner's jury to bring in a verdict that a named person has unlawfully killed the deceased. By analogy it followed that it was not intended that it would be open to the jury to find that the deceased had brought about his own death by suicide.

(2) The failure to give the widow and the next of kin any opportunity to be heard before the making of the grave and damaging finding of suicide amounted to a departure from the rules of natural and constitutional justice. If they had been given an opportunity they could reasonably have sought leave to be represented at the inquest, to have witnesses cross-examined on their depositions, to address the jury and to offer to make available to the coroner further evidence which might be of assistance at the inquest.

(3) Even assuming that the finding of suicide was a verdict that was open to the jury, it was open to challenge on the grounds that there was insufficient evidence to support it.

(B)

**Mr. Thomas Francis Greene v
Dr. Kieran McLoughlin,
Coroner for Galway West.**

**Mr. Thomas Francis Greene v
Dr. Kieran McLoughlin,
Coroner for Galway West.**

Supreme Court 1990 No. 16

(Hamilton CJ, O'Flaherty and Blayney JJ)

26 January 1995

Mr. Vivian Greene died on 10 May 1988 as a result of suffering a single gunshot wound to the head. An inquest into the death was held by the Coroner for Galway West, who sat with a jury. Despite objections from the solicitor acting for the deceased's family, the deceased's doctor gave evidence to the effect that he had been suffering from severe depression. Because she was unfit to attend, a statement from the deceased's mother was read at the inquest. In it she said that Mr. Greene had gone into the toilet at the family home in order to clean a rifle, there had been a noise and when she entered the toilet she found him bleeding from the forehead and in a sitting position. A garda officer testified that the rifle would discharge accidentally only if dropped vertically on to its butt. The respondent informed the jury that they could not bring in a verdict of suicide. Instead they would have to bring in one of four possible verdicts: (i) Death due to discharge from a rifle in accordance with medical evidence; (ii) Death due to discharge from rifle in accordance with medical evidence while balance of mind disturbed; (iii) Death due to discharge from rifle self-inflicted while balance of mind disturbed; (iv) Death due to discharge from rifle occurring accidentally. The jury returned a verdict in terms of the second alternative. The applicant

who was the brother of the deceased, instituted judicial review proceedings in which he sought to have the verdict quashed on the grounds that the coroner had exceeded his jurisdiction under section 30 of the Coroners Act 1962 by considering and investigating criminal liability and by failing to confine the inquest to ascertaining the identity of the deceased and how, when and where death occurred. In the High Court, Johnson J. held that the coroner had exceeded his jurisdiction. He pointed out that regardless of the way in which the question to the jury was formulated, once the mental capacity of the deceased was brought into question, the whole issue as to criminal liability in respect of possible suicide was being investigated and considered, even though a verdict of suicide could not be brought in because of the way in which the questions to the jury were framed. The respondent, the Coroner for Galway West, appealed this ruling to the Supreme Court.

Held

The Supreme Court in dismissing the appeal:

- (1) The manner in which the respondent conducted the inquest was clearly in breach of section 30 of the 1962 Coroners Act. He considered and investigated criminal liability, and failed to confine the inquest to ascertaining the identity of the deceased and to ascertaining how, where and when death occurred.
- (2) As no third party was involved in the deceased's death and suicide was a crime at the time of the death (which was prior to the enactment of the Criminal Law (Suicide) Act 1993, the calling of evidence as to whether the gun could discharge accidentally and as to the mental health of the deceased constituted considering and investigating the question of criminal liability. This evidence was relevant solely to the question

of whether the deceased deliberately discharged the rifle and whether he was capable of doing so.

(3) How death occurs in any particular case is a matter to be determined in the light of medical science. It is a medical question for a doctor to be answered, if necessary, by performing a post-mortem examination. When sitting with the jury the respondent had attempted to ascertain the circumstances in which the deceased's rifle was discharged. This was not confining the inquiry into how death occurred, but going outside it in order to inquire into what gave rise to the physical injury which resulted in death.

(C)

**Dr. Brian Farrell, Dublin City Coroner v
the Attorney General**

**Dr. Brian Farrell, Dublin City Coroner v
the Attorney General, Supreme Court 1 I.R.
203 (1998), (Hamilton C.J, Barrington and
Keane JJ) 20 November 1997**

The Supreme Court addressed itself to the question of whether the jurisdiction of the Attorney General to order an inquest into the death of a person to be held, even though one had already taken place, was confined to cases in which the verdict in the first instance was quashed by the High Court. The background to the case was as follows:

The applicant, the Dublin City Coroner, had conducted an inquest with a jury into the death of Mr. Thomas Docherty while undergoing a routine operation. At the inquest, the question arose whether the deceased had died as a result of the administration of a test dose of penicillin or from some other cause. At the inquest the wife of the deceased, gave evidence that her husband had been allergic to penicillin. Evidence was given on behalf of the hospital that there was no conclusive proof of an allergy to penicillin and that the medical evidence was to the effect that this did not cause the death. Evidence was given by a pathologist that the deceased had suffered from coronial arterial disease. On the basis of the evidence and a summing up by the applicant, the jury returned a verdict that the deceased died from "acute cardiac failure and pulmonary oedema, due to an episode of hypertension possibly due to an anaphylactic reaction to penicillin combined with severe coronary arterial disease". Prior to the inquest, a post-mortem had been carried out on the applicant's request which concluded that although there was no

demonstrable cause of death at post-mortem, however, given the documented history of allergy to penicillin, death was probably due to circulatory failure from acute anaphylaxis to penicillin.

Following the inquest, under section 24 of the 1962 Coroners Act which appeared to give the Attorney General powers to order a fresh inquest, the deceased man's wife made representations to the Attorney General expressing concerns about a number of aspects of how the inquest was conducted, the primary concern being that the post-mortem report had not been produced for the jury and that, therefore, the presence of a documented history of allergy to penicillin had not been disclosed at the inquest. The Attorney General subsequently investigated the circumstances of the case including corresponding with the applicant concerning the matters raised. From a consideration of all the information available, the Attorney General concluded that he did not consider that a further inquest was necessary and in July 1994 he wrote to the wife of the deceaseds conveying this decision.

She was disappointed at this conclusion and made further representations to the Attorney General herself and through others. Subsequently, the Attorney General appeared to change his position on the matter and, in November 1994, decided to order a new inquest under section 24 of the 1962 Coroners Act. This decision was confirmed by his successor in December 1994. Also in that month, the applicant sought and was granted judicial review, comprising an order of certiorari quashing the decision of the Attorney General to direct a fresh inquest on the basis that the exercise of his power under section 24 (1) was unreasonable in law and ultra vires in that there were no circumstances under which he could properly have concluded that the holding of a fresh inquest was

necessary and on the basis that he took irrelevant considerations into account, and a declaration that section 24(1) was unconstitutional.

Throughout 1995, 1996 and 1997 the case went from the High Court to the Supreme Court, back to the High Court and ultimately back to the Supreme Court. The core issue centred on whether the Attorney General had the power to order a fresh inquest where one had already been held. Both High Court judgements ruled that the Attorney General had no such power.

person's family, heirs or other interested parties.

Held

In November 1997, the Supreme Court overruled both of these High Court decisions on the core issue and confirmed that the Attorney General did, in fact, have the power to order a fresh inquest where new evidence came to light. However, on the particular facts of this case, the Court ruled that the exercise of that power was unreasonable and ultra vires his powers under section 24(1) and subsequently it upheld the earlier decision of the High Court granting an order of certiorari to the applicant.

Quite apart from considering the extent of the power of the Attorney General to order a new inquest under section 24(1) of the 1962 Coroners Act, the Supreme Court stated that the public policy grounds underlining the requirement that an inquest should be held in the circumstances defined in the 1962 Coroners Act, were helpfully explained in England by the Brodrick Committee on Death Certification and Coroners, London 1971, as follows:

- 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

(D)**Mr. Denis Desmond & MCD Management Services Ltd v Mr. Cornelius Riordan, Coroner for City of Cork.****Mr. Denis Desmond & MCD Management Services Ltd v Mr. Cornelius Riordan, Coroner for City of Cork, High Court 1996/253 (Morris J) 14 July 1999**

This case considered the issue of whether or not a coroner enjoys absolute privilege in respect of anything he says in the course of an inquest, irrespective of his state of mind. The case was tried as a preliminary issue to a defamation action. The first named plaintiff, Mr. Denis Desmond is the Managing Director of the second named plaintiff, MCD Management Services Limited who are a limited company engaged in the business of organising and promoting rock concerts. This company organised the Feile rock music festival which took place in August 1995 at Páirc Uí Chaoimh, Cork.

During the course of this event, a young man Mr. Bernard Rice drowned, apparently in attempting to gain entrance to Páirc Uí Chaoimh by swimming across the River Lee. On 15 September 1995, while conducting an inquest into the death of Mr. Rice, the defendant Mr. Riordan, the Coroner for Cork City was alleged to have spoken and published words concerning the plaintiffs which they alleged were defamatory and for which they were pursuing a defamatory action.

It was contended by the defendant Coroner that the plaintiffs were precluded from maintaining these proceedings by virtue of the fact that the alleged statements were made in the course of his acting as a lawfully appointed coroner and conducting a coroner's court pursuant to the 1962 Coroners Act.

Held

In his judgment Morris pointed out that the immunity from suit enjoyed by the judiciary exists not for the benefit of the Judge but for the benefit of the community as a whole. This immunity was necessary and desirable so that a judge might perform his duties and functions freed of concern that in the course of performing them, he might defame a third party and be required to be answerable to that party in damages.

However, as the granting of this immunity to the judiciary imposed a limitation upon the constitutional rights of the citizen to vindicate his good name, such immunity must be limited to the degree to which its granting was necessary to enable a judge to administer the law freed of the concern that he would be made answerable for his actions.

Morris held the following:

- 1) The essential ingredient in the consideration of the matter was the state of knowledge of the judge. Once a judge was aware of the fact that he was exceeding his jurisdiction, and continued to act, then he ceased to be exercising his judicial functions and the need for the immunity ceased. A coroner appointed under the 1962 Coroners Act could enjoy no more immunity from suit than a court of local and limited jurisdiction.
- 2) The duties of the coroner were "encapsulated" in section 30 of the 1962 Act which provides that questions of civil or criminal liability should not be considered or investigated at any inquest and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when and where the death occurred.
- 3) A coroner enjoys absolute privilege in respect of anything that he says while he is performing his duties as a coroner in the holding of an inquest in accordance with section 30 of the Coroners Act, irrespective of his state of mind.

Once he strayed outside those functions, and once he knew that he was no longer performing those functions, he ceased to enjoy that privilege.

APPENDIX H

LIST OF CORONER DISTRICTS *

Carlow	Limerick City
Cavan	Longford
Clare	Louth
Cork South	Mayo East
Cork North	Mayo South and West
Cork West	Mayo North
Cork City	Meath
Donegal South West	Monaghan North
Donegal North East	Monaghan South
Donegal North West	Offaly
Donegal South East	Roscommon
Dublin County	Sligo
Dublin City	Tipperary North
Galway North	Tipperary South
Galway West Region	Tipperary East
Galway East Region	Waterford East
Kerry North	Waterford West
Kerry South East	Waterford City
Kerry West	Westmeath
Kildare	Wexford North
Kilkenny	Wexford South
Leitrim	Wicklow West
Laois	Wicklow East
Limerick South East	
Limerick West	<i>*Each district has one coroner</i>

APPENDIX I
CORONER'S ANNUAL RETURNS FOR 1999

District	Deaths reported (no post-mortem or inquest required)	Deaths reported (post-mortem only)	Deaths reported resulting in inquest	Total no. of deaths reported
Carlow	10	14	16	40
Cavan	27	32	25	84
Clare	53	35	37	125
Cork City	65	138	113	316
Cork South	15	57	46	118
Cork North	10	28	26	64
Cork West	26	73	31	130
Donegal South West	12	16	10	38
Donegal North East	2	5	14	21
Donegal North West	20	49	10	79
Donegal South East	1	7	8	16
Dublin City	653	950	465	2068
Dublin County	836	323	231	1390
Galway North	7	13	4	24
Galway West Region	46	111	78	235
Galway East Region	50	53	26	129
Kerry North	11	9	15	35
Kerry South East	22	27	15	64
Kerry West	5	9	17	31
Kildare	77	38	42	157
Kilkenny	37	39	30	106
Laois	11	52	23	86
Leitrim	21	13	17	51

District	Deaths reported (no post-mortem or inquest required)	Deaths reported (post-mortem only)	Deaths reported resulting in inquest	Total no. of deaths reported
Limerick City	6	14	12	32
Limerick South East	40	74	47	161
Limerick West	4	26	22	52
Longford	3	17	11	31
Louth	76	86	54	216
Mayo East	4	8	4	16
Mayo South and West	14	57	23	94
Mayo North	7	17	19	43
Meath	18	64	32	114
Monaghan North	21	7	10	38
Monaghan South	3	6	6	15
Offaly	27	81	18	126
Roscommon	22	42	33	97
Sligo	90	48	29	167
Tipperary North	23	22	11	56
Tipperary South	24	47	24	95
Tipperary East	3	10	2	15
Waterford City	40	41	19	100
Waterford East	5	8	23	36
Waterford West	7	4	7	18
Westmeath	22	41	29	92
Wexford North	1	27	22	50
Wexford South	35	39	48	122
Wicklow West	4	7	13	24
Wicklow East	7	28	16	51
Total	2523	2912	1833	7268

APPENDIX H

OUTLINE CORONERS' RULES

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

- 1.1 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 post-mortem 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

Notes for assistance of Rules Committee

Part 1. General

1.1. DEFINITION OF TERMS

In this section a definition of terms, even the most basic, must be included. This definition should reflect and expand on the definition of terms in section 2 of the 1962 Act. For example a post-mortem examination means a full three-cavity examination to be carried out by a qualified pathologist, or a trainee pathologist under his/her direction. A list of “properly interested persons” as they apply to each stage of the coroner cycle should be defined.

Suggestions for essential terms to be defined:

- post-mortem
- histopathologist
- preliminary inquiry
- jurisdiction
- inquest
- interested persons
- pm report
- toxicology
- fact of death certificate (interim coroners certificate)
- verdict
- recommendation
- appropriate post-mortem facilities. *

* UK National Health Service Building Note 20(HMSO) is recommended as a reference point for the appropriate standard for post-mortem facilities.

Part 2. Deaths reported to coroners

2.1. REPORTABLE DEATHS TO A CORONER

Suggested headings for deaths reportable to a coroner:

- sudden deaths from unknown causes
- any case where the cause of death is unknown
- any accident caused by any vehicle, aeroplane, train or boat
- where there are suspicious circumstances, violence or misadventure
- suicide
- if the deceased has not been seen and treated by a registered medical practitioner within 28 days before death
- due to possible negligence, misconduct or malpractice
- death occurred within 24 hours of admittance to hospital
- any death which may have been caused by anaesthetic, diagnostic or therapeutic procedure
- any maternal death that occurs during or following pregnancy (up to a period of six weeks post-partum) or that might be reasonably related to pregnancy
- any death of a child in care
- any infant death, such as sudden infant death syndrome
- certain stillbirths
- if the deceased was in a mental health facility, in prison or in Garda or military custody.
- deaths due to want of care, exposure or neglect

- any death due to accident at work, occupational disease or poisoning
- where a body is to be removed from the State
- where a body is unidentified
- in certain circumstances where a body is to be cremated
- where a body or human remains is “discovered”
- the death of persons in vulnerable groups to be defined by the Rules Committee
- any others.

The above list is comprehensive but should not be considered all-inclusive.

2.2. WHO MUST REPORT A DEATH?

The following is a list of persons who are obliged to report a death to the coroner or to the coroner’s officer:

- every medical practitioner, registrar of deaths or funeral undertaker, every occupier of a house or other dwelling, and every person in charge of any institution or premises, in which a deceased person was residing in at the time of death. (See section 18.3, 18.4 of the 1962 Coroners Act.)
- any member of the Gardaí who becomes aware of a death in the coroner’s jurisdiction.

2.3 WHEN IS IT NECESSARY TO HOLD A POST-MORTEM EXAMINATION?

A post-mortem examination is to be held where it cannot be established that death occurred naturally including in the following instances:

- all unnatural deaths
- certain sudden or unexplained deaths

- when there are suspicious circumstances, violence or misadventure
- possible negligence, misconduct or malpractice
- certain deaths occurring within 24 hours of admittance to hospital
- any death where it appears to have been caused by anaesthetic, diagnostic or therapeutic procedure
- any death of a child in care unless a certificate has been issued from a qualified medical practitioner that s/he had attended the child in the last illness
- certain infant deaths
- if the deceased was detained in prison or in Garda or military custody
- deaths due to want of care, exposure or neglect
- any death due to accident at work, occupational disease or poisoning.

Part 3. Post-mortem examinations

3.1 WHO MAY CARRY OUT A POST-MORTEM?

- a suitably qualified histopathologist
- a suitably qualified trainee histopathologist under his/her direction

3.2 WHEN SHOULD A PATHOLOGIST NOT CARRY OUT A POST-MORTEM?

- where there may be a conflict of interest
- where the conduct of a member of the hospital staff, where the pathologist is involved, could be called into question and the coroner is aware of the fact
- where any relative of the deceased specifically asks the coroner that the examination not be made by such a pathologist.

A hospital pathologist will not normally carry out a post-mortem where the circumstances of death are questionable or suspicious or overtly homicide as in such cases the State Pathologist is called upon.

3.3 PRESERVATION OF MATERIAL AND RECORDS

- pathologists carrying out a post-mortem are to make provision to preserve material which in their opinion, bears upon the cause of death
- the relevant records of the case are also to be maintained
- suggested material and records to be maintained include the following:
 - Exhibits
 - Notes
 - Post-mortem report
 - Toxicology report
 - Organs (until no longer required)
 - Blocks and slides
- the periods for how long material and records should be kept should be identified by the Rules Committee.

3.4 ORGANS AND BODY PARTS: REMOVAL, RETENTION AND DISPOSAL

- coroner's legal entitlement to remove and retain
- clarification of circumstances and procedures for removal, retention and disposition

3.5 THE POST-MORTEM REPORT

- the pathologist must submit the report to the coroner

- families have a right to see the pathologist's report if no inquest will take place. Due to the nature of the contents, it would be preferable to have the report forwarded to their GP for explanation
- a post-mortem report be standardised
- copy of the post-mortem report should, on request from the coroner, be made available to the Gardaí.

Part 4. Special Examinations

4.1 AUTHORISATION FOR A SPECIAL EXAMINATION

The coroner can directly request the State pathologist to undertake a post-mortem.

Note: Where the circumstances of a death are questionable, may be suspicious, are suspicious, or where a body is found with unexplained marks or injuries etc, it is desirable to have a forensic post-mortem.

Part 5. Interim Certificate of Death

5.1 CRITERIA GOVERNING THE ISSUING OF A "FACT OF DEATH" CERTIFICATE

Criteria governing the issuing of a fact of death certificate (interim coroners certificate)

Part 6. Inquests

6.1 WHEN SHOULD A CORONER BE DISQUALIFIED FROM HOLDING AN INQUEST?

- when there has been a professional relationship with the deceased
- when there is a professional relationship with an interested person or witness, such as a doctor in the same practice or hospital for instance.

6.2 CIRCUMSTANCES WHERE FLEXIBILITY OF JURISDICTION ARE REQUIRED

- to ensure concurrent jurisdiction between coroners and deputies
- to provide for agreed jurisdiction in cases where death occurs in different jurisdictions arising from the same incident
- where the deputy coroner may also be disqualified or compromised or is otherwise unable to conduct the inquest.

6.3 NOTICE OF AN INQUEST

- a minimum period of adequate notice should be introduced in the rules with procedures to ensure this to be defined. A process should be introduced for giving advance warning when dealing with adjournments

6.4 CIRCUMSTANCES WHEN A JURY MUST BE USED

- all existing situations except for road traffic accidents
- all other enactment's which require juries at inquest should be reviewed.

6.5 EMPANELLING THE JURY

Procedures to be defined for empanelling juries, in accordance with the Juries Act, 1976.

6.6 RECORDS TO BE KEPT

The following records should be kept:

- depositions
- maps
- photographs
- expert reports
- copy hospital notes or notes extract
- post-mortem report

- toxicology reports
- verdicts
- recommendations
- copy of Coroners Certificate
- other.

6.7 TAKING DOCUMENTARY EVIDENCE AT INQUEST

Define procedures for taking documentary evidence at inquest.

6.8 REQUESTING DOCUMENTARY EVIDENCE AT INQUEST

The coroner is allowed to admit non-contentious documentary evidence in accordance with certain procedures. Define these procedures.

6.9 CORONER'S DISCRETION FOR NON-RELEASE OF DOCUMENTS BEFORE INQUEST

A coroner should release all documents to "interested parties" except in certain circumstances. Define the exceptions.

In certain circumstances of death, documents will, by the nature of things, be accessible to interested persons in advance e.g. a legal representative of a hospital board would have prior access to certain records relating to a hospital death.

6.10 WITNESS ANONYMITY

Witness anonymity may be granted in the following circumstances:

- if there is a threat to the personal security of a Garda or member of the Defence Forces
- if there is a threat to the personal security to any witness, or to their family
- if there is a threat to national security.

6.11 PROTOCOLS FOR EXAMINING WITNESSES

Witnesses can only be called by the coroner.

- the witness will be examined first by the coroner and if the witness is represented at the inquest, lastly by their representative
- members of the deceaseds' family should also to be allowed to ask the witness questions
- interested persons can make a request to interview a witness but the coroner retains final discretion.

6.12 INQUEST ADJOURNED DUE TO CRIMINAL PROCEEDINGS

- procedures to be followed
- the coroner's officer is to inform all interested parties in good time
- it must be made clear to the families that the reopening of the inquest cannot produce a finding or verdict of any civil or criminal liability or an outcome which can conflict with that of a criminal court.

6.13 MANDATORY INQUESTS

- under the existing provisions in the 1962 Coroners Act
- deaths in Garda custody, prison or workplace
- under other enactments.

Part 7. Verdicts

7.1 WHAT VERDICTS ARE AVAILABLE TO THE CORONER?

- accidental death
- death by misadventure
For example, a heroin overdose.
- medical accident/misadventure.
This imparts no blame or wrongdoing on

behalf of the doctor and would be used, for example, where complications arose from a medical procedure or administration of drugs

- suicide
In declaring a verdict of suicide there are three essential things to look for:
 - the deceased took his/her own life without any third part involvement
 - the person was intent on taking their life
 - there is proof beyond a reasonable doubt that injuries sustained are self-inflicted and the deceased had such intention.
- unlawful killing.
See section 40 of the Act. Such a verdict could be returned where the deceased was found with gunshot wounds that could not have been self-inflicted or where someone was stabbed/kicked to death. The time frame from that actual event to the inquest would be substantial.) In declaring a verdict of unlawful killing a coroner is to be mindful of the following:
 - there are no criminal proceedings
 - that unlawful killing is proved beyond reasonable doubt
 - no one can be associated with the killing
 - the investigation by the Gardaí has ended
 - no person may be expressly or by implication be named for the killing.
- want of attention at birth.
In declaring such a verdict the coroner must note the following:
 - the child was abandoned
 - the child's mother was never found
 - no other person is under suspicion.
 - proof beyond reasonable doubt is secured.

- stillbirth.
For example, if a baby's body was found and at the inquest it was discovered that the baby was in fact, stillborn
- industrial disease
- in accordance with the findings of a criminal court. (Section 25).
Usually the verdict "murder", "manslaughter" will be in accordance with the verdict of the criminal court
- death by natural causes.
If during an inquest into a road traffic accident, it was discovered that the deceased died of a heart attack prior to the accident taking place, death was by natural causes and should be recorded as such
- open verdict
Only by default.

7.2 FINDINGS

In exceptional circumstance verdicts may be confined to findings. It is sometimes difficult to determine a verdict and in those circumstances "findings" may be more appropriate. A finding would be applied in such cases as the following:

- where a person is killed by a member of the Defence Forces or Garda Síochána acting in the course of their duty
- where a burglar has been killed by an occupant of the premises
- in certain cases where criminal proceedings took place where there was no prosecution.

Part 8. Review

8.1 PROCEDURES TO BE IN THE REVIEW SYSTEM

Procedures to be used in the review system should include the following:

- procedures to be used in lodging an application for a review
- procedures to be used by Review Board in processing an application for a review
- range of recommendations available to the Review Board
- range of decisions which can be reviewed.

Part 9. Removal from office

9.1 PROCEDURES FOR REMOVAL FROM OFFICE BY THE MINISTER

Procedures for removal from office by the Minister and the circumstances under which coroners can be removed from office.

A coroner can be removed from office by the Minister in the following circumstances:

- under the existing provisions in the 1962 Coroners Act
- disbarring arising from professional misconduct.

Part 10. Procedures for clearance for burial

Specify clearance procedures for burial of body.

Part 11. Forms design

Rules Committee to be empowered to design all coroner forms.

Part 12. Revision of rules

Define procedures for revision of Rules by Rules Committee.

Part I To be completed and signed by the Coroner

APPENDIX K

DRAFT FORM FOR INCLUSION IN DIALOGUE WITH DESIGNATED PERSON (SEE SECTION 3.3.2)

CORONERS ACT 1962

I **confirm** that it has been explained to me that the coroner has, under law, ordered a post-mortem examination on the body of _____ and that the purpose of the coroner's post-mortem is to establish or clarify the cause of death.

Small tissue samples are usually retained as part of the normal post-mortem practice and form part of ongoing medical records held in relation to any deceased persons. In the context of establishing the cause of death, it is, however, sometimes necessary to retain organs or other parts of the body for examination and analysis. This process may take some time and will, in almost all cases, extend beyond the time of burial of the body. Because of this, please indicate below your wishes in this matter by ticking the appropriate box..

Please tick as appropriate

I prefer not to be told if organs or other parts of the body have been retained.

I understand, however, that, on release of the organs by the coroner, they will be sensitively disposed of in accordance with nationally agreed hospital practices.

I prefer not to be told if organs or other parts of the body are retained before burial but,

I would like to be told when the coroner releases them.

I prefer to be told before burial that organs or other parts of the body have, in fact, been retained at post-mortem.

I confirm that I have been given a copy of "Coroner's post-mortem – a leaflet for the bereaved".

Signatures _____

EDUCATION AND MEDICAL RESEARCH

After formal release by the coroner, the retention of organs or other parts of the body for use in education and medical research always requires your specific consent. Many people often wish to grant this consent which can be of great benefit to the future treatment of medical problems. Should you wish to do so, the form of consent and the options available to you for final disposal of the organs are set out in the attached form*

* standard consent form for non-coroner cases

APPENDIX L

FORM FOR REGISTRATION OF A DEATH

To the Registrar of Births and Deaths for the District of _____ in the County of _____

I hereby certify that in pursuance of the Coroner's Act, 1962, I, on the _____

Strike out whichever two are Inapplicable

(a) held an inquest

(b) adjourned an inquest at which evidence of identification and any medical evidence as to the cause of death were given

(c) decided, as a result of post-mortem examination held on the _____ 19 _____ not to hold an inquest on the body of _____ and I found as follows:

Date of Death _____ day of _____

Place of Death (Full Address) _____

Sex of Deceased _____

Cause of death and duration of last illness

Approximate interval between onset and death

I
Disease or condition(a)
directly leading to death due to (or as a consequence of)

.....

Antecedent causes
Morbid conditions, if,(b)
any, giving rise to the due to (or as a consequence of)
above cause, stating the
underlying condition last(c)

.....

.....

II
Other significant
conditions contributing
to the death but
not related to the
disease or condition
causing it.

.....

Witness my hand, this Day of

Signature

Coroner for District of

Address

Part II To be completed and signed by the nearest available relative of deceased

Particulars of the Deceased

First Names _____ Surname _____

Address _____

Marital Condition _____
 (State whether bachelor, spinster, married, widowed, or divorced)

Age of Deceased _____
 (age to be stated in hours if under one day, in completed days, if under one month, in completed months if under 1 year, otherwise in completed years last birthday)

Occupation of Deceased _____
 The occupation should be described as exactly as possible. If the Deceased was retired state "Retired" and previous occupation.

Signature

Full Name
 of Relative _____

Address _____

Relationship to Deceased _____

Date _____

This form, when completed and signed by the Coroner and relative of the Deceased, to be forwarded immediately from the Coroners' Office to the Registrar of Deaths for the registration of the Death.

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