Left Out in the Cold

ICCL press briefing on the Coroners System in Ireland

APRIL 2021

"If you think this system is capable of finding out what happened to your relative because it is a really good system and you can put your faith in it? Think again."

Find the full report here: https://www.iccl.ie/wp-content/uploads/2021/04/ICCL-Death-Investigations-Coroners-Inquests-the-Rights-of-the-Bereaved.pdf

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Irish Council for Civil Liberties

Key insights

Ireland's system of investigating death is inadequate and **can compound and even aggravate the suffering** of loved ones.

Root-and-branch reform was demanded by an independent Working Group in 2000. **Twenty-one years later**, those reforms have still not been implemented. This failure on the part of successive governments means **grieving families are** side-lined, marginalised, and **left out in the cold** as they wait to find answers.

Insights:

- The Coroner's service is a network of **part-time, under-resourced** & **under-trained** coroners. Due to these incredible pressures, it functions with **neither thoroughness nor compassion.**
- Grieving families are faced with **a maze of confusing details or lack of information** from the inadequate Coroner's website, to inaccessible legal advice, to stone walling from key actors when they seek information about the process.
- The Coroner's Service is **not independent from An Garda Síochána.** This gives rise to serious issues when the death involves the behaviour of gardaí.
- **David & Goliath**: Grieving families are not guaranteed and often unaware of legal supports. In contrast, the State and its institutions bring the full force of their legal arsenal.
- **Delays** in finding answers **can span decades.**
- Inconsistencies between districts mean **an inquest into a death in Dublin is not the same as an inquest into a death in Kerry.**
- Families find themselves with **no waiting areas, no accommodation, no support** when they attend inquests. They are literally left out in the cold.
- The system **cannot be trusted** to guarantee to families that what happened to their loved one will never happen again.

Key Quotes

A suicide researcher says "we don't get reliable suicide data for several years. If a person dies it shouldn't be three years to get their death finalised and registered with a cause'.

A GSOC investigator says "on occasion we have been asked to swear in, to administer the oath to jury members. **We've got no legal standing to do so,** we've got no authority to do."

"For the past sixteen years we've been trying to find out what happened to him".

Family member of a man who died in suspicious circumstances

"The coroner had [a witness account of an assault] the day of the inquest and didn't release it to us. For 14 years, while they were telling us it never happened, they had this statement, which we have, that it did happen, and they had it from day one."

" It's like they use the inquest to gauge for any further cases, for how much they will have to pay out, how far it will go, how strong the family are, how much they will fight to get the truth. They use it as a gauge and they'll just drag it out. They drag it out over years, and they don't mind that, they just hope the family will go away."

"anybody who had been through the process would say if you do nothing else go and find yourself a lawyer … if you think this system is capable of finding out what happened to your relative because it is a really good system and you can put your faith in it? Think again. And that is the information leaflet you would really write."

Recommendations

We make 52 recommendations for urgent root-and-branch reform of the system. They can be grouped into three broad categories.

- **Put families at the centre of the process.**
    - Consult with bereaved families and establish a **Charter for the Bereaved** which would clearly address their needs and rights.
    - Redesign the website and information system with shocked and bereaved people in mind.
    - Make legal aid and counselling available to the bereaved.

- **Fund an independent, consistent and fully-professional service.**
    - Appointment of a Chief State Coroner and full-time Senior Coroners in each region.
    - All Coroners to have legal training and experience as a legal professional
    - Counselling to be made available to all staff, and they should be trained in trauma-informed practice
    - The service should be made entirely independent of An Garda Síochána.

- **Introduce Minimum Standards of Practice**
    - Establish maximum acceptable time lapses at all stages, including for medical examinations, provision of information, and holding of inquests.
    - The needs of families should be anticipated and provided for.
    - Recommendations by juries should be followed-up. There should be follow-up procedures where systemic failings are identified.
    - Jury selection should be randomised.

The failings identified in this report demand root-and-branch reform. They are systemic failings. Tinkering around the edges will not address them.

The State must undertake this as a matter of great urgency, for the families and loved ones of those who die in contested circumstances and for all of us to know that steps are being taken to prevent deaths in similar circumstances in the future.

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About ICCL

The Irish Council for Civil Liberties (ICCL) is Ireland's oldest independent human rights body. It has been at the forefront of every major rights advance in Irish society for over 40 years. ICCL helped legalise homosexuality, divorce, and contraception. We drove police reform, defending suspects' rights during dark times. In recent years, we led successful campaigns for marriage equality and reproductive rights.

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