An Examination of the Operation of the Coroner's Service

ICCL Submission to the Joint Oireachtas Committee on Justice

April 2022

Irish Council for Civil Liberties

Introduction

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

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

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

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

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

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

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

[3] ibid 9, Recommendations 18 & 20.

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

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

[6] ibid 8, Recommendation 9.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Comments

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

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

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

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

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

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

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