LAW SOCIETY OF IRELAND

Public Consultation on The Reform of The Coroner Service

Submission to the Department of Justice

Date 19 January 2024

Response to Public Consultation on the Reform of the Coroner Service

Introduction

The Law Society of Ireland (the **Law Society**) appreciates the opportunity to provide views on the recently launched Coroner Reform Consultation by the Minister of Justice. As requested, we will focus on the inquests strand of the consultation paper and respond to the specific questions raised.

Executive Summary

In summary, we submit that the Coroner Service in Ireland must be reformed to modernise the structure and efficiency of the service. The new structure of the Coroner Service should provide for a Chief Coroner with a national jurisdiction under the Department of Justice.

We note that in 2000 a comprehensive review of the Coroner Service was published by a Working Group on behalf of the then Department of Justice, Equality and Law Reform. It recommended 'radical reform and a major reconfiguration of the Coroner Service'. This has not happened and according to the Irish Council for Civil Liberties (**ICCL**) in its 2021 research report into Death Investigation, Coroners' Inquests and the Rights of the Bereaved

> "There remains: no coherent national organisation of coroners working collectively under centralised direction; Gardaí continue to work as coroners' officers; the system of selecting coroners' juries remains inconsistent and in some Districts it is inappropriate that members of the local community are appointed repeatedly; there is a lack of centralised training for coroners appointed by local authorities; governance of the coronial system remains unclear; there has been minimal reorganisation of Districts and the bulk of coronial work is carried out by part-time coroners who are dependent on limited administration staff and Gardaí investigators."

The Law Society submits that the process and procedure of inquests needs to be reviewed and reformed as a priority. The current procedure in operation is inappropriate for several reasons including (1) the method of jury selection (2) the resourcing of the Coroners Court (3) the role of An Garda Síochána in delivery of the service (4) how inquests under Article 2 of the European Convention of Human Rights (**ECHR**) are dealt with and the delays in these types of inquests and (5) the availability of legal aid for families of the bereaved.

The Law Society submits that jury selection should be random from the electoral register (see response to question 4.2).

In addition, we submit that the Coroners Service needs to be appropriately staffed and trained with full time senior Coroners, part-time deputy and assistant Coroners, full time officers and secretarial staff. All newly appointed Coroners should have appropriate legal training. Information provided to bereaved families by the Coroner should provide guidance on accessing appropriate legal advice and representation. Currently legal aid is not guaranteed for families' legal representation. The Law Society supports the principle that all sides to a legal dispute should be equally resourced. We submit that legal aid should be available to all bereaved families seeking legal representation at inquests.

Consultation Part 2 Questionnaire

Part 1 Structure and Roles

1.1. Should a standalone independent Coroner Service be established?

Yes, a standalone independent Coroner Service should be established. The Law Society propose that a single, centralised function be established under the Department of Justice with a Chief Coroner and centralised administrative staff to support Coroners.

1.2. What services/functions should such a body be responsible for?

The Law Society agree with the functions set out in paragraph 1.16 of the consultation paper which we list below for ease of reference.

A Coroner's function is to investigate sudden and unexplained deaths and will include some or all of the following;

- Engaging with An Garda Síochána or the Garda Síochána Ombudsman Commission (**GSOC**);
- Engaging with medical professionals (e.g. GP or hospital staff);
- Engaging with mortuary services and funeral directors;
- Directing a postmortem examination including the provision of, histology, and toxicology services;
- Liaising with histopathologist or the Office of the State Pathologist;
- Family liaison;
- Issuing interim death certificates;
- Organising inquest facilities including translation or other related services;
- Organising witnesses to attend an inquest;
- Liaising with legal representatives;
- Liaising with the Civil Registration Service to enable the issuance of a death certificate

1.3. To what degree should the Coroner Service be centralised or regionalised/ localised (please reference individual stages in the Coroner process where possible)? Please refer to Figure 1 on page 13 of the consultation document.

The Law Society submit that a centralised service is the most appropriate model based on the operation of the Northern Ireland model which has undergone positive reform over recent decades. Case allocation and management arrangements should be established so that the workload is evenly spread among Coroners across Ireland and a consistent service is delivered to bereaved families. Stages 1, 2 and 3 in the Coronial death investigation flowchart should take place in the office of the Chief Coroner in Dublin with Stages 4, 5 and 6 taking place as determined by appropriate geographical location and Coroner capacity considerations.

1.4. Not applicable to this submission.

1.5. What should the responsibilities of a Chief Coroner be?

The Law Society submit that the Chief Coroner should:

- Facilitate the orderly and efficient operation of the system.
- Support Coroners by providing guidance and leadership.
- Prepare manuals and a code of practice to guide Coroners.
- Shape the practice and procedure of Coroners in the functions of their office.
- Provide guidance on the interpretation of case law.
- Hear complex and or contentious inquests where appropriate.
- Put in place training arrangements for Coroners and their staff.
- Oversee the transfer of cases between Coroners and direct Coroners to conduct investigations as appropriate.
- Maintain a public register of Coroners' recommendations.

Part 2 Pathology and Related Services

Not applicable.

Part 3: Reportable Deaths

3.1. Should Ireland revise the number of circumstances that a death must be reported to a Coroner?

(b) No

At present the Law Society understands that the Coroner Service is unable to handle the current case numbers.

The Law Society notes in paragraph 3.6 of the consultation paper that Ireland has the highest percentage of registered deaths reported to Coroners compared to five other jurisdictions (Northern Ireland, England and Wales, New Zealand, Victoria and British Columbia).

The Coroners (Amendment) Act 2019 increased and clarified the range of reportable deaths. Section 16A of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019 provides a lengthy list of types of deaths that must be reported to the Coroner. These include various forms of homicide, suicide, maternal deaths, and deaths of infants.

3.2. Should all perinatal deaths be reportable to a Coroner?

(b) No

The Law Society submit that not all perinatal deaths should be reportable to the Coroner or be the subject of an inquest as this may, in certain cases, cause distress to families where the cause of death is known. For instance, in families where there is a known genetic issue such as hydrocephalus in a previous birth or several other common family genetic issues the cause of death of the infant will be known to both the medical practitioners and the families involved.

Part 4: Inquests

4.1. What functions/duties should An Garda Síochána have in the Coroner death investigation process? Please give reasons for your response.

Currently, when investigating deaths reportable to the Coroner, An Garda Síochána

- Provide information to the Coroner regarding the deceased.
- Organise a formal identification of the body.
- Where a visual identification is not possible, arrange for DNA testing for comparison with a close family member and liaise with Forensic Science Ireland (FSI).
- Prepare a detailed report to the Coroner which include statements taken by An Garda Síochána during the investigation.
- Summonsing juries for inquests.
- Plays a lead role where a jury is required for an inquest.

An Garda Síochána conduct investigations and take statements from relevant witnesses. These are submitted by way of depositions to the Coroner. Issues may arise where An Garda Síochána have arrested somebody who has died in Garda custody or were there has been a Garda operation that led to a death in that operation. There could be a perception of bias in these cases. Therefore, the onus very often falls to GSOC to investigate separately and independently these deaths or in the case of deaths in prison a separate internal investigative section.

Sometimes at an inquest you may have representations from An Garda Síochána and from GSOC both of whom have conducted separated investigations. The families of the deceased may be given documentation that is compiled by An Garda Síochána and GOSC in conjunction with the Coroner's Office. However, the sheer volume of these statements can overwhelm the Coroner's Office and they rely heavily on AGS and GSOC to collate these documents. The relationship between Coroners and An Garda Síochána may be a matter of concern in certain cases particularly where death investigation involves behaviour of An Garda Síochána or other State institutions. An Garda Síochána investigations must be thorough, independent, transparent, and impartial. The centrality of An Garda Síochána role in gathering and presenting evidence, liaising with families, preparing depositions for the Coroner and servicing inquests could, in certain circumstances, create doubts by families regarding independence.

An Garda Síochána and GSOC often claim privilege in relation to documents and the Coroners do not have judicial authority to rule on the issues of privilege being raised. The Coroner must, in these cases, refer the matter to the High Court. Where deaths have occurred during AGS activity the privileged documents are usually the ones that are most relevant to the inquest as far as the family of the bereaved is concerned.

The current process needs to be further examined and the role of AGS in the delivery of the service should undergo a detailed review to ensure that its role is confined to investigation of deaths.

4.2. Accepting that an inquest is concerned with establishing facts and not apportioning blame or liability, how should a jury for an inquest be selected and by whom?

The Law Society submits that jury selection should be carried out in the same manner as jury selection under the Juries Act 1976 which is a process of random selection from Electoral Registers by County Registrars.

The Law Society has concerns about the current process of AGS choosing the juries in the Coroners Court. It is necessary for interested parties to make a specific application to the Coroner that the jury is not to be selected by AGS in Article 2 enquiries.

The Law Society also note that very little information is given to the family of the deceased in relation to the membership of the jury in advance of the inquest. A process like that used in criminal trials could be considered whereby family representation are given a list of the prospective jurors and can ensure that there is no conflict in relation to their service on the jury. In contested cases, lawyers representing properly interested persons could be able to challenge the constitution of the jury.

4.3. What is the most appropriate venue for an inquest to be held? Please provide reasons for your response.

The Law Society agrees with paragraph 4.25 of the consultation paper that facilities for Coroner's inquests should, where possible, include courtrooms or family rooms with appropriate public waiting areas recognising the need for privacy for bereaved families and witnesses, meeting rooms and rooms for ancillary services such as bereavement support and appropriate spaces/amenities for children.

4.4. What alternative supports could be provided to families to minimise the need for legal representation?

The Law Society submits that legal representation is crucial in questioning those involved directly in a death, the representatives of State institutions whose decisions are under scrutiny and other expert witnesses called by the Coroner. State institutions are often legally represented and in these cases we submit that legal aid should be available to all bereaved families seeking legal representation at inquests.

Notwithstanding this general comment, the Law Society submits that better information could be available for bereaved families as a matter of course in the running of the Coroner Service.

The Coroner Services website's public-facing information pages could be re-designed to make them more user friendly. This is often the first port-of-call for bereaved families while preparing for post-mortems and inquests. The ICCL in its 2021 research report into Death Investigation, Coroners' Inquests and the Rights of the Bereaved noted that

> "Consistent with other jurisdictions that use accessible language with translations available, the website should provide detailed information on: the function and duties of Coroners; the Coroner's jurisdiction; reported deaths, post-mortems and the holding of inquests; the purpose, conduct and conclusion of inquests; the question of liability; the civil standard of proof and the range of verdicts; narratives added to/ replacement of short-form verdicts; Article 2 inquests; juries and their appointment; pre-inquest reviews and adjourned inquests; disclosure of documents; calling of witnesses; media reporting."

The Law Society submits that families should be supported with services such as bereavement counselling and a family liaison person from the Coroner's office to explain the inquest process and be available to answer any questions from families about the inquest.

4.5. What is the best approach to recording and monitoring Coroner recommendations?

The Law Society submits that the newly established office of the Chief Coroner should maintain a list of recommendations made at inquests and publish these on its website. The

Chief Coroner's office could establish a system to centrally record all recommendations. The Law Society does not believe the new Coroner Service should have a role in monitoring the implementation of the recommendations however any failure to follow up jury and Coroner recommendations for reform in institution policy and practice should be addressed.
The newly established Coroner Service in Ireland could publish a quarterly summary of Coroner recommendations.

4.6. Should some form of review mechanism in respect of Coroner decisions be introduced?

The Law Society does not think a new review mechanism should be introduced in respect of Coroner decisions. A person who is dissatisfied with a decision of a Coroner may apply to the High Court for Judicial Review of that decision. Northern Ireland and England and Wales adopt a similar approach allowing Judicial Review of Coroner decisions rather than having another review mechanism which would require additional staffing and financing and such a review mechanism may have to allow access to the Courts for Judicial Review in any event.

4.7. Not applicable**.**

Part 5: Other

5.1. Please provide any other views, opinions, or proposals on how a reformed Coroner Service should be structured and operated.

The Law Society emphasises the importance of legal representation at an inquest.

The role of legal representatives in an inquest is to represent the next of kin or any other 'properly interested person' and to ensure their interests are protected during an inquest. Those who can apply to have 'properly interested person' status at an inquest include (1) the next of kin, (2) other relatives of the deceased, (3) an executor of the deceased's will or appointed personal representatives, (4) anyone who may be responsible for the death in some way, (5) others appearing to the Coroner to have a proper interest.

The Coroner can direct written submissions from legal representatives which provides an opportunity to address any issues on behalf of a properly interested person.

A solicitor can also request that an Article 2 inquest be conducted which essentially provides the Coroner with greater scope to investigate a death than they would have in normal circumstances.

Article 2 of the ECHR provides protection for the right to life. Under Article 2 the State has (in broad terms) a duty to protect the right to life. This includes a duty not to take life without justification, as well as a duty to ensure that laws, systems, and procedures are in place to protect life to the greatest extent reasonably practicable. Examples of where Article 2 might be engaged (or apply) include the death of a person following contact with An Garda Síochána or the death of a psychiatric in-patient in a State institution.

The position of the Coroner in some of these cases is that they are performing the only investigative enquiry that is open to the public and presently the ability of the Coroner to conduct these enquiries is somewhat curtailed. For instance, most of these cases involve investigations by An Garda Síochána and by GSOC and both An Garda Síochána and GSOC may claim privilege in relation to certain documents. The Coroner does not have the power to determine issues raised in relation to privilege. Therefore, any issues relating to privilege must be determined by the High Court first and then referred back to the Coroner's Court. A more

efficient system could be put in place whereby the Coroner or a designated Legal Officer attached to the Coroners Court can rule on claims of privilege in the cases of deaths in custody. This could save an enormous amount of time and difficulty to the families while they await the outcome of High Court proceedings. Article 2 enquiries can very often take a considerable amount of time.

It is submitted that the operation of Article 2 inquests needs to be reformed to ensure appropriate and efficient access to justice to those involved. It is submitted that if the Coroners Court cannot be given sufficient legal oversight and ability to rule on issues such as privilege that Article 2 enquiries could more properly be dealt with by the Courts rather than by the Coroner's Office.

The Law Society submits that:

1. A codified set of rules governing the procedures in the Coroners Court should be put in place. A code of practice could be introduced to establish uniformity in standards, support for the bereaved and detailed information about the service.

2. An expansion of the legal aid system to allow family members of the deceased to have representation in the Coroners Court in certain cases.

3. A new centralised IT system to allow members of the public have access to all inquest files at their request.

4. Further review as to whether the Coroner's Court is a suitable venue to deal with Article 2 enquiries for reasons including:

    a. the Coroner is not able to rule in relation to privilege being claimed by either An Garda Síochána or GSOC in relation to operational information. This operational information is sometimes critical to the case from the point of view of the family of the deceased. It deals with the knowledge, planning and structure of the operation that took place that ultimately led to the death of the person being examined at the inquest. The current system whereby the High Court must rule on privilege and then send the matter back to the Coroner's Court is causing considerable delays.
    b. there are sometimes issues in relation to An Garda Síochána giving evidence behind screens in the Coroner's Court because they are part of surveillance operations and need to maintain anonymity. These kinds of issues could be better dealt with in the Court system rather than in the Coroner's Court.
    c. there are concerns in relation to the representation of the family of the deceased in the Coroner's Court. Currently there is a panel and only persons on this panel can be assigned to represent the family on legal aid. In the Parole Board, there is a panel but it is possible for the inmate to make their own selection and if the person selected by the inmate is a suitable person, they can represent them at the parole hearing. A similar system could be in place in relation to the Coroner's Court to avoid a situation whereby the bereaved family end up with having civil solicitors dealing with what are primarily criminal investigations and the solicitors who are most familiar with the case not being able to represent the families.
    d. It is not appropriate that Juries be selected by An Garda Síochána for Article 2 inquests.

Conclusion

In conclusion, the Law Society supports the reform of the Coroner Service in Ireland to ensure that the service is effective and efficient to deal with the growing number of reportable deaths. The Law Society supports a new service with a Chief Coroner with a national jurisdiction under the auspices of the Department of Justice. It is regrettable that the Coroners Bill 2007 was never progressed following Second Stage in the Senad.

The current structure of the service is not appropriate to deliver a modern, efficient service. Coroners receive no formal training in terms of the role of a Coroner. There are no statutory rules on Coroner practice and procedure and no detailed guidance documents have been produced for the current Coroner Service in Ireland. There is no centralised system of recording Coroner recommendations or riders at inquests. Facilities at inquests for bereaved families are often inadequate.

The Law Society notes that Northern Ireland, England and Wales, New Zealand, Victoria and British Columbia all run a centralised Coroner Service.

The Law Society agrees that the post-mortem examination is one of the key pillars supporting the death investigation process and the completion of a post-mortem examination in a timely manner is essential for the bereaved as the Coroner may then direct the release of the body to the family. Although we have not responded to Part 2 of the questionnaire (Pathology and Related Services) we note with concern the current typical waiting time of between 4 and 6 months for the completion of a post-mortem examination. This time delay is undoubtedly very difficult for bereaved families who are unable to make final arrangements for the deceased.

The Law Society appreciates the opportunity to contribute these responses to the consultation questionnaire for the Department of Justice and we will be glad to engage further on any matters raised.

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