Submission to Joint Committee on Justice

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

I will begin by offering my sincere thanks for the opportunity to address the Committee as to the operation of the Coroners Service, one of the oldest and most important public services in existence in Ireland.

I have represented many bereaved families in the Coroners Court - spouses, parents and children searching for answers as to how and in what circumstances their loved ones died. Too many times I have left the Coroners Court with families whose grief has been compounded and whose questions remain unanswered. During the process these families are at their most vulnerable. They deserve truth, justice and accountability, and we owe it to them to provide a Coroners Service which upholds these principles.

I hope that my account of working with bereaved people will help to inform the Committee and I will endeavour to make sure that the families I represent have their voices heard through my submission. I am here today because of them.

We need to modernise and humanise what is a vital public service which has come under increasing scrutiny. This afternoon's hearing is not before its time, and much credit is due to the Committee for putting reform of the Coroners service on the agenda.

I believe it is fair to say that little is known about the Coroners Service by people who do not have to come into contact with the system. The question has been asked: "*When was the last time an interview was held for a Coroner's post?*" There is a need to reflect high levels of transparency, accountability and fairness across the service, and to this end it would be appropriate if the Minister for Justice took over the formal appointment of Coroners nationwide, with selection procedures and interviews for such posts.

There are at present 38 Coroners offices in Ireland (in Cork alone there are 4 offices – Cork City, Cork North, Cork South and Cork West) and Coroners are appointed by the local authority after selection by the Local Appointments Commission. In Dublin Coroners are appointed by the Minister for Justice.

The Department of Justice is responsible for the legislation governing the role and responsibilities of Coroners nationwide, while matters such as their expenses are managed by the relevant local authority. The question has also been asked: "*How much money are Coroners paid?*" They are remunerated out of public money and the salaries payable to Coroners should be published because this is a matter of public interest.

It is fundamental to the maintenance of confidence in the Service that Coroners must not only be independent but that they must also be impartial. They must treat all witnesses with respect and refrain from comments that suggest they have made up their minds in advance. Where there is need for a jury at a particular inquest then the Coroner should ask An Garda Siochana to select jurors from the electoral register.

Experience has taught me that what bereaved families want above all else is a professional investigation into the death of their loved one. They do not seek platitudes. Rather they seek a fair and thorough investigation which leaves no stone unturned. For this, it is essential that Coroners are seen to treat all 'interested persons' the same.

The professionalism of the Coroner in the lead-up to the inquest will set the tone and if a Coroner appears to be dismissive, disengaged or disinterested at the pre-inquest stage then it will create distress and anxiety for the family before the inquest even opens. For example, I am aware that families have sought the attendance of medical consultants under whose care their deceased loved ones were prior to death but have been notified that unless a series of questions to be posed is submitted to the Coroner in writing in advance of the inquest, their request will not be facilitated. This is unacceptable.

Coroners act on behalf of the State. When State institutions (such as the Health Service Executive) are involved there may be a perception that the Coroner is overly-protective of the State interests if he or she refuses to accede to reasonable requests from the family in advance of the inquest hearing.

Thus we urgently need standardisation across the system in order to ensure fair procedures are followed in every Coroners Court, and to maintain faith in the Service. There are noticeable inconsistencies between districts nationwide, in relation to: full-time/part-time coronial appointments; staffing and support; offices and accommodation; location of inquests; jury selection; legal representation; scope and depth of inquests; and information provided to families.

Crucially, the mechanism for follow-up on the implementation of recommendations made following an inquest must be formalised. At present there is no imperative for the agencies or entities contacted regarding recommendations made to follow through or report back. Coroners should have a duty to report about deaths with a view to preventing future deaths. The person or entity to whom the report is addressed should in turn be under a duty to respond within a specified timeframe and the response should contain details of the action taken or proposed to be taken, and setting out a timescale.

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

We owe it to those who have to go through the extremely difficult process of an inquest into the sudden and unexplained death of a loved one that glimmer of hope it can offer – the prospect of important changes that can be brought about through recommendations made. To effect change we must formalise the mechanism for follow-up of recommendations made at inquest. Only this will enable the kind of learning that will lead to changes and the prevention of future deaths.

Coroners have significant discretion when making decisions and/or carrying out an inquest, and the review system is not user-friendly, particularly when compared with the review mechanisms in place in the Courts. Introducing a formal, published set of Coroners Rules would go a long way towards ensuring consistency. A Review Board or panel should also be established (consisting of perhaps a member of the Attorney

General's office along with a pathologist, a Coroner and an outsider). Matters could then be referred to the board/panel either before, during or after an inquest.

When a State institution is directly involved in a death, the potential for the Inquest to fully interrogate the circumstances of death must not be compromised. Sharing of information is vital so as to assist the Coroner and to maintain trust. There should be a presumption in favour of disclosure. Equality of arms must apply, and bereaved families should be entitled to the level of representation which is available to State institutions.

Last, a new post of Coroner's Officer should be introduced at regional level to act as a general support to both Coroners and families. Such officers should provide compassionate and empathetic support. This would permit the standards of service for the bereaved to be raised to an acceptable level for a public service in the 21st century.

Doireann O'Mahony B.L.
26th May 2022