Opening Statement (Shortened Version) of Professor Denis Cusack,
Senior Coroner for the District of Kildare:
For the Joint Oireachtas Committee on Justice
Tuesday, 31st[h] May 2022.

23rd May 2022

I thank the Cathaoirleach and members of the Committee for the kind invitation to present to and assist the Committee in this discussion on the topic of "An examination of operation of the Coroner's Service". I am addressing the Committee both in my individual professional capacity as Senior Coroner for the District of Kildare and on behalf of the Coroners Society of Ireland and its Council.

The Coroner's forensic and medico-legal death investigation, including any *post mortem* examination and inquest hearing in Coroner's Court, is carried out in accordance with the provisions of Bunreacht na hÉireann, Common Law, and the provisions of the Coroner's Act 1962-2020 and other relevant statutes including the European Convention on Human Rights Act 2003.

I was privileged to serve on the Department of Justice's Review of the Coroner Service Working Group which produced the Report of 2000 which made many recommendations of a wide-ranging nature on reform of the Coroner Service in Ireland.

At page 2 of that Report under the heading of "Ethos of the Irish Coroner Service" it was stated: "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".

It is critical to state that the Coroner Service is a service for the living as well as the dead. It must be a service balancing legal formality with compassionate sensitivity to the bereaved and recognising the dignity of and respect due to the deceased person.

An inquest (which occurs in the minority of Coroners' inquiries) is a public inquiry hearing into the death of a person or persons. The Coroner is the Judicial Officer of the State investigating certain categories of deaths (with more than 80% of all deaths in the State in 2021 being reported to the Coroner Service) and as the inquisitor and in that function must have a wide judicial discretion tempered of course by rules of natural justice and Constitutional principles. The Coroner is unique in the Common Law world as being responsible as an investigating Judicial Officer of the State as well as presiding at the public inquest hearings.

The purpose of the Coroner's inquest is now expressly set out in section 18A of the Coroners Acts 1962-2020.

There is provision in the law if the Coroner so wishes for a rider or recommendations to be appended to the verdict. Recommendations of a general character designed to prevent further fatalities may be so appended.

There have been many very significant legislative reforms of the coroner's role in the intervening period since the Report of 2000 through the great efforts of all concerned: Ministers, Coroners and Department Officials with tremendous positive input from the Public, relevant Stakeholders and TDs and Senators. The reforms in investigation of maternal deaths and in civil legal aid are two examples of worthy reform now in place (the latter still needing some further work).

Notwithstanding these positive legislative reforms, little or no progress has been made in the area of structural and organisational reform of the Service. In Part 2 of the Coroners Bill 2007 very significant reforms and restructuring were proposed, many in line with the recommendations of the Working Group Report of 2000 (but now needing some updating). For various reasons, none of these provisions has been followed through in any meaningful way or at all since the Bill lapsed with the dissolution of the then Dáil and Seanad.

The Coroner Service continues to provide great service to the citizens of our State. I say this with knowledge of many international death investigation systems, being on governing councils of a number of international forensic and medico-legal organisations and having published papers with international colleagues in this area. As already said, our death investigation service is also very much a service for the living (the bereaved and others affected by deaths) as well as upholding the human rights and dignity of the deceased. But this is being achieved through the individual and collective efforts of the Coroners supported by the Departmental Officials and staff in the Local Authorities, an Garda Síochána, medical doctors and others (truly seen and tested during this Covid-19 pandemic emergency as with so many services). The structure, organisation and financing of the Coroner Service no longer meet the needs of a modern forensic and medico-legal death investigation service and have not done so for some time. The structure, organisation and financing are not fit for purpose in this modern era. It is time to drive innovative change.

In relation to reforms which would enhance the Coroner Service, I refer to my letter to the Minister for Justice in November 2021 and summarise those reforms as follows with a brief illustrative (but not exhaustive) list of broad areas of needed reform which include:

1. The re-organisation of the Coroners' Districts within a larger Regional structure with shared operational, office, administrative and investigative framework and support;

2. Support service arrangements for pathology *post mortem* examination, toxicology and histopathology;

3. The appointment system and terms and conditions for Coroners with more full-time Coroners as Districts are amalgamated and caseloads increase;

4. The appointment of Coroner's Investigation Officers on a regional and shared basis;

5. The appointment of a Chief Coroner and Deputy Chief Coroner to enhance leadership and consistency in practice;

6. The establishment of a structured Coroner Service Agency with an Agency Director; and

7. The establishment of a Coroner Service Advisory Committee.

I also include in this opening statement and briefing some information on forensic death investigation pertinent to the Committee's current considerations of the Coroner Service.

There are three broad areas of forensic and coronial death to which I will now make reference: the underlying system and standards set out internationally for such investigation in the context of coroner's investigations in Ireland; the forensic identification of human

remains (in the context of the current debate on exhumation and examination of remains in the mother and baby home inquiries and proposed legislation); and an example of the oversight function of the Coroner Service of certain categories of deaths which do not proceed to *post mortem* examination or inquest hearing but which remain an important safeguard of the vulnerable within our society.

The reference information documents I have pre-circulated (and publicly available) in those three areas to which I alluded include:

1. Death Investigation System (peer-reviewed international European Council of Legal Medicine papers (4) 2014-2022);

2. Forensic Identification of Human Remains (report of 2022); and

3. Coroner's Investigation and Oversight of Deaths not resulting in post mortem or inquest hearing (Covid-19 paper and report 2020-2021).

I thank the Cathaoirleach and Members of the Committee for their courtesy and attention and am happy to take questions and assist in any way I can.