DÁIL ÉIREANN

AN COMHCHOISTE UM DHLÍ AGUS CEART

JOINT COMMITTEE ON JUSTICE

Dé Máirt, 31 Bealtaine 2022

Tuesday, 31 May 2022

Tháinig an Comhchoiste le chéile ag 3 p.m.

The Joint Committee met at 3 p.m.

Comhaltaí a bhí i láthair/Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Patrick Costello,	Robbie Gallagher,
Réada Cronin,*	Michael McDowell.
Martin Kenny.	

* In éagmais / In the absence of Deputy Pa Daly.

I láthair / In attendance: Senator Lynn Boylan.

Teachta / Deputy James Lawless sa Chathaoir / in the Chair.

Operation of the Coroner Service: Discussion

Chairman: We are holding this meeting in a hybrid format. Some members may be participating remotely from their offices in the Leinster House precinct. Apologies have been received from Deputy Pa Daly, who is abroad on parliamentary business, but is being substituted for by Deputy Réada Cronin. Deputy Jennifer Carroll MacNeill and Senator Barry Ward send apologies. Senator Lynn Ruane may join us at a later stage. Senator Vincent Martin sends his apologies. Deputy Patrick Costello is giving a speech in the Dáil Chamber and hopes to join us later in the meeting.

The purpose of our meeting is to engage with stakeholders who made a written submission to assist the committee in the examination of the operation of the Coroner Service. Before I welcome the witnesses, I will speak on how we operate in this committee. This committee processes a significant amount of legislation. We effectively mirror the Department of Justice. We also reserve time in our diary for an elective module once a month, where we nominate a topic of interest to the committee for examination and consideration. This month's module relates to the Coroner Service, which is why the witnesses are here. I thank them for their interest and for contributing to our discussion.

I welcome Professor Denis Cusack, senior coroner for the district of Kildare; Mr. Steven Smyrl, director of Massey and King and an accredited genealogist; and Ms Nicola Morris, president of Accredited Genealogists Ireland. From the Irish Council for Civil Liberties, I welcome Ms Doireann Ansbro, head of legal and policy; and Ms Sinéad Nolan, communications manager. I also welcome Mr. Roger Murray, senior counsel, Mr. David O'Malley and Ms Doireann O'Mahony BL, barrister and practitioner, all co-authors of the recently published work, *Medical Inquests*. It was published to wide acclaim in recent months and represents a significant contribution to studies on the subject. We are delighted to have the three authors here and indeed all the witnesses. I think it will make for an interesting meeting.

There are some housekeeping notes at the beginning of the meeting. As always, we advise witnesses of parliamentary privilege. Witnesses and members are reminded of the long-standing parliamentary practice that they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable, or otherwise engage in speech that might be regarded as damaging to the good name of the person or entity. If their statements are potentially defamatory in relation to an identifiable person or entity, they will be directed to discontinue their remarks. It is otherwise known as good manners. The witnesses are new to meetings in these chambers, but the reminder is for members too. I ask mobile phones to be turned to airplane mode if possible. Even though they may not be making noise, the signal can transmit and interfere with sound recordings and afterwards, it can transpire that something was missed because of interference with the signal. I ask members who are participating remotely to keep their device muted until they are speaking and to remember to unmute when they speak so that we can hear them at the right times and not hear them at the wrong times.

We have adopted a format whereby the witnesses' presentations are kept relatively short, which allows time for significant questions and answers and engagement with the committee as the meeting unfolds. Each opening statement will be limited to three minutes. I think all the witnesses have tailored their remarks accordingly. We have a clock in the top corner, if they want to keep an eye on that to help with their timekeeping. I will have to be strict on that to make the meeting flow smoothly. Once we have had an opening statement from all of the

witnesses and the organisations they represent, we will have a round robin among members of the committee. Each member will have seven minutes in which to engage, including both the questions they wish to pose and the answers that the witnesses may wish to give. We will have a clock for that too. There are three members present physically and two others present virtually. Other members typically join the meeting in the course of the afternoon. We may have a second round of such questions and answers depending on available time.

I will call Professor Cusack first, followed by Mr. Smyrl, Ms Ansbro, Mr. Murray and Ms O'Mahony. Each of our guests will have three minutes. First on my list is Professor Cusack, who is welcome to the committee. I invite him to make his presentation. I will remind him when his three minutes are up.

Professor Denis Cusack: 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 the examination of operation of the Coroner 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 president of Coroners Society of Ireland. There are a number of matters on which I am happy to elaborate at a later stage.

The coroner's forensic and medico-legal death investigation, including post mortem examination and inquest hearing, is carried out in accordance with the provisions of Bunreacht na hÉireann, common law and the provisions of the Coroners Acts, together with 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. That report included 107 recommendations of a wide-ranging nature for reform of the Coroner Service in Ireland. I stress that it is the Coroner Service and the coroners themselves who have been driving and pushing reform in those 20 years. At page 2 of that report, under the heading of "Ethos of the Irish Coroner Service", it was stated that the investigation of sudden and unexplained death takes many forms throughout the world. There is a relatively wide range of unexplained deaths. Our work reflects the essential value placed by our Constitution on life itself. I stress that this is about compassionate sensitivity with legal formality and humanity.

The Coroner Service is for the living as well as the dead. It must be a service which balances that legal formality with compassionate sensitivity. There is an overemphasis on inquests, which only occur in a minority of coroner's inquiries. An inquest is a public inquiry and 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. I refer the committee to section 18A of the Coroners Acts of 1962 to 2020. I will refer later to recommendations of a general character designed to prevent further fatalities.

There have been many significant legislative reforms of the coroner's role in the intervening period since the report of 2000. Senator McDowell is familiar with the coroner's rules and the Bill he introduced as Minister for Justice. The reforms in investigation of maternal deaths and in civil legal aid are two important issues. For various reasons, other reforms have not been followed through with regard to Part 2 of the Coroners Bill. 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.

I have, in my submission to the committee, listed seven headings for reform. Those relate

to the reorganisation of districts within a larger regional structure, with shared operational, office, administrative, investigative framework and support; support service arrangements for pathology, post-mortem examination, toxicology and histopathology; an appointment system and terms and conditions for coroners with more full-time coroners as districts are amalgamated; the appointment of coroner's investigation officers on a regional and shared basis; importantly, the appointment of a chief coroner and deputy chief coroner to enhance leadership and consistency in practice; the establishment of a structured Coroner Service agency with an agency director; and the establishment of a Corner Service advisory committee. I have also included methods of death investigation but I am not going to go through them unless asked to do so by the committee at a later stage. I thank the committee members for their attention.

Chairman: I thank Professor Cusack. He will have ample time to engage with the committee in the course of the hearing. His submission is noted and will be published on the committee's website. He can elaborate on the submission as the meeting goes on. That is the way we tend to work.

Mr. Smyrl is also welcome before the committee. He has three minutes to make his opening remarks.

Mr. Steven Smyrl: I thank the committee for the invitation to speak. The input today from genealogists pertains to the coroners' responsibility for registering deaths and the effect this has on the extent to which much of the required biographical data is omitted from such registrations. The origins of the Coroners Service developed out of a fiscal role surrounding death brought to Ireland by the English colonists in the 12th century. By the 18th century, it had developed into one almost entirely restricted to establishing the facts around unexplained deaths.

Unlike other courts, that of the coroner is not adversarial but rather inquisitorial. It is this role of establishing facts and gathering information which led, under the Registration of Births and Deaths (Ireland) Act 1863, and reconfirmed in the Civil Registration Act 2004, to coroners being given responsibility for registering the deaths of those who demise was sudden, violent or simply unexplained. Since 1863, under successive legislation the registration process has remained largely unchanged. Currently, section 41 of the 2004 Act requires that the coroner "shall give the appropriate registrar a certificate containing the required particulars of the death concerned and that registrar shall register the death in such manner as [the Registrar General] may direct".

Under the 1863 Act there were eight key particulars to be recorded in each registration. They comprised the date and place of death, the name of the deceased, the deceased's sex, marital status, age and occupation, the cause of death and the name, qualification and address of the informant.

From our modern day perspective, 160 years later, the obvious omissions in the data recorded should have rung alarm bells. For whatever reason, the system adopted in Ireland was almost identical to that implemented in England and Wales a generation earlier in 1837. By contrast, the data recorded in Scottish civil death registrations from 1855 included vital additional information including the deceased's place of birth and their parents' names, including their mother's maiden surname.

The failings of the Irish system are that for many death registrations, once they move beyond living memory, it can be almost impossible to match a death record to a birth record. As genealogists, we tend to refer to this as "genealogical snap", referencing the children's card game

where two picture cards must match. Historically, in terms of civil registration, only a name and age on a death registration will match, or approximately match, the same data recorded on a birth registration, and even then, this is beset with problems. For instance, for married women, only their husband's surname will be recorded and not their own birth surname.

In the years leading up to the drafting of the Civil Registration Bill 2003, a significant amount of lobbying, spearheaded by the Council of Irish Genealogical Organisations, was undertaken by genealogists to ensure that the death registration system in Ireland was brought into line with guidelines set by the United Nations. We felt it was imperative that for the system to have any integrity, much broader biographical data would need to be recorded so that, again referencing genealogical snap, all three vital records of a citizen's life - those of birth, marriage and death - could be linked together.

Under section 37 of the 2004 Act, for each deceased person death registrations are required to record their date and place of birth and the name and birth surname of their mother and father. This system came into operation on 5 December 2005 under SI 764 of that year.

I have approximately three more paragraphs to read. Should I continue?

Chairman: We will wrap it up there to be fair to everybody and to be consistent. We will move on to the next speaker. Mr. Smyrl will have time to come back in and elaborate on all those points as the meeting unfolds.

Ms Ansbro is up next. She has the floor for three minutes.

Ms Doireann Ansbro: The Irish Council for Civil Liberties, ICCL, published a report on the coronial system last year authored by Professor Phil Scraton and Dr. Gillian McNaull. They interviewed coroners, bereaved families, lawyers and others involved in the coronial system and made 52 recommendations for root and branch reform. The ICCL is now conducting a public awareness campaign on the need for reform.

Primarily, the coroners system must be properly resourced and put on a professional footing. Families and loved ones must be given more information and support, and recommendations from coroners must be given the due attention required to ensure tragedies that can be prevented are prevented. We need a nationwide, full-time coronial service with fully trained coroners and adequate support. A chief coroner should be appointed to manage the service. An inspectorate should be put in place and a code of practice should be developed. A formal jury selection process must also be established and we call on all parties to support Senator Boylan's current Private Members' Bill on this issue or for the Government to prioritise its own Bill on jury selection.

The lack of direct support to bereaved families was identified by the Department of Justice in 2000 as perhaps the most serious deficiency in the Coroner Service. According to the interviews conducted for our report, little has changed 22 years later. Most families we interviewed reported negative experiences. Some faced long, unexplained delays. Families reported being marginalised, not having access to information they need and experiencing retraumatisation.

The steps that have been taken so far in preparation for the reopened Stardust inquests demonstrate how the inquest process can be properly conducted in the most complex of cases and we congratulate the coroner and the State on the efforts being made to finally get to the truth of what happened on that tragic night. However, more information and support must be provided to all families who have lost loved ones in unexplained circumstances. While we welcome

the new guidance note published by the Irish Human Rights and Equality Commission, we consider that more support is required. We believe the following: families should have access to bereavement counselling; legal aid must be more widely available; and an independent family liaison officer should be appointed.

The absence of a structured process to follow up on coroner recommendations is of deep concern and must be urgently addressed. We note the commitment by An Garda Síochána to review internal processes to implement such findings and we urge them to make such reviews public. For many families, structural failings mean the present system does not provide an effective mechanism to get to the truth about how and why their loved one died. These failings also mean that the public interest in getting to the truth of what happened and to prevent future deaths is not being met. We call for all-party support for our key recommendation to establish a nationwide fully professional coroner service in Ireland.

Chairman: I welcome Mr. Murray SC to the proceedings and he also has three minutes.

Mr. Roger Murray: I thank the Chairman and members for the invitation to attend in order to share my experience as a lawyer of 25 years in terms of my interaction with the coroner service. The committee's work is of vital importance. The coroner service is an underappreciated keystone of democracy and the rule of law. The questions that the committee has addressed look at the core challenges to making a service that is fit for purpose in the 21st century.

I have represented over 100 families at mostly medical inquests located anywhere from Belfast to Cork. What strikes me most is how helpful a well-run inquest can be to healing. The converse is also true, as a badly-run inquest compounds the hurt and distress felt by a bereaved family. Poor knowledge of the law, injudicious behaviour by coroners and unopposed obstruction and, in some cases, obfuscation by medics leave deep and lasting scars.

I had the privilege of representing the families of Dhara Kivlehan and Sally Rowlette at Sligo inquests in 2014, which added to the national debate on maternal deaths. The learning that emerged from those well-handled medical inquests has undoubtedly saved lives.

In February of this year, I acted for the family of the late Shane Banks, who was a 43-year-old father of three children who died following surgery in Galway. That inquest, which was presided over by Dr. Ciarán MacLoughlin, who has since retired, heard from almost 30 witnesses over three weeks. It is the longest running medical inquest in the history of the State. No stone was left unturned by Dr. MacLoughlin and the thoroughness of his investigation is an example to others. During those three weeks, hearings were heard in the function room of a rowing club, the council chambers of Galway Country Council and, most farcically of all, the stage of the Town Hall Theatre. These are not settings that are appropriate to the gravitas of a coroner's court.

Coming here today, I took soundings from some coroners. I asked them was there any message that they wanted me to convey and their resounding reply was that proper resources are badly needed. Together with my colleague, Mr. David O'Malley, we have summarised some of the points that have been made in my submission. I shall deal with the first number of those points before handing over to my colleague, Mr. O'Malley, who will deal with the remainder.

We have summarised the conclusions contained in my submission, the first one of which concerns the qualifications or experience or both of coroners, which I know is part of the committee's bailiwick. What is the appropriate length of qualification? Should coroners be le-

gally qualified only? Other speakers have already addressed the committee by mentioning the coroner's jury. We add our voice to those who called for a properly representative jury to be present at inquests. The number should be uneven and there should be a simple majority. We need to introduce coroners' rules in order that there are no surprises on the day of the hearing. Crucially, we should follow the example of England and Wales in having a statutory system of prevention of future death reports. There should be an obligation on coroners to identify failings and call on those who have the authority to do so to remedy those failings. Next, the prevention of future death reports should be clear, brief, focused, meaningful and designed to have practical effect.

With the permission of the Cathaoirleach, I would now like to hand over to my colleague, Mr. O'Malley.

Chairman: No, because we allow only one speaker per organisation or group. I assure Mr. Murray that Mr. O'Malley will have ample time to comment over the course of our proceedings. We have learned from experience that it is better to have questions and answers for the bulk of the meeting, so opening statements are short for that reason.

Ms Doireann O'Mahony: I offer my sincere thanks for the opportunity to address the committee. I have represented many bereaved families in the coroners' courts across the country. They were spouses, parents and children who were searching for answers as to how, and in what circumstances, their loved ones died. There have been too many times that I have left a coroner's court with families whose grief has only been compounded by the process and whose questions remain unanswered. During the process these people are at their most vulnerable. They deserve truth, justice and accountability. We owe it to them to provide a service that upholds these principles.

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

We need to modernise and humanise what is a vital service, which is one of the oldest public services in Ireland but that has come under increasing scrutiny. This afternoon's hearing is not before time. Much credit is due to the committee for putting reform of the coroner service on the agenda.

I believe it is fair to say that little is known about the service by people who have not come in contact with it. The following question has, for example, been asked. When was the last time that an interview was held for a coroner's post? I am not quite sure of the answer but I believe there is a need to reflect very high levels of transparency, accountability and fairness across the service. To this end it would be appropriate for the Minister for Justice to take over the appointment of coroners nationwide. Coroners are appointed by local authorities around the country after being selected by the Commission for Public Service Appointments, whereas in Dublin they are appointed by the Minister. The following question has been asked. How much are coroners paid? Of course they are remunerated out of the public purse. I believe that the salaries payable to coroners should be published.

It is fundamental to the maintenance of confidence in the service that coroners must not only be independent but also impartial. They must treat all witnesses with respect and not give the impression that they have made up their minds in advance. Experience has taught me that most of all, families want a professional service and a professional investigation. The professional-

ism of the coroner in the lead-up to an inquest very much sets the tone. For example, I have been involved in many inquests where coroners have refused to accede to the request made by families for the attendance of consultants under whose care their deceased loved one was in the lead-up to his or her death unless, and until, a series of questions to be posed to the consultant are provided, which is unfair and is not right. We urgently need standardisation across the system. There are noticeable inconsistencies between districts.

I echo what the other speakers said about recommendations. I mean that recommendations made at inquests need to have force. There should be a duty on coroners to report those recommendations to the relevant entities and a duty on the entities to respond back within a timeframe as to what has or will be done.

We owe it to those who have to go through the extremely agonising and tortuous process of an inquest but there is one glimmer of hope that it can offer, which is learning will come about that will prevent future deaths. I believe that the review system is not user-friendly and ordinary people are intimidated by the idea of having to go to the High Court. I believe that it would be of great benefit were a review panel or board to be established in order that matters could be referred to it, as appropriate.

Lastly, I echo the call for a new post of coroner's officer to be introduced at a regional level. While members of An Garda Síochána in coroners' courts around the country provide an excellent level of care for relatives, the establishment of a new post of coroner's officer is the way forward as it would permit the standards of a service for the bereaved to be raised to an acceptable level for a public service in Ireland in the 21st century.

Chairman: I thank all of the witnesses for their opening statements. Now I will open up the meeting so members can ask questions and contribute in the order that they have indicated. Some of the committee members are physically in this room and others are online. I ask members to indicate whichever witness or witnesses they want to respond to their questions. I advise all of the witnesses that if they wish to make a contribution then please indicate their intention to me. If a question or comment is not directly addressed at a witness or witnesses then please feel free to raise a hand or pitch in and give me a nod if they want to comment. First up is Deputy Kenny.

Deputy Martin Kenny: I thank all of the witnesses for their participation. I have read the opening statements and other associated material and I was struck by how all of the witnesses have requested that proper resourcing be put in place. I imagine from my own experience - I am in the north west, in the Sligo-Leitrim area - that it is very much an *ad hoc* system run by the county councils. I believe that is one of the primary problems. I would be interested to hear how the witnesses feel that could be changed in a way that is adequate. Personally, I think it needs to go towards regionalisation, where a number of counties would come together and there would be a permanent, full-time and properly staffed and resourced coroner, and this would be done across the different parts of the country. Getting that part of it right would be one of the fundamental things we need to try to do.

Have the witnesses any sense of what the cost would be to the State, additional to the current cost? Ms O'Mahony mentioned that we do not know the full cost of the service. If we do not know the cost, we are not able to measure it. Do we have a measure of that? If we have, I would be delighted to get an assurance on that. What level of additional funding would it take to get that professionalisation put in place? Professor Cusack might want to answer on that.

Professor Denis Cusack: The local authorities value for money report came out only a few years ago and it looked at this in great detail and costed the whole service, so that information is there. The last time it was costed, it was somewhere in the region of €8 million but that was nearly 20 years ago.

The Deputy says it is within the remit of the local authority. The local authorities actually have little or no role other than the formal appointment of the coroner and the payment of fees for pathologists and witnesses. Other than that, it is left up to the coroner. There is a commonality. I would not agree with everything that has been said and I think there are some misunderstandings on the role of the coroner. The coroner service is not like the Courts Service. The coroner service is the body of coroners. It is not a section of the Department of Justice. That is why I think it is the coroners who have been driving this reform.

On reviewing for this, I had to refresh my memory. I actually chaired the sub-committee on the services of that reform. Of the 107 recommendations, many of them that have since been put forward as being new or innovative were actually put into that report in 2000. Senator McDowell brought forward the 2007 Bill. If we look at Part 2 and Part 3 of that Bill, many of the answers to what we need are there and we do not need to reinvent the wheel.

I stress that we are very tied up with inquests. Coroners issue interim certificates, cremation certificates, out-of-state certificates, insurance reports, follow-up for families, documents, research with the Health Research Board and coroner's certificates. From 2019 to 2021, which goes back to pre-Covid days, out of 17,822, only 12% of the death investigations proceeded to inquest and 20%, or one in five, to post mortem. The vast majority of the coroner's work is actually done in the office in investigating the death and helping the families, for example, in getting a death certificate to get a will, to get probate or to get insurance. We have co-operated, helped and advised. I would advise the committee not to get too bogged down with the inquests. Inquests are extraordinarily important and medical inquests are extraordinarily important, and every death must be inquired into but let us not forget the majority of death investigations are not medical inquests and they are not contested inquests; they are post mortem examinations and follow-up with families.

I am going to address the issue raised by Mr. Smyrl, with whom I had enormous correspondence when I was president of the council of coroners from 2008 to 2010. We do not disagree on the aims but the coroner service is not a civil registration service and it is not a genealogical service. I will tell the committee why later on, if the members wish. Because of the complexities of family life in Ireland today, the best people to help with civil registration and genealogy are the family. They know their deceased one, they know the family, they know the origins. Appendix L of the 2000 report set that out in the year 2000. We have a commonality but it is how we get there. I would agree that many of our recommendations are very similar. It is just how we get there in order to have a more global view.

All of the time, I want to come back to the point that it is a legal formality, it is a legal system, but there is a compassionate sensitivity to the bereaved and to the dignity and respect of the deceased. If I could sum it up in one word again, it is the humanity of the coroner service and what the coroners are doing within the legal framework but, sometimes, we lose sight of that with legal frameworks. Much of what is in the report about support services, bereavement and counselling is not within the remit of the coroners. Many of the reforms and many of the faults that we might say of people dealing with the justice system could be said for the High Court, the Circuit Court, the Supreme Court, the District Court and tribunals. We need to focus on a wider approach of supporting families. That should not simply be in saying how we sup-

port by counselling and support in the courtroom and in the courthouse for the coroner's court, and I think we should be looking at the entire criminal justice system. The report from the Irish Human Rights and Equality Commission was only published on 6 May, and the coroners had an input into that in terms of looking at it with the officials. We have a lot of the answers together and maybe it is just a difference of emphasis.

I want to assure the committee on behalf of the coroner service - my very good colleague, Dr. Cullinane, is here in the Gallery - that we are striving to continue the reforms and we have been pushing the door for reforms. We, above all people, have the greatest perspective in our privilege in being able to serve our citizens. We need to drive reform and I think we are very united in that. I think of the families. I have sent the committee recommendations from last month. I think we are very much at one, if we can work together.

Chairman: Consensus has broken out among the committee. That concludes Deputy Kenny's slot for this round. I call Senator McDowell.

Senator Michael McDowell: I welcome our guests and thank them for their very thoughtful written presentations, which I have had the opportunity to read, and for the oral presentations. As Professor Cusack mentioned, in the year 2000 he presented a report to my predecessor as Minister for Justice, John O'Donoghue. In the flurry of law reform that I presided over, we only got to the point of publishing in April 2007 a Bill for the reform of the coroner service. The electorate did their bit with me two months later, and that was the end of my personal involvement. I want to thank the coroners for that report. As Professor Cusack has stated, the Bill largely depended on that report, although maybe there were some aspects of it that the coroners would have preferred to have been slightly differently drafted. However, in general terms, it is the fruit of their work. If we are having an inquest, we should have an inquest as to what happened to the 2007 Bill, its strange death and the fact it is 22 years since Professor Cusack's group reported and nothing has happened.

There are a few things that I want to say and that I want to bounce off all of those present. First, I think it is hugely important that we emphasise the inquisitorial nature of inquests and the coroners' function, generally speaking. Second, to go back to Professor Cusack's point, we need very definitely to work out in our own heads that only a small minority of cases go to an inquest before a jury, where there is a real clash of testimony or something that needs to be resolved in any way by having lawyers or representation. The vast majority of coroners' inquests are different. However, that does not mean the non-inquest approach is irrelevant, for example, to protect us from a Dr. Shipman situation. I do not know how Ireland would detect a Dr. Shipman, to be honest. I wonder whether it would happen. This is an issue we have to deal with.

I have said it is inquisitorial. At this stage in my career I can say we cannot go down the road of judicialising everything. We cannot have people dragged to the courts. Whatever can be done to keep people away from the courts must be done. The courts are adversarial. The decency and humanitarian approach that have been mentioned require an inquisitorial approach.

I fully support reform of the selection of juries. I am slightly critical, and I hope nobody will take offence, of the idea of people starting to object to jurors. This is crazy. We could have 20 people interested in the outcome of an inquest as, for instance, with regard to the Stardust. If they get seven challenges each, as the legislation suggests, God only knows how long it would take to get a jury empanelled. If there is one interest group on the other side, if I may use that phrase, to give that person only seven challenges as against 150 would be very unfair. We have to think this through more carefully. Clearly, it is not satisfactory that a member of An Garda

Síochána just goes down to the local main street and selects people he or she finds available and puts them in to act as a jury. I believe seven is enough. We do not need substantial juries unless somebody else has a contrary point of view.

I have a question for Professor Cusack. What happened to my legislation? We do not need an inquest but perhaps a death certificate as to what happened to it. What was the cause of death?

Professor Denis Cusack: I must give credit to the Senator's successors. When we met the late Brian Lenihan, who briefly served as Minister with responsibility for justice, we thought we were there but the recession hit us. In recent months, the Minister, Deputy McEntee, the Minister of State, Deputy Naughton, and parliamentary questions from Members of the Opposition have highlighted very much the proper questions to be asked. Much of the legislative reform has been passed. I will cite two examples. The first is civil legal aid, which is still imperfect and could be better but this could be said about the entire civil justice system. The other is maternal deaths and I worked on this with Clare Daly, when she was a Deputy, and her researcher. These are two very important reforms. Much has been done piecemeal but Parts 2 and 3 have not. Neither have sections 55 and 56 in the Bill, which deal with the recommendations. A good deal has been done but work on the financing, structure, organisation, the chief coroner's office and the coroner's investigator has not. Coroners are struggling to keep the service going. As the Senator said, we have struggled during Covid-19. Kildare was tragically hit by it and we provided a service there. We do this with the enormous help of the Garda, GPs, hospital consultants and others.

Senator Michael McDowell: On what basis are coroners now remunerated?

Professor Denis Cusack: It is the same basis as we negotiated in 1997. People say their salaries should be published but they are published. It is a very simple formula. There are three areas as Dublin and Cork are different because of their size. Other areas have approximately €22,000 to run the entire office. As the Senator has asked I will give the details. For each death reported it is approximately €129. If there is a post mortem it is €180 . It is €520 for an inquest.

Senator Michael McDowell: It is per item.

Professor Denis Cusack: If the coroner runs an inquest, and some of them take dozens of hours or two days, it is €520. They simply take it. The Minister has answered this question. We are public servants. Our remuneration, out of which we pay everything, is an open book. There is no secret.

Senator Michael McDowell: I am not suggesting there is but it is a little bit Victorian to pay per item. Is that the right way to do it?

Professor Denis Cusack: I was on the team that negotiated it. When I took office the remuneration was £3,000 and I was losing approximately £5,000 a year running the service. It should be properly structured. I do not want to get into industrial relations matters but we should have a properly structured service. Money should be put into the support service. The Senator is quite right. There are a lot of structures. There are many things about which I could tell and inform the Senator. Many of them are positive. I want to come out of this meeting being supportive and positive because we owe it to the people who have died and their families.

Chairman: Reference was made to being paid per item. What is an item? Is it a letter or a hearing?

Professor Denis Cusack: Heavens, no. Letters are free.

Chairman: What are the items?

Professor Denis Cusack: They are set down in statute in Schedule 2 to the amending legislation. For every death reported where a coroner has to consider what to do and whether it needs a post mortem or can be signed off, that is €128. If it goes to post mortem, then the coroner has to go through the post mortem and issue further certification. This is approximately €180. If it goes to full inquest, it is €520. I have the figures and we can do a quick sum. In 2021 there were a total of 25,421 cases. Of these, 18,746 were report only and this can be multiplied by €128. There were 4,574 post mortem only, which can be multiplied by €180. There were 2,101 inquests and this can be multiplied by €520. It is a simple calculation. Out of this the coroner's service must pay everything. There are also expenses. We have to pay pathologists and the State Laboratory for toxicology. Witnesses probably have to be paid although many witnesses do not put in for expenses. All of this is certified by the coroner and it comes from the local authority. Local authority managers have an interesting perspective on why it should still be a local system from the 19th century and not a centralised system in the Department of Justice.

Chairman: I thank Professor Cusack. That answers the question.

Deputy Réada Cronin: I am pleased to be standing in for Deputy Daly today although I would have attended the meeting anyway. We are speaking about modernising and humanising this vital service. It is one of the oldest public services we have in the State. Professor Cusack was the coroner in Kildare. As he said, there were a disproportionate number of deaths in the first wave of Covid. I heard him speak on "Drivetime" and I listened back to it because I was so taken by what he said. He gave people back their dignity in death. He referred to them as the unique and loved. So much of the conversation about older people at the time was almost as if they had reached their best before date. What is another year? A year might be the difference between a first great-grandchild being born and a first day at school. These years are important. It is great to have Professor Cusack's input.

There is potential for the office of the coroner to be a voice for people. Professor Cusack approached the nursing home deaths in a way that showed what is possible in the coroner's court to demystify the legal and medical processes and remove barriers so that ordinary people can be part of it. There is potential for this. Professor Cusack said he was involved in the Department of Justice's review of the coroner system in 2000. He said 107 recommendations were made. Have many of them come to life yet? Which of those that have not would Professor Cusack be most interested in seeing implemented immediately? For me it might be the centralisation of the process.

Professor Denis Cusack: It would be with regard to the structures. It is not a panacea. I met with the chief coroners of Singapore, Canada and England and Wales. This approach enhances procedures and consistency, but it must be undertaken within a structure. It is like everything else. One does not abolish something, as we often do, without putting something else in its place. We are all terribly aware of this point from our health service. Therefore, regarding the recommendations, I refer to the establishment of an office of the chief coroner and deputy coroner. Additionally, though, some areas of the country are struggling to get pathologists. Some of my colleagues cannot get pathologists and bodies are being moved. It is terrible for a family to find a loved one's body being moved 100 km because there is no pathologist. I

stress all these aspects.

I am not sure we need to have mandatory juries in any cases. Regarding discretion, this is an inquisitorial system and there must be wide discretion. I believe lawyers and others misunderstand an inquisitorial system because we live in a common law, adversarial system in the main. When we have an inquisitorial system, however, we should be able to work together based on information. On whether we need juries, we have abolished them for almost everything. I understand, indeed, that the abolition of juries in defamation cases is being considered. The last case of this type was the Dunne case in 1988 for personal injuries. It was a medical case. Therefore, I wonder whether we need to have mandatory juries. Why could we not have good and qualified coroners? We can talk about the qualifications. I believe we have the right mixture. In the early stages, more medical knowledge is needed to sort out how to proceed with the investigation. Later, there is a need for legal qualifications. What is the best qualification for a coroner? It is to be medically and legally qualified and to have a lot of common sense and humanity. I do not think that can be put into statutes.

Chairman: That makes sense. I am just looking at the other side of it.

Mr. David O'Malley: Generally, I echo the remarks of Professor Cusack regarding the rules for coroners and a coroner's office. It works well in the UK in respect of the inquisitorial nature of things. Cross-examination should just be examination, as we discussed earlier.

I agree with Senator McDowell that juries must be representative of the community. I refer not to people picking holes in juries, but the same people should not be showing up all the time. In the west of Ireland, I see the same people turning up every time I do an inquest. That should not happen.

I did the first inquest involving Covid-19 in the history of the State in Mayo. The family members were not interested in verdicts etc. Those are only gateposts. They are instead interested in how death occurred and the wider recommendation, from a societal perspective, from the coroner. It is mandatory now in the context of all Covid-19 deaths. This is a chance for us all to learn lessons. There are real-time data to assist in charting trends, preventing future deaths and making recommendations for processes in the State. Therefore, we have been a bellwether in the Covid-19 situation and this is a good opportunity to learn lessons. I felt I had to address those couple of points.

Mr. Roger Murray: Regarding what Senator McDowell said about the inquisitorial nature of the inquiry, as commented on by Professor Cusack, it is vitally important to understand this aspect. In our civil law system, which is adversarial, there is a contest. In the criminal courts tomorrow, for example, there will be those acting for the accused and those acting for the prosecution. It is a contest between two skilled teams of lawyers. The truth can quickly get lost in that situation. Similarly, in a civil case, there is a plaintiff and a defendant and people are trying to score points off each other in the context. In an inquest, however, the process is inquisitorial. The coroner is the person who holds the ring and decides on the witnesses to be called, based on the evidence. The truth remains central to that process.

Professor Cusack referred to the consistency of the figures in this regard. Approximately 2,000 deaths annually are the subject of an inquest. The importance of those proceedings to society cannot be underestimated. Turning to the cost to the State in respect of getting answers, repeated studies by academics, including Boothman *et al* from 2014, show that the reason people go to lawyers in the first instance after an adverse medical event is not to seek compen-

sation but to get answers. Therefore, the State could save itself considerable amounts of money by investing in the coronial service to ensure in a medical context, where there are unanswered questions around a death, that a properly run and resourced inquest can address and answer all those queries. Compensation might be the very last thing on the family's mind thereafter.

Regarding the question raised by Deputy Kenny concerning the structure or umbrella the coronial service should fall under, the recommendations Professor Cusack referred to suggested, and I refer to this in my submission as well, that the coronial service should be attached to the Courts Service and that a new statutory agency should be established to be known as central coroner services to reflect the core concept of service. In this regard, an important Venetian saying comes to mind, namely, the dead open the eyes of the living. It is crucial to emphasise the public importance of the lessons that arise from a properly run inquest. It was also recommended that the central coronial service should have the logistics to support the undertaking of functions such as salaries, expenses and organisational set-up, training and development of a high-quality service and best practice procedures and information dissemination. That latter point is something to which my colleague and co-author, Ms O'Mahony, has repeatedly referred. There is also the importance of ensuring information available to the public. My colleagues from the Irish Council for Civil Liberties, ICCL, and the report by Professor Phil Scraton and Dr. Gillian McNaull, made particular reference to the dearth of information available to people. It was also suggested there should be a national information system for coroners and that an annual report or presentation on the coronial service be produced. The saving to the State of having a properly resourced and run coronial service will have a significant knock-on effect in respect of addressing societal concerns and suspicions, especially concerning medical deaths.

Professor Denis Cusack: These systems are in place in New Zealand, Canada and in the state of Victoria in Australia. We have models to draw on.

Ms Doireann Ansbro: I will comment on costs and juries. On costs, what we found in our report was that one of the crucial things missing in this context, and this aspect goes back to the 2000 report as well, as I mentioned in the opening statement, was information for families and the attitude of the people involved in the coronial service to families. Providing information should not cost that much. This is about the people engaging with the families, giving them information at every step of the process. It is about explaining at the outset what the coronial system does and what the family members can expect from a post mortem. In those 10% of cases where they happen, and it may only be 10% but nevertheless I agree with Mr. Murray on this point, inquests are vital for the service provided to families and to society at large. I refer to providing information concerning what is going to happen initially and what may happen afterwards. This kind of approach could radically change a family's experience of the service and without costing that much. It is the same situation with attitudes. I am delighted to hear Professor Cusack talk about a service that is founded on compassion and humanity. Unfortunately, however, our report, and the interviews done with family members, showed many families did not experience compassion. I emphasise again that everyone who interacts with families should have that attitude of compassion and humanity, whether those are members of An Garda Síochána, the members of the future support service, which I am sure we are going to find resources to fund, and, of course, the coroners themselves. Everyone involved in this process should bring that attitude of compassion and humanity to bear, and that can greatly change the experience of families while not costing much at all.

Turning to the points made about juries, I must respond because it is of great concern to

the ICCL that our right to a jury seems to be continuing to be eroded. We are fundamentally committed to the constitutional right to a jury across the courts, but also in contested inquests. This is because we consider it not only a fundamental right in our Constitution but also that a jury can add significantly to the perception of justice and bring the changing attitudes of society into a process such as the current coronial one. Equally, a jury reflects the changing make-up and diversity of our communities when such important decisions are being made. This aspect brings me to the jury selection issue, which is fundamental. It is a burning issue now for the Stardust inquiries. We need to get this facet sorted out. We can resolve it very quickly, as Senator Boylan has done with her Private Members' Bill. I believe the Government is committed to it as well, so I urge the Government to make that a priority. As we have heard, not only are gardaí potentially just going to the local community and asking people to participate, but we also heard about families seeing advertisements on Facebook from the Garda looking for jury members. It is an absolutely unprofessional approach at present so we must change it, and we can change it urgently.

Deputy Patrick Costello: On the subject of juries in the coroners' courts, I am aware, from talking to people who have been in the unfortunate position of having lost family members and being involved in inquests, of inquests being delayed or not happening because the coroners could not get a jury in place. The witnesses are talking about pulling in the same people and the like. Is an inquest not even getting off the ground still happening or is there still a risk of that? That is one thing.

We have been talking a great deal about the chief coroner's office and the suggestion of looking at other models. Some more information about that would be interesting to discuss. I am curious about one thing. If we are trying to keep our coroner system as an inquisitorial system, how does that work in New Zealand, Canada and the UK, which are also adversarial common law systems? What about the juxtaposition of those different systems?

The information, the data and the like are very interesting and important, but that work cannot happen unless somebody is being paid to put it together. This gets to the need for proper secretarial support, administrative support and so forth. I am not sure compiling reports and statistical information, while important, is on that list of payments.

There is another matter I wish to flag. I do not know if it was raised previously, and my apologies if it was. We could go down a rabbit hole regarding the cost of justice to the State. We can save money and we can save lives if recommendations are followed. The problem is the recommendations are not followed. They are often just recommendations. We know in this committee what often happens to the recommendations we make. I would love to hear from the witnesses about the other jurisdictions and about making recommendations more binding, if that is possible in any way. That will obviously have impacts if we are looking at the inquisitorial approach and the lack of juries. There is a wider justice piece there. However, with regard to the piece about making recommendations stronger and more binding, how do other jurisdictions do that?

I have rambled a little, so I will summarise. It is about the other jurisdictions in terms of how they manage the inquisitorial versus adversarial aspect and the piece about making the recommendations better. I saw many people shaking their heads when I made my point about juries, so I think that has been answered.

Chairman: I will refer to the panel momentarily, but I echo the point that was made a few times about other jurisdictions doing this better and differently and how exactly that is admin-

istered. That could be an illustrative point for our findings from today. Does Deputy Costello wish to direct his questions to any particular witness?

Deputy Patrick Costello: I will start with Mr. Murray.

Mr. Roger Murray: First, with regard to recommendations, the model is there from the jurisdiction in England and Wales. In 2013, it introduced a new set of coroners rules that made it mandatory for a coroner, if information became available to that coroner during the course of an inquest, to come back with what is called a prevention of future death report. Let us take the example of an accident on a railway where there is a lacuna relating to safety equipment, for example, a guard rail. I came across a situation recently where the windows on some trains can still be lower down, and in that particular inquest the coroner made a recommendation to the authority in charge of the train that it must fix or remedy this problem. The way it works is very interesting. The coroner identifies the lacuna and the person who has the responsibility or the ability to fix it. Crucially, the coroner does not tell the person how the coroner thinks the person should fix it. The onus is on the person to whom the coroner is writing to come back within eight weeks with details of how the person proposes to fix it. A report must not only go to the individual coroner but also go to the chief coroner. Those prevention of future death reports are mandatory if a coroner identifies it in the context of an inquest.

At present, recommendations are returned by inquests and juries throughout this country that have moral authority and that certainly have saved lives, in my opinion and in my experience, but the difficulty, as has been identified by this committee, is there is no follow-up and there is no penalty if somebody does not respond to them. There is no legal imperative or obligation on them to do that. We add our voices to those calling for the recommendations to be put on a statutory footing. The model is there - the prevention of future deaths reports in the UK. Perhaps Ms O'Mahony has some thoughts on that.

Ms Doireann O'Mahony: This is something that has been covered quite extensively in the media over recent months. Certainly, Ann Murphy of the *Irish Examiner* has covered a great deal about recommendations and families' disappointment with the lack of follow-through. For example, a number of coroners around the country made recommendations that automated external defibrillators, AEDs, be at all Garda stations around the country because, obviously, everyone knows where the Garda stations are. That has not happened. The question was put to An Garda Síochána and the response was the Garda simply does not have the funding for it. This is the situation. The same sound recommendations are being made time and again by coroners but nobody is following up on them. It would be very sensible if we were to follow what is being done in the UK and have force behind the recommendations and have a statutory duty on the coroner to send a report and a duty on the entity or organisation in turn to report back within a specified timeframe. That would give a level of comfort to families as well. My experience is the verdict returned at an inquest is just a piece of paper with a word on it and is meaningless for them. What matters for them is knowing that decent recommendations can be made that can effect change and prevent future deaths.

I wish to comment on another thing before it is glossed over, which is the issue of the local authorities *vis-à-vis* the Department of Justice. We are all in agreement on the point that coroners have to be independent. However, how can a coroner be independent when he or she is answerable to the local authority? I give the example of Cork city. There are delays there at present and the coroner is at the mercy of the city council for funding, staffing and so forth. I speak from experience. Last year, I represented a widower whose wife and child died in a

hospital in Cork. Their inquests were pushed back on a number of occasions. Eventually, they were listed on 30 August which, of course, suited everybody else and all the hospital staff, not to mention the fact this was the widower's son's first day at school. It was adjourned on that occasion again and the coroner said, "I cannot get a courtroom and I cannot get a place to hold the inquest." This is a funding issue. We fought and fought and eventually the coroner secured a facility in a hotel in Cork for three days, so there were three days to have the inquest heard.

The committee members heard at the outset that one of the longest-running inquests took place earlier this year, which ran over 14 days, yet in Cork there was an inquest into two deaths that was confined to three days. It sat with a jury. It started in the morning and ran on well past a time a judge would sit in court and late into the evening on each of the three days. That was very hard for the jury, the lawyers, the coroner and all the witnesses, not least the family members. I do not believe that is right. We cannot just gloss over the fact that local authorities in certain parts of the country and in certain coroner districts have too much power. It is a postcode lottery and one does not get the same treatment in Cork as one might get in Kildare or Dublin. That is simply a fact and it has to be said. Uncomfortable as it is for people to hear and for me to say it, it has to be said.

Chairman: Ms Ann Murphy of the *Irish Examiner* was mentioned. Ms O'Mahony has been in touch with her. Ms Murphy has given good coverage to this issue in the *Irish Examiner*. She filed a written submission to the committee that was very helpful to us. She was not in a position to attend today's meeting but she made a significant contribution, which will form part of our deliberations when we produce our report, so I wanted to acknowledge her.

I will move on to our next Member, Senator Boylan, for the next interaction.

Senator Lynn Boylan: I thank all the speakers. The discussion has been fascinating. I am not a member of the Joint Committee on Justice so I am learning a lot sitting here. I am here particularly to raise the issue of the Stardust inquest, which is coming up, we hope, in September. Professor Cusack was involved in writing the report in 2000, which stated that the Coroner Service is a service for the living and should serve to reassure society as a whole. That is where I am coming from in the context of the Stardust and the jury selection. The initial inquest that took place was considered by Professor Scraton to be an abject failure. There followed a judicial inquiry, which concluded with the finding of probable arson. That stood on the public record for 28 years, so an entire community was tarred with the possibility that it was one of their own who caused the fire and the 48 deaths. The idea of an inquest is not only to get answers for the relatives but also, as a society, to be able to learn and to try to prevent this from happening to any other family in the future. The fact that we in the Stardust campaign were able to collect 48,000 signatures in a matter of weeks shows not only the public interest in this issue but also the public awareness that this is an unclosed event in Irish society and that the families deserve answers to what happened to their loved ones that night.

I was concerned to hear Professor Cusack speak of the right to a jury. Seeing things from the perspective of these families, they had the first inquest, which involved a coroner. All they were told was that their loved ones died of smoke inhalation and that was it. There was nothing about the context as to how they inhaled the smoke. Then there was the judicial inquiry, which was judge-led. The families are now expected to go into a new inquest and, if they are not to have a jury, to have blind faith that things have changed and that they will get the answers they did not get 41 years ago.

While I have an interest in this because I brought forward a Bill on the matter, I do not care

if it is done by my Bill, by the Minister's or by regulation. The right to have one's peers hear what happened is a really important issue. I am glad the ICCL has called for this to be resolved because we have an issue with reform of the coronial system, and all of that has to happen. We also face a deadline of September. The Dáil is about to go into recess. If we do not have legislation of some form to allow for independent jury selection, the inquest will not begin in September. It just will not happen. It also sends out a message internationally that we think it is appropriate that the Garda select the jury or that there be no jury in an inquest in which the Garda will have questions to answer as to how it preserved the site on the night of the fire. On foot of that, I am here to lobby on behalf of the families of the Stardust and for their right to an independently selected jury.

Chairman: Before we get into a response, the Senator makes a good contribution but the report produced to today's hearing is on the generalities of the system as opposed to any one specific inquiry. I understand that Oireachtas Members will, of course, have an interest in particular inquiries. That is natural and part of our role. However, we will avoid a specific discussion because we do not want to prejudge any future hearing. We will discuss the generality of the matter. If that touches on specific matters, that is fine, but we will keep the discussion at the general policy level. Does Professor Cusack wish to come back in?

Professor Denis Cusack: I wish to clarify the matter of the jury. I agree with Senator Boylan. What I am saying is that we do not need a jury in every case. The question is whether it should be mandatory in the list. For contested or complex issues, I believe that there should be a jury and that we need to look at jury selection. Last month, I held an inquest into maternal death. I had a jury. I complimented the jury on its deliberation, its wisdom and its thoughtfulness. One particular juror, a lady, came up with extraordinarily perceptive questions. There is a place for juries. What I am asking is whether we need to look at the matter. Is it not better to have it refined?

As for information, there are three websites. Citizens Information is fantastic. Every time we get in a family we send them out a booklet. I do not wish to take issue with the 52 recommendations of the ICCL report. I commend them, and this is not in any way to diminish the importance of those families, but some of those cases go back 20 years, to a different era, and fewer than 20 cases are examined. During those 20 years there were 41,000 inquests, so we need to be very careful, without diminishing the importance to those families of the issues they faced, in drawing wide conclusions when we are talking about less than 0.1% of all inquests over 20 years. I was saddened by some of the things I read in the report and I hope they belong to a different era.

As for the regulations, we were there before England and Wales. As for the Coroners (Investigations) Regulations of England and Wales, to which Mr. Murray referred, there is regulation 28, and regulation 29 requires a report to be sent back. I refer, however, to Senator McDowell's Bill when he was Minister for Justice, Equality and Law Reform. Subsection 54(2) of that Bill states:

> Where an inquest has addressed a recommendation to a Minister of the Government, a local authority or a statutory body, the Minister, local authority or body shall issue a response to the recommendation to the coroner concerned in writing no later than 6 months [I think that is a bit long] from the date of receipt of the recommendation and shall indicate the measures, if any, taken or proposed to be taken on foot of the recommendation.

We were there in 2007, so perhaps we could fine-tune that. They have excellent templates in England and Wales. I recognise Coroner MacLoughlin's inquest recommendations on maternal deaths. They made a great difference. I have sent the ten recommendations to the committee. They show the wisdom of the jury. Not only did we work with the jury but, in its absence, we also asked the legal representatives how they could help us frame recommendations, what they would like to see and what the family would like to see. We had an expert witness, Dr. Peter Boylan. I can mention him because this is in the public domain. We asked him what he made of this. Together we came up with ten recommendations. It was the jury that decided in the end which recommendations to make, and I commend the jurors' wisdom. We worked on the recommendations together. They were sent to the people I have listed. I always ask for an acknowledgement. I ask them to let me know of any steps they have taken. All I can do, however, is ask them that; I cannot require them to do so. That needs to be strengthened. We have that in models abroad and in the 2007 Bill. Again, I think we are at one. We have a commonality.

Chairman: What is rare is wonderful - in these Houses anyway, perhaps not in the witnesses' areas. I am conscious that Mr. Smyrl has not come in yet. If he wishes to take the opportunity to come in now, he may address a number of the points raised.

Mr. Steven Smyrl: We have heard some wonderful debate and contributions today. We feel pretty small by comparison because our bugbear, as Professor Cusack rightly pointed out, is to do with the registration of deaths. Professor Cusack is right that perhaps ten or 12 years ago we had some communication. There may have been a little confusion, however, because we are absolutely in agreement with what Professor Cusack said, namely, that the Coroner Service is not to be involved in genealogy, genealogical research or gathering of information. In the two submissions I have made, the first, more extensive one to the committee and the short three-minute contribution, which I did not manage to finish within three minutes, we quite clearly say that what we would prefer to see with the registration of deaths is that the system be widened out. At the moment, for any death that takes place where the coroner is not involved, the doctor issues a medical cause-of-death certificate. It is a very simple device. Whether it is in paper form or whether some sort of IT solution is found in more modern times, that document is then brought to the registrar and the death is registered. Then the next of kin are able to provide the information required. That is a really important thing for the next of kin because they want to feel involved. Being able to provide some key information that only they can give, that is, the date and place of birth of the deceased and his or her parents' names, gives them a real input into the system. We suggest that the coroner system be widened out and that, in future, the coroner issue some kind of medical form of death certificate, a document that would set out his or her findings, to the next of kin or the legal representative, which would then be brought to the registrar. That would resolve this issue. We have talked about the humanity of all of this.

One of the things that my colleague and I would say is that the lack of information in registrations is a concern. When looking at deaths registered prior to 2004, under the old regulations which involved very brief information, we found that, once those deaths moved beyond living memory, it was no longer possible for anybody to say that a given Mary Murphy, born in Limerick, was the same person as a Mary O'Connor who died up in Dublin. Since 2004, the maiden surname of a woman, the birth name of a woman, the date and place of birth and the parents' names, including the mothers' maiden name, are included. We joke that it is like the old card game, snap. You can put the records together. That is really the nub of our proposal and submission to the committee. I ask that the committee take those recommendations on board.

Professor Denis Cusack: That is exactly what we suggested in Appendix L to the report of

2000 so we are at one again. We suggested it 22 years ago.

Chairman: Most of us were not Members of the Oireachtas at that time but we note that history is on our side.

Mr. David O'Malley: I just wished to echo what the Senator was saying earlier. I come from Ballina and the first ever inquest there was that of Michael Tolan. To a packed town hall and with a fully random jury and a number of medical experts, P.J. Ruttledge examined the death of Michael Tolan very thoroughly. We have moved on, and the inquest in the Savita Halappanavar case and other high-profile inquests have also had full juries. It is important that juries be considered very strongly in the case of big contested inquests. Coroners across the country have different levels of experience. I have done inquests all over the country and the difference between different counties is remarkable. There have been other inquests in other jurisdictions in respect of Hillsborough and Ballymurphy. As a society, we cannot shy away from allaying public suspicion and rumour and finding out what happened to people. In the case of Stardust, the first inquest was terrible. The families were presented with judicial findings that are still not satisfactory. We now have an opportunity for Ireland to lead from the front on this. I agree 100% with the Senator's Bill. I also push strongly for random jury selection because justice needs to be done and, more importantly, to be seen to be done. As a society, we really need to lead on this. I 100% commend the Senator's work.

Mr. Roger Murray: I will make a couple of very quick points arising from the discussion, if I might. To add to what to Mr. O'Malley has said, I congratulate Senator Boylan on her campaign. On the importance of inquests, we have spoken about their legal consequences and their consequences from a genealogical perspective. They also have consequences from a societal point of view. I will quote from the letter from the Attorney General regarding the reopening the Stardust inquiry. In his decision under section 24, which is a very important and innovative feature of the 1962 Act, the Attorney General sits in a unique position to direct an inquest to take place. Even if an inquest has already taken place or if the coroner is recalcitrant or reluctant, the Attorney General has the power to order that an inquest take place. That is what happened in the case of the Stardust inquiry. The letter from the coroner is worth quoting for the public record. He said there is "a distinct and separate imperative that the community as a whole should be satisfied, even if belatedly, that there be sufficient inquiry at any Inquest held to maximise the chances that the truth should emerge." He said this would endeavour "to serve the further public interest grounds, well established in law, of allaying rumours and suspicion, and of drawing attention to the existence of circumstances which, if unremedied, might lead to further deaths."

I am conscious that certain matters relating to Stardust are *sub judice*. We will not dwell on those but will rather go back to what Senator Boylan and my colleagues from the ICCL have said and the impact of the European Convention on Human Rights Act 2003. Pursuant to our obligations under the 1998 Belfast Agreement, the State was obliged to transpose into Irish law its obligations under the European Convention on Human Rights, which led to the 2003 Act. There is a lot of case law in England and Wales in this regard and, if there is an Article 2 inquest where there is an element of state responsibility for deaths and an obligation to conduct an effective investigation, the reality is that there is an adversarial contest. I will quote from Dame Elish Angiolini's independent review of deaths in custody in the UK, who said:

> The reality is that Inquests into deaths in police custody are almost always adversarial in nature.

[...]

There is nothing inherently wrong with an adversarial approach as it may be the best way to robustly test evidence in court. However, it needs to be recognised as such.

It was referenced in the McNaull-Scraton report that there is an inquisitorial process with an adversarial layer imposed upon it. We add our voices to those saying that the use of juries should be maximised to the nth degree because juries are smart and are the experts in common sense. Too often, I have been in courtrooms for inquests or civil cases where lawyers have been quoting law and arguing back and forth. The people who pay attention to the facts and who seem to have the monopoly on common sense are the ladies and gentlemen of the jury.

Ms Doireann Ansbro: I will respond to Professor Cusack for the record, if I may. He talked about how we should not draw conclusions on the basis of 0.1% of 41,000 inquests.

Professor Denis Cusack: I said that we needed to be careful drawing conclusions.

Ms Doireann Ansbro: That is fair enough, but I disagree with the idea that we are only talking about 0.1%. In our report, we are talking about the families who have fought for 20 years and who have been consistent and committed advocates for reform and change and who have bravely continued their fight and spoken to us for this report. We have not asked 41,000 people to tell us how they feel. People have come to us. It is fair to draw the conclusion that these people are representative of many more families who have not had a good experience in the coronial system.

Professor Denis Cusack: The coroners were very saddened to read some of those contributions and they agree with Ms Ansbro that this is where compassion comes in. These families have fought hard and we must listen to their stories and learn.

Ms Doireann Ansbro: I agree.

Chairman: We have time for a supplementary round of questions if members would like one. For members' information, there is a bit of housekeeping business to be tended to within this committee session as well. They should be mindful of that but, if members wish to pose a supplementary question, they may.

Deputy Martin Kenny: It has been a most interesting conversation. I have a couple of points to make. The issue of inquests and the verdict, which often is not one the family expects or is satisfied with, was mentioned. One of the questions put to those coming in here was whether there was an alternative or better way to appeal such verdicts. What mechanism should be put in place to allow for appeals where people are dissatisfied with the outcome? What are the witnesses' views on the admissibility in later court actions of the findings of a coroner's report?

Ms Doireann O'Mahony: In and of itself, a verdict has no place in a forum where criminal or civil liability does not come into the fray. Perhaps, "findings of the coroner" would be more appropriate terminology going forward. The verdicts, in and of themselves, can be pretty meaningless to families. Alternatively, families might have high expectations or hopes of getting a particular verdict and may feel disappointed if that verdict is not returned by the coroner or the jury.

I will make a point while I have a chance. A moment ago, we were talking about how justice must be done and how it must be seen to be done in public. From my real lived experience of

meeting many different people who have been through this process, I know that what matters to them is that their loved ones are not forgotten in the middle of it all. When things get heated and debates rage, the people at the centre of the matter can often feel forgotten. I have personally been told by family members that they have felt like furniture at inquests. Particularly in the case of hospital death inquests, there will sometimes be two or more sets of solicitors coming in for the hospitals and consultants. There will be multiple people and boxes of papers. The families feel their voices are not being heard. I have been involved in inquests where members of the family have given statements or depositions to the coroner and then the hospital has tried to have those statements ruled out or redacted in large part. In other words, it makes families feel as if they are being gagged and as if their voices do not matter. That is something that is very important and that is why things could be made fairer if we were to have a set of coroners' rules and a review board or review panel. Reference was made to the prohibitive nature of judicial review. That is where somebody appeals a decision. It is terribly expensive and it takes an awfully long time. As I said, most people are frightened off by the idea of going to the High Court and they just do not have it in them. They are exhausted, broken down, grieving and the last thing in the world they want is to have to go to the High Court. If we had, as was recommended a quarter of a century ago, a review board or panel perhaps made up of a member of the Attorney General's office, a coroner, a pathologist and a layperson, matters could be referred to that board or panel as they arise either in the lead up to or during an inquest and that would save time and costs and would mean people would not always have to resort to a judicial review.

Chairman: I will take supplementary questions if any member wishes to come back in.

Deputy Patrick Costello: I wish to make one brief point. I wish to clarify a matter for our report writing after this session. In terms of the recommendations, we have spoken a good deal about the postcode lottery. Would I be right in assuming that currently there is no central collection of figures and recommendations and it is quite possible every coroner is making the exact same recommendations about the exact same cause of death without anyone putting them all together and joining the jigsaw?

Mr. Roger Murray: The Deputy has hit the nail on the head. I would refer to the prevention of future death guidelines in the UK from the chief coroner in England and Wales. He said the prevention of future death reports are vitally important if society is to learn from deaths. He also said coroners have a statutory duty rather than simply a power, where appropriate, to report about deaths with a view to preventing future fatalities. He further said a bereaved family will be able to say a person's death was tragic and terrible but at least it is less likely to happen to somebody else. He said prevention of future death reports, PFDs, as they are called, are not intended as a punishment; they are done for the benefit of the public. The guidance goes on to state in regard to PFDs that they should not be unduly general in their content, that sweeping generalisations should be avoided and that they should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect. The model is there with respect to what prevention of future death reports should look like. They save lives. I know that because I have seen carefully crafted recommendations. I would echo what Professor Cusack said. I would commend juries on their ability, after hearing days of evidence, to distil it down into four or five net points. In large measure, the recommendations are practically capable of being put into effect. Deputy Costello is correct in pointing out that currently there is no follow-up in regard to it. There is nobody saying the coroner in County Clare made this recommendation a month ago and, therefore, it is redundant for you to say it. I think if there was that level of scrutiny, more lives would be saved.

Professor Denis Cusack: I made such a recommendation three years ago. We would support that. However, we must be very careful. The most central person is the deceased. I remind everybody every now and then the most important person here is the person, sadly, who is not here, the deceased, then their family and then others. In one case I dealt with a photograph of a deceased was held up by a family member, which I thought was very poignant, for the entire two days. I agree with the PFDs. The model is there. We recommended a central database, and I am sorry I sound like a broken gramophone record, 20 years ago in order that these could be collected and seen. However, we need to be careful. Reference was made to the families. In my experience Ireland has changed during the past 20 years. Often we do not have a single voice for the family. Sometimes there are two or three and there are very serious tensions among them. It is sometimes difficult to say who is the family. Each section of the family must be given equal hearing; each has the same rights.

I have made recommendations about roles for which the local authorities are responsible. I must say in all my years in this role, Kildare County Council has never taken an adverse approach to me, my funding or my resources. The coroner remains independent. I would give credit to Kildare County Council. We are independent judicial officers. We must be brave, hear evidence, rely on the facts and bring in a verdict or findings based on that. Sometimes that is not what the families wish to hear. We are not there to bring in findings for any particular person unless they are based on evidence but we must listen very carefully to the family.

In terms of admissibility, I would refer to section 55 of the 2007 legislation which deals with non-admissibility in criminal proceedings of evidence given at inquest and section 56 which deals with admissibility of a report in civil proceedings. We have done a good deal of this.

With regard to delays, I want to make another point. One of the questions asked by the committee was about closure. As a doctor and a coroner, I have a difficulty with the word "closure". When we lose somebody dear to us, I do not think we ever really close that off. There is always hurt, a gap, a loss. There is always a pain at Christmas, anniversaries and birthdays. The closure is about bringing them to the end at least of the procedure and they feel they do not have that hanging over them. That is the closure. I hope for some people we may bring an emotional closure. I talk about serenity, peace or acceptance. I am not sure we can ever close off on a loss of a loved one but what we can do is bring a closure to proceedings that are burdensome. I will say this, as I will be saying it publicly next Tuesday at my coroner's sitting, with respect to adjournment of inquests for criminal proceedings in certain areas. I will not mention any authority regarding accidents and fatalities at work, but I am dealing with a case has been going on for six years. I cannot proceed with my inquest as only last year the case went from the Director of Public Prosecutions to criminal proceedings. Only two days ago, with regard to another accident at work case, the partner and brother of the deceased told me they are desperate and hurt. They asked why was it taking so long. I had to tell them that I agreed with them and that I felt their hurt but I could not proceed because there are still applications before me. That is now over three years. We must examine certain aspects of that. That was dealt with by the way and this is one of the matters on which we did not agree with the Department under section 57 of the legislation or section 25 of the current Bill. Article 2 refers to a death inquiry being independent, effective, reasonably prompt, sufficiently open to public scrutiny and involving the next of kin. We must do all of those and we can do that better together.

Mr. Roger Murray: I briefly wish to return to a point Deputy Kenny raised on verdicts. It is important for the committee to be aware that currently there is no statutory definition of what a verdict is. There is no list of available verdicts. They have arisen by custom and practice.

The rules come in and are there in draft form, and have been for the past two decades. The model in England and Wales is available, whereby there is a menu in terms of the potential verdicts available and what the criteria and thresholds are. It is correct, as Ms O'Mahony said, that the threshold for a particular verdict in front of one coroner will vary considerably from district to district. If we had uniformity of approach and objective criteria on whether one meets the threshold for medical accident or for medical misadventure or whether it is a narrative situation, it would provide enormous clarity to families and would certainly help the legal advisers. It is important to counsel families before they go in to temper their expectations. There is no outcome that will give them vindication. The only outcome is one where there has been a complete and thorough investigation of all of the facts. The recommendations and the learning that arise are of much more significance to them.

Professor Denis Cusack: People believe coroners live in prehistoric caves. The justice plan for 2022 has the reforms as a priority. Even though the report of the coroner's rules committee is not statutory, we have been following the recommendations. We hold twice yearly educational meetings and often the legal coroners help with the education of medical coroners. I assure the committee that we are aware of the weaknesses, deficiencies and defects in the system and we are trying to address them. Like everybody else, as professionals we know we can always learn and do better. We must never become arrogant or out of touch. We could do with support for the reforms, as everybody has agreed. We would do an even better job.

For my sins I am president of a European forensic body. Covid has kept me in office because we have to meet in person in general assembly to change roles. I have been stuck in office for the past two years when I should have vacated it. I know what international death investigation systems are. I know what they are like in the civil system in the non-common law world. I have listed four papers with regard to international bodies. Without being complacent and without in any way being smug I can say the Irish death investigation system is very good. It has deficiencies and is in need of reform, which we must recognise. We must also compliment our system, including the legal representatives who come before coroners, whom I always welcome. They are very important when families need this form of assistance. I would like to see a better civil legal aid system and criteria introduced.

Chairman: Civil legal aid is a topic the committee will examine on another occasion. This has been a very useful exercise. I thank the witnesses and members for their time. The discussion has highlighted the value of the deep dive the committee does when we take on a module and scrutinise it. It has been highly informative for me and I am sure other members will agree. We will produce a report. We will consider at another meeting the deliberations today and the written submissions we have received.

Mr. Murray made a comment earlier that the dead open the eyes of the living. I can see it working its way into report. It is very pithy. I am also reminded of Joyce and the last lines of his short story about the "snow falling faintly through the universe and faintly falling, like the descent of their last end, upon all the living and the dead". Sometimes, just like snow, change comes dropping slowly. There is an opportunity for us in this exercise to effect change. This is what this committee is about; we scrutinise the work of the Department and we also put forward our own recommendations. It is not always the case at committee meetings but today there has been agreement on many of the points raised. It is a very useful template. I look forward to our deliberations and to the report, of which the witnesses will all be able to get copies. I hope it will reflect all of the views expressed today and in written submissions.

I ask committee members to remain because we have some private housekeeping to deal

with. I thank all of the witnesses and the organisations they represent for their input. This has been a very useful productive meeting.

The joint committee went into private session at 4.55 p.m. and adjourned at 5.08 p.m. until 3 p.m. on Tuesday, 14 June 2022.