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Bill Digest

Coroners (Amendment) Bill 2018

Bill No. 94 of 2018

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Abstract

The *Coroners (Amendment) Bill 2018* proposes amendments to the *Coroners Act 1962* that provide for new categories of deaths that must be reported to a coroner and (subject to certain exceptions) be the subject of an inquest. These new categories include maternal deaths.

The Bill also updates the 1962 Act to allow inquests to examine the circumstances surrounding a death and to improve resources – such as access to post-mortem examinations and powers to obtain evidence – available to coroners. It also provides for families of deceased persons to be kept informed about the work being undertaken by a coroner. In inquests involving maternal deaths, families can be provided legal aid .

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Legal Disclaimer

Summary

The Minister for Justice and Equality, Charlie Flanagan T.D., published the *Coroners (Amendment) Bill 2018* on 2 August 2018.[1] The purpose of the Bill is to update and clarify the powers and functions of coroners under the principal legislation, the *Coroners Act 1962*. The principal changes proposed in the Bill include:

- new categories of deaths that must be reported to a coroner. These include maternal deaths and the deaths of children during birth or in the year after it;
- requiring (subject to limited exceptions) inquests to be held into maternal deaths;
- powers for coroners to investigate not just the proximate cause of a death, but also the surrounding circumstances;
- increased powers for coroners to procure post-mortem examinations and to obtain documentary and other evidence; and
- provision for families of deceased persons to be informed of decisions relating to examinations and inquests, and for civil legal aid to be provided to them.

The proposals in the Bill concerning maternal deaths are a response to numerous calls for such deaths to be better and more transparently investigated. They reflect previous legislative proposals including a Government Bill in 2007 and the *Coroners Bill 2015*, a Private Member's Bill sponsored by Clare Daly T.D.[2]

Other proposals in the Bill reflect recommendations made in a 2000 report on the State's coroner's services by a working group established by the Department of Justice and Equality. However, the Bill does not implement the most far-reaching of that group's recommendations, namely a centralised national coroner service under the aegis of that Department.

The Bill has not been the subject of pre-legislative scrutiny under Standing Order 146A of Dáil Éireann. At the time of writing, the Library & Research Service has sought clarification from the Department of Justice and Equality on the reasons for this.

[1] 'Minister Flanagan publishes the Coroners Amendment Bill 2018', Department of Justice and Equality, press release, 2 August 2018, available here.

[2] The *Coroners Bill 2015* was referred to the Select Committee on Justice, Defence and Equality by a resolution of Dáil Éireann on 11 December 2015. In its report published on 8 February 2017, the Select Committee noted the views of the Department of Justice and Equality that the 2007 Bill on which the 2015 was based was "fundamentally outdated". In view of the Department's work on new legislation, the Committee recommended postponing the 2015 Bill's committee state for 6 months. It also recommended that the coroner service be comprehensively reformed and that new legislation should require post-mortem examinations for all maternal deaths.

Table of Provisions

Table 1 below summarises all provisions of the *Coroners (Amendment) Bill 2018*. Further discussion of key provisions of the Bill can be found in the Principal Provisions section of this Bill Digest.

Table 1: Provisions of the Coroners (Amendment) Bill 2018

Section	Title	Effect
1.	Definition	Standard provision that defines the 1962 Act as 'the Principal Act'
2.	Amendment of section 2 of the Principal Act	Amends definitions used in the 1962 Act, including new definitions of 'maternal death', 'late maternal death', 'direct maternal death' and 'indirect maternal death' and of 'post-mortem examination'
3.	Amendment of section 6A of Principal Act	Amends provisions concerning the coroner's district of Dublin, including a new provision for the administrative and financial arrangements of that office and the salaries of coroners in it to be funded by the Minister for Justice and Equality. Also provides for continuity in office of the current coroner and deputy coroners for Dublin.
4.	Amendment of section 8 of Principal Act	Technical amendments relating to the coroner's district of Dublin
5.	Amendment of section 13 of Principal Act	Amends provisions concerning deputy coroners to take account of different treatment of the coroner's district of Dublin
6.	Amendment of Principal Act – reporting of deaths	Inserts a new Part IIA (new sections 16A and 16B) into the 1962 Act, dealing with reporting of deaths
7.	General duty to hold inquest	Amends section 17 of the 1962 Act to provide for (among other things) mandatory inquests into maternal deaths, but subject to limited exceptions
8.	Amendment of section 18(1) of Principal Act	Extends the grounds on which a coroner may choose to hold an inquest by including cases where a death certificate is not properly completed
9.	Purpose of inquest	Inserts an new section 18A into the 1962 Act stating the purpose of an inquest and providing for cases where an inquest is unable to make

		findings in respects of all requisite matters
10.	Notice of inquest	Provides for notice of the holding of an inquest to be given to family members, witnesses and others
11.	Amendment of section 24 of Principal Act	Technical provision providing for costs and expenses where a coroner is requested to hold an inquest outside his or her district
12.	Identification of body of deceased person	Provides new procedures and rules concerning viewing or identification of a deceased person and giving evidence in respect of doing so
13.	Amendment of section 30 of Principal Act	Deletes words so as to allow inquests to inquire into broader circumstances surrounding a death
14.	Amendment of section 31 of Principal Act	Adds words so as to prohibit findings made at an inquest from censuring or exonerating an person. Also provides for recommendations in respect of public health or safety.
15.	Amendment of section 32 of Principal Act	Adds words specifying that the record of an inquest to be signed by a coroner (and, if appropriate, a jury) must include its findings as well as the verdict
16.	Post-mortem examinations and related matters	Replaces section 33 of the 1962 Act and adds new sections 33A, 33B, 33C, and 33D which deal with post-mortem examinations, personnel and reports of the examination
17.	Amendment of section 37 of Principal Act	Updates provisions concerning offences of failure to attend an inquest in response to a summons. Includes new provisions allowing the High Court to compel witnesses or jurors to attend.
18.	Power with respect to taking of evidence, etc., at inquest	Updates and expands coroners' power to examine witnesses and require the production of documentary or material evidence
19.	Taking of evidence from person about to leave State	Authorises a coroner to take evidence before the convening of an inquest if the witness is about the leave the State
20.	Amendment of section 40(1) of Principal Act	Removes the requirement to hold an inquest with a jury in cases where the deceased person died in a road traffic accident
21.	Amendment of section 46 of Principal Act	Technical provision updating penalties for obstructing coroners or failing to comply with certain of their directions
22.	Entry to premises to inspect,	New provision authorising coroners to apply for

	copy, take extracts from or seize documents, etc.	warrants to enter premises to obtain evidence for the purposes of discharging their statutory functions
23.	Expert advice and assistance for coroners in certain circumstances	New provision authorising coroners to seek and obtain expert advice and assistance
24.	Supply of forms to coroner	Provides for the supply to coroners of forms and stationery for their statutory functions
25.	Amendment of section 58 of Principal Act	Technical provision relating to payment of fees and expenses relating to post-mortem examinations, of witnesses at inquests and relating to storage or custody of bodies
26.	Amendment of section 60 of Principal Act	Adapts provisions relating to provision of legal aid to family members so as to take account of changes (such as inquests into maternal deaths) proposed under the Bill
27.	Offences by body corporate	Adds a new section 61 to 1962 Act making certain corporate officers liable for criminal offences committed by their corporation
28.	Amendment of Principal Act – Second Schedule specifying reportable deaths	Adds a new Schedule 2 to the 1962 Act, which lists types of death that are reportable
29.	Repeals	Repeals provisions of the 1962 Act
30.	Short title, collective citation and commencement	Standard provision. If enacted, the Bill may be commenced by ministerial order at different times or for different purposes.

Glossary

Table 2 outlines the meaning of some of the terms used in this Bill Digest.

Table 2

Coroner	An official responsible for investigating and reporting on the causes of deaths of persons, principally where the death is unexpected, unexplained or where it occurs in State custody or detention. Coroners are appointed and hold office under the *Coroners Act 1962* (as amended). Coroners are generally responsible for deaths occurring in individual local authority districts and are appointed by the relevant local authority. The coroner's district of Dublin covers Dublin city and county and the coroner is appointed by the Minister for Justice and Equality. To be appointed, a coroners must be qualified as a medical practitioner, barrister or solicitor and have practised as such for at least 5 years.
Inquest	A formal statutory inquiry under the 1962 Act into the identity of a dead person and the cause of their death. An inquest is an inquisitorial process led by the coroner, who selects and questions witnesses, and who may be assisted by a jury.
Maternal death	Defined by section 2 of the Bill as "the death of a woman while pregnant, or within 42 days of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes and, without prejudice to the generality of the foregoing, includes a direct maternal death or an indirect maternal death occurring during that period". This is based on the definition in the World Health Organisation's *International Classification of Diseases*.
Post-mortem examination	Defined by section 2 of the Bill as a full external and internal examination of a body, as well as ancillary examinations of tissues, organs or samples, carried out by or under the direction of an appropriately qualified medical practitioner
Verdict	The formal conclusion reached by an inquest as to the cause of a death. There are no prescribed forms of verdict, though section 31 of the 1962 Act prohibits verdicts containing any censure or exoneration of a person. Common forms of verdict returned by inquests – such as 'death by misadventure', 'accidental death' or 'open verdict' – reflect coroners' custom and practice, as well as decisions of the courts.

Background

Coroners and Inquests

Coroners are independent officers of the State who are responsible for investigating and reporting on sudden, unexplained, violent or unnatural deaths.

Although coroners are not judges, they conduct their work primarily through the holding of inquests, which have many of the characteristics of court proceedings including being held in public, the calling of witnesses and, in some cases, the use of juries. An inquest is an inquisitorial process[3] whereby the coroner calls witnesses, questions them, directs the lines of enquiry and (except where the coroner sits with a jury) decides on a verdict. Other persons with an interest in the matter, such as the family of the deceased, have the right to see evidence and examine witnesses, but the coroner has ultimate control over the course of proceedings. In a 1998 decision of the Supreme Court, Keane J. quoted with approval a UK Government report that listed public policy justifications for holdings inquests:

I. To determine the medical cause of death;
II. To allay rumours or suspicions;
III. To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;
IV. To advance medical knowledge;
V. To preserve the legal interests of the deceased person's family, heirs or other interested parties.[4]

To achieve these purposes, coroners have statutory powers to order post-mortem examinations of bodies, to have bodies exhumed and to summons witnesses and examine them at inquests.

The Coroners Act 1962

The principal legislation currently regulating coroners and their work is the *Coroners Act 1962*. This Act provides for the appointment of coroners and deputy coroners, the reporting of deaths, and the holding of inquests into them. This section of the Digest outlines the main provisions of the 1962 Act.

Coroners and their deputies are appointed by local authorities, except in the case of the coroner for Dublin city and county. In 2011, the 1962 Act was amended to amalgamate the Dublin city and county coroner districts and to provide for the appointment of the coroner for Dublin by the Minister for Justice and Equality.[5] In general, a coroner – who must be a registered medical practitioner, barrister or solicitor of 5 years' standing – is required to reside in the area of the local authority that appointed him or her, and is responsible for investigating deaths that occur in his or her appointed

[3] An inquisitorial process is one where a judge or presiding officer (such as a coroner) initiates and controls the direction of proceedings, including the choice of lines of enquiry and the examination of witnesses. This contrasts with adversarial proceedings, where the parties initiate the proceedings, with the judge acting as an arbiter between them and hearing the evidence that they choose to call. Inquisitorial processes are widely used in the criminal and administrative systems of countries with civil law systems, such as those in continental Europe. Courts in countries with common law systems – such as Ireland – are commonly adversarial in nature. Tribunals of enquiry are generally inquisitorial in nature.

[4] *Report of the Committee on Death Certification and Coroners* (Cmnd. 4810) (U.K. Government, 1971) quoted by Keane J. in *Farrell v Attorney General* [1998] 1 IR 203 at 224.

[5] Section 32, *Civil Law (Miscellaneous Provisions) Act 2011*

district. (Some local authorities' areas are divided into more than one coroner districts.) A coroner is generally works part-time in that role, and each coroner operates independently of coroners in other districts. Coroners are required to appoint a deputy coroner, who must be similarly qualified.[6]

The annual returns for coroners published by the Department of Justice and Equality for 2017 discloses a total of 11,856 deaths reported to 39 coroner's districts in that year. Of these, 3,338 led to reports and post-mortem examinations.[7]

Reporting deaths

Section 18 of the 1962 Act provides for reporting of deaths to coroners. Under subsection (3), members of An Garda Síochána must inform a coroner of any death in the coroner's district of which the Garda becomes aware, where "a medical certificate of the cause of death is not procurable". In effect, this applies to any case where the identity of the dead person is not evident or where the cause or general circumstances of the death cannot be readily established.

Subsection (4) creates a similar obligation for persons including doctors, undertakers and the occupier of a dwelling or manager of an institution where a person was residing at the time of his or her death. These persons must report any death that they know or believe occurred through means such as violence, misadventure, malpractice, negligence "or any cause other than natural illness or disease" for which the deceased had been treated by a doctor in the preceding month. The report must be made to the coroner for the district, though subsection (5) also allows it to be made to a Garda sergeant or a higher-ranking officer. Failure to report a death is an offence under section 18 of the 1962 Act.

Mandatory and discretionary inquests

Under section 17 of the 1962 Act, a coroner is obliged to hold an inquest into every death in his or her district that he or she believes to have occurred:

- in a violent or unnatural manner,
- suddenly and from unknown causes, or
- in a place or in circumstances that give rise, under other applicable legislation, to an obligation to hold an inquest.

Section 18 gives coroners a discretionary power to hold an inquest where "a medical certificate of the cause of death is not procurable". In effect, this covers cases where the identity of the deceased person, the time of death or the causes or general circumstances surrounding the death cannot easily be established.

Under section 24, the Attorney General may direct any coroner to hold an inquest into a death, the circumstances of which make it desirable to do so.

The body of the deceased person

Section 27 of the 1962 Act provides that the body of a deceased person into whose death an inquest is being held must be viewed by the coroner or a Garda who gives evidence of doing so at

[6] Department of Justice and Equality, Coroner Service web site, contains contact details for all coroners and deputy coroners, available here

[7] Department of Justice and Equality, Coroners Annual Returns 2017, available here

the inquest.[8] Subsection (2) provides that an inquest jury is not obliged to view the body "unless a majority of [them] so decides" or if the coroner directs them to do so.

Under section 46 the 1962 Act, a coroner is entitled to secure possession of a body if he or she "considers it necessary to hold an inquest on, or a post-mortem examination of, the body". It is an offence for any person to obstruct the removal of a body in such cases. If it is proposed to remove the body of a person from the State (for burial abroad or similar reasons), section 48 of the 1962 Act provides that a coroner with jurisdiction may certify that he or she is satisfied as to the cause of death and that there is no need to retain the body in the State.

Exhumations of bodies may be undertaken only by order of the Minister. Under section 47 of the 1962 Act, a senior Garda (not below the rank of inspector) who suspects that a death occurred violently or unnaturally may ask a coroner to request the Minister to order an exhumation. The Minister may make or refuse the order "as he thinks fit".

Post-mortem examinations

Section 33 of the 1962 Act gives a coroner power to order a post-mortem examination of the body of any person in relation to whose death an inquest is being, or is to be, held. A coroner may also request the Minister to arrange a 'special examination' of parts or substances. When requested by a senior Garda to do so, the coroner must arrange such examinations.

Under section 19 of the 1962 Act, a coroner may decide, based on the results of a post-mortem examination, that an inquest is not necessary. However, he or she may not do so where an inquest is obligatory under section 17, such as where the deceased died violently.

Juries

Part IV of the 1962 Act (sections 39 to 45) deals with juries for inquests. A jury of between 6 and 12 persons is required for inquests where the coroner is of the opinion that the death was caused by:

- murder, infanticide or manslaughter,
- accident, poisoning or a notifiable disease, or
- a road traffic accident. (Note that the Bill proposes to remove this requirement.)

Juries are also obligatory where a death occurs where other legislation requires an inquest to be held, or in circumstances "that could be prejudicial to the health or safety of the public or any section of the public".

Evidence

Section 26 of the 1962 Act provides that a coroner may summons a witness to attend and give evidence at an inquest. Section 38 of the 1962 Act authorises coroners to examine on oath the witnesses who appear at inquests. Witnesses have the same immunities and privileges – such as against self-incrimination or in respect of legal professional privilege – as those appearing before the High Court. Contempt of the inquest proceedings, refusal to take an oath or answer a

[8] Exceptions apply to cases where another coroner or deputy coroner has viewed the body. Exceptions also apply where the body has already been buried "and no good purpose will be effected by exhuming [it]", or where the body has been destroyed or is irrecoverable.

summons, or refusal without good reason to answer a coroner's question are offences that may be punished by High Court as if they were contempt of court.

Verdicts, recommendations and riders

Section 30 of the 1962 Act states the purpose of inquests as being **to ascertain "the identity of the person in relation to whose death the inquest is being held and how, when, and where the death occurred"**. In keeping with that, it prohibits any consideration or investigation by an inquest of civil or criminal liability. Similarly, section 31 prohibits verdicts or 'riders' to them that contain "a censure or an exoneration of any person". It does however permit verdicts to be accompanied by "recommendations of a general character designed to prevent further fatalities".

The 1962 Act does not specify particular types of verdict available to coroners and juries. The Department of Justice and Equality's website for the State's coroner services[9] lists a range of available verdicts including:

- accidental death;
- misadventure;
- suicide;
- open verdict;
- natural causes (if so found at inquest); and
- in certain circumstances, unlawful killing.

These are not prescribed by statute; they have arisen from the custom and practices of coroners and the influence of court decisions on the nature and purpose of inquests and coroners' jurisdiction under the 1962 Act.

The 1962 Act does not clarify the purpose of a 'rider' to a verdict. The leading textbook on coronorial practice in the State notes that the language of the 1962 Act suggests that 'recommendations' refer to general statements intended to prevent further deaths, while 'riders' are any other findings relating to an inquest's conclusions as to the circumstances surrounding a death. It states however that "[i]n practice the 'recommendation' is commonly referred to as the 'rider' ".[10]

Amendment of the 1962 Act

The 1962 Act has had few amendments since its enactment. Apart from technical amendments, the most significant changes are summarised below:

- the *Coroners (Amendment) Act 2005* removed obsolete provisions that prevented a coroner from calling more than two medical practitioners to give evidence at an inquest;
- the *Civil Law (Miscellaneous Provisions) Act 2011* amalgamated the coroners' districts of Dublin City and County and provided for the Minister for Justice and Equality to appoint a coroner and deputy coroners for that district;
- the *Courts and Civil Law (Miscellaneous Provisions) Act 2013* inserted section 60 into the 1962 Act, which provides for legal aid for family members of persons into whose deaths inquest are held.

[9] Available here

[10] Brian Farrell, *Coroners: Practice and Procedure,* Round Hall Sweet & Maxwell, (2000) p.337

The Department of Justice published in 2000 the report of a working group set up to review the State's coroner service.[11] (This report is discussed further below.) The report says that, apart from the 1962 Act, which updated some legislative aspects of coroners' work, "there has never been a comprehensive review of the Irish coroner service in terms of assessing its adequacy for societal needs."

Maternal deaths

Maternal deaths – that is, deaths of women during or in the immediate aftermath of pregnancy – have been the focus of recurring public concern and controversy.[12]

The **Confidential Maternal Death Enquiry of Ireland ('MDE Ireland')** is a project backed by the HSE, the Department of Health, the Institute of Obstetricians and Gynaecologists and the State Claims Agency. It was established in University College Cork in 2009 in response to the concerns about the reliability of official statistics. It uses a methodology that allows aggregation and comparison of figures with a similar project in the UK. This is intended to highlight the incidence of maternal mortality, shed light on causes of maternal deaths and so identify ways to prevent them. **Figures published by MDE Ireland** show maternal death rates between 2009 and 2013 in the range of **8.6 to 10.4 per 100,000 pregnancies**, which are comparable to rates in the UK and many other countries with advanced economies and health systems.[1] In contrast to this, annual rates of maternal deaths reported by the **Central Statistics Office** for the years 2009 to 2013 range from **1.3 to 4.4 per 100,000 births**.[1]

In a number of high-profile cases of maternal deaths, relatives of deceased women have sought to have inquests held but have found it difficult or even impossible to persuade a coroner to do so.[13] Campaigners argue that a lack of transparency about the incidence and causes of maternal deaths prevents lessons being learned that could prevent the recurrence of errors or mishaps.[14] In a 2015 opinion piece, Dr. Jo Murphy Lawless, of the School of Nursing and Midwifery, Trinity College, Dublin argued for inquests into all maternal deaths:

> "[T]he inquest process is the one reliable instrument families have to get to the core of what happened. … A maternal death casts a deep chill over the entirety of a maternity unit. Given the legal neutrality of a coroner's inquest in determining how a woman died, staff too would benefit from what we can learn through the inquest process."[15]

Campaigners also point to inconsistencies in the way in which maternal deaths have been recorded in official statistics, which have led to significant underreporting of these incidents.[16]

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[11] Department of Justice, Equality and Law Reform, *Review of the Coroner Service – Report of the Working Group* (2000), available here

[12] See, for example, "Call for automatic inquests after all maternal deaths", *The Times (Irish edition),* 26 February 2018, available here (Factiva).

[13] *Pepper v Bofin*, (Unreported) High Court (Gannon J) *The Irish Times*, 8 March 1989; "Irish maternal mortality figures" (Letter to the editor), *The Irish Times*, 15 August 2016

[14] "Keeping up the fight for more safety in maternity services", *Irish Independent*, 28 November 2015

[15] "Inquests are essential to understanding maternal deaths", *Irish Independent*, 25 November 2015

[16] "Data shows under-reporting of maternal deaths", *The Irish Times*, 25 September 2007;

Coroners Bill 2015

The *Coroners Bill 2015* is a Private Member's Bill presented to Dáil Éireann on 2 July 2015 by Deputy Clare Daly. This Bill is based on a 2007 Government Bill that was intended to provide for extensive reform of the coroner services in the State.[17] The 2007 Bill had provided for maternal deaths (that is, death of woman during or up to 42 days after the end of pregnancy) to be reported to a coroner. Significantly, however, Deputy Daly's Bill required them not only to be reported but also that a post-mortem examination be conducted and an inquest held in relation to them.[18] In her speech introducing the *Coroners Bill 2015*, Deputy Daly highlighted the need not just for accurate data on maternal deaths but also for those deaths to be examined at inquests:

> "The reason I am pushing this legislation is it is absolutely and urgently needed. It is largely the 2007 Bill with the addition of a provision to provide for an automatic inquest in cases of maternal deaths. It is urgently needed given the experiences of the families of the women who tragically died during childbirth in the past few years … A total of 14 children lost their mothers, yet the bereaved families had to fight to get [a] verdict [of medical misadventure]. Why is a verdict important? It is important not just to give the families closure but also to help prevent future deaths. It is an absolute necessity."[19]

Responding on behalf of the Government, the then Minister of State at the Department of Finance, Simon Harris TD, welcomed the substance of its proposals but said that provisions of the 2007 Bill included in it had become obsolete and inappropriate for current circumstances. He said the Government would be proposing substantial amendments at Committee stage to deal with organisational and financial matters, to improved support for bereaved families and to bring it up to date with legal and forensic development, particularly in relation to the European Convention on Human Rights.

The *Coroners Bill 2015* was referred to the Select Committee on Justice, Defence and Equality by a resolution of Dáil Éireann on 11 December 2015. In its report published on 8 February 2017, the Select Committee noted the views of the Department of Justice and Equality that the 2007 Bill on which the 2015 was based was "fundamentally outdated". In view of the Department's work on new legislation, the Committee recommended postponing the 2015 Bill's committee state for 6 months. It also recommended that the coroner service be comprehensively reformed and that new legislation should require post-mortem examinations for all maternal deaths.

Human rights

Decisions of the European Court of Human Rights have stressed the obligation of states to investigate unexplained deaths or those that occur in circumstances that involved official persons or authorities. These include cases brought against the United Kingdom that related to deaths caused by police and security services.[20] The deaths in those cases had been examined by means including official enquiries, prosecutions, civil actions and inquests, but in circumstances where evidence had been suppressed or withheld on national security grounds, and against a

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[17] *Coroners Bill 2007* (lapsed)

[18] *Coroners Bill 2015*, section 46(g), section 75(g) and Schedule 3

[19] Dáil Éireann, 25 July 2015, *Coroners Bill 2015* Second Stage Debate, accessible here.

[20] *McCann v United Kingdom* (1995) 21 EHRR 97 (arising from actions of the SAS in Gibraltar in 1988); *McKerr v. United Kingdom* (2002) EHRR 20. Due to the similarity of issues, the judgment in *McKerr* also covers three other cases arising from deaths in Northern Ireland that involved the actions of UK security services. The deaths were at the centre of the Stalker and Sampson inquiries in the 1980s into allegations of a 'shoot-to-kill' policy by UK security services.

background of allegations of collusion and a lack of official impartiality. The Court has also pointed out that a state's obligation to investigate can extend to deaths that occur in hospitals, so as to be able establish the cause of death and any liability on the part of health professionals.[21]

The *Coroners (Amendment) Bill 2007* and the *Coroners Bill 2015* both included provisions requiring coroners to have regard to the *European Convention on Human Rights Act 2003* in the performance of their functions. (That Act requires every organ of the State to perform its functions "in a manner compatible with the State's obligations under the Convention provisions".) Speaking on the 2007 Bill, the then Minister for Justice, Brian Lenihan TD, said:

> "The European Court of Human Rights has, through several judgments, validated the important and primary role of the coroner's inquest in fulfilling this State's obligations under the Convention to investigate any death involving public authorities or institutions. The court has also interpreted Article 2 of the Convention as providing for a more extensive investigation of the circumstances of death and has indicated that an extension of the scope of the inquest is effectively required to meet the obligations of the Convention. I note that in its report on the Bill, the Irish Human Rights Commission welcomed the approach adopted as meeting our obligations under Article 2."

A full discussion of the European Court of Human Right's rulings is beyond the scope of this paper but it is important to note the emphasis that the Court places on the fundamental nature of the right to life safeguarded by Article 2 of the Convention. The Court has held that it follows that, in the very limited cases where the State or its agents might be justified in taking life, there must be an assurance of a prompt, effective and independent investigation of the circumstances of the death to ascertain whether the use of force was justifiable. The investigation must be capable of contributing to any prosecution arising from any breaches of the law it identifies.[22] Arising from the European Court of Human Rights' decisions, other relevant issues include:

- the independence of the investigation,
- the ability to compel the attendance of witnesses and the production of documents, and
- keeping relatives of the deceased informed of the progress of inquiries.

Other proposals for reform

There have been two major reviews of the State's coroner services in the last 20 years. The first of these was undertaken by a Department of Justice Working Group that published a major review of the State's coroner services in 2000 ("the Working Group Review"). The second, which derived from a recommendation in the Working Group Review, was a report published in 2003 on coroners' rules ("the Coroners' Rules Report"). The reviews proposed extensive reforms of the State's coroner service and the *Coroners Act 1962* including:

- the creation of a new Coroner Service, under the direction of a Chief Coroner and Deputy Chief Coroner, having responsibility for overseeing, managing and supporting the work of all coroners in the State;
- reducing the number of coroners and having them operate on a regional basis;
- updating and clarifying the rules and protocols for reporting and investigating deaths, for holding inquests and rendering verdicts;

[21] *Erikson v Italy* (2000) 29 EHRR CD 152

[22] *McCann v United Kingdom* (1995) 21 EHRR 97

- permitting coroners to issue 'certificates of fact of death' pending the conclusion of an inquest;
- updating and clarifying the powers, jurisdiction and responsibilities of coroners and of coroner's officers;
- improving the provision of information to deceased persons' family and friends;
- providing for standardised rules of procedure and best practice to be followed by coroners throughout the State;
- improving coroners' access to necessary resources such as mortuaries, post-mortem examination facilities and pathology services;
- removing obsolete provisions, such as those relating to inquests on treasure trove,[23] requiring a coroner and/or a jury to view a body, and dictating the place of coroners' residences.

The 2007 and 2015 Bills address many of these and propose a complete reorganisation of coroner services under a national Coroner Service. However, the *Coroners (Amendment) Bill 2018* addresses only some of these issues.

The Coroners (Amendment) Bill 2018

The Government has introduced the *Coroners (Amendment) Bill 2018* to clarify, modernise and strengthen the powers of coroners and to enhance compliance with the requirements of Article 2 of the European Convention on Human Rights, which protects the right to life.

In the press release that accompanied the publication of the Bill, the Minister for Justice and Equality, Charlie Flanagan TD highlighted provisions of the Bill that increase the power of coroners to inquire not just into the proximate causes of a death but also into the wider circumstances in which it occurs. He also cited cases of maternal and perinatal deaths (that is, of children during or shortly after birth) that, the Minister said, should have been reported to coroners but were not.

As previously stated, the Bill adopts some of the recommendations made by the Working Group Review in 2000, and some provisions included in the 2007 and 2015 Bills. These include:

- clarification of the purpose and scope of inquests,
- an extended list of types of death that must be reported to a coroner, including maternal deaths, stillbirths and deaths of infants during birth or in the first year of their lives,
- revised procedures for reporting deaths,
- a requirement (subject to limited exceptions) to conduct post-mortem examinations and inquests into maternal deaths and deaths that occur in certain other circumstances,
- removal of the strict requirement that the coroner (or a Garda who gives evidence at the inquest) view the body of the deceased person,
- new powers for coroners to obtain evidence, including power to summon witnesses and documents, and to apply for search warrants,
- provision for family members of the deceased person to be kept informed of the coroner's work and to be involved in the process of any inquest.

The Bill does not implement some of the more far-reaching changes proposed in the Working Group Review and the earlier Bills. Notable among these is the Working Group's proposal to

[23] Section 49 of the 1962 Act provides for the holding of inquests into 'treasure trove' – that is, historic artefacts of gold or silver found under the ground – which had historically been treated as Crown property. Since 1994 such materials have been 'archaeological finds' with a statutory mechanism for asserting State ownership of them, subject to payment of a reward to the finder: *National Monuments (Amendment) Act 1994*, s. 14. However, the coroner's jurisdiction over treasure trove remains in effect.

centralise the control and resourcing of coroners under a new national Coroner's Service under the aegis of the Department of Justice.

The press release also lists amendments which, subject to advice and approval by the Attorney General, the Minister proposes to introduce at Committee Stage. These are:

- to authorise coroners to inquire into stillbirths where there is cause for concern, for example, arising from matters raised by the bereaved parents;
- to allow a coroner to seek directions from the High Court on a point of law in relation to the performance of their functions;
- providing for the Minister to make regulations on the proper storage and disposal of any material removed during post-mortem examination, including, where requested and appropriate, return to a family member for disposal; and
- providing for coroners to direct a hospital to make available the medical records of a deceased person available.

The Bill has not undergone pre-legislative scrutiny as provided for in Standing Order 146A of Dáil Éireann. At the time of writing, the Library & Research Service has sought clarification from the Department of Justice and Equality on the reasons for this.

Principal Provisions

This section of the Digest examines the main legislative effects proposed in the Bill. The Bill proposes numerous amendments to the *Coroners Act 1962*, many of which are technical in nature. For that reason, the following discussion focusses on the most important changes proposed in the Bill and is arranged thematically rather than as a sequential discussion of the Bill's provisions.

Definitions

Section 2 of the Bill sets out definitions of terms used in it. The most significant of these are of the terms '**maternal death**' and '**late maternal death**'. These definitions are derived from the World Health Organisation's *International Classification of Diseases*[24] and correspond to the case definitions used by MDE Ireland.

A 'maternal death' is defined as the death of a woman:

- while pregnant or up to 42 days after the end of her pregnancy,
- from any cause related to or aggravated by the pregnancy or its management,
- but not caused by "accidental or incidental causes".

A '**late maternal death'** is defined as the death of a woman more than 42 days but less than 365 days after the end of her pregnancy, where the death was caused by anything related to or aggravated by the pregnancy or its management. The definition includes direct or indirect maternal deaths (discussed below) but excludes any death due to "accidental or incidental causes".

The definitions of 'maternal death' and 'late maternal death' both include **'direct' and 'indirect maternal deaths'**. These terms look to the cause of a maternal death. A 'direct maternal death' is one that results from "obstetric complications of the pregnant state" arising during pregnancy, labour or the puerperium,[25] whether from obstetric interventions, omission or incorrect treatment "or a chain of events resulting from any of them". An 'indirect maternal death' is one that results from a previous existing disease or a disease that developed during pregnancy and which is not the result of obstetric intervention, but which "was aggravated by the physiological effects of pregnancy".

The Bill provides that all maternal deaths and late maternal deaths must be **reported to a coroner.** It also proposes that, in general, these deaths must also be subjected to **post-mortem examination** and have an **inquest** conducted into them. These provisions are examined in greater detail below.

Reporting deaths

Reportable deaths

Section 6 of the Bill proposes to insert a new Part IIA (sections 16A and 16B) in the 1962 Act. The new sections deal with cases where a death must be reported to a coroner and the persons who

[24] World Health Organisation, *International Classification of Diseases* 10th ed. available here

[25] The puerperium is the period of approximately 6 weeks after childbirth during which a woman's reproductive organs return to their original non-pregnant state.

are obliged to make the reports. The new provisions will replace the current subsections (3) to (6) of section 18, which are repealed by section 29 of the Bill.

The proposed new section 16A provides for 'reportable deaths' – that is, categories of death that must be reported to a coroner. The categories proposed in section 16A are considerably wider than those currently provided for in the 1962 Act. Some, such as deaths that occur by violence, misadventure, negligence or "unfair means" are provided for in the current section 18(4) of the 1962 Act (which, as noted above, the Bill proposes to repeal). However, the new section 16A adds a list of **new categories of reportable deaths** that is set out in a proposed new Schedule 2 to the 1962 Act.

The new categories include:

- maternal deaths and late maternal deaths,
- any death of a stillborn child, of a child during birth or infant death (that is, during the first year of life),
- deaths by suicide or that may be by assisted suicide,
- death by notifiable diseases,
- deaths by drug reactions or overdoses,
- deaths by prion diseases,
- deaths that may be due to a healthcare acquired infection, and
- any death "where an allegation has been made or a concern has been expressed regarding medical care provided to the deceased or the management of his or her healthcare".

The categories of reportable death under the proposed new Schedule 2 also include:

> "Any death occurring in or other health institution–
>
> (a) that is unexpected,
>
> (b) within 24 hours of presentation or admission, whichever is the later, or
>
> (c) of a person transferred from a nursing home."

The proposal to require reporting of maternal deaths reflects the views of the Working Group on the Coroner Service, which also recommended that deaths among 'vulnerable groups' should be reportable. The Working Group suggested that the 'vulnerable groups' be specified in greater detail by the subsequent review of coroners' rules and recommended that this be done in a way that avoided stigma and that focussed on persons "in some category of formal care rather than those who were merely being supported by the community care concept underpinning current approaches in this area."[26] Notably, however, the Coroner's Rules Report suggested the compulsory reporting of the "[d]eath of any mentally ill or intellectually disabled person who, at the time of death, resides in a place of care, including an institution or a community care residence", as well as deaths occurring in nursing homes.[27]

The new section 16A(3) proposed by section 6 of the Bill provides for the Minister for Justice and Equality to **amend, add to or remove categories of reportable death**. Orders under this new provision will require approval by each House of the Oireachtas.

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[26] Working Group Review, section 3.3.3, pp. 56-57

[27] Coroner's Rules Report, pp. 6-7

Persons obliged to report deaths to a coroner

Section 6 of the Bill also proposes a new section 16B of the 1962 Act, which deals with the persons who are obliged to report deaths to a coroner. The list in the proposed new section 16B(3) includes medical practitioners, nurses, paramedics, persons in charge of institutions such as nursing homes or of aircraft or ships in which a death occurs. The categories of person required to report deaths are generally the same as under the current law, but the proposed amendments will extend that duty to the broader range of reportable deaths set out in the new Schedule 2.

Another new provision relates to reports of **stillbirths** or **intrapartum deaths** (that is, of a baby during childbirth.) In such cases, any medical practitioner, nurse or midwife having care of the woman concerned at the relevant time is obliged to report the death or stillbirth.

A reportable death must be reported to a coroner "as soon as practicable after [the obliged person becomes] aware of it". However, section 16B(5) deems the obligation to have been met if the obliged person **reports it to a member of the Garda Síochána**.[28] Any Garda becoming aware of a reportable death (whether from his or her own knowledge, or through a report of another person) must report it to the appropriate coroner as soon as practicable.

Subsection (7) applies where a reporting person is a **medical practitioner** who treated the deceased person before his or her death, or (in the case of a stillbirth or intrapartum death) treated the woman concerned, or if he or she examined the body of the deceased person. In such cases, the medical practitioner must inform the coroner whether he or she (the medical practitioner) can certify under the *Civil Registration Act 2004* the cause of death to the best of his or her knowledge and belief. As will be discussed below, this is relevant to a coroner's decision as to whether an inquest must be held.

Under the proposed new section 16B(2), **failure to report a reportable death is an offence** that can be punished on summary conviction by a class B fine (up to €4,000). However, a person is not obliged to report a reportable death if they have reasonable grounds for believing that another obliged person has already reported it.

Where a person reports a death, subsection (8) requires them to give the coroner (or to a member of the Garda Síochána) **all information available to them** to assist the coroner in the performance of his or her statutory functions.

Identification of the body

Section 12 of the Bill proposes to replace section 27 of the 1962 Act, which requires a coroner or a Garda who gives evidence at the inquest to view the body of the deceased person. The replacement section (which changes the section's heading from 'View of the body' to 'Identification of body of the deceased person') reflects recommendations of the Working Group, which called for "a statutory requirement for the **formal identification of the body by an appropriate party**".

The proposed new section 27 removes the existing requirement that a coroner view the body, which the Working Group described as impractical.[29] Instead, a Garda, a family member of the deceased person, or – if the circumstances so require – a person qualified to identify human remains may be asked to view the body or the other evidence of identity and to give identification

[28] Section 18(5) of the 1962 Act currently requires that a report be made to "a member of the Garda Síochána not below the rank of sergeant".

[29] Working Group Review, section 3.3.4, p. 57

evidence to the coroner. This would allow identification, in circumstances such as where the body has been buried or destroyed, by **examining other evidence of identity,** such as genetic material, dental records or personal effects.

The proposed new section 27 removes the current provision in the 1962 Act providing for the inquest jury to view body if the coroner so directs or if a majority of the jury vote to do so. The Working Group Review described this as "rooted in antiquity" and recommended its removal.[30]

Another change under the proposed new section 27 concerns the current requirement that a Garda who views a body must give evidence of identification in person at the inquest. In line with a recommendation of the Working Group,[31] the new section would allow the identification evidence given to the coroner (whether by a Garda, family member or other person) to be presented to the inquest. **The identification evidence will be presumed to be correct** unless shown otherwise, and the person giving it will not be obliged to attend the inquest unless the identity of the deceased person is disputed.

The proposed new section 27(4) addresses cases where it is **not possible to identify the deceased person**. In such cases, the coroner may nevertheless inquire into the circumstances of the death and hold an inquest. There is no corresponding recommendation in the Working Group Review.

When are inquests held?

Obligatory inquests

Section 7 of the Bill proposes amendments to section 17 of the 1962 Act, which deals with cases where a coroner is obliged to hold an inquest.

Currently, a coroner must hold an inquest if a death occurs in his or her district and the coroner is of the opinion that the death may have occurred:

- in a violent or unnatural manner,
- suddenly and from unknown causes, or
- in a place or circumstances that give rise, under other legislation, to the need to hold an inquest.

Section 7(a) of the Bill proposes to change the second category above to deaths that occur "**unexpectedly** and from unknown causes".

Section 7(c) of the Bill provides for **obligatory inquests in two additional circumstances**:

- deaths of **persons who were in State custody or detention** at the time of their death or immediately before it, and
- **maternal deaths or late maternal deaths**.

The proposed obligation to hold an inquest into maternal and late maternal deaths is subject to exceptions provided for in the proposed new sections 17(3) and (4). A coroner may decide not to hold an inquest if he or she is **satisfied that the maternal or late maternal death was natural**

[30] Working Group Review, section 3.3.4, pp. 57-58.

[31] Working Group Review, section 3.3.4, pp. 57-58

and, for that reason, an inquest is not required. Before so deciding, the coroner must **consult the woman's family** and have regard to matters listed in the proposed new section 17(4):

- whether the woman's death was reported as required under the proposed new section 16A;
- whether the coroner has received sufficient information about the death,
- whether a post-mortem examination was performed under the Act and a report produced, and
- the views of the family (expressed in writing) "as to whether the death was a natural one".

Section 24 of the 1962 Act provides for another circumstance in which a coroner is obliged to hold an inquest. This can arise when the circumstances of a death cause the **Attorney General** to form the opinion that holding an inquest is advisable. In such a case, the Attorney General may request any coroner – regardless of whether the person died in that coroner's district – to hold an inquest, and the coroner is obliged to do so.[32] The Bill does not seek to amend that provision but does propose changes to arrangement for payment of the coroner's fees and expenses. These proposed changes are discussed under the heading 'Coroner's district of Dublin' below.

Discretionary inquests

Section 18 of the 1962 Act provides for cases in which a coroner has a discretion as to whether to hold an inquest. Section 18 allows a coroner to hold an inquest into a death **"if he [or she] so thinks proper"** in cases where:

- the coroner has been informed that body is lying in his or her district, and a medical certificate of the cause of death is not procurable, and
- the coroner inquires into the circumstances of the death but is unable to ascertain its cause.

Section 18(2) clarifies that this discretion does not apply in any case where section 17 obliges a coroner to hold an inquest, such as where the death occurred violently or where another statute requires an inquest.

The question of whether a **medical certificate of the cause of death is procurable** is relevant to the issue of reporting deaths. As noted above, the new section 16B proposed in the Bill will oblige a medical practitioner who treated the deceased person immediately before death, or who examined that person's body after death, to report the death to a coroner or Garda "as soon as practicable after becoming aware of [the] reportable death" and to provide all relevant information available to them. The proposed new section 16B(7) further requires a medical practitioner to inform the coroner whether he or she (the medical practitioner) can sign a death certificate stating the cause of death to the best of his or her knowledge. These new reporting requirements will therefore **assist coroners in deciding whether to hold an inquest**.

Section 8 of the Bill proposes to amend section 18(1) to add a new condition allowing a coroner to decide whether to hold an inquest. This deals with cases where a coroner is of the opinion that that a **death certificate has not been "completed in a satisfactory manner** to facilitate the registration of the death" under relevant legislation. Similarly to cases where no certificate is

[32] In *Farrell v Attorney General* [1998] 1 I.R 203 the Supreme Court held that the Attorney General's power under section 24 extends to cases where an inquest had already been held and a verdict returned. However, the Court found that the facts in that case did not provide sufficient grounds for the Attorney General to order a second inquest.

procurable, a coroner may investigate the death and, if he or she is unable to ascertain its cause, hold an inquest.

The current section 19(1) of the 1962 Act allows a coroner to decide not to hold an inquest if the **results of a post-mortem examination indicate that there is no need to do so**. As is discussed below in relation to post-mortem examinations, the Bill proposes to replace section 19 with new provisions dealing with post-mortems. Similarly to the current provision, the proposed new section 33(4) allows a coroner to decide on the basis of a post-mortem report that an inquest is not necessary. Under the proposed new section 33(5), this discretion does not apply in any case where an inquest is obligatory under section 17.

Notice of inquests

As currently in effect, the 1962 Act does not specify a notice period for inquests or require a coroner to notify family members or other interested persons.

The Working Group Review stressed the need for sensitivity when dealing with families and the importance of informing them about and involving them in the process of the coroner's work. The Review noted the "misunderstandings and needless trauma" that can be caused by poor public understanding of coroners' work and inadequate communication with the families of deceased persons.[33]

Consistent with that concern, section 10 of the Bill provides for a new section 18B which requires the coroner to give at least 14 days' notice of the holding of an inquest to a family member of the deceased, to any witnesses required to attend, and to any other person who, in the coroner's opinion, should be notified.

A coroner may hold an inquest on less than 14 days' notice if, in light the circumstances of the death (such as that of a foreigner in the State), doing so would facilitate attendance of an important witness, or if the deceased person's body is to be removed from the State. However, the coroner may not hold the inquest on short notice if doing so would unfairly prejudice the interests of a family member.

Purpose of an inquest

Section 9 of the Bill proposes a new section 18A(1) of the 1962 Act:

> "The purpose of an inquest shall be to establish—
>
> (a) the identity of the person in relation to whose death the inquest is being held,
>
> (b) how, when and where the death occurred, and
>
> (c) to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred,
>
> and to make findings in respect of those matters (in this Act referred to as 'findings') and return a verdict."

The proposed new section 18A(1) reflects a recommendation of the Working Group, which proposed that "**the duties and powers of a coroner at an inquest should be stated in positive terms**" along lines similar to those in the Bill.[34] The new provision replaces phrasing in section 30

[33] Working Group Review, p. 49

[34] Working Group Review, section 3.3.6, p. 62

of the 1962 Act, which confines inquests to "ascertaining the identity of the person in relation to whose death the inquest is being held and how, when and where the death occurred".[35]

The essential nature of these functions is underscored by subsections (2) and (3) of the proposed new section, which require an inquest to be adjourned or ultimately closed if it is unable to establish the matters specified in subsection (1). This reflects the public policy arguments for the holding of inquests that were cited with approval by Kean J by the Supreme Court in *Farrell v Attorney General*.[36]

The third purpose referred to in the proposed new section 18A(1) – establishing, if considered necessary, "**the circumstances in which [a] death occurred**" – also reflects the Working Group Review. The Working Group acknowledged the need for inquests to avoid considering questions of civil or criminal liability but argued that restricting inquests to consideration of the proximate medical causes of death would not "take into sufficient account the core reason for having a coroner system in the first place". It recommended that a coroner's jurisdiction should extend beyond investigating the medical causes of death to the surrounding circumstances of death.

This clarification of the remit of an inquest is reflected in section 13 of the Bill, which proposes to amend section 30 of the 1962 Act. Section 30 currently prohibits any consideration at an inquest of questions of civil or criminal liability. It goes on to provide:

> "… and accordingly every inquest shall be confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when, and where the death occurred."

Section 13 of the Bill proposes to delete that restriction, and so allow an inquest to inquire into the broader circumstances outlined in the proposed new section 18A(1).

The phrasing of the proposed new section 18A(1) suggests that 'establishing' the deceased person's identity and the cause and circumstances of their death is a process distinct from "making findings in respect of those matters". Similarly, the provision distinguishes the 'verdict' of an inquest from its 'findings'. The distinctions between those terms is considered below in the section headed 'Findings, verdicts, riders and recommendations'.

Evidence

An inquest's objective of establishing a deceased person's identity, and the cause and circumstances of their death, requires a means of obtaining evidence. Similarly, under section 18(1), a coroner deciding whether to hold an inquest must inquire into the circumstances of a death to determine whether its cause is ascertainable. The Bill proposes new measures by which coroners may obtain the evidence required to carry out their functions and for inquests to achieve their purpose.

Post-mortem examinations are an important source of evidence as to causes of death and, in many cases, the identity of a deceased person. The Bill makes extensive changes to provisions of the 1962 Act dealing with post-mortem examinations: these are examined separately below.

Sections 26 of the 1962 Act provides for witnesses to be summonsed to inquests, while section 37 provides for criminal penalties for failure to attend on foot of a summons.[37] Section 17 of the Bill

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[35] Section 13 of the Bill proposes to delete those words in section 30.

[36] [1998] 1 IR 203. See p. 2 above.

[37] These sections were substituted by section 1 of the *Coroners (Amendment) Act 2005*

proposes changes to section 37, restricting the offence to cases where the person summoned does not have a **reasonable excuse for his or her failure to attend**. It also allows the High Court to **compel a person to attend** and to make an order of costs in respect of the matter. This reflects a recommendation of the Working Group Review, which called for compellability measures similar to those available to tribunals of enquiry and Oireachtas Committees.[38]

Section 18 of the Bill proposes extensive amendments of section 38 of the 1962 Act, which provides for coroners to examine witnesses at inquests on oath. The proposed changes would allow coroners to require the **production of evidence such as documents, articles or substances** as well as providing for **oral evidence**. In keeping with the inquisitorial nature of inquests, the proposed new section 38(1)(b) would allow a coroner to "**direct a witness to answer questions**". Failure without reasonable excuse to comply with a direction of a coroner under these new provisions will be an offence punishable on summary conviction by a class A fine (up to €5,000) or 12 months' imprisonment. A similar punishment is provided for a new offence, committed by a person who gives **false or misleading evidence to an inquest**. However, as under the current provisions of the 1962 Act, witnesses will be entitled to the same immunities and privileges (such as against self-incrimination) as witnesses before the High Court.

Section 19 of the Bill proposes a new section 38A that deals with cases where a witness (or potential witness) is **likely to be outside the State** at the time of an inquest. The new provision will allow a coroner to take evidence (whether oral, documentary or otherwise) from the witness at any time before the inquest.

Section 22 of the Bill proposes a new power for coroners to obtain **warrants to enter premises and obtain evidence**. This is to be implemented by way of a new section 49A, which provides for a coroner to apply to the District Court for a warrant in respect of:

> "any documents, articles, substances or things required by the coroner for the performance of his or her functions under this Act in relation to the death of any person".

With the authorisation of the District Court, the coroner may inspect, copy or seize the evidence in question, but must return it once it is no longer required. The coroner must exercise his or her power under the warrant within one week of its issue by the District Court. Obstruction of a coroner in the execution of a warrant is an offence that can be punished with a class A fine and up to 12 months' imprisonment.

The wording of this provision makes clear that a coroner may seek a warrant not only for the purposes of an inquest but for "performance of his or her functions under this Act in relation to the death of any person". This would include inquiries into the circumstances of a death prior to a coroner's decision under section 18(1) as to whether an inquest should be held.

Expert advice and assistance

Section 23 of the Bill proposes a new section 53A, which would allow a coroner inquiring into a death to obtain expert advice or assistance from a person with requisite expertise. This does not relate to any specific recommendation of the Working Group, but may address concerns raised in its Review concerning the position of part-time coroners and the need to ensure consistency in approaches to coroners' work.[39]

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[38] Working Group Review, section 3.3.6, pp. 65-66

[39] Working Group Review, pp. 6-7, 48

Post-mortem examinations

Section 33 of the 1962 Act deals with post-mortem examinations and 'special examinations' – that is, examination by test or analysis of body parts, substances or such like. Section 33 currently permits a coroner to order a post-mortem examination of the body of **any person into whose death an inquest is being or is proposed to be held**. If the coroner wishes the State Pathologist to conduct the examination, or the State Laboratory to conduct a special examination, he or she must request the Minister to arrange the examination. (A coroner is obliged to request such an examination **if asked to do so by a senior Garda**.)

Section 16 of the Bill proposes to replace that section and to insert new sections 33A, 33B, 33C and 33D into the 1962 Act. These reflect recommendations made by the Working Group, which highlighted concerns expressed to it about the availability of pathologists and access to and resources for post-mortem services.[40] The recommendations[41] include:

- a statutory obligation to order a post-mortem into every death suspected of not being due to natural causes;
- regulation under Coroner's Rules of the removal, retention and disposition of tissues and organs in post-mortems conducted by or for coroners;
- power for coroners to request post-mortem examinations by the State Pathologist without the need to ask for approval of the Minister;
- Coroner's Rules to specify procedures for cases where a pathologist's association with a hospital is inappropriate or may be called into question.

The proposed new section 33(1) provides for a coroner to direct that a post-mortem be carried out "for the purpose of inquiring into the death of a person". In contrast to the current provision, this would not require that an inquest into the death be in train or planned. It therefore allows a coroner to request a post-mortem **as part of the investigation mandated by section 18(1)**, allowing the coroner to decide whether an inquest should be held.

The proposed new subsection (3) requires the coroner to ensure that, as far as practicable, the family of the deceased person is informed of the post-mortem examination and that materials may need to be retained. (See the section of this Digest headed 'Retention of organs and materials' below for a discussion of this.)

Obligatory post-mortems

Under the current law, a coroner is obliged to request the Minister to have the State Pathologist conduct a post-mortem only if so requested by a senior Garda. The proposed new section 33A requires a post-mortem to be conducted in the following cases:

- deaths that, in the coroner's opinion, may have occurred violently, unnaturally or in suspicious circumstances;
- deaths that, in the coroner's opinion, may have occurred unexpectedly and from unknown causes, or in an unexplained manner;
- deaths occurring in State custody or detention, or immediately after release;

[40] Working Group Review, p. 5

[41] *Ibid.* section 3.3.5, p. 13

- maternal deaths or late maternal deaths;
- deaths for which other legislation requires a post-mortem to be conducted;
- deaths resulting from causes such as industrial injuries, accidents at work or occupational injuries.

A coroner must also direct a post-mortem to be conducted by the State Pathologist if so requested by a Garda of the rank of inspector of higher, an officer of the Defence Forces not below the rank of commandant, a designated officer of GSOC or an officer authorised under legislation to investigate fatal accidents, incidents or diseases. This reflects a recommendation of the Working Group, which proposed that senior Gardaí should be able to request the services of the State Pathologist without recourse to the Minister.[42]

Who conducts post-mortem examinations?

The proposed new section 33B provides that a post-mortem conducted by direction of a coroner shall be made by a registered medical practitioner, who may be assisted by other medical practitioners, technicians or clinical assistants. This contrasts with the current provision under section 52 of the 1962 Act, which requires post-mortems to be conducted by a single medical practitioner. The coroner may allow a single assistant medical practitioner if he or she considers it necessary, but the coroner must "furnish the Minister with a statement of his reasons for considering it to be necessary".

Under the proposed new section 33(2), the medical practitioner who conducts the examination shall do so "under the direction of the coroner".

As under the current section 52(2) of the 1962 Act, the proposed new section 33B prohibits post-mortems being conducted or assisted by a medical practitioner who treated the deceased person in the 28 days before his or her death. Similarly, a pathologist associated with a hospital may not conduct or assist at a post-mortem if, in the coroner's opinion, the conduct of the medical practitioner "in relation to his or her attendance on the deceased person" is likely to be called into question at an inquest.

Further post-mortem examinations

The proposed new section 33C allows a coroner to direct further post-mortem examinations by the same or a different medical practitioner. This will apply where doing so is made necessary by further information relating to the death becoming known, or where the first post-mortem was not conducted properly.

Report of post-mortem examination

The proposed new section 33D requires the medical practitioner who conducts a post-mortem on the direction of a coroner to furnish the report to the coroner as soon as practicable. The report must record whether tissues or materials were retained for further examination or the inquest. (See the section of this Digest headed 'Retention of organs and materials' below for a discussion of this.)

If the post-mortem was requested under section 33A(2) (that is, by a Garda Inspector, a senior officer of the Defence Forces, a designated officer of GSOC or a statutory authorised officer), the

[42] Working Group Review section 3.3.5, p. 13

coroner must forward the report to the officer "no later than the commencement of the inquest". If no inquest is held, the report must be forwarded as soon as practicable.

The proposed new section 33D(6) allows a medical practitioner who conducts a post-mortem to furnish the coroner with a preliminary report before furnishing the full report.

The proposed new subsection (4) provides that a coroner may **forward a copy of the post-mortem report to members of the deceased person's family** if they so request. However, the Working Group Review expressed concerns about providing reports directly to families:

> "Where an inquest is not being held, relatives should be informed of their right to receive a copy of the post-mortem report. In view of the fact that such reports may often contain information which could be harrowing to families, the Group felt that, where possible, such reports should be routed through the family doctor who [is] trained to present such information in a sensitive and clear fashion to the relatives.[43]

If an inquest is held, the Working Group suggested that coroners should have some discretion to withhold disclosure of materials such as post-mortem report, but that the presumption should be in favour of disclosure. The Working Group recommended that legislation

> "…should be worded to reflect the idea that documents should be released, save for a number of specifically defined situations to be set out in Coroner's Rules. In any refusal of documents, the grounds for refusal should be given to the applicant."[44]

The proposed new subsection (5) provides that a coroner must not forward the report to family members if criminal proceedings in relation to the death are being considered or have been instituted, and the coroner thinks, because of a risk of prejudicing the proceedings, that it is not proper to do so.

Retention of organs and materials

As noted above, the new section 33(3) proposed in the Bill provides that families of deceased persons should, where possible, be informed before a post-mortem of the possibility that body parts or materials may be retained for further study or analysis. Similarly, the proposed new section 33D requires the post-mortem report to record any such retention.

The Working Group Report stressed the need for a "sensitive, structured and consistent approach" to the issue of organ retention.[45] It recognised that the nature of coroners' work can make it essential to retain organs or materials, but recommended that the purpose of an examination and the possibility of retention be discussed with families by means of "a well defined, structured, and bereaved-centred dialogue between relatives and a designated person who would be available around the time of death". The Review suggested that hospitals should appoint 'designated persons' to be trained in how to discuss with families issues related to post-mortems and retention, whether arising from coroners' duties or otherwise. Once the coroner's work to identify the deceased and establish the cause of death have been completed, the retained organs or materials should be returned to the family or disposed of in agreed manner.

The Working Group also noted practical issues that had been raised with it by persons involved in the coroner service. These included the need to distinguish between the retention of tissue

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[43] Working Group Review, section 3.3.2, p. 50

[44] Working Group Review, section 3.3.6, p. 64

[45] See generally on this topic Working Group Review, section 3.3.2, pp. 52-56

samples on microscope slides and the retention of larger-scale samples. The former were essential to ensuring the quality of pathology services and the conduct of coroners' business, while the latter were more likely to give rise to difficulties and distress for families. It recommended that retention of organs and tissues "should continue to be carried out by the medical authorities in accordance with any national revised practices currently being worked out by those authorities."

Findings, verdicts, recommendations and riders

Findings and verdicts

As noted previously, the purpose of an inquest stated in the proposed new section 18A(1) suggests that there is a distinction between, on the one hand, 'establishing' the matters outlined under subsection (1) (that is, the circumstances and medical cause of death) and, on the other hand, making 'findings' about them. Similarly, section 18A(1) makes it clear that those 'findings' are something distinct from the 'verdict' of the inquest, but does not make clear how they differ.

Common forms of verdict such as 'death by misadventure', 'accidental death' or an 'open' verdict appear to have their origins in custom and practice rather than statute.[46] Leading Irish and English textbooks on coronorial law suggest that the verdict of an inquest should be the conclusions drawn from the inquest's findings on the identity of the deceased person and the cause and circumstances of his or her death.[47]

The distinction between 'findings' and the verdict are underscored by section 14(a) of the Bill, which proposes an amendment to section 31 of the 1962 Act. Section 31, prohibits a verdict or 'rider' from containing censure or exoneration of any person. The amendment proposed by section 14(a) of the Bill would extend that prohibition to the 'findings' of the inquest. Similarly, section 15 of the Bill proposes to amend section 32 of the 1962 Act, which requires a coroner to sign the record of the verdict returned at an inquest; the proposed amendment would also require signature of the inquest's 'findings'.

The Bill does not give effect to the recommendation of the Working Group Review that express provision should be made for suicide verdicts in appropriate cases.[48]

Recommendations and riders

Section 31(1) of the 1962 Act provides that neither an inquest's verdict "nor any rider to the verdict at an inquest" shall censure or exonerate any person. (As noted above, section 14(a) of the Bill proposes extending that prohibition to the findings made at an inquest.)

Section 31(2) permits "recommendations of a general character" that are designed to prevent further fatalities. Section 14(b) of the Bill proposes also allowing recommendations "that are considered necessary or desirable in the interests of public health or safety".

The reference to a 'rider' in section 31 is the only one in the 1962 Act. Neither it nor the Bill explains what a rider is or what its effect may be. The leading textbook on Irish coronorial practice

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[46] The Working Group Review recommended that inquests should return a verdict of suicide in every case where it was proved beyond a reasonable doubt that a person took their own life. The Bill makes no provision for this. See Working Group Review, section 3.3.6, p. 62

[47] Farrell, B. *Coroners: Practice and Procedure* (2000) Round Hall Press, at p. 340; *Jervis on Coroners*, 12th ed. (2002), Sweet & Maxwell, p. 301. The Working Group Review (at p. 62) expressed concern at the lack of consistent criteria for reaching verdicts. It suggested that a review of Coroners' Rules be used to produce guidelines to address this problem.

[48] Working Group Review, section 3.3.6, p. 62

suggests that a rider is "a statement added or appended to a verdict"[49] and that it is different in nature from a recommendation intended to prevent further deaths (or, in the terms proposed by section 14(b) of the Bill, in the interests of public health or safety). As noted above however, the same text suggests that riders and recommendations are in practice considered the same.

Coroner's district of Dublin

As noted previously, the coroner's district of Dublin is unique in the State for covering more than one local authority's area. Moreover, the coroner for Dublin is appointed by the Minister for Justice and Equality rather than a local authority.

Section 3 of the Bill proposes to amend section 6A of the 1962 Act so that "administrative and financial arrangements" in respect of the Dublin coroner's office are taken over by the Minister. Section 3 also proposes minor consequential amendments relating to the Minister's appointment powers for the coroner, deputy coroners, and temporary replacements (such as for illness etc.).

Offences by body corporate

Section 27 of the Bill proposes a new section 61 of the 1962 Act. This is a standard provision that in intended to allow conviction of corporate officers such as directors for criminal offences under the Act that are committed by their company.

Legal Aid

Section 60 of the 1962 Act[50] deals with provision of civil legal and advice for a member of the family of a person into whose death an inquest is held. As currently in effect, legal aid is available in cases where a person died in the custody of the State, while being detained by State authorities, was a child in care, or the death has implications for public health or safety.

Section 26 of the Bill proposes that civil legal aid also be available to a family member for inquests into maternal deaths or late maternal deaths.

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[49] Farrell, B. *Coroners: Practice and Procedure* (2000) Round Hall Press, at p. 359, quoting Murdoch, H. *Murdoch's Dictionary of Irish Law.*

[50] Inserted by section 24 of the *Courts and Civil Law (Miscellaneous Provisions) Act 2013*

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