An Roinn Dlí agus Cirt
Department of Justice

Public Consultation on the Reform of the Coroner Service

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Abbreviations

ABS	Australian Bureau of Statistics
AGS	An Garda Síochána
APT	Anatomical Pathology Technician
BDMV	Births Deaths and Marriages Victoria
CSoI	Coroners Society of Ireland
CSNI	Coroners Service for Northern Ireland
CSO	Central Statistics Office
CT	Computerised tomography
DDM	Dublin District Mortuary
DoJ	Department of Justice
DJELR	Department of Justice Equality and Law Reform
FSI	Forensic Science Ireland
GP	General Practitioner
GSOC	Garda Síochána Ombudsman Commission
HSE	Health Service Executive
ICCL	Irish Council for Civil Liberties
ICT	Information and communication technologies
IHREC	Irish Human Rights and Equality Commission
NIIO	National Initial Investigations Office (New Zealand)
NISRA	Northern Ireland Statistics and Research Agency
ONS	Office for National Statistics (UK)
OSP	Office of the State Pathologist
PME	Post-mortem examination
RCPI	Royal College of Physicians of Ireland
SLA	Service Level Agreement
VIFM	Victorian Institute of Forensic Medicine

Introduction

The Coroner Service provides an important public service to the living and in particular to the next-of-kin of the deceased. It not only provides closure for bereaved friends and family, but can also perform a wider public service by identifying matters of public interest. As noted in a 2000 review of the Coroner Service, "Coroners are part of a multi-faceted system…" supported by a range of interacting services[1].

The purpose of this public consultation exercise is to seek views, observations and proposals on how the Coroner Service might be reformed. The experiences of bereaved friends and families will be central to this exercise and in this respect a questionnaire has been included to capture the views and opinions of those who have engaged with the Coroner Service (Appendix 2A).

Certain aspects of this consultation process may be more specifically relevant to those providing related services e.g. Pathologists, Histopathologists, members of An Garda Síochána etc. (Appendix 2B).

The Department of Justice ("the Department") is seeking submissions in relation to 4 key strands;

i) Structure and Roles – Chapter 1
The structure of the Coroner Service is as prescribed in the Coroners Act 1962, as amended ("the Act"). While the Act has undergone a number of amendments, the structure of the Coroner Service remains largely as intended by the Act, other than in respect of the amalgamation of a number of Coroners districts. The Department is interested in canvassing views and opinions as to how the Coroner Service should be best structured to provide an improved service to bereaved families into the future.

ii) Pathology and Related Services – Chapter 2
The provision of the Pathology / Histopathology service is a core input into the death investigation process. In this regard, it is critically important that the provision of post-mortem examination (PME) and ancillary services such as toxicology and histology are considered in detail.

iii) Reportable Deaths – Chapter 3
The Act prescribes the circumstances in which a death must be reported to a Coroner and also the persons who are obliged to report the death. The Department is seeking views in relation to death reporting, the types of deaths which should be reported and the structure required to support this.

iv) Inquests – Chapter 4
There are certain scenarios prescribed in the Act whereby a Coroner is duty bound to hold an inquest i.e. where a deceased person was in State custody

[1] P.5, DJELR, Review of the Coroner Service: Report of the Working Group, 2000.

or detention at the time or immediately before death, and in the case of maternal or late maternal death. Otherwise, the Coroner may hold an inquest if s/he deems it necessary. The Department is seeking views on roles and responsibilities in relation to inquests, the use of juries, venues for inquest, Coroner recommendations at inquests etc.

v) Public Survey and Consultation Questions – Appendix 2

The views of all stakeholders will be central to future reform of the Coroner Service. With this in mind, questions have been developed to;

(a) Capture past experiences and garner views and opinions of how interactions with the Coroner Service by bereaved family and friends could be enhanced into the future.

(b) Garner views and opinions on specific issues as discussed in chapters 1 – 4.

Submissions should be made no later than 17.00 on Friday 19 January 2024. If questions arise, please email coronerconsultation@justice.ie

1. Structure and Roles

Current Structure of the Coroner Service

1.1. The Coroner Service comprises of a network of coroners located in districts throughout the country (see 1.12). Coroners are independent quasi-judicial office holders whose function is to investigate sudden and unexplained, violent and unnatural deaths. The death investigation process may involve a post-mortem examination (PME), in order to establish the cause of death, as well as an inquest in certain instances.

1.2. The jurisdiction of the Coroner is to investigate relevant deaths of persons lying within the boundaries of his/her district. Certain exceptions to this geographical jurisdiction are provided for by the "the Act", such as;

- Section 20 – Coroner and Deputy Coroner being absent, ill, incapacitated or disqualified or there being a vacancy;
- Section 21 – multiple deaths arising from one occurrence;
- Section 23 – where the body is destroyed or irrecoverable;
- Section 24 – inquest on order of Attorney General;
- Section 34 – holding of an adjourned inquest by a different Coroner;
- Section 46 – removal of a body to the district of another coroner pending PME or inquest.[2]

1.3. A Coroner may hold office until age 72, unless they retire, resign or are removed from office before that age. A Coroner appoints a Deputy Coroner for the district who may act as Coroner to the district during periods of absence on the part of the Coroner. In limited circumstances a Deputy may act contemporaneous to the Coroner. All Coroners and Deputies must be a qualified barrister / solicitor of 5 years standing or a medical professional of 5 years standing.

1.4. Coroners are not required to undertake formal training in terms of the role of a Coroner. No statutory rules on Coroner practice and procedure apply, nor have any detailed guidance documents been produced for the Coroner Service in Ireland.

1.5. The Department of Justice has responsibility for legislating for and determining the policy of the Coroner Service in Ireland. The principal legislation governing the Coroner Service is the Coroners Act 1962, as amended.

1.6. There is no centralised funding for the Coroner Service. The Department of Justice has direct responsibility for providing financial support to the Dublin District Coroner's Office since 1st January 2018. The relevant Local Authorities fund the Coroner Service in all other Coroner districts. The costs associated with funding the Coroner Service includes Coroners' fees and retainers, pathology and histology expenses, State Laboratory expenses, fees for witness attendance at inquests, and mortuary and undertaker fees.

[2] P.69, Brian Farrell, Coroners: Practice and Procedure, Dublin, Round Hall Sweet & Maxwell, 2000

1.7. Coroners are remunerated on the basis of an annual retainer intended to cover on call duty and office costs and a 'fee-per-item', i.e. a fee for each death reported, a separate fee where a PME is directed and a separate fee where an inquest is held.

1.8. The Department of Justice provides administrative support (premises, staffing, ICT and HR services) to the Dublin district Coroner since 2018. The Cork City Coroner receives certain administrative supports from Cork City Council. The remaining Coroners receive no formal administrative supports from Local Authorities.

1.9. A review of the Coroner Service ("the Review") was published in 2000. At the time of the Review there were 48 Coroners; the Review noted, "*The high number of coroners in the country is related more to a time of poor communications and transport rather than to an analysis of service requirement. Like many aspects of any service which has evolved over time without serious review, arrangements have continued based on nothing more than tradition. There is currently no link between the organisational structure and the most appropriate and effective means of delivering the service.*"[3]

1.10. Many of the recommendations of the 2000 Review related to the strengthening of the legal provisions regarding the work of the Coroner. In this regard, many of the relevant recommendations have been implemented in the intervening period. Such amendments were effected through Acts in 2005, 2011, 2013, 2019 and 2020 (Appendix 3).

1.11. The Coroners Bill 2007 proposed a major reform to the structure of the Coroner Service. It provided for a full-time Coroner Service with a Chief Coroner with a national jurisdiction under the auspices of the Department of Justice. However, due to the major challenges then confronting public finances, the administrative restructuring proposed in the 2007 Bill was not progressed following Second Stage in the Seanad.

1.12. The Oireachtas Joint Committee on Justice's 2023 report on the operation of the Coroner Service recommended that the Coroner Service, "…should be re-structured to establish an office of the Chief Coroner and an office of the Deputy Coroner, to steer leadership of the Service." The Committee further recommended that a new statutory Coroner Service agency be established "…to uphold the fundamental principles of the Coroner's Service and assist with administrative and organisational duties".[4]

1.13. Today, Ireland has 34 Coroners covering 37 districts. The majority of Coroners work as solicitors, barristers or doctors and carry out their Coroner function in addition to these roles.

Death Investigation Process

1.14. Death reports are made to individual Coroners in each district.

1.15. A Coroner may direct a PME in order to establish the medical cause of death. A Coroner is mandated under the Act to direct a PME in certain circumstances. Upon receipt of a

[3] P.72, DJELR, Review of the Coroner Service: Report of the Working Group, 2000.
[4] P.6, Joint Committee on Justice, Report on an Examination of the Operation of the Coroner's Service, February 2023.

PME report a Coroner will decide, based on the evidence to hand, that a death certificate can issue or that an inquest is required.

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

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

1.17. Depending on the complexity of the case, a Coroner in executing their death investigation function may require, to varying degrees, medical advisory support, investigative support, administrative support, legal support and family liaison support. Currently, there is no central source for the delivery of these supporting services to Coroners.

1.18. There is no centralised ICT system in place for logging and managing the death investigation function across the Coroner Service nationwide. This lack of centralisation means that the manner in which a death investigation is managed/recorded by Coroners may vary between districts. Additionally, apart from basic data gathered from Coroners' annual returns to the Minister for Justice, detailed data on the cause of deaths in Ireland is not routinely gathered other than at district level.

1.19. A reformed Coroner Service may include the development of these supporting services, thereby creating consistencies and efficiencies in the death investigative process for bereaved families throughout the country.

1.20. A number of other jurisdictions which have reformed their Coroner Service, established a central Coroner Agency tasked with centralising ICT systems, standardising processes etc. Reflection on the manner by which these jurisdictions manage their death investigation process provides helpful insights.

International Comparisons

1.21. New Zealand[5], the Australian state of Victoria[6], the Canadian state of British Columbia[7], and Northern Ireland[8] have established a Coroner Agency/Body which centralises much of the Coroner Service.

1.22. In New Zealand the National Initial Investigation Office (NIIO) is the centralised initial point of contact when deaths are reported to the Coroner under the New Zealand Coroners Act. The NIIO is a 24-hour service providing support to a Duty Coroner, who is drawn from a Coroners Court rotational weekly roster. The NIIO comprises full-time staff who coordinate the 'first 48 hours' of the Coroner process, including the initial reporting of a deceased person by a doctor, hospital or the police. The decision whether or not to proceed to a PME is centralised through a Duty Coroner. The NIIO coordinates any PME and the release of the deceased's body to the family. The NIIO collects, collates and records the initial information and findings for the progression of a case to a Coroner based at a regional office.[9]

1.23. Northern Ireland centralised its Coroner Service (the CSNI) in 2006 and Coroners have jurisdiction across the whole of Northern Ireland (i.e. there are no Coroner districts or regions).[10] Coroners and their support staff operate from a single location in Belfast. There is a single, centralised function for reporting deaths to the CSNI and liaison officers and administrative staff assist the Coroners. A Medical Officer provides oral and written medical advice relating to reported deaths, PME reports, expert reports or inquest proceedings to Coroners and bereaved families. The Medical Officer has regular contact with key stakeholders including practitioners, hospital doctors, pathologists, and the police.[11] The CSNI has two solicitors employed by the CSNI who provide advice and support to Coroners. The solicitors are responsible for advising the Coroners in respect of legal issues which arise in the preparation for and conduct of inquests and any Judicial Review applications.[12] Prior to 2015 inquests were assigned to the Coroner who had taken the initial death report. A 2015 review of the CSNI however recommended that case allocation and management arrangements be revised so that the workload is evenly spread among Coroners and a consistent service is delivered to bereaved families.[13] The single jurisdiction in Northern Ireland means that cases can be allocated to Coroners in a way that prioritises efficiency and consistency of service instead of allocating cases solely based on where a body is lying.

1.24. In Victoria, Australia, Coroner death reports are managed by the Victorian Institute of Forensic Medicine's (VIFM) 24 hour Coronial Admissions and Enquiries (CA&E) unit. The VIFM's Forensic Pathologist reviews all the case details and provides the Duty Coroner

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[5] Coronial Services of New Zealand, 30 September 2021.
[6] Coroners Court of Victoria, How to report a death, 31 May 2019.
[7] BC Coroners Service, About the BC Coroners Service, downloaded 6 September 2023.
[8] P.33, CSNI, Working with the Coroners Service for Northern Ireland, May 2017.
[9] NZ DoJ, When someone dies suddenly: A guide to coronial services in Aoteaora New Zealand, November 2022.
[10] P.5, Review of the Coroners Service for Northern Ireland: Report of the Review Team, June 2015.
[11] P.21, Review of the Coroners Service for Northern Ireland: Report of the Review Team, June 2015.
[12] P.25, Review of the Coroners Service for Northern Ireland: Report of the Review Team, June 2015.
[13] P.35, Review of the Coroners Service for Northern Ireland: Report of the Review Team, June 2015.

with the information to help decide whether a medical examination is required. The Coroner will consider this recommendation, together with the wishes of the family.[14]

Roles within the Coroner Service

1.25. Within a reformed Coroner Service, consideration must be given to the provision of the following essential supporting services to the Coroner:

A. Medical advice / support
B. Investigative support
C. Legal support
D. Administrative support
E. Family liaison support

There are a number of roles that do not exist within the Coroner Service in Ireland, that do exist in other jurisdictions.

1.26. Ireland does not have a Chief Coroner. In jurisdictions that have established this role, there are variances in what the role entails. Table 1 below provides a high level overview of Chief Coroner functions in 5 jurisdictions.

NORTHERN IRELAND	• Responsible for supporting Coroners by providing guidance and leadership • Shaping the practice and procedure of Coroners in the functions of their office • Guidance on the interpretation of case law • Hearing complex and or contentious inquests when appropriate
ENGLAND & WALES	• Provides support, leadership and guidance for Coroners • Sets national standards/rules for Coroners • Puts in place training arrangements for Coroners/staff • Oversees transfers of cases between Coroners and directs coroners to conduct investigations • Provides guidance notes on legal issues • Keeps a register of death investigations lasting more than 12 months • Monitors the reporting of inquest recommendation to appropriate authorities
CANADA - BRITISH COLUMBIA	• Supervises and directs Coroners in the performance of their duties • Creates rules for investigations and inquests • Conducts training programmes for Coroners • Brings the findings and recommendations of Coroners, juries and review panels to the attention of appropriate persons • Prepares manuals and a code of ethics to guide Coroners • Publishes public information about the prevention of deaths • Appoints employees necessary for the administration of the Act
AUSTRALIA – VICTORIA	• Responsible for discharge of the business of the Coroner's Court • May assign duties to a Coroner

[14] VIFM, Families: Frequently Asked Questions, downloaded 2 August 2023.

	• May delegate functions of the Chief Coroner/Coroner to a Registrar
NEW ZEALAND	• Facilitates the orderly and efficient operation of the system • Oversees coroners' investigations by managing workloads and issuing practice notes • Facilitates the provision of support services, cultural, legal, medical, or other specialist advice • Legal/ medical support services facilitated by Chief Coroner • To help to inform and to achieve consistency in coronial decision making and conduct • To maintain a public register of Coroners' recommendations

Table 1: Overview of Chief Coroner functions in 5 jurisdictions

1.27. The Chief Coroner as head of a National Coroners' Agency could have a number of responsibilities such as; overall responsibility for the provision of Coroner Service; supporting Coroners through the provision of guidance, training and legal supports; the adoption of rules and procedures for inquests, the provision of suitable venues for Coroner inquests; budget management, establishment and compliance with good governance standards etc.

1.28. The Chief Coroner's role could also involve responsibility for the management of Coroner workloads and throughputs.

1.29. Duty Coroners could triage the initial stages of a death investigation.

1.30. A Medical Support office could provide medical advices throughout the death investigation process.

1.31. Investigative Officers could have responsibility for gathering evidence for the purpose of death investigation by obtaining written statements and assembling the evidence from various parties, such as AGS, medical professionals and health and safety officers. Investigative Officers may also have duties such as arranging PMEs and ensuring the body of the deceased is released on the direction of a Coroner.

1.32. Family Liaison Officers would keep the family informed throughout the death investigation process.

Centralised / Localised Structures

1.33. A Centralised function could result in specific stages of the death investigation process being allocated to Coroners without regard to the location of the Coroner, i.e. each Coroner could investigate a death (to the extent required) in any part of the country, as per the Northern Ireland model.

1.34. A Localised/Regionalised function could result in specific stages of the death investigation process being allocated to a Coroner by reference to a specific geographical area (e.g. on a local/regional basis). The Chief Coroner under this structure could also have the power to allocate cases to Coroners in different geographical areas as necessary.

1.35. Based on the flowchart in Figure 1 below, the Department is seeking views as to what key stages of the Coroner's death investigation could / should be centralised or localised/regionalised. It is also seeking views as to how the above supports as identified in 1.24 above would be best delivered within such structures.

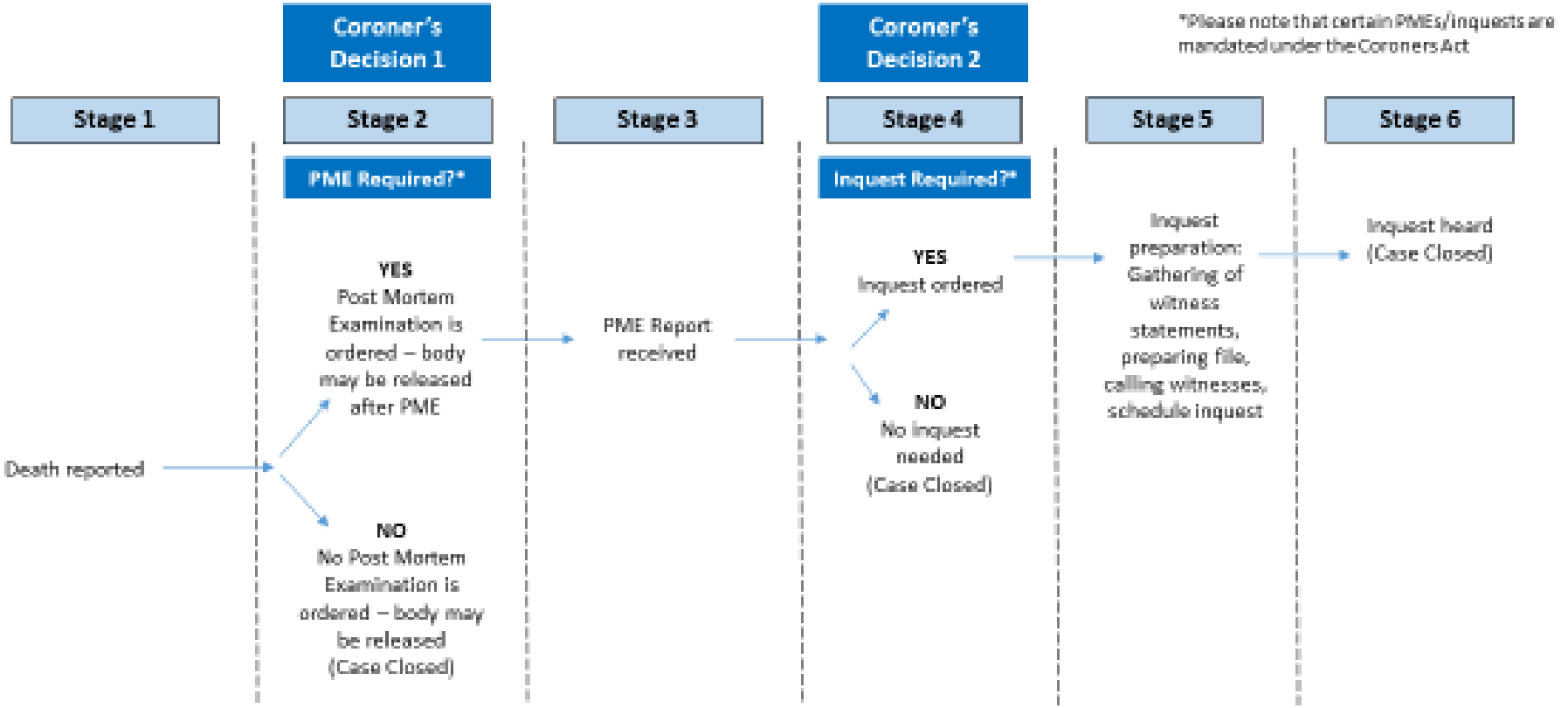

Figure 1: Coronial death investigation flowchart

2. Pathology and Related Services

2.1. The post mortem-examination (PME) is one of the key pillars supporting a Coroner's death investigation process.

2.2. Under Section 2 of the Act, the definition of a PME includes, "…any ancillary examination by way of analysis, test or otherwise of the body or of material (whether of tissue, organs, biological fluids or other parts or contents of the body or of any other substance or thing relevant to such examination) carried out by an appropriately qualified registered medical practitioner or under his or her direction."

2.3. Over 95% of all PMEs carried out in Ireland every year are at the direction of a Coroner.[15]

2.4. Table 2 below shows the number of Coroner PME cases from 2018 to 2022. Since 2018, based on Coroners' annual returns data, the number of PME cases increased by over 2,000 (37%). See Appendix 4 for a breakdown of PMEs by coronial district.

Year	PME cases (no.)	Increase in PME cases since 2018 (no.)	Increase in PME cases since 2018 (%)
2018	5,467	N/A	N/A
2019	5,724	257	4.7
2020	5,955	488	8.9
2021	6,678	1,211	22.5
2022	7,485	2,018	36.9

Table 2[16]: Coroner annual returns - Increase in coronial PME cases since 2018

2.5. There is no single cause for the increase in PME cases. However, the Coroners (Amendment) Act 2019 increased the range of reportable deaths and this has contributed to the increase.

2.6. The majority of PMEs are performed by pathologists who specialise in histopathology (the study of changes in tissues caused by disease).

2.7. PMEs are usually carried out in hospital mortuaries. In Dublin, PMEs also take place in the Dublin District Mortuary (DDM).

2.8. Pathologists are assisted by Anatomical Pathology Technicians (APTs). APTs perform a number of important functions in a mortuary including: receiving and storing bodies, preparing bodies for PMEs and reconstituting bodies after a PME.

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[15] P.10, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, approval date 13 February 2023.

[16] "Coroners Annual Returns 2018 – 2022"

Note: Coroners' annual returns data reflects the average number of PMEs per year. This is due to the fact that the figure is indicative of the year in which a death investigation was closed, either on foot of a PME report (i.e. when an inquest was not directed by the Coroner) or on conclusion of an inquest.

2.9. The completion of a PME in a timely manner is essential for the bereaved as the Coroner may then direct the release of the body and final arrangements can be made.

2.10. A Coroner must await receipt of the PME report before making a decision as to whether or not an inquest is required (unless the death belongs to a category for which an inquest is mandated under the Act). If a Coroner decides an inquest is not required, then the death investigation is finalised and a death certificate can issue.

2.11. There is no established timeframe by which a PME report must be received by a Coroner; the current typical waiting time is between 4 and 6 months.

2.12. In contrast, a number of Coroner districts in England and Wales can provide PME results in a significantly shorter timeframe. In Manchester, it takes 5-7 working days (after receipt of medical information from the deceased's GP) to provide family members with the results of the PME.[17] In South Wales it takes about 5 working days from the time a PME is ordered to when the report is received by the Coroner.[18] In West Yorkshire, "A report is delivered to the Coroner by the pathologist within a few weeks of the post-mortem examination to confirm or reveal the medical cause of death."[19]

2.13. In New Zealand it can take several months for a completed PME report to be sent to the Coroner. However, immediately after the PME the pathologist will prepare a provisional PME report for the Coroner. A Coroner case manager will then share the findings of the provisional PME report, including a provisional cause of death, with the family.[20]

2.14. The ability of the Consultant Histopathologist to finalise a PME report is dependent upon the provision of a number of ancillary tests such as histology; toxicology; microbiology; neuropathology; radiology and the availability of secretarial / administrative support.

2.15. There are challenges to securing the delivery of the Coroner PME service. A shortage in Consultant Histopathologists overall within the healthcare system[21] is exacerbated within the Coroner PME context by the fact that the service is provided to Coroners on a grace and favour basis only.

2.16. Increased pressures on pathologists to provide treatment to the living, and the retirement of pathologists are also contributing factors.

2.17. A number of hospitals have withdrawn the PME service to Coroners. In Dublin the withdrawal of such services has led to more bodies being directed to the DDM for PME; 1,053 PMEs were completed in the DDM in 2022 compared to 557 in 2018 and 708 in

[17] Manchester City Council, When death occurs, downloaded 14 August 2023.
[18] Coroner for South Wales Central Area, What Happens if a Post Mortem Examination is Needed?, downloaded 14 August 2023.
[19] City of Bradford Metropolitan District Council, The Coroner's Office and Inquests, downloaded 14 August 2023.
[20] Victim Support, The post-mortem, downloaded 14 August 2023.
[21] P.43, National Doctors Training and Planning, Specialties of Pathology: An Expert Stakeholder Informed Review, April 2023.

2019.[22] This increased workload has on occasion led to longer waiting times for the completion of a PME and thereafter the release of the body to families.

2.18. In Cork the majority of PMEs are carried out by one pathologist, whilst in another part of the country locum pathologists provide the PME service to Coroners.

2.19. It should be noted that the Office of the State Pathologist (OSP) carries out all PMEs in respect of criminal, suspicious or unusual deaths. The OSP is co-located with the DDM.

2.20. Pathologists themselves are becoming increasing less likely to perform Coroner PMEs. This is due to a number of factors (in no particular order):

- Dissatisfaction with rates of remuneration. Currently pathologists are paid on a fee per item basis for conducting Coroner directed PMEs
- Highly demanding workloads;
- Increased number of Coroner directed PMEs;
- The preparation and time required to attend inquests;
- Lack of administrative support.[23]

2.21. The Royal College of Physicians of Ireland (RCPI) Faculty of Pathology is, "a postgraduate medical training college dedicated to ensuring that doctors have the skills to provide patients with the best possible care."[24] The Histopathology Standing Committee (HSC) within the Faculty, conducted surveys in 2020 to understand the views of trainees and consultants in histopathology in relation to the coronial autopsy service.[25] In 2022 the RCPI published a report which made recommendations based on the survey findings.

2.22. The RCPI report noted that, "*If the trend of withdrawing services to the coroners continues, there will not be enough histopathologists in the future to do all the coronial autopsies required within a reasonable time frame."*[26] This will not only impact Coroners but will have knock on effects on the time taken to release of bodies to family members, the production of PME reports, the holding of inquests, and the issuing of death certificates.

Ancillary Services

2.23. The Coroner PME service is also facing difficulties in the provision of supporting services to the pathologist.

2.24. Histopathology examination (the study of bodily tissue) is undertaken in a laboratory setting, usually within a hospital environment. There is no single SLA or contractual agreement in place for the delivery of histology services to all Coroners. Due to internal demands in respect of caring for the living, some hospitals do not provide this service for Coroners. The Dublin District Coroner engages the services of the Royal Victoria Eye and

[22] Data provided by OSP, April 2023.
[23] Reasons provided through engagement with pathologists, Coroners, and the Standing Committee on the Provision of Coroner Directed Post-Mortems.
[24] RCPI, About Us, downloaded 6 September 2023.
[25] P.5, RCPI, Faculty of Pathology "Review of the Provision of Coronial Autopsy Service - Histopathology Standing Committee", January 2022.
[26] P.28, RCPI, Faculty of Pathology "Review of the Provision of Coronial Autopsy Service - Histopathology Standing Committee", January 2022.

Ear Hospital. Other Coroner districts utilise services in hospital laboratories whilst Coroners in the south of the country have engaged a private contractor.

2.25. The OSP has one full time laboratory technician who processes all histology samples from an onsite laboratory.

2.26. Whilst all toxicology is carried out by the State Laboratory, the increasing number of requests for toxicology tests has placed a strain on this service. This results in longer waiting times.

2.27. Post-mortem X-rays or computed tomography (CT) scanning can be utilised in complex trauma cases, gunshot or explosive injuries. This delivery of these services is presently dependent on the availability of hospital facilities.

2.28. There can also be difficulties in securing biochemistry testing, e.g. testing of glucose, electrolyte (sodium, chloride, potassium).

2.29. Access to experts in the field of paediatric and perinatal pathology is also challenging to secure due to a shortage in relevant specialities.

The future of PME and related services

2.30. The demand for PMEs within the death investigation process will remain; as a consequence, the demand for pathologists and APTs, ancillary testing services, mortuary facilities, administrative and family bereavement supports will also remain crucial.

2.31 The newly reformed coronial system must secure the delivery of pathology and ancillary services for Coroners. How this can be best achieved falls for consideration. Here again recourse to how other jurisdictions manage the delivery of these services as part of their death investigation process provides valuable insight.

2.32. Appendix 5 provides an overview of how the PME service is provided in five other jurisdictions. As illustrated, some other jurisdictions have a centralised pathology service which includes the delivery of ancillary testing facilities and CT scanning with administrative supports being provided through a dedicated autopsy facility. In other jurisdictions the service is being provided through a series of long-standing contracts / SLAs with individual hospitals.

2.33. The RCPI Report proposes the following approach: *"Initially a hub and spoke model, where a group of collaborating hospitals includes a university teaching hospital…Ultimately this could evolve into a regionalised autopsy service where the main hospital base is a centre of excellence and works closely with the forensic pathology service. Such collaborative groups would ensure access on a regional basis to specialist expertise in neuropathology, perinatal and paediatric pathology and allow the development of radiology support services."*[27]

[27] P.6-7, RCPI, Faculty of Pathology "Review of the Provision of Coronial Autopsy Service - Histopathology Standing Committee", January 2022.

2.34. An alternative proposal is for a central pathology service to take responsibility for the provision of all coronial PME and ancillary tests. This option would involve the provision of a suitable facility, pathologists, APTs, laboratory and administrative supports.

3. Reportable Deaths

3.1. Section 16B of the Act prescribes categories of persons who are obliged to report deaths to a Coroner for the district in which the body is lying.

3.2. The following types of deaths must be reported to the Coroner:

- Sudden, unnatural, violent, or unexplained deaths (where a doctor cannot sign a Death Notification Form)
- Deaths where the doctor has not attended to the deceased in the last month
- Deaths in certain other categories (see below)

3.3. The Coroners (Amendment) Act 2019 increased the range of reportable deaths. Amongst other things, the Act broadened the Coroners' powers relating to mandatory reporting and inquest of maternal deaths, deaths in custody or childcare situations.[28]

3.4. The Act further provided for mandatory reporting to a Coroner of a stillbirth, death intrapartum, or infant death (i.e. a perinatal death).[29]

3.5. Table 3 shows the percentage of registered deaths reported to Coroners for the period 2018 - 2022. Prior to the 2019 Act, ~53% of deaths were reported to a Coroner whereas post the 2019 Act, ~70% are reported

	Deaths registered	Deaths reported to Coroners	%
2018	31,140	16,383	52.61
2019	31,184	16,704	53.57
2020	31,765	21,965	69.15
2021	33,055	23,736	71.81
2022	35,477	24,778	69.84

Table 3[30]: Deaths registered and reported to Coroners 2018 - 2022

3.6. Ireland has the highest percentage of registered deaths reported to Coroners compared to five other jurisdictions (Northern Ireland, England and Wales, New Zealand, Victoria and British Columbia), see table 4 below;

[28] DoJ, Minister Flanagan announces final commencement of provisions of the Coroners (Amendment) Act 2019, 28 June 2021.

[29] Data from Coroners' annual returns shows an increase in the number of deaths reported since 2018. The Coroners (Amendment) Act 2019 commenced in September 2019, therefore the full impact of the increased death reporting requirements in the Second Schedule would only be fully reflected from 2020 onwards. The impact of COVID-19 (as a notifiable disease, all deaths wholly or partly due to COVID-19 are reportable to a Coroner) should also be considered.

[30] **Sources:** coroners.ie, Coroners' Annual Returns 2018 – 2022 and CSO Table VSA03

Note: Coroners' annual returns total deaths reported data reflects the year in which a death investigation was closed, either following a death report, on foot of a PME report (i.e. when an inquest was not directed by the Coroner), or on conclusion of an inquest.

Jurisdiction	Population	Registered deaths	Death rate (%)	Deaths reported to Coroner	Registered deaths reported to Coroner (%)
Ireland (2022)	**5,149,139[31] (2022)**	**35,477[32] (2022)**	**0.69**	**24,778[33] (2022)**	**70**
Northern Ireland (2022-2023)	1,910,500[34] (2022)	17,159[35] (2022)	0.90	4,914[36] (2022-23)	29
England and Wales (2022)	59,641,800 [37] (2022)	577,160[38] (2022)	0.97	208,400[39] (2022)	36
Canada - British Columbia (2020)	5,155,495[40] (2020)	41,332[41] (2020)	0.80	2,674[42] (2020)	6
Australia – Victoria (2021-2022)	6,704,300[43] (2022)	48,001[44] (2022)	0.72	7,200[45] (2021-2022)	15
New Zealand (2021)	5,116,400 (2021)[46]	34,932[47] (2021)	0.68	4,985[48] (2020-2021)	14

Table 4[49]: Percentage of deaths reported to Coroners in Ireland and five other jurisdictions

3.7. The range of circumstances for which a death is reportable to a Coroner in Ireland is higher than in comparable jurisdictions. Consideration should be given to the level of death reporting in this jurisdiction - is it too high, about right, or indeed is there an argument to introduce a requirement that all deaths be notified to a newly established Coroners' Agency.

4. Inquests

4.1. An inquest is an inquiry into a death reported to a Coroner, conducted in public in order to establish the identity of a deceased, the cause of death and to the extent the Coroner

[31] CSO, Press Statement Census of Population 2022 - Summary Results, 30 May 2023.
[32] CSO, Vital Statistics Yearly Summary 2022, 26 May 2023.
[33] coroners.ie, Coroner's Annual Returns 2022, 21 March 2023.
[34] NISRA, 2022 Mid-year Population Estimates for Northern Ireland, 31 August 2023.
[35] NISRA, Monthly Death Registrations, 11 August 2023.
[36] P.128, NICTS, Annual Report and Accounts 2022-2023, 1 July 2022.
[37] ONS, England and Wales population mid-year estimate, 21 December 2022.
[38] ONS, Deaths registered summary statistics, England and Wales: 2022 edition of this dataset, 11 April 2023.
[39] Ministry of Justice, National statistics Coroners statistics 2022: England and Wales, 11 May 2023.
[40] Statistics Canada, Population estimates on July 1st, by age and sex, 21 December 2022.
[41] Statistics Canada, Deaths, by place of residence and place of occurrence, 8 September 2023.
[42] Statistics Canada, Coroner and medical examiner investigated deaths and mortality rates, by age group, 17 November 2022.
[43] ABS, National, state and territory population, 15 June 2022.
[44] BDMV, Deaths registered per month, August 2023.
[45] Coroners Court of Victoria, Annual Report 2021-2022, November 2022.
[46] Stats NZ, Population summary figures, 20 February 2023.
[47] Stats NZ, Deaths increase as population ages, 17 February 2022.
[48] Office of the Chief Coroner New Zealand, Annual Report 2020/21, November 2021.
[49] Note: Most recent same year data used for each jurisdiction.

believes necessary, the circumstances of the death. An inquest may be held with or without a jury. A verdict is returned at the end of an inquest.

4.2. An inquest is an inquisitorial process whereby the Coroner is actively involved in trying to determine the facts of a death. It is not an adversarial process and does not involve a determination in respect of criminal or civil liability and so process and procedure varies. The fact that a person cannot be blamed or exonerated at an inquest is not subject to consultation.

The role of AGS

4.3. Members of An Garda Síochána (AGS) act as agents of the Coroner when investigating deaths reportable to a Coroner. The AGS, when reporting a death to a Coroner may provide some or all of the following information, depending on what details are available to them:

- Personal details of the deceased;
- Circumstances of the case;
- Details of any marks or injuries on the body;
- Medical history;
- Next of kin details;
- The names of any Gardaí who attended the scene.

4.4. A member of AGS may organise a formal identification of the body. The Coroner must be absolutely certain of the identity of a deceased before the body can be released to the family.

4.5. In cases where it is not possible to visually identify a person, DNA testing (for comparison with a close family member) is required. For DNA testing tissue samples are taken to Forensic Science Ireland (FSI) for analysis and recorded on the FSI database. AGS typically arrange for a close relative to be swabbed and sent to FSI for comparison. FSI will then send a report to the Coroner and AGS.

4.6. For inquest cases, AGS will prepare a report for the Coroner. The content of the AGS report will vary depending on the complexity of a case. Statements taken by AGS during the investigation into the death will be transcribed in the form of depositions to be read into evidence at the inquest.

4.7. AGS also plays a lead role when a jury is required for an inquest.

Jury Selection

4.8. An inquest may be held with or without a jury at the discretion of the Coroner. However, a jury must be empanelled in certain circumstances: These include where death was due to homicide, or occurred in prison, or resulted from an accident at work. A jury is also necessary if a death occurred in circumstances, the continuance or possible recurrence of which might be prejudicial to the health or safety of the public or any section of the public. Under Section 41 of the Act, a Coroner's jury shall consist of not less than six and not more than twelve persons.

4.9. AGS have a role in the assembly or summonsing juries for inquests. The current method of selecting a jury for an inquest is provided for under Section 43 of the Act. This provides

for the Coroner to inform a member of AGS to "assemble" a jury. There is no guidance as to how the selection process should operate and no provision for random selection.

4.10. This contrasts with the system for jury selection under the Juries Act 1976 whereby a process of random selection from Electoral Registers by County Registrars is prescribed. Such a selection process aims to ensure the jury selected is representative of society as a whole.

Inquest Recommendations

4.11. As noted by an IHREC information note, "Sometimes the coroner or the jury attaches what are known as "riders" or "recommendations" to the inquest verdict. These riders or recommendations are normally of a general character and may be designed to help prevent further deaths."[50] Section 31 of the Act refers to riders and recommendations.

4.12. There is no central structure or system for recording recommendations from Coroners and no way of monitoring their implementation.

4.13. In the Australian state of Victoria, recommendations can be made to any Minister, public statutory authority or entity that may help prevent similar deaths. A body who receives a recommendation from a Coroner must respond, in writing, within three months stating what action, if any, has or will be taken. The Court publishes inquest findings with recommendations and the subsequent responses on its website.[51]

4.14. The Coronial Services of New Zealand website provides a link to inquest findings, including any recommendations, on its website. The Coroner Service also publishes a quarterly summary of Coroners' recommendations.[52]

Legal Aid

4.15. An inquest is not adversarial; it is an inquisitorial process that aims to establish the facts of a death. No person at an inquest is required to defend him/herself against possible findings of civil or criminal liability. Legal aid is not provided as a right to bereaved families.

4.16. A family member may apply to the Coroner for an application to be made to the Legal Aid Board, on their behalf. A Coroner has discretion to make this application on the family's behalf in all circumstances except those provided for in Section 60(5) of the Act, whereby a Coroner is required to make the application. The application is subject to means testing by the Legal Aid Board.

4.17. Coroners granted 27 requests for legal aid in 2022 and 15 requests in 2023 (up to the end of August). The number of death investigations in which an inquest was heard in 2022 (2,435 cases), indicated that ~1% involved an application for legal aid.

4.18. While figures are not available in this regard, the presence of legal representation at Coroners inquests is becoming more common.

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[50] P.20 IHREC, Information on the Rights of Families at Inquest, May 2022.
[51] Coroners Court of Victoria, Findings, downloaded 28 June 2023.
[52] Coronial Services of New Zealand, Findings & Recommendations, 21 December 2022.

Review of Coroner Decisions

4.19. Currently, a person who is dissatisfied with a decision of a Coroner may apply to the High Court for Judicial Review (JR) of that decision. While the legislation provides for JR proceedings to be initiated, if leave is granted to bring JR proceedings, the Judge will provide a determination on costs at conclusion of the JR.[53] There is no other review process in respect of a Coroner's decision or a verdict in a Coroner's death investigation.

4.20. In England and Wales the situation is similar to Ireland where there is no right of appeal against a Coroner's decision but a person may apply for a Judicial Review. The Coroners and Justice Act 2009, "*…provided for a new system of appeal against some decisions and determinations made in connection with investigations and inquests into deaths.*" This section was never brought into effect and has since been repealed."[54] Respondents to a House of Commons report noted that an appeals system, as envisaged under the 2009 Act would require staffing, resources, and financing. [55]

4.21. Northern Ireland also only allows Coroners' decisions or findings to be challenged by way of a Judicial Review.[56]

Inquest Facilities

4.22. Whilst, an inquest can provide much needed answers for a bereaved family it can often be a stressful and upsetting experience during which they may relive the circumstances surrounding the death of their loved one. Accordingly, it is important that an inquest is held in an appropriately respectful environment.

4.23. The Dublin Coroner has a co-located office and Courtroom. This facility has limited capacity and the Richmond Education Centre is also being used to hold inquests for the Dublin District. The facility has co-located office space for the Coroner, and a space which can be utilised by families and/or legal advisors.

4.24. Inquests in districts other than Dublin may be held in local Courthouses. However there is no guarantee of the availability of courtrooms for Coroners and in such instances a Coroner may have to source an alternative venue.

4.25. Facilities for Coroner's inquests should where possible, include courtrooms, family rooms, appropriate public waiting areas, meeting rooms and rooms for ancillary services such as bereavement support. Providing an appropriate space to support the dignity of grieving families is paramount in terms of providing appropriate facilities for Coroners inquests.

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[53] Order 84 of the Superior Court Rules sets out Judicial Review procedures.
[54] P.3, House of Commons Library, Challenging coroners' decisions, 5 March 2020.
[55] P.30, House of Commons Justice Committee, The Coroner Service: First Report of Session 2021-22, 18 May 2021.
[56] P.8, Northern Ireland Courts and Tribunals Service, Coroners Inquest, June 2013.

Appendix 1: Glossary

Anatomical Pathological Technician (APT) Perform a number of functions in a mortuary including, receiving and storing bodies, preparing bodies for PMEs and reconstituting bodies after a PME.
Autopsy See "post-mortem examination" (PME) below.
Coroners Society of Ireland (CSoI) The representative body for Coroners in Ireland.
Consultant A consultant is a registered medical practitioner who, by reason of their training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for service users in their care, or that aspect of care on which they have been consulted, without supervision in professional matters by any other person.[57]
CT scan A computerised tomography (CT) scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside your body.[58]
Death certificate A death certificate is the official document for confirming the registration of a death. If a death is reported to the Coroner and it is the subject of a PME or inquest, the death will be registered when the Coroner issues his certificate after the PME or inquest.[59]
District The coroner's district refers to the geographical area covered by a coroner.
Family May include immediate biological family and / or other relatives, spouses, partners (including civil, same sex and de facto partners). Coroners (Amendment) Act 2019, definition of family member, in relation to a deceased person, means: (a) a parent, grandparent, child, brother, sister, nephew, niece, uncle or aunt, whether of the whole blood, of the half blood or by affinity, of the person, (b) a spouse, a civil partner within the meaning of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010 or a cohabiting partner of the person, (c) any other person who is ordinarily a member of the person's household, or any child who has been placed in foster care with the person or any person referred to in paragraphs (a) to (c), and includes a reference to any such member of the person's family who is adopted.[60]
Forensic Science Ireland (FSI) FSI is an associated office of the Department of Justice. FSI provides a scientific service to Coroners by analysing DNA samples submitted by Coroners.
Histology

[57] P.2-3, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[58] Mayo Clinic, CT scan, 6 January 2022.
[59] Coroners.ie, Register a death with the Coroner, 6 December 2021.
[60] P.3, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.

The study of the structure of tissues by means of special staining techniques combined with light and electron microscopy.[61]
Histopathology The branch of medicine concerned with the changes in tissues caused by disease. It involves the microscopic examination of human tissue for the diagnosis of disease (histology).[62]
Histopathologist A qualified pathologist who has training and experience in the performance of microscopic examination of biological samples and post mortem examinations, and who is a Registered Medical Specialist on the Register of Medical Specialists (Division of Histopathology) of the Medical Council of Ireland.[63]
Infant death Infant death means the death of a live born child occurring immediately after birth or within 365 days of birth. (Coroners (Amendment) Act 2019)[64]
Inquest An inquest is an inquiry in public by a Coroner, sitting with or without a jury to establish the identity of the deceased person, how, when and where the death occurred and the circumstances in which the death occurred and to make findings and return a verdict.[65]
Interim death certificate An interim death certificate issued by a Coroner certifies the fact of a person's death. The certificate is not provided for in statute, but may be of assistance to next of kin when dealing with the Department of Social Protection, Probate (Wills) Office, Post Office, banks and other financial institutions whilst awaiting the full death certificate from the Civil Registration Service following the completion of the Coroner's investigation.[66]
Intrapartum During labour and delivery or childbirth.[67]
Jury selection (for civil and criminal trials) The Juries Act 1976 provides for a process of random selection from Electoral Registers by County Registrars for criminal and civil trials. This is in contrast with the process of assembling or summonsing juries for coronial inquests by a member of AGS (or GSOC in certain circumstances).
Jury summons (for Inquests) The assembly of a jury for an inquest is provided for under Section 43 of the Act - this provides for the Coroner to inform a member of AGS (or GSOC in certain circumstances) to "assemble" a jury of not less than six and not more than twelve persons qualified to be jurors at the inquest. The member of AGS may if he or she thinks it necessary, serve summonses in the prescribed form to ensure their attendance.
Late maternal death A late maternal death means the death of a woman occurring more than 42 days and less than 365 days after the end of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental

[61] P.4, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[62] P.4, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[63] P.4, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[64] P.5, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[65] coroners.ie, Common terms associated with the Coroner Service, 6 December 2021.
[66] coroners.ie, Common terms associated with the Coroner Service, 6 December 2021.
[67] P.5, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.

causes and, without prejudice to the generality of the foregoing, includes a direct maternal death or an indirect maternal death occurring during that period. (Coroners (Amendment) Act 2019)[68]
Local Authorities Local Authorities operate within specific geographic areas called local government areas. Each local government area has a council.[69]
Maternal death A maternal death means 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. (Coroners (Amendment) Act 2019)[70]
Office of the State Pathologist (OSP) The Office of the State Pathologist (OSP) is an independent body under the aegis of the Department of Justice. The OSP provides the State with a national forensic pathology service. The main activity of the OSP is the performance of post mortem examinations in cases of sudden, unexplained death where a criminal or suspicious element is present (referred to as "State" cases). In some cases, this will involve a visit to the scene of death. The pathologists deal with homicides as well as a wide range of natural and unnatural deaths (for example: road traffic accidents, other accidents, drug-related and prison deaths) as instructed by the Coroner.[71]
Pathologist A pathologist is a doctor who is trained to identify whether a violent event may have occurred, or whether there is disease in the organs and tissues of the deceased. A doctor qualified in the study of pathology. For the purposes of this document 'pathologist' should be interpreted as histopathologist unless otherwise specified.[72]
Pathology Pathology is the study of disease.[73]
Paediatric Refers to infants, children and adolescents from birth up to the age of 16.[74]
Perinatal The perinatal period is that which occurs in, is concerned with, or is in the period around the time of birth. It generally refers to the period from 24 weeks gestation up to seven days after birth. The way the term is used varies widely for example, perinatal pathology tends to refer to all foetal and placental pathology irrespective of gestational age (adapted from the Merriam-Webster dictionary). The first seven days after birth is also known as the early neonatal period.[75]
Post-mortem examination (PME) A PME is a special medical examination of a body carried out by a pathologist to find out the cause of death. A detailed examination of a body after death, ordered by a coroner in order to determine the cause of death and any contributing factors. It involves:

[68] P.5, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[69] Local Government Information Unit, Local government facts and figures: Ireland, downloaded 15 August 2023.
[70] P.5, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[71] OSP, Office of the State Pathologist, 23 February 2023.
[72] P.6, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[73] P.6, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[74] P.6, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[75] P.6, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.

• the noting and description of marks or injuries on the body. • the dissection of organs from the head, chest and abdomen. • ancillary investigations where appropriate to include toxicology, histopathology, microbiology and any other investigations that may be required. This is a compulsory PME required by law and consent from the deceased's family is not required.[76]
Post-mortem examination (PME) report The report compiled from information obtained as a result of PME. A PME report includes: a. Basic demographic details. b. A brief clinical summary. c. Description of external and internal examinations. d. A report of histology and other investigations, where appropriate. e. A summary of findings. f. A concluding commentary. g. A 'cause of death' in the standard international form for the 'medical certificate of the cause of death'.[77]
Radiology Any imaging carried out on the deceased's remains following death, for example, X-rays, CT scan, and MRI.[78]
State Laboratory The State Laboratory is a scheduled office under the aegis of the Department of Public Expenditure, NDP Delivery and Reform. It is the Government's principal analytical chemistry laboratory and provides forensic toxicology services to support Coroners' investigations into cases of unexplained deaths.[79]
Stillbirth A baby delivered without signs of life from 24 weeks' gestation and/or with a birth weight of ≥ 500 grams.[80]
Toxicology A toxicology test is performed by a toxicologist who helps a pathologist detect chemicals and substances such as alcohol, poisons or medications.[81]

[76] P.7, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[77] P.7, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[78] P.7, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[79] The State Laboratory, Homepage, downloaded 15 August 2023.
[80] P.8, HSE, HSE National Clinical Guidelines for Post Mortem Examination Services, 15 August 2023.
[81] coroners.ie, Common terms associated with the Coroner Service, 6 December 2021.

Appendix 2: Consultation Questionnaires

2A. Consultation Part 1 Questionnaire

The focus of **Consultation Part 1** is to gather insights from the lived experience of those who having suffered the loss of a loved one and have interacted with the Coroner Service.

With this in mind, questions have been developed to capture past experiences and garner views and opinions of interactions with the Coroner Service by bereaved family and friends in terms of what worked well and whether there are elements which could be enhanced into the future.

Certain individuals may wish to respond to both Consultation Part 1 and Part 2.

[*Filter Question*]

Please tick **one** of the boxes below.

(a) I have interacted with the Coroner Service due to the loss of a loved one and I **have not** attended an inquest hearing? An inquest is a public hearing where a Coroner reads out a formal verdict at the end of the proceedings. ☐ [answer Part 1.1. only]

(b) I have interacted with the Coroner Service due to the loss of a loved one and I **have** attended an inquest hearing? An inquest is a public hearing where a Coroner reads out a formal verdict at the end of the proceedings. ☐ [answer Part 1.2. only]

[*Part 1.1.] Interaction with the Coroner Service*]

1. Prior to your interaction with the Coroner/Coroner Service, what was your knowledge of the service?

(a) No knowledge ☐

(b) Some knowledge ☐

(c) A high level of knowledge ☐

2. Which of the following parties communicated with you throughout the Coroner's inquiry into the death of your loved one (tick boxes as appropriate)?

(a) The Coroner/Coroner's office ☐

(b) An Garda Síochána ☐

(c) A legal representative ☐

(d) Other – please specify ☐ [Free text box]

Was the level of communication adequate?

(a) Yes ☐

(b) No ☐

4. (a) Was a post-mortem examination (PME) on the body of the deceased directed by the Coroner?

(i) Yes ☐

(ii) No ☐ [skip to Q.5.]

(b) Did you understand why a PME was required?

(i) Yes ☐
(ii) No ☐

(c) How long did it take to receive the results of the PME?
(i) 0-3 months ☐
(ii) 3-6 months ☐
(iii) 6-12 months ☐
(iv) More than 12 months ☐

(d) Who (if anyone) explained the results of the PME to you?
(i) Coroner ☐
(ii) Medical professional ☐
(iii) Other – please specify ☐ [Free text box]
(iv) Nobody ☐

5. Please provide any views, opinions or proposals on how a reformed Coroner Service should be structured and operated. [Free text box]

6. Finally, where did you first hear about this public consultation on the reform of the Coroner Service?
(a) Newspaper article ☐
(b) Social media ☐
(c) Word of mouth ☐
(d) Don't know/can't remember ☐
(e) Other – please specify ☐ [Free text box]

Thank you for taking the time to complete this questionnaire. Your views and opinions will help inform the Department of Justice's programme of reform to address identified issues and drive innovative change across the Coroner Service. The public consultation process will be vital in identifying how the Coroner Service will operate in the future. The Department will carefully examine all responses after the consultation closes on Friday 19th January 2024.

[Part 1.2.]]The inquest

1. Prior to your interaction with the Coroner/Coroner Service, what was your knowledge of the service?
(a) No knowledge ☐
(b) Some knowledge ☐
(c) A high level of knowledge ☐

2. Which of the following parties communicated with you throughout the Coroner's inquiry into the death of your loved one (tick boxes as appropriate)?
(a) The Coroner/Coroner's office ☐
(b) An Garda Síochána ☐
(c) A legal representative ☐
(d) Other – please specify ☐ [Free text box]
Was the level of communication adequate?

(a) Yes ☐
(b) No ☐

3. (a) Was a post-mortem examination (PME) on the body of the deceased directed by the Coroner?
(i) Yes ☐
(ii) No ☐ [skip to Q.4.]
(b) Did you understand why a PME was required?
(i) Yes ☐
(ii) No ☐
(c) How long did it take to receive the results of the PME?
(i) 0-3 months ☐
(ii) 3-6 months ☐
(iii) 6-12 months ☐
(iv) More than 12 months ☐
(d) Who (if anyone) explained the results of the PME to you?
(i) Coroner ☐
(ii) Medical professional ☐
(iii) Other – please specify ☐ [Free text box]
(iv) Nobody ☐

4. How long did the inquest into the death of your loved one take?
(a) One day ☐
(b) One to three days ☐
(c) More than three days to one week ☐
(d) More than one week

5. Where was the inquest held?
(a) Dublin District at Store Street
(b) Dublin District at Richmond Education Centre ☐
(c) Courthouse ☐
(d) Hotel ☐
(e) Local hall or clubhouse ☐
(f) Other – please specify ☐ [Free text box]

6. What was your impression of the suitability of the inquest venue?
(a) Suitable ☐
(b) Unsuitable ☐

7. Was the information about the inquest process explained to you in an easy to understand way?
(a) Yes ☐
(b) No ☐

8. Did you have legal representation at the inquest?

(a) Yes ☐

(b) No ☐

If you answered "No" do you feel that legal representation was required?

(a) Yes ☐

(b) No ☐

9. Please provide any views, opinions or proposals on how a reformed Coroner Service should be structured and operated. [Free text box]

10. Finally, where did you first hear about this public consultation on the reform of the Coroner Service?

(a) Newspaper article ☐

(b) Social media ☐

(c) Word of mouth ☐

(d) Don't know/can't remember ☐

(e) Other – please specify ☐ [Free text box]

Thank you for taking the time to complete this questionnaire. Your views and opinions will help inform the Department of Justice's programme of reform to address identified issues and drive innovative change across the Coroner Service. The public consultation process will be vital in identifying how the Coroner Service will operate in the future. The Department will carefully examine all responses after the consultation closes on Friday 19th January 2024.

2B. Consultation Part 2 Questionnaire

Consultation Part 2 is targeted towards interested parties who are involved either directly or indirectly in supporting the delivery of the Coroner Service.

Questions here have been developed to garner views and opinions of stakeholders on specific issues as discussed in chapters 1 – 4 of the consultation document.

Certain individuals may wish to respond to both Part 1 and Part 2.

Part 1: Structure and Roles

1.1. Should a standalone independent Coroner Service be established?

(a) Yes ☐ - Please give reasons for your response [Free text box]

(b) No ☐ - Please give reasons for your response [Free text box]

1.2. What services/functions should such a body be responsible for? [Free text box]

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

1.4. How should the following supports be provided within the death investigation process? E.g. centralised/regionalised, through existing State bodies, through a newly established body etc.

A. Medical advice support [Free text box]
B. Investigative support [Free text box]
C. Legal advisory support [Free text box]
D. Administrative support [Free text box]
E. Family liaison support [Free text box]

1.5. What should the responsibilities of a Chief Coroner be? [Free text box]

Part 2: Pathology and Related Services

2.1. How should the following services be delivered on a sustainable basis for Coroner directed PMEs?

A. Pathology service [Free text box]
B. Mortuary facilities[Free text box]
C. Specialist pathology perinatal / neuropathology [Free text box]
D. Ancillary testing services (histology, toxicology, microbiology) [Free text box]
E. X-ray / CT scanning [Free text box]
F. Family liaison & bereavement services [Free text box]

Part 3: Reportable Deaths

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

(a) Yes ☐ - Please give reasons for your response [Free text box]

(b) No ☐ - Please give reasons for your response [Free text box]

If “Yes” should it be revised:

(a) Upwards ☐ - Please give reasons for your response [Free text box]

(b) Downwards ☐ - Please give reasons for your response [Free text box]

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

(a) Yes ☐ - Please give reasons for your response [Free text box]

(b) No ☐ - Please give reasons for your response [Free text box]

Part 4: Inquests

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

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

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

4.4. What alternative supports could be provided to families to minimise the need for legal representation? [Free text box]

4.5. What is the best approach to recording and monitoring Coroner recommendations? [Free text box]

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

(a) Yes ☐ [see 4.7 below]

(b) No ☐ - Please give reasons for your response [Free text box]

4.7. If the answer to 4.6. above is “yes”:

(a) What form should this review process take? [Free text box]

(b) What “decisions” should be subject to review? [Free text box]

Part 5: Other

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

5.2. Capacity in which you are responding:

(a) Coroner ☐

(b) Medical professional ☐

(c) Member of the public ☐

(d) Bereavement/support group ☐

(e) Member of An Garda Síochána or GSOC ☐

(f) Legal professional ☐

(g) Organisation/Public Body ☐ - please specify [Free text box] [Go to Q5.3.]

(h) Member of the media ☐

(i) Other – please specify ☐ [Free text box]

5.3. If you are willing to be contacted for further consultation, please provide an email address below.
Organisation email [Free text box] [Optional]

Thank you for taking the time to complete this questionnaire. Your views and opinions will help inform the Department of Justice's programme of reform to address identified issues and drive innovative change across the Coroner Service. The public consultation process will be vital in identifying how the Coroner Service will operate in the future. The Department will carefully examine all responses after the consultation closes on Friday 19th January 2024.

Appendix 3: Amendments to the Act, 2005-2020

Many of the recommendations of a 2000 Review of the Coroner Service related to the strengthening of the legal provisions regarding the work of the Coroner.

In this regard, there has been significant implementation of many of the relevant recommendations, sometimes to a greater extent than that envisaged by the Review, in the intervening period.

Such improvements were effected through amendments to the Coroners Act 1962, as can be seen in the table below:

Year	Amendment
2005	The Coroners (Amendment) Act 2005 ended the restriction on the number of medical witnesses allowed at inquest.
2011	The Civil Law (Miscellaneous Provisions) Act 2011 provided for the restructuring and amalgamation of coronial districts. Coroner districts within counties have been amalgamated as the opportunities have arisen. There were 48 districts in 2000, this has reduced to 37 in 2023.
2013	The Courts and Civil Law (Miscellaneous Provisions) Act 2013 provided for legal aid and legal advice by certification by the coroner to the Legal Aid Board in relation to inquests.
2019	The Coroners (Amendment) Act 2019 clarified, strengthened and modernised coroner's powers in the reporting, investigation and inquest of deaths. The scope of enquires at inquest was expanded beyond being limited to establishing the medical cause of death, to seeking to establish, to the extent the coroner considers necessary, the circumstances in which the death occurred. The Act also broadened the coroner's powers relating to mandatory reporting and inquest of maternal deaths, deaths in custody or childcare situations and significant new powers to compel witnesses and evidence at inquest.
2020	The Civil Law and Criminal Law (Miscellaneous Provisions) Act 2020 provided, among other items, for the assignment and appointment of temporary coroners to act simultaneously with other coroners in exceptional circumstances to be utilised as part of the national response to the COVID-19 pandemic.

Appendix 4: Caseloads and Population Sizes for all Districts

The coronial case data in the table below is based on 2022 Coroner annual returns. It should be noted that Coroners' annual returns data reflects the year a case was closed. A PME may have been ordered in 2021 but if the PME report is received by the Coroner and a death certificate is issued after receipt of a PME report (or an inquest is held) in 2022 then the case will only be included in the 2022 annual return.

The population data is Census 2022 data from the CSO. It is not possible to provide the population of coronial districts which are part of an administrative county with more than coronial district. Therefore, where there is more than one district in a county, the total county population is used to calculate the "Coroners per Person" figure.

The same person is Coroner for the districts of Offaly and Westmeath, and another person is Coroner for Leitrim and Sligo. However, as these are separate districts, each of the four districts has one Coroner in the "Coroners per District" column.

Coroner District	Report Only	Report and Post-Mortem	Report, Post-Mortem and inquest	Total Cases	Population	Coroners per District	Coroners per Person
CARLOW	137	31	16	184	61,968	1	61,968
CAVAN	220	41	36	297	81,704	1	81,704
CLARE	491	72	56	619	127,938	1	127,938
CORK CITY	858	315	284	1,457	224,004	1	224,004
CORK NORTH	259	49	32	340	360,152	1	120,051
CORK SOUTH	483	79	82	644		1	
CORK WEST	195	47	15	257		1	
DONEGAL	1,023	170	101	1,294	167,084	1	167,084
DUBLIN	4,807	1,752	830	7,389	1,458,154	4	364,539
GALWAY EAST	278	98	29	405	277,737	1	92,579
GALWAY NORTH	43	26	4	73		1	
GALWAY WEST	934	152	93	1,179		1	
KERRY NORTH	67	30	6	103	156,458	1	52,153
KERRY SOUTHEAST	243	78	8	329		1	
KERRY WEST	316	130	50	496		1	
KILDARE	494	172	44	710	247,774	1	247,774
KILKENNY	340	131	41	512	104,160	1	104,160
LAOIS	218	47	22	287	91,877	1	91,877

LEITRIM	76	26	7	109	35,199	1	35,199
LIMERICK	753	166	79	998	209,536	1	209,536
LONGFORD	100	8	14	122	46,751	1	46,751
LOUTH	378	122	92	592	139,703	1	139,703
MAYO	720	184	104	1,008	137,970	1	68,985
MAYO NORTH	64	19	14	97		1	
MEATH	350	71	55	476	220,826	1	220,826
MONAGHAN NORTH	48	24	10	82	65,288	1	32,644
MONAGHAN SOUTH	47	12	9	68		1	
OFFALY	343	98	20	461	83,150	1	83,150
ROSCOMMON	199	66	36	301	70,259	1	70,259
SLIGO	234	113	37	384	70,198	1	70,198
TIPPERARY	720	171	52	943	167,895	1	167,895
WATERFORD CITY	413	168	33	614	127,363	1	42,454
WATERFORD EAST	119	18	13	150		1	
WATERFORD WEST	46	11	5	62		1	
WESTMEATH	386	127	25	538	96,221	1	96,221
WEXFORD	577	146	51	774	163,919	1	163,919
WICKLOW EAST	238	67	26	331	155,851	1	77,926
WICKLOW WEST	76	13	4	93		1	
Total	**17,293**	**5,050**	**2,435**	**24,778**	**5,149,139**	**41**	**120,796**

Sources:
coroners.ie, Coroners' Annual Returns 2022, 21 March 2023.
Population data based on administrative counties: cso.ie, Census 2022 Table FY003A, 30 May 2023.

Appendix 5: Post-Mortem Examination Services in Five Jurisdictions

NORTHERN IRELAND	ENGLAND & WALES	CANADA - BRITISH COLUMBIA	AUSTRALIA - VICTORIA	NEW ZEALAND
PME Services • Mostly provided by the State Pathologist's Department (receives funding and administrative support from DoJ) at Regional Forensic Mortuary • Paediatric/ perinatal PMEs carried out in Liverpool due to lack of available pathologist in NI	**PME Services** • Provided by pathologists at request of Coroner, outside of contracts • Current shortage in pathologists available to carry out PMEs	**PME Services** • Provided by a forensic pathologist under contract with the Coroner Service	**PME Services** • Provided by the equivalent of the OSP (i.e. the Victorian Institute of Forensic Medicine (VIFM) as directed by Coroner • Co-located with purpose-built mortuary, laboratory, and court facility	**PME Services** Provided by 4 service providers across 10 hospitals (2018-2025 - extendable to 2031)
Forensic PME Services Provided by the State Pathologist's Department – all pathologists are forensic pathologists)	**Forensic PME Services** Provided by registered Home Office forensic pathologists	**Forensic PME Services** Provided by a forensic pathologist under contract with the Coroner Service	**Forensic PME Services** Provided by VIFM	**Forensic PME Services** Provided by forensic pathologists under contract
Histology, radiography, toxicology, etc. Forensic Science	**Histology, radiography, toxicology, etc.** • Histology/ radiography	**Histology, radiography, toxicology, etc.** • Unclear where histology/radiography performed.	**Histology, radiography, toxicology, etc.** Provided by VIFM	**Histology, radiography, toxicology, etc.**

Northern Ireland provides toxicology services to the State Pathologist	services arranged by Coroner/ pathologist • Toxicology services arranged by Local Authorities under contract	• Provincial Toxicology Centre also provides forensic toxicology analyses for the BC Coroners Service		Provided by 4 service providers
Mortuary provider Centralised Mortuary – Royal Victoria Hospital site	**Mortuary provider** Provided by Local Authorities/ local hospitals	**Mortuary provider** Provided by private independent licenced mortuary service provider	**Mortuary provider** Provided by VIFM	**Mortuary provider** Provided by 4 service providers