Death Investigation, Coroners' Inquests and the Rights of the Bereaved

A RESEARCH REPORT FOR
THE IRISH COUNCIL FOR CIVIL LIBERTIES

Phil Scraton and Gillian McNaull

Irish Council for
Civil Liberties

Coimisiún na hÉireann um Chearta an Duine agus Comhionannas
Irish Human Rights and Equality Commission

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Coronial inquests are inquisitorial, public, fact-finding hearings directed towards ascertaining the identity of the deceased and the time, place, cause and circumstances of death. These facts are often referred to as the 'who, when, where, what and how' of death; however, this categorical listing belies the sometimes controversial work of coroners, the facts they find and the processes through which they find them. There exists a potential for inquests to determine the truth of death through a process of public scrutiny, which has at its heart the prevention of avoidable death through the making of recommendations. However, this perspective must be balanced by acknowledging the damage wrought by coronial processes, including post-mortem practices, delays in inquests, adversarial inquest tactics and inequality of legal representation, which families, activists, campaigners, governments and practitioners have sought to address through reform.

Rebecca Scott Bray, 2020

Foreword

Over many years, the Irish Council for Civil Liberties (ICCL) has encountered numerous families in different circumstances who have lost loved ones in tragic circumstances. Consistently, cases have given rise to specific human rights issues concerning the causes of death. Families have also experienced further trauma and hardship as a consequence of the investigations that followed. In our work we have become keenly aware that our systems of investigating death are inadequate, and can compound and even aggravate the suffering of those affected by tragic loss of life.

Led by this experience, in 2018 ICCL joined together with Dr Vicky Conway of DCU and Prof Phil Scraton of Queens University Belfast to make an application to the Irish Human Rights and Equality Commission for grant support for a research project that would document the gap between Ireland's human rights obligations to effectively investigate deaths and the reality of those investigations as they are experienced. We are grateful to the Commission for their crucial support for this report.

The history of how the Irish inquest system has been neglected for many years is an urgent matter of public interest. The stories of those who have been through the system and of those who work in it demonstrate the ongoing human rights violations that flow from successive governments' failure to implement reforms that are both obvious and achievable. From the outset, ICCL believed that human rights improvements in the system of inquests is possible – and we have been impressed by the radical reform of the inquest system in the United Kingdom over recent decades in which Phil has played a significant role.

This report goes beyond demonstrating human rights failings. It sets out a comprehensive programme of reform, centred on 52 recommendations. These are addressed to Government and the Oireachtas, Coroners, the Garda, and the media. ICCL intends to use this report as the platform for a campaign to secure that reform. We received substantial grant support from Community Foundation Ireland for this campaign which will ensure its recommendations mark the beginning of a new system of investigating deaths in Ireland.

ICCL would like to thank in particular Phil Scraton and Dr Gillian McNaull for their exceptional work on this report, and also to Dr Vicky Conway who played a key role in the early stages of the project. We thank the current and former coroners who gave generously of their time and whose insights into the system are invaluable and lawyers who gave honest and frank views on their experience of the system. Most of all, ICCL thanks the families who shared their stories and their pain and loss. This report is for them.

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Executive Summary

KEY FINDINGS

Coroners are appointed by local authorities and are qualified lawyers or medical practitioners. In Ireland, they are overwhelmingly part-time appointments. Their main role is the investigation of sudden, unnatural, violent or unexplained deaths. They determine the identity of the deceased, when and where they died, and without establishing liability for the death, 'how' they died. Should the cause of death be unknown, sudden, unnatural, or in violent circumstances, the coroner will hold a post-mortem and decide on the appropriateness of holding an inquest. As discussed later, there are certain circumstances, such as deaths in prison, when inquests are mandatory. Inquests hear evidence from witnesses called by the coroner including those giving 'expert' opinion. The coroner calls and examines evidence, invites further examination from lawyers representing those given 'interested party' status, summarises the evidence, directs the jury on points of law, offers the jury a choice of short-form verdicts in line with the evidence heard and invites their comments and recommendations.

In 2000 a full and comprehensive review of Ireland's Coroner Service was published following informed, detailed research by a Working Group on behalf of the then Department of Justice, Equality and Law Reform. It was unequivocal in recommending 'radical reform and a major reconfiguration of the coroner service'. It noted that full realisation of its detailed proposals would be an evolutionary process but laid the ground for a 'clear strategy for change', expecting its longer term objectives to be achieved in full by 2020.

This research demonstrates that legal and procedural reform has fallen well short of that desired objective. There remains: no coherent national organisation of coroners working collectively under centralised direction; Gardaí continue to work as coroners' officers; the system of selecting coroners' juries remains inconsistent and in some Districts it is inappropriate that members of the local community are appointed repeatedly; there is a lack of centralised training for coroners appointed by local authorities; governance of the coronial system remains unclear; there has been minimal reorganisation of Districts and the bulk of coronial work is carried out by part-time coroners who are dependent on limited administration staff and Gardaí investigators.

The research findings detailed in this Report demonstrate that the Public Sector Duty, introduced under the Irish Human Rights and Equality Commission Act 2014, regarding the operation of the coronial process, necessary legal reform, institutional accountability and cultural change, has not been met. As a consequence, the rights of families and their loved ones continue to be compromised. Inevitably, this has a lasting, damaging impact on families already suffering bereavement.

The Coroner Service/ An tSeirbhís Chróinéara

The knowledge, experience and professionalism of Ireland's Senior Coroners, informing the demanding work expected of the Coroner Service, is evident in their contributions to academic scholarship, to public understanding and to this research project. More recently, given high profile cases and media coverage, public awareness of inquests and their findings has risen. However, serious structural and organisational concerns identified in the 2000 Review remain unaddressed. Twenty years on, as a consequence of socio-economic change and social behaviour, the complex demands on the Service have increased markedly. Regional disparities identified in 2000 persist, and the Service remains seriously under-resourced, particularly in the cities. Consequently, burdened by unacceptable levels of delay, it is unable to function with thoroughness and compassion. It

remains a disparate Service; a network of part-time coroners without the necessary support of specialist, trained investigators and dedicated administrative staff. Districts also were recommended for review in 2000. While clearly there is evidence of good practice, disparities and inconsistencies regarding information, accommodation, investigation, procedure and outcome, remain and have a lasting impact on families.

Public Awareness and Access to Information

The Coroner Service website's public-facing information pages are poorly designed, incomplete and not user-friendly. This is a significant concern as bereaved families visit the site, often their first port-of-call, in distress while preparing for post-mortems and inquests. Consistent with other jurisdictions that use accessible language with translations available, the website should provide detailed information on: the function and duties of Coroners; the Coroner's jurisdiction; reported deaths, post-mortems and the holding of inquests; the purpose, conduct and conclusion of inquests; the question of liability; the civil standard of proof and the range of verdicts; narratives added to/ replacement of short-form verdicts; Article 2 inquests; juries and their appointment; pre-inquest reviews and adjourned inquests; disclosure of documents; calling of witnesses; media reporting.

The Role of An Garda Síochána

The relationship between coroners and the police is a matter of concern particularly when death investigation involves the behaviour of gardaí and/ or others in State institutions which have a close working relationship with gardaí. In the course of the research, bereaved families and their lawyers questioned the thoroughness and impartiality of Garda investigations. It was their perception that informal social relationships and influence, particularly in close communities, had consequences for the independence of investigations. The centrality of their investigative role in gathering and presenting evidence, liaising with families, and servicing inquests, created further doubts regarding coronial independence. Families and their solicitors also expressed concern that 'protecting' the bereaved from exposure to the full details of deaths, however considerate in intent, led to poor communication, lack of transparency and unnecessary suspicion that case details were being withheld.

Independent Pathology

Concerns were raised regarding the thoroughness of information about the circumstances of death presented to pathologists by Garda investigators, potentially framing medical examination into the cause of death. While information-sharing is both necessary and inevitable, it can extend to speculation on the cause of death. In other jurisdictions, the relationship between police investigators and State pathologists has been a cause for concern resulting in bereaved families seeking alternative pathology examinations. The admissibility of independent expert medical evidence remains at the coroner's discretion.

Legal Representation

While some families interviewed had been aware of their entitlement to legal representation, this did not apply to all families. As demonstrated in other jurisdictions, well-prepared and informed legal representation is crucial in questioning those involved directly in a death and its examination, the representatives of institutions whose operational decisions are under scrutiny, and expert witnesses called by the coroner. Invariably, institutions are legally represented. Legal aid is not guaranteed for families' legal representation causing some to pursue civil suits to access financial support. 'Equality of arms' - the principle that all sides to a legal dispute should be equally resourced - should be considered fundamental in holding inquests that examine thoroughly all avenues regarding how a person died.

Delay

The research shows that, from the 2000 Review through to recent cases examined by the research, delays in holding inquests remain unacceptable. While accepting that inquests are held following the exhaustion of other domestic remedies, this does not explain the inordinate length of time some bereaved families are compelled to wait for an inquest. Long delays, some spanning a decade, are arduous and painful, creating uncertainty and extending the grieving process indefinitely. Official explanations given to bereaved families are: waiting lists; delayed criminal court proceedings; bereaved family challenges to an investigation or requesting a second inquest; administrative complications.

Inconsistencies in Process and Procedure

The 2000 Review identified significant inconsistencies in the administration, application and conduct of all elements of the coronial process across Ireland. They remain an issue and the research identified significant inconsistencies between Districts: full-time/ part-time coronial appointments; staffing and support; offices and accommodation; location of inquests, some held in local halls/ hotels; jury selection; legal representation; scope and depth of inquests; lack of information provided to bereaved families.

Marginalisation of Bereaved Families

The 2000 Review clearly affirmed the *primary objective* of inquests to be the establishment of positive communication with bereaved families, enabling access to a full and thorough understanding of the circumstances in which their loved ones died. Yet two decades on, many families expressed frustration and anger regarding their experiences of marginalisation from the coronial process. For those seeking information on the investigation and inquest the Coroners' Service website provides minimal detail. For example, it lists sixteen distinct pieces of legislation without providing any explanation of their meaning.

Research interviews conducted with bereaved families regarding the circumstances of death, the likely cause of death, the investigative role of the coroner and the function of an inquests, demonstrated that the information provided to them by the investigators was inconsistent and deficient. Little attention was paid to the pains of sudden bereavement and the significance of the inquest as a milestone in their grieving process. Bereaved families attending inquests reported feeling adrift and exposed, without welcome nor reference made to their attendance; no waiting room, no separate seating, no explanation of the proceedings and no recognition of their interest. It must be recognised that while those engaged at inquests in a professional capacity are familiar with the setting, process and roles of other participants, bereaved families are not.

Institutional Interests and Adversarial Process

Situated on a continuum of death investigation, inquests are adjourned until criminal proceedings, focused on establishing liability, have been dismissed or completed. Regarding deaths in contested circumstances, however, those seeking explanations for what happened and those directly involved in the events surrounding the death are well aware that liability is a central issue. It is self-evident that in establishing 'how' a person died, the circumstances of the death must be revealed and examined in detail. With State or private institutional interests (eg. security companies, social services and care providers) legally represented at inquests, an adversarial stage is set with bereaved families requiring experienced legal counsel. Invariably, coroners state that inquests are 'truth-finding' exercises, yet when powerful institutional interests are at stake it is inevitable that lawyers' exchanges are adversarial and directed towards the jury.

Verdicts and Outcomes

Bereaved families' responses to inquest verdicts included: dissatisfaction with the depth and breadth of inquiry; imbalance of evidence heard; defensiveness and protection of institutional interests; alleged bias of the coroner; scope of verdicts offered and the verdicts delivered. In deaths involving the use of force, or the behaviour of the deceased prior to their death, bereaved families were concerned that the reputation of their loved ones was questioned and a 'hierarchy of victimhood' influenced the outcome. Accepting deaths in certain circumstances as 'inevitable' (eg. deaths of mothers or babies in hospital; perceptions of the deceased's 'risky' behaviour or negative reputation; suicide; deaths of cyclists) diminished the preventative function of inquests and the potential of recommendations to result in institutional reform.

Accountability and Oversight

Bereaved families who experienced deficiencies in the process felt unable to pursue their negative experiences and voice their concerns about the outcome. Lack of consistency across Districts and weak mechanisms of coronial oversight and accountability have enabled persistent, discrepant and discretionary decision-making in a context of minimal central oversight. This concern reflects divergence in decisions regarding: thoroughness of investigating deaths; holding inquests; calling witnesses; limitations placed on evidence; the verdicts offered; and subsequent recommendations. Families' lawyers were concerned that critical verdicts, accompanied by recommendations for changes in institutional policies and/or practices, were not reviewed to establish their efficacy.

Recommendations

Charter for the Bereaved[1]	
1	Government (Minister for Justice) should initiate the fullest possible consultation involving bereaved families, advocacy groups and campaign organisations with the intention of establishing a Charter for the Bereaved.
2	The Charter should provide a clear overview of the statutory role and obligations of An Garda Síochána and other State agencies in servicing inquests, distinguishing between lawful obligations and discretionary practices.
3	The Charter should commit Government and its agencies to a statement of rights of the bereaved concerning: information; viewing the body; identification; post-mortems; return of the body; return of personal effects; access to the location of death; crisis support.
4	The Charter should establish an appropriate time frame for the coronial investigation of deaths, the gathering of evidence and the holding of inquests.
5	The Charter should be published and made available to all who suffer sudden bereavement in contested circumstances, in disasters or related tragedies.
6	The Charter should affirm that those bereaved, injured or affected by disasters have a right to privacy and a right to be protected from further suffering as a consequence of intrusive journalism.
7	The Charter should ensure that all State agencies and those working with them involved with the reporting, analysis and investigation of deaths have received anti-discrimination awareness training focused on class, race, gender, sexuality, culture, age and ability.

Structural Reform of the Management and Delivery of Coroner's Services	
8.	Rationalisation of the thirty-nine Coroner districts to create a region-based, distinct agency reflecting population distribution, demography and case numbers.
9.	Acceptance by central government of the need to increase significantly the funding necessary to meet the requirements of an independent, professional Coroner Service in its routine work and in conducting thorough investigations into deaths in contested circumstances.
10.	The 2000 Review recommended the establishment of a 'new coroner agency'; the eighteen significant functions it listed as 'shaping the new service' should be realised.
11.	An Inspectorate should be appointed to monitor consistency in practice across the coronial service.
12.	A code of practice should be introduced to establish uniformity in standards, appropriate accommodation throughout the regions, support for the bereaved and detailed information on the Service.
13.	The role of An Garda Síochána in the delivery of the Service should undergo significant review to ensure that its role is confined to the investigation of deaths.

[1] A version of this Charter was first published in: Davis, H. and Scraton, P. *Beyond Disaster: Identifying and Resolving Inter-Agency Conflict in the Aftermath of Disasters: Research Report* London: Home Office Emergency Planning Division, 1995

Further Staffing and Training for the Coroner's Service

14.	Appointment of a Director/ Chief Coroner with responsibility for the management and operation of the Coroner Service.
15.	Appointment of full-time Senior Coroners to each regional office.
16.	Appointment of part-time Deputy and Assistant Coroners to the regions in line with the current demands on the regions taking into account the uneven distribution of complex cases.
17.	Appointment of full-time coroners' officers and secretarial staff to each region.
18.	Development of a national training programme for coroners in post and new appointees.
19.	All newly appointed coroners to have legal training and to have practiced for a minimum of five years as barristers or solicitors.
20.	Coroners' officers and secretarial staff processing cases should receive appropriate support and counselling on request.

Protecting the Rights of Bereaved Families, including Information Provision and Support

21.	A redesigned web-site should publish full and thorough information as indicated in the research findings.
22.	Legal Aid should be available to all bereaved families seeking legal representation at inquests.
23.	Consideration should be given to extending the circumstances in which bereaved families will have the automatic right to an inquest.
24.	Those conducting interviews with the bereaved, survivors or witnesses to the death/s should be trained in trauma-informed practice and bereavement awareness.
25.	Counselling should be made available to bereaved families and to those giving evidence at inquests.
26.	Investigators should establish and maintain regular consultations with the bereaved, informing them of progress and explaining fully any delays.
27.	Information provided to bereaved families by the coroner should provide: • guidance on accessing appropriate legal advice and representation; • advice on the purpose, function and objectives of the coroner's court; • awareness of and access to bereavement counselling.
28.	Bereaved families and those close to the deceased should be informed of the reasons for holding post-mortems.
29.	Well in advance of the inquest, families should be given the opportunity to access, in full, the findings of post-mortems.
30.	Bereaved families should be reassured that pathologists' medical examinations and the conclusions they draw are not unduly influenced by accounts of the circumstances of death given by police investigators.

Recommendations

Protecting the Rights of Bereaved Families, including Information Provision and Support *(continued)*

31.	Pathologists should complete their examination quickly to enable release of the body to the bereaved family without delay, ensuring that the bereaved are informed of where their loved one is accommodated.
32.	Bereaved families and those close to the deceased should be informed that details contained in post-mortem reports will be revealed at the inquest and could be reported by the media.
33.	In advance of the inquests and in good time, detailed information should be provided on evidence disclosure to enable families and their lawyers to prepare thoroughly.
34.	In preparation for inquests bereaved families and those close to the deceased should be provided with detailed information to ensure that they understand the process - its function, its procedure and its possible outcomes.
35.	At inquests, priority should be given to the duty of care for the bereaved, providing appropriate trauma support to those affected directly by the death.
36.	In attending inquests, the vulnerabilities of those close to the deceased and those giving evidence as witnesses should be anticipated, identified and accommodated by appropriately trained staff.
37.	At the opening of inquests into multiple deaths the coroner should enable the bereaved to present pen portraits of the deceased.

Improving the Human Rights Compliant Practice at Inquests

PROMPTNESS	
38.	Extended delays to holding inquests must be ended ensuring that case investigations, necessary reports to the Coroner and the commencement of proceedings progress without delay and prioritise the needs of the bereaved.
PREVENTING RECURRENCE	
39.	Narrative verdicts delivered by juries where deaths have occurred in similar circumstances should be regularly reviewed to identify systemic, recurring deficiencies in institutional practices.
40.	The review process should be conducted under the direction of the Director/ Chief Coroner, engaging with Government or other agencies as appropriate to ensure narrative verdict recommendations are implemented.
41.	'Special Procedure' inquests should be introduced in the aftermath of tragedies involving multiple deaths or when a pattern of systemic failure is discernible across the jurisdiction.
42.	The failure, identified by solicitors and bereaved families, to follow-up jury and Coroner recommendations for reform in institutional policy and practice must be addressed.
43.	At inquests that identify institutional practices contributing to a death, juries should be encouraged to provide detailed narratives with the intention of avoiding recurrence of the circumstances.

Improving the Human Rights Compliant Practice at Inquests *(continued)*

PREVENTING RECURRENCE	
44.	Jury selection should be random from the electoral register.
45.	In high profile, contested cases lawyers representing properly-interested persons should be able to challenge the constitution of the jury.
46.	Subject to privilege regarding self-incrimination, a duty of candour should obtain regarding evidence given by witnesses who had a duty of care for the deceased, including during arrest, in custody or in hospital/residential home.
47.	All inquest proceedings should be recorded and made available to properly-interested persons and, if requested, they should be transcribed.
48.	All evidence presented at an inquest, with the exception of that derived in statements made by a person since deceased, should be subject to questioning by lawyers representing properly-interested persons.
49.	At inquests, recognising their need for privacy, bereaved families and witnesses should be provided with discrete accommodation within the building, refreshments and, if necessary, independent support.
50.	Following the conclusion of inquests, counselling services should be available to bereaved families and witnesses should they consider referral necessary.

Role of the Media in Reporting Inquests

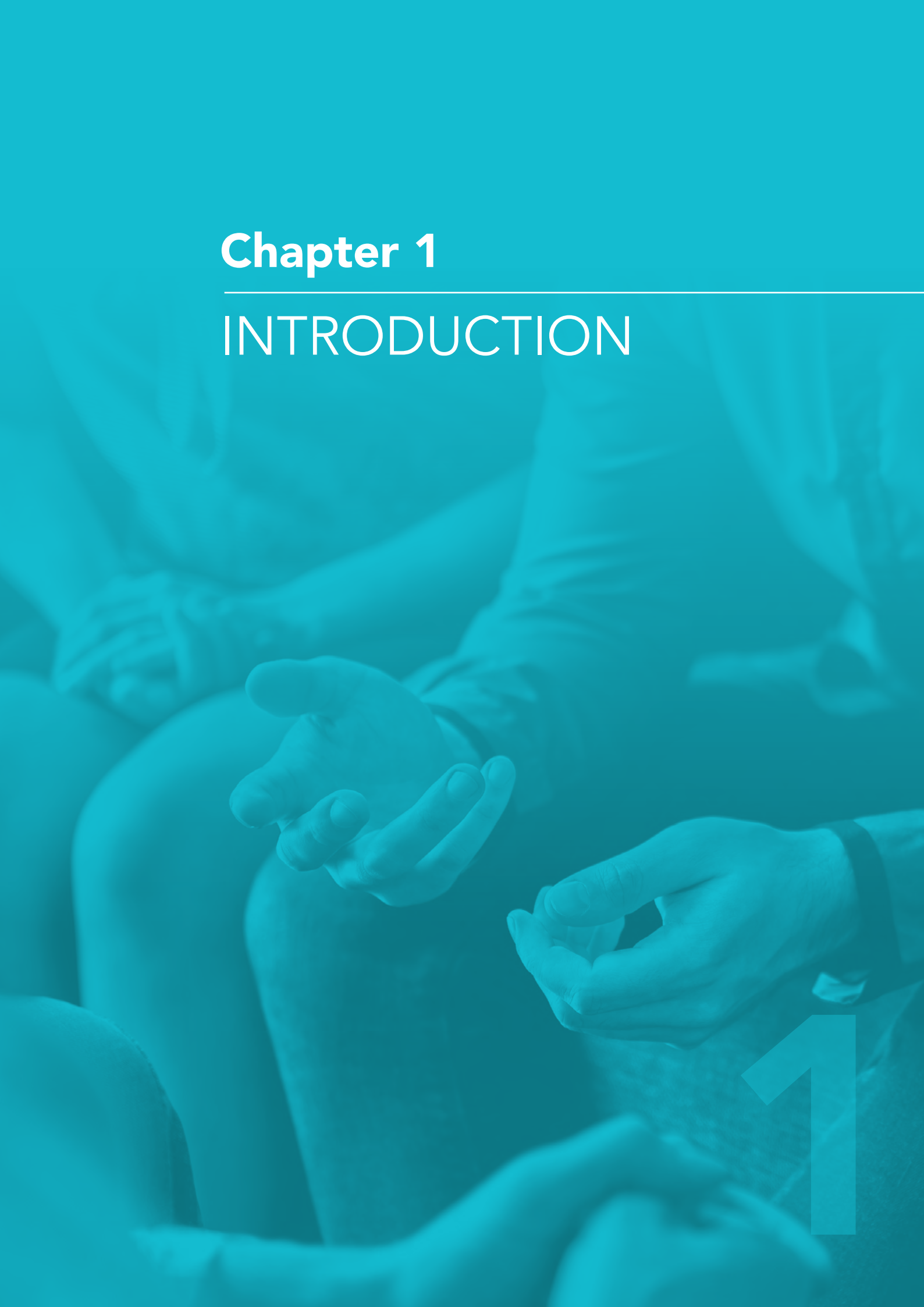
51.	Regarding the conduct, details and outcome of inquests the media should report within the Press Council of Ireland's Code of Practice, specifically: Principle 1 – Truth and Accuracy; Principle 5 – Privacy; Principle 7 – Court Reporting; Principle 10 – Suicide; and the Broadcasting Authority of Ireland Codes and Standards.

Further Research on Instutionalised Racism

52.	Within the Coroner's Service, its support agencies and the An Garda Síochána, further research is required to identify and eliminate all forms of institutionalised discrimination focusing particularly on the experiences of the Irish Traveller Community.

Chapter 1

INTRODUCTION



Chapter 1
Introduction

In 2019 31,134 deaths were registered in Ireland.[2] 17,822 were referred to local coroners of which 12,098 were subject to a coroner's report, a further 3,499 to a report and post-mortem and 2,225 to a report, post-mortem and inquest.[3] Across the Republic of Ireland's twenty-six counties there are thirty-nine coronial districts.[4] Yet, these bald figures strip death of its meaning as each death has a context, both historical and immediate. Most deaths are mourned by family and friends. Some become the focus of investigation because they occur in unexplained or suspicious circumstances. Coroners are legally obliged to hold an inquest if they believe a death 'may have occurred in a violent or unnatural manner' or 'unexpectedly and from unknown causes'.[5] Inquests are mandatory for deaths in or following release from custody, and also for maternal deaths or late maternal deaths.[6] Their courts, however, do not determine criminal liability.

Contextualising the Coroner's Court

It is only when people have direct personal experience of the legal system in action do they gain some knowledge of its complexity, its function and its operation. Until then, their understanding is informed primarily by popular discourse, both factual and fictional, reflecting fascination with 'crime', culpability and punishment. Courtroom dramas and their attribution of guilt or innocence, sentencing or vindication, are stock-in-trade of commonly-held perceptions and a broadly-shared understanding of crime. This fascination extends to drama documentaries, 'real life' reconstructions of well-publicised cases that foreground often disturbing experiences and reflections of those involved, invariably their stories recounted alongside the professional opinion of 'experts'.

In reconstructing events and establishing the 'truth' of what happened, the legal process becomes a place of examination and arbitration between competing accounts. Put simply, the 'act' is perceived as breaking a law; those assumed to be culpable are arrested and, depending on sufficiency of evidence, they are charged with a specific criminal offence or multiple offences. A criminal court, presided over by a judge or magistrate, hears evidence from eye-witnesses and professionals whose testimonies are cross-examined by lawyers for the prosecution and for the defence. In more serious cases the judge sits with a jury. The outcome is the determination of guilt or innocence based on the evidence presented and cross-examined.

Following a death in contested circumstances a decision is reached by the public prosecutor on whether there is sufficiency of evidence to charge an individual or individuals with a crime. If it is judged that there is no evidence, or insufficiency of evidence, to anticipate a conviction for a criminal offence, the coroner's inquest becomes the only court in which evidence is presented and examined. Inquests are presided over by a coroner, usually a lawyer or medical doctor, appointed within a specific geographical jurisdiction. They have four core objectives: identification of the deceased; when they died; where they died; and 'how' they died. Liability for the death must not be attributed, yet in contested cases it becomes bereaved families' primary focus.

Bereaved families, however, attend inquests in the aftermath of sudden bereavement seeking a true, detailed account of the specific circumstances and broader context of the death of their loved ones. Often without legal representation, they

[2] https://www.cso.ie/en/releasesandpublications/ep/p-vsys/vitalstatisticsyearlysummary2019/ (accessed 29 December 2020)
[3] Coroners' Annual Returns, Ireland. http://www.coroners.ie/en/cor/pages/publications (accessed 29 December 2020)
[4] Post partition there are thirty-two counties on the island of Ireland, twenty-six in the Republic of Ireland and six in the jurisdiction of Northern Ireland
[5] Coroners Act 1962, Sec. 17
[6] Coroners (Amendment) Act, 2019, Sec. 10

hear the coroner's examination of the witnesses called on his/ her discretion. It is usual for those witnesses directly or indirectly involved with deaths in contested circumstances, and their employers, to be legally represented. As a court of inquiry there is no prosecution and no defence. In contested cases, while the evidence establishes 'how' death occurred, liability is rarely far from the surface and is the over-riding priority for the bereaved. When personal, collective or institutional liability is at stake, inquests become adversarial.

Families are unaware of the full impact that the process will have on their quest for truth, and on their emotions as they hear what is often distressing and contentious evidence. Understandably they anticipate a full and thorough examination of the facts contextualising their loved one's death, particularly whether in the circumstances there were acts or actions which contributed to or directly caused the death. Prior to an inquest, coroners have broad discretion regarding information provided to families about their case, its investigation, the court process and the potential outcome. If legally represented, families are dependent on their solicitor for information on how the court operates, how evidence is presented and examined, whether a jury is empanelled, the discretion of the coroner in hearing and summarising the evidence and the verdicts that might be delivered.

Families and friends of the deceased become immersed in a formal, unfamiliar process, steeped in legal procedure and language. Often they report feeling passive, external observers of an unfolding, internalised tragedy. Yet others directly and professionally involved appear to be on familiar ground, both formal and informal. They understand the process, share knowledge and operate within a legal discourse impenetrable to the bereaved. It is not unusual for bereaved families to express concern that prevailing medico-legal processes of death investigation dehumanise the lives of the deceased. Following a succession of high profile cases in the UK and Ireland, involving families' campaigns, independent human rights' organisations such as INQUEST and civil rights' lawyers, coroners' inquests have emerged as significant sites of examination, revelation and accountability with the potential of exposing institutional malpractice regarding the circumstances of deaths and the adequacy of their investigation.

Reform Obstructed

By the mid-1990s there was growing concern that the existing coronial framework in Ireland, rooted in 1962 legislation, was decreasingly fit for purpose in meeting the expectations of bereaved families seeking full and truthful accounts of the circumstances of loved ones' deaths. Traumatised by loss, unaware of the function of the coroner's court, oblivious to the limitations of inquests and often without legal representation or economic means, families vocalised their concern regarding the inadequacy of inquests. This mounting concern raised the issue, beyond individual inquests, that the broader public service function of inquests in terms of death prevention was not being realised. Of particular concern was the State's failure to meet its 'right to life' obligations under Article 2 of the European Convention on Human Rights. It was suggested that the twin responsibilities of coronial investigation – revealing the full circumstances on 'how' a person came by their death and using the verdict as an opportunity to prevent further deaths in similar circumstances – were not being met.

Progress towards a reformed Service has been piecemeal and limited. In late December 1998 the Department of Justice, Equality and Law Reform appointed a Working Group to review Ireland's coronial service and the efficacy of the 1962 Act. Its extensive meetings, division of informed responsibility, international consultation and commissioned research resulted in a detailed report recommending a full overhaul of the Service, its funding and its status to meet the needs of an increasingly complex society. Anticipating the eventual realisation of its reform agenda it stated that its *primary objective* was to provide the means through which positive communication with bereaved families could be achieved.

A further seven years passed before a Coroners Bill was introduced but abandoned at the onset of the 2007 General Election. A further eight years elapsed before, in 2015, Deputy Clare Daly introduced her private members Coroners Bill encompassing many of the reforms previously anticipated. Her Bill was subsumed by the Government's 2018 Coroners (Amendment) Bill. In February 2020 the Act passed into law. Rather than realising the comprehensive overhaul of the coronial system anticipated by the 2000 Report, the Act merely amended six decades' old legislation (see Chapter Two). Twenty years on from the Review's recommendations for extensive reform of the Office of Coroner, only limited amendments to the 1962 Act have been achieved.

Article 2 Compliance

Concerning full and thorough investigation of the most contentious deaths examined at inquests are those constituting a potential breach of Article 2 of the European Convention on Human Rights. This obliges the State to protect by law everyone's right to life, prohibiting the intentional deprivation of life.[7] Article 2 of the European Convention on Human Rights establishes a fundamental obligation on member States regarding the right to life of their citizens. It affirms that: 'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law'. Further, 'Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection'.

This Article imposes two fundamental duties on the State, its institutions and its employees: to refrain from actions that jeopardise the life of a person in their care or under legitimate restraint; and to ensure that life in such circumstances is protected. There is a State duty to investigate alleged breaches of these duties of care and protection. In meeting the four requirements of an inquest - the identity of the deceased, the time of death, the place of death and the circumstances – the latter historically was addressed as establishing 'by what means' it occurred. Following a defining case in England (R [Middleton] v West Somerset Coroner, 2004) the House of Lords ruled that compliance with Article 2 should address 'in what circumstances' the person died.

All inquests have a duty to inquire into the circumstances of a death thoroughly and effectively particularly when a death is sudden or unexplained which raises the question regarding the significance of an additional level of scrutiny imposed by Article 2. Such enhanced scrutiny is imposed primarily to ensure that the inquest is both meticulous in detail and transparent in hearing evidence to satisfy the needs of the bereaved. Article 2 inquests are held with a jury and it is usual for short-form verdicts to be accompanied by a narrative reflecting concerns raised by the circumstances of the death. This includes commentary on the broader context in which a person died which is not necessarily directly causative of death.

The European Court has established that Article 2 obliges member states to ensure that the lives of people within their jurisdictions are safeguarded in circumstances in which the right to life could be compromised. Its reach, therefore, includes circumstances in which State institutions fail in their responsibility to administer and maintain their duty of care. Not only should the State 'refrain from intentional' or 'unlawful taking of life' but is obligated to 'safeguard the lives of those within its jurisdiction' ensuring that 'preventive operational measures' are in place. Circumstances include: healthcare; industrial or environmental tragedies/ disasters; road safety, on transport, building sites, at playgrounds, in schools and public places; emergency services and medical care provided in State/ private institutions; custodial institutions and in the process of arrest and detention. The latter extends to the expectation on prison authorities and the police to take effective measures ensuring that the lives of those incarcerated are not put at risk and adequately protected from self-harm or suicide.

State actors are obliged to minimise the circumstances in which lethal force is used and the lives of detainees compromised. In such cases the State must demonstrate that lethal force was both necessary and proportionate to the threat posed by the deceased. Deaths in custody, however, are not confined to the use of force and there is a duty of care obligation on the State including: appropriate medical examination on admission; healthcare provision while being held; monitoring those 'at risk' of self-harm and suicide; and guarding against the use of force in controlling or restraining those in custody. Significantly for this study, Article 2 places an expectation on States to conduct prompt investigations, noting the significance of maintaining public confidence, and ensuring open scrutiny. The European Court has been critical particularly of circumstances in which the investigation was inaccessible to bereaved families.

The Research

Consistent with the Irish Human Rights and Equality Commission Act 2014, this project was conceived by the Irish Human Rights and Equality Commission to research and make recommendations regarding the

[7] Guide on Article 2 of the European Convention on Human Rights, Right to Life, 31 December 2020, Council of Europe. Available at: https://www.echr.coe.int/Documents/Guide_Art_2_ENG.pdf

significance of the Public Sector Duty to the realisation of human rights within Ireland's coronial system. That Duty places a statutory responsibility on all public bodies to promote equality, prevent discrimination and protect the human rights of all people involved with their operation, service provision and policy implementation.[8] The research proposal raised 'numerous' human rights concerns particularly with regard to the over-reliance on An Garda Síochána for carrying out coronial functions, the informality of coronial procedures, severe under-resourcing of the system, lack of training and the lack of mandatory inquests for deaths in police custody. It stated that the complexity of anticipated society-wide 'historic abuse' cases together with minimal critical analysis of the system combined to prompt an examination of rights implementation.

As the research progressed, from interviews with families bereaved in diverse circumstances to those with campaigners, researchers, lawyers and coroners, it became apparent that the Public Sector Duty as specified in the 2014 Act was not being met and that a human-rights-based approach to coronial culture and practice is, at best, limited. Consistent with the Project's aims, the research focused on the policy, practice, priorities and limitations with regard to human rights within the current, institutional processes of death investigation. From the experiences of coroners, lawyers and, most significantly, families, it identifies systemic failures to protect the rights of the bereaved. Beyond the functioning of inquests, the research also considers the institutional defensiveness of public bodies and State agencies in their investigation of deaths in contested circumstances and in their co-operation with coronial investigation.

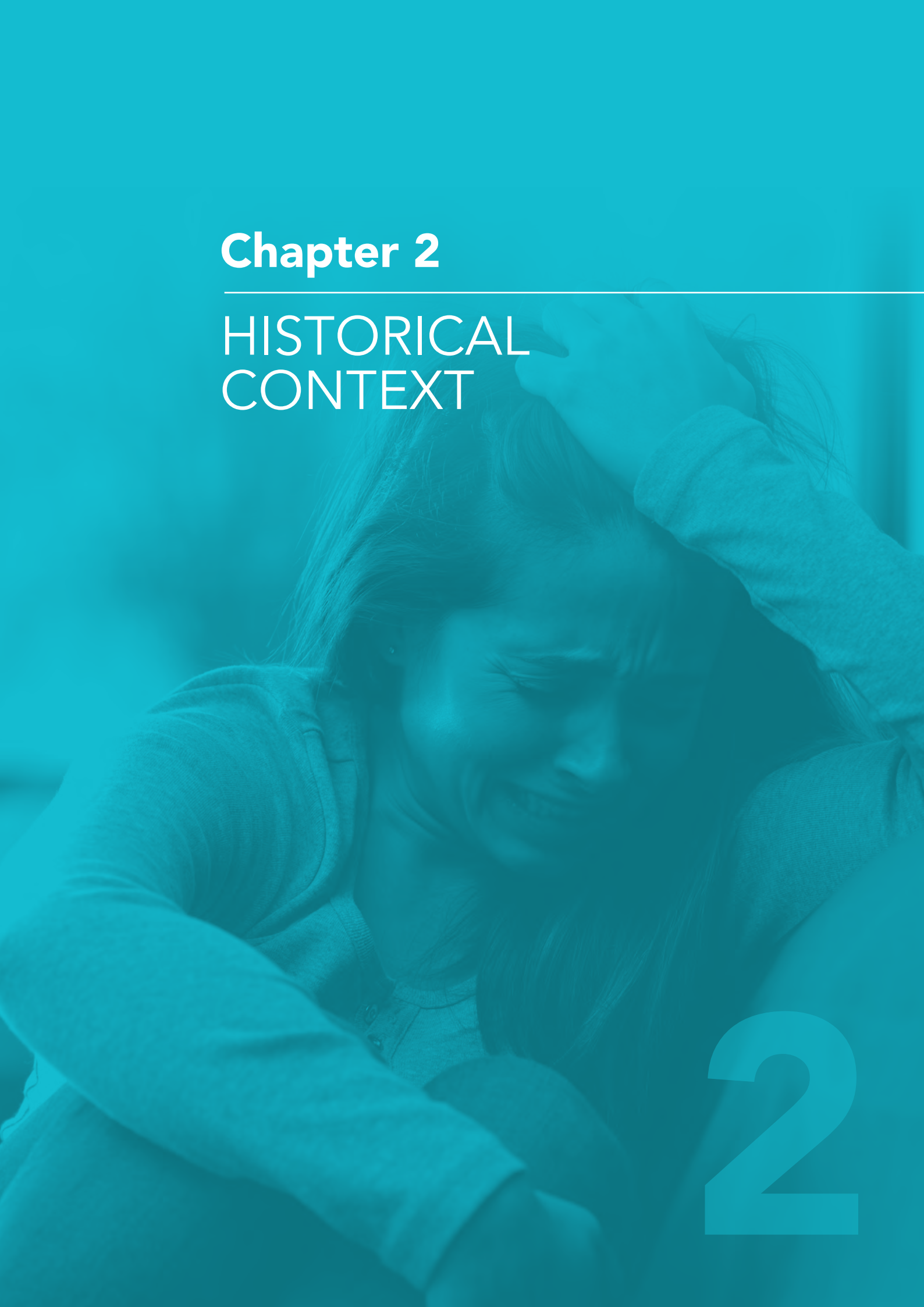
In its conceptualisation the project's primary objective was, and remains: bereaved families' experiences of death investigations; the information they receive; their awareness of the role of coroners; and the function of inquests. Their accounts are central to understanding the extent to which the Public Sector Duty is realised. They are complemented by interviews with campaigners, researchers, solicitors and coroners. The project also considers the significance of overlapping roles and potential conflict of interests between coroners, An Garda Síochána and the Garda Síochána Ombudsman Commission (GSOC). As the following chapter demonstrates, their inter-relationships have been the cause for concern among non-governmental organisations (NGOs), politicians and human rights commentators and this is an important focus of the research. Further, the project reviews the role and function of the coronial system, revisiting the case for fundamental reform. It is written to inform public and political discourse, establishing an incontrovertible case for reform of the Service and encouraging further research into what has been a neglected yet crucial element within social justice.

The project's research is presented in five chapters. Chapter Two situates the research within its relatively recent context, specifically the 2000 Review and the two decades of equivocation that followed. Chapter Three considers a range of evidence from representatives of GSOC and NGOs regarding coronial independence, remit and informality within the investigatory process. It raises key issues regarding delayed inquests, the depth of investigation and the question of death prevention. Chapters Four (bereaved families), Five (solicitors for bereaved families) and Six (coroners) are also empirical, focusing on the in-depth interviews regarding the investigation of deaths, the gathering and sharing of information, delay in holding inquests, the suitability of venues, identification and accommodation of the needs of the bereaved and witnesses, legal representation, thoroughness and inconsistency of process, juries, verdicts and post-inquest support. As the final chapter concludes, piecemeal reforms will not deliver a Service that satisfies its human rights obligations to bereaved families and wider society.

[8] Irish Human Rights and Equality Act, 2014, Sec. 42

Chapter 2

HISTORICAL CONTEXT



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Chapter 2

Historical Context

This chapter situates the primary research within recent tensions, political debates and institutional equivocation regarding the extent of reform considered necessary to ensure that coronial investigation, professional practice and integrated support services operate consistently across the jurisdiction. It traces the impact of Government policy reversals regarding the integration of pathology and coronial services in a modern facility. Against a background of limited changes in legislation and minimal reorganisation of the Service it considers the lasting significance and continuing relevance of the discarded Review published in 2000.

The Office of Coroner

Coroners are medical doctors, solicitors or barristers, the majority of whom are part-time appointments. Each district coroner has a deputy. With the exception of Dublin, where the coroner is appointed by the Minister for Justice, they are appointed without generic professional training by local authorities. They are given considerable individual discretion. Required to live in the district to which they are appointed, coroners remain in post until they reach the age of 70. Except for Dublin and Cork, coroners do not have dedicated offices and in most circumstances inquests are held in public buildings, halls or hotels.

Coroners can be removed from office for misconduct, neglect of duty, unfitness for office, physical or mental incapacity, but there is no comprehensive record of dismissals. Responsibilities for governance are shared between Government Departments: Justice (policy, legislation, appointment of the Dublin Coroner); Health (pathology and the holding of post-mortems); and Housing, Local Government and Heritage (local appointments, costs); as well as with local authorities (mortuaries).

Given the significance of the office of Coroner, not least the expectations of families bereaved in contested circumstances, the oversight of the inquisitorial process is limited, if not inadequate. While coroners provide annual written reports these are a brief overview of each death, the post-mortems and the inquests conducted. No annual report is submitted, nor are recommendations collected and published. In contrast to other jurisdictions, Coroners have no dedicated offices, no formal training. There is scant centralised appraisal of procedures adopted, and weak transparency including minimal detailed evidential records of individual cases. Lacking in oversight and central governance the process of death investigation and institutional accountability fails the expectations of families bereaved in contested circumstances.

The Coroners Act 1962 requires doctors, registrars, funeral undertakers, house residents or those with responsibility for institutions where the deceased was living, who consider the death was caused by violence, misadventure, negligence, misconduct or malpractice, to report the facts and circumstances to the coroner. Known as the 24-hour rule, this responsibility extends to events prior to death, other than illness, that might require investigation. Referral also applies to deaths following a hospital operation or other medical procedure. The coroner then is required to initiate a police investigation to establish the identity of the deceased, the circumstances of their death and details of any relevant witnesses. Should it be established that death was due to natural causes the coroner will issue a death certificate. Otherwise, a post-mortem will follow. Should the post-mortem conclude that death was due to natural causes the body is released to the family. However, the coroner will hold an inquest should the post-mortem be inconclusive in establishing the cause of death.

An inquest is inevitable when a death might 'have occurred in a violent or unnatural manner, or suddenly and from unknown causes'.[9] Juries are mandatory

[9] Irish Human Rights and Equality Act, 2014, Sec. 18

for deaths that occur in prison or Garda custody.[10] While deaths of patients in mental health institutions, children in care, workers contracting occupational and infectious diseases or involving breaches of health and safety regulations, are not necessarily explicit in legislation the expectation is that they will be referred to the coroner. Maternal death inquests of mothers and/ or of babies previously were not referred. As will be discussed below, this has changed given the growing awareness of systemic failures in pre-natal and birth care.

As stated earlier, once matters of criminal liability have been resolved, either through prosecution or a decision not to prosecute, inquests focus on establishing the deceased's identity and when, where and how they died. Invariably, 'how' a person died is the priority for the bereaved who expect the examination of facts to attribute responsibility for deaths that occur in contested circumstances. They attend an inquest expecting answers to questions regarding the context in which a person died and who had responsibility for safeguarding their loved one's health and welfare. Deaths on the road, in hospitals, in mental health institutions, from prescribed drugs, as a consequence of crowd safety failures, and so on, invariably raise expectations among the bereaved that the inquest will identify systemic failures but also, were appropriate, indicate personal responsibility should a 'duty of care' have been compromised.

In establishing the circumstances of death, particularly in cases when specific acts or failures to act might have contributed to the death, the inquest treads a fine line regarding liability. Accordingly, at the coroner's discretion, witnesses directly involved and those offering expert opinion, are called to give evidence under oath. There is no compulsion, however, for witnesses to answer questions. Inquest juries are empanelled at the coroner's discretion, usually selected by the local Gardaí who, with the exception of Dublin, also service inquests including organising the presentation of evidence. Legal aid is discretionary and can be granted to bereaved families, particularly in cases involving deaths in custody or where the coroner considers a case to be in the public interest. Legal representation is important given that evidence presented to the inquest and examined by the coroner should also be subject to examination by interested parties. In cases where there is controversy regarding the circumstances in which the death occurred, the 'fine line' of liability becomes most evident and, invariably, lawyers' questioning is directed towards influencing the inquest verdict.

The immense discretion afforded to coroners across the coronial districts creates a patchwork of inconsistency in process and practice. This ranges from the decision to proceed with an inquest and empanel a jury to identifying and calling witnesses, keeping a precise record of evidence presented, the coroner's summation of the evidence and the verdict reached. Alongside such discretion in process is the broader issue of the adequacy of a service that generally operates on a part-time, *ad hoc* basis without independent administrative support, premises or other facilities necessary in handling complex cases. It has limited powers of investigation to access full and thorough information regarding deaths in complex institutional contexts, including custody, care homes and hospitals.

As will be considered in this Report, experiences of bereaved families and their legal representatives demonstrate a range of inconsistencies in districts outside Dublin and other cities. In those districts, under-resourcing requires that coroners lean heavily on police investigative support. Often, these are the same officers who have reached a prior investigative decision regarding the circumstances of death and have concluded that no further action is required. Gardaí involvement extends throughout the coronial process: reporting deaths; viewing the deceased; decisions regarding exhumation; servicing the coronial investigation; jury selection; presentation of evidence; inquest adjournment to accommodate criminal proceedings. The close relationship and familiarity between coroners and police officers throughout the investigation and inquest has raised concerns that the integration of their roles and powers limit coronial autonomy, thereby inhibiting independence. There appears to be no oversight nor scrutiny of the police role in the process or in implementing coronial recommendations.

Criticisms of the process also include delay in progressing inquests, particularly those inquiring into deaths in custody. Of specific concern has been delays in police investigations and Director of Public Prosecution reviews ahead of making the decision whether or not to proceed with prosecutions. Inquests cannot be held until criminal proceedings have been abandoned or completed. Although the majority of inquests are held within a year, a significant

[10] Farrell, B. *Coroners: Practice and Procedure* Dublin: Round Hall Press, 2000

proportion of contentious cases are delayed for over a year leaving families without answers to often difficult questions regarding the context in which their loved ones died. Such matters raise important questions concerning transparency of process, particularly the failure to publish case findings or recommendations, or a comprehensive annual report. In this context reporting 'can often be reduced to little more than an insipid review of documents and questioning of witnesses with no meaningful conclusions being reached' thus failing to meet the 'State's investigative obligations'.[11]

Accommodation

As the above overview demonstrates, political debate and families' campaigns persisted for two decades. Simultaneously, the buildings and accommodation for the State Pathology Service and the Dublin Coroner, whose court handled the majority of deaths in Ireland, became the focus of considerable controversy. From the late 1990s when its previous building had been demolished, the Pathology Service was housed in prefabricated buildings on a Dublin City Council site. It did not have facilities appropriate for coronial investigation. In 2006 it was proposed that a state-of-the-art, fully integrated medico-legal centre would be built to serve the Pathology Service and the Dublin Coroner. Its construction was delayed by planning objections and errors in the tendering process. Finally, work commenced in mid-2010 but within months a national economic crisis resulted in the building contractor going into receivership halting construction on the site. Two years later the Government withdrew funding and eventually the partly-constructed building was demolished. The initial substantial investment in the project was lost.

During this period the City-based Coroner's Offices and Court, built over a hundred years earlier and never upgraded, were refurbished and a modest extension was added. Throughout this two-year period, inquests were held elsewhere. In September 2010 construction work began on buildings to house the State Pathology Service and the Coroner's Office in the grounds of the Dublin Fire Brigade Training Centre in Marino. The then Minister for Justice, Dermot Ahern, announced he had 'secured funding' for 'the development of a modern and high-tech facility' that would be 'world class'. It had been achieved through a partnership between the City Council and the Department of Justice and Law Reform and was heralded as affirmation of the 'close working relationship' between pathology and coronial investigation.[12] However, construction work on the Marino site was also abandoned and in 2015 the State Pathology Service and the City mortuary were relocated to a former Garda station. The Coroner's Court and Offices remained in their century-old, partly refurbished premises. Dermot Ahern's vision of a world class, high-tech facility incorporating and facilitating both agencies never materialised.

Coroner Service Review 2000

As mentioned previously, in 2000 a comprehensive Review of the Coroner Service in Ireland was completed by a Working Group whose research was led by Professor Denis Cusack, Department of Forensic Medicine, University College Dublin. Far-reaching in its Terms of Reference it sought to consider, 'all aspects' of the Service drawing on comparisons with 'comparable jurisdictions'. It affirmed the coronial 'mission' as 'a public service for the living, which, in recognising the core value of human life, provides a forensic and medico-legal investigation of sudden death having due regard to public safety and health epidemiology issues'. In that context it would 'identify the issues which must be addressed to ensure that the coroner service represents an appropriate response to the needs of society'. 'Radical reform and major reconfiguration' were necessary, to be achieved via a 'clear strategy for change' supported by a 'commitment to resourcing such change'.[13]

The Working Group recognised that far-reaching reform of what was an outdated service required a combination of short, medium and long term implementation focusing on: funding the Service; organisational structure; ancillary services; and law reform. Recognising and considering the diversity in operation across other coronial jurisdictions, the Review identified four broader contextual issues. First, prioritising positive communication with bereaved families. Second, a centralised national structure ensuring 'integrated and planned evolution of the service'. Third, developing 'rules-based legislation' to accommodate the complexity of a changing social

[11] Michael Finucane, Solicitor, Statement to the Joint Oireachtas Committees on Public Service Oversight and Petitions and on Justice, Defence and Equality regarding Ireland's compliance with Article 2 of the European Convention on Human Rights, specifically on the right to life, 10 June 2015.

[12] see: http://www.justice.ie/en/JELR/Pages/PR10000116

[13] *Review of the Coroner Service: Report of the Working Group*, Department of Justice, Equality and Law Reform/ An Roin Dli agus Cirt, Comhionannais agus Athchoirithe Dli, Dublin, p3

and political context. Finally, establishing a fully 'integrated support system' throughout the Service. Three 'key areas of reform' were prioritised: legal; support services; restructuring. Recommendations to overcome barriers to change included: Coroner's Rules adjusted to combine regulatory reform and 'best practice guidelines'; revised jurisdiction boundaries; a new review system overseen by a newly-established Review Board.

Recognising the diversity of institutional practices between agencies, the Review specified the necessity of integrating services to enable the effective functioning of the Coroner Service: pathology; mortuary facilities; fluid and tissue analysis; and, establishment of a 'client-centred service for the bereaved'. This, 'perhaps more than any other change' would 'transform the quality of the coroner service in Ireland'.[14] Regarding structural change the Review recognised the organisational limitations of an out-of-date structure, inadequate funding and fragmented management. The number of coroners required reduction to ensure highly-trained, specialist appointments working collectively and supported by appropriately trained professionals. These objectives could be realised, the Review stated, only through organisational restructuring, improved management, devolved budgets, and appropriately skilled staff. To deliver such ambitious organisational change and objectives, the Review Group recommended the establishment of an autonomous coroner agency. This radical recommendation was opposed by the Department of Finance whose priority was to retain the Office of Coroner within the existing court service.

The Working Group recognised that implementation of its recommendations would take time and, in part, be determined by the retirement and the replacement of the existing cohort of coroners. It affirmed, however, that a 'definite, articulated and sequenced implementation strategy is critical'.[15] In the immediate context there was 'an absolute requirement' for coroners to consult with bereaved families, particularly regarding retention of body parts and/ or organs. The Working Group considered that bereaved families' 'right to know', particularly regarding organ retention, was 'sacrosanct'. Statutory provision, therefore, should include directions involving the 'removal, retention and disposition of organs and body parts'.[16]

Eighty-eight detailed recommendations were made in the Report. They included: coronial appointments, retirements, qualifications and jurisdictions; procedures and rules; information provision to the bereaved particularly concerning organ/ body part retention; reporting of deaths; dealing with the bodies of the deceased and post-mortems; the conduct of inquests including the availability of documents, attendance of witnesses, empanelling juries, media reporting, and the review process for coronial decisions. Forty-one recommendations specified necessary changes in the organisation and management of the Service including its infrastructure, critical support services, histology and toxicology, post-mortem facilities, a 'new' coroner agency specifying its operational functions, structure and financial support. The latter, to be delivered via necessary legislation, would 'facilitate the early implementation' of the new organisational structure, its administration and its operation.

Slow Progress

The ambition and intentions underpinning the Review, including its detailed objectives, soon gathered momentum. In 2007 the Coroners Bill proposed the comprehensive overhaul of the system previously envisaged by the 2000 Review. A statutory Coroner's Service would be established, headed by a Chief Coroner and Deputies with coroners appointed across the regions. The Bill affirmed the independence of the office. Inquests would not be limited to determining the medical cause of death but exploring directly relevant, wider contextual issues. Deaths in all forms of custody would require an inquest. It specified that coroners' duties should be extended to ensure publication of a full written report on inquests and to submit an annual report on each jurisdiction. Further, the Chief Coroner should publish a full annual report on the Service. Long overdue, the functions, composition and selection of juries would be thoroughly overhauled. In most part the 2000 Review proposals were adopted although the role of Gardaí as coroners' officers, therefore lead investigators, was affirmed. In April 2007 the Bill became a casualty of the Government's dissolution. Following a general election, a coalition government was formed and the Bill lapsed. Within months Ireland was in the grip of a financial crisis and nationwide recession.

Eight years on, in Dáil Éireann, Deputy Clare

[14] *Review*, op.cit. p6
[15] *Review*, op.cit. p9
[16] *Review*, op.cit. p9

Daly introduced the Second Stage of her Private Members Coroners Bill 2015. Her primary objective was to ensure that inquests into maternal deaths would become mandatory in response to concerns regarding the medical treatment of healthy women.[17] She noted that the 2007 Bill had 'incorporated many of the recommendations of the coroners review group in 2000 and the coroners rules committee from 2003 in order to update and overhaul the functions of the coroner' but the delay in changing the legislation was 'absolutely unacceptable'. The Maternal Death Enquiry Team had recorded that 'between 2011 and 2013, there were 27 maternal deaths occurring during or within 42 days of pregnancy … seven were classified from direct causes' and only three had inquests. Given what was known regarding 'lack of care and appropriate and timely diagnosis', and there being 'two or three maternal deaths of all categories in Ireland every year', there was good reason to introduce an 'automatic public inquest' in such cases. Arguing that it was essential to 'know in full why a death happened and what lies behind it', she dismissed 'confidential inquiries because hospitals and the HSE hide the truth behind them'. Full transparency required 'public inquests so that families get answers but also to enforce genuine accountability on the part of the HSE'. Only through 'an automatic inquest and vastly improved disclosure methods' could those whose care within which women had died be 'open ... to public scrutiny'.

Deputy Daly's Private Members' Bill included many reforms previously proposed in the 2007 Bill. It was welcomed publicly by the Government yet did not progress into law. It was then included in a Departmental review of the coroners' service and eventually overtaken by the Government-initiated Coroners (Amendment) Bill 2018. Speaking at the Second Stage debate, Clare Daly stated her incredulity that the coronial service was 'operating under legislation dating back to the 1960s' having failed to modernise to meet the demands of the late 20th Century.[18] The delay in progressing necessary reform was a 'shocking indictment of the system', exposed by the 'heroic struggle' of the bereaved, 'whose human tragedies have been turned into a movement to change the law … by the families of the women who died in maternity hospitals'. Clare Daly stated that between 2007 and 2014, 'the families of Tania McCabe, Evelyn Flanagan, Jennifer Crean, Bimbo Onanuga, Dhara Khivlehan, Nora Hyland, Savita Halappanavar and Sally Rowlette, not satisfied with the partial explanations offered to them by the HSE [Health Service Executive], had to fight tooth and nail for inquests'. It was, she argued, essential for individual families to have unfettered access to the full context in which their loved ones died as confidential, internal inquiries provided no reassurance.

Legislative Reform

Having acknowledged that legislative change was long overdue, on 10 July 2019 the Minister for Justice and Equality, Charlie Flanagan T.D., announced the progression of the Coroners (Amendment) Bill 2018 through both Houses of the Oireachtas. He stated that existing legislation would be amended to 'strengthen and modernise' coronial powers regarding the reporting and investigation of deaths, giving 'a wider scope for inquiry at inquests, clarifying that they are not limited to establishing the medical cause of death, but that they may also seek to establish, to the extent the coroner considers necessary, the circumstances in which the death occurred'. Establishing compliance with the European Convention on Human Rights, coroners' powers were extended giving access to necessary evidence and relevant records, and compelling witnesses to attend inquests. Regarding the contentious issue of access to medical records of the deceased, the Minister's statement specified new coronial powers to compel hospitals and related institutions to provide medical records of the deceased prior to post-mortems.

The Minister recognised the significance of key questions 'in a number of high-profile cases which have caused great public unease'. These included the 'unacceptable' failure to refer 'maternal deaths and perinatal deaths occurring in hospitals, which should have been reported to coroners because they raised issues of medical error and were 'unnatural deaths' under the Coroners Act 1962'. Consequently, 'bereaved families, and in some instances even coroners, experienced considerable difficulty in obtaining basic information that should have been provided to them'. Reporting maternal deaths to the coroner, followed by an inquest, would be mandatory together with stillbirths, intrapartum and perinatal deaths. Noting that referral had been 'already established as good practice', mandatory referral would be extended to include deaths in custody or detention.

[17] https://www.oireachtas.ie/en/debates/debate/dail/2015-12-11/23/ accessed 5 January 2021
[18] https://www.oireachtas.ie/en/debates/debate/dail/2018-09-19/29/ accessed 5 January 2021

Reforms were directed towards those responsible for care and custody, 'including hospital authorities' to 'support the development of transparent and accountable oversight for checking and investigating certain types of death'. The 'most important' objective being, to 'support timely and transparent provision of information by health and other authorities to bereaved families'. Acknowledging families' campaigns for transparency regarding the circumstances in which women had died in childbirth, he 'hoped' that the legal reforms would 'provide a positive legacy'. Recognising the 'extensive work and contribution of MEP and former Deputy, Clare Daly' regarding maternal deaths, he confirmed new legislation would meet her demands while 'providing for a wide range of other key reforms to coronial law'.

On 23 July 2019 as the Coroners (Amendment) Act was passed. The Minister stated that it extended 'the scope of enquiries at inquests' beyond determining 'the medical cause of death', to reveal 'the circumstances in which the death occurred'. The Act introduced 'key provisions to strengthen the effectiveness of the coroner's inquest' that would 'improve compliance with [the State's] obligations under the European Convention on Human Rights'. These were: affirmation that 'the purpose of the inquest goes beyond establishing the medical cause of death' to 'establishing the circumstances' without attributing liability; all 'maternal and late maternal deaths' to be reported to the coroner and inquests held; similarly, 'all stillbirths, *intrapartum* deaths and infant deaths'; also deaths in 'State custody or detention'. Under the Act it would be an offence not to inform the coroner of a mandatory reportable death. Further, coroners were required to inform bereaved families of inquest details.

This legislation extended the discretionary powers and duties of the coroner to hold post-mortems including provision of information to bereaved families. It established a duty to direct a post-mortem examination by a medical practitioner where a death 'appears violent or unnatural; or unexpected and from unknown causes; or to have occurred in suspicious circumstances; or to be a death in State custody or detention, a maternal death or late maternal death; or to be a death which may have occurred in circumstances requiring an inquest under another enactment, or which may be due to specified work-related causes'.[19]

A significant additional provision gave coroners the power to instruct hospitals and doctors to provide medical records of the deceased prior to a post-mortem.[20] A written report of the post-mortem should be provided to the coroner as soon as possible, recording organ or body sample retention. The report should be made available to police investigators before the opening of an inquest.

Failure of witnesses or jurors to attend an inquest once summoned without reasonable excuse became an offence.[21] The High Court can order witnesses to attend. Coroner's powers regarding evidence were extended, specifically the production of documents and direction to witnesses to answer questions during the course of an inquest.[22] Unreasonable refusal can lead to an application to the High Court to ensure compliance. Regarding immunity, witnesses are given the same protection as obtains in the High Court, and knowingly giving false or misleading information at an inquest is an offence.

On 21 February 2020 Charlie Flanagan announced commencement of provisions of the Coroners (Amendment) Act claiming they would strengthen and modernise coroners' powers in reporting, investigating and inquiring into reportable deaths not previously covered by legislation. The Act would, he stated, 'improve the capacity of the Dublin Coroner Office which will now be able to conduct more inquiries into deaths'. It would also reduce the significant backlog of inquests waiting to be held.

Limits to Reform

Twenty years on from the Review's recommendations for phased root and branch reform of the Office of Coroner, two decades during which demands of reformers and bereaved families were thwarted by false starts and equivocation, limited amendments to the 1962 Act were introduced. As the above discussion demonstrates, the opportunity to create a coherent national organisation of coroners working collectively under centralised direction was missed. Gardaí continue to work as coroners' officers, jury selection continues to be inconsistent, there is no centralised training for coroners who will still be

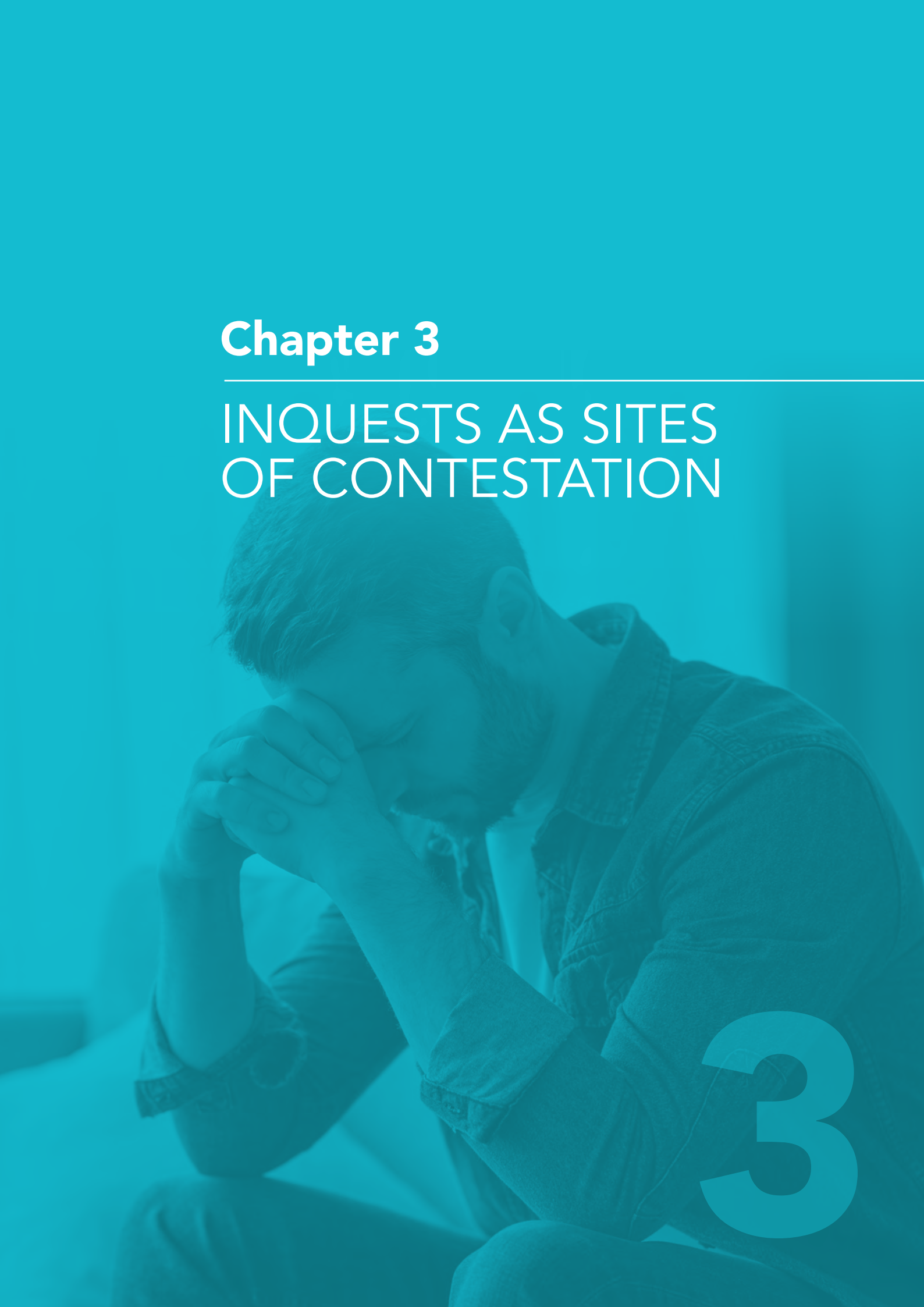
[19] Coroners (Amendment) Act 2019, Section 33
[20] Op.cit., Section 33(D)
[21] Op.cit., Sections 23 and 37
[22] Op.cit., Section 24

appointed by local authorities and governance of the coronial system remains unclear. The main bulk of coronial work across the Districts is handled by part-time coroners, limited administration staff and Gardaí investigators.

The 2000 Review recommendations prioritised bereaved families' interests as central to the inquest process. This prioritisation was to be delivered through strategic managerial reform, expanded coronial powers, greater transparency in investigation and outcomes, and appropriate funding. In particularly contentious cases bereaved families could have confidence in an independent, investigatory process combining professional consistency and compassionate intervention. These priorities were central to the 2007 and 2015 Bills, yet the detailed overhaul of an outdated process envisaged by those proposals, reflecting the Review, did not materialise.

Chapter 3

INQUESTS AS SITES OF CONTESTATION



Chapter 3

Inquests as Sites of Contestation

As previously established, consistent with other international jurisdictions, the Irish Coronial System occupies contested and occasionally controversial terrain between inquiry and liability. When bereaved families seek a full and thorough examination of the facts and events surrounding the death of loved ones it is their intention to establish institutional responsibility. This objective is at odds with a court of inquiry that is prohibited from attributing liability to any person or persons involved directly or indirectly in events leading up to the death. Yet, inquiring into the circumstances of a single death or multiple deaths, inquests explore the context and reach verdicts consistent with the facts presented and examined. Inquest recommendations are made with the intention of preventing recurrence of death in similar circumstances.

Invariably, when deaths occur in hospitals, mental health institutions, in prison, police cells, during arrest or where there is the possibility that there has been a failure by public authorities or private institutions in their duty of care, and there is judged to be insufficiency of evidence to pursue a prosecution, the inquest becomes the sole forum in which evidence is heard and examined. This chapter explores issues of contention and impediments to meeting the expectations of the bereaved.

Coronial Independence

Throughout coronial investigations, coroners work closely with gardaí. In deaths involving the members of An Garda directly, when their actions are under scrutiny, coroners work with the Garda Síochána Ombudsman Commission (GSOC). Concern has been raised by families and their lawyers regarding the independence of coroners given their close working relationship with An Garda Síochána, not least officers having dual investigative roles as gardaí and coroners' officers. Invariably, operational independence arises at various points during the investigation process. For example, a GSOC representative outlined concerns regarding coronial ownership of evidence. He recalled advising a coroner that a post-mortem should be conducted and seeking permission to release exhibits, including a vehicle: '*The response I got was very much, "Why are you asking me?" "Well, because you may need the vehicle for coronial proceedings for the inquest*". The coroner replied, '*you are absolutely right, but I have never been asked that before in all my years of being a coroner*'. He had never been consulted by gardaí regarding the release of exhibits.

Coronial Remit

As previously noted, the Coroner's (Amendment) Act 2019, extended the coroner's remit, particularly regarding investigation into maternal deaths and still-births. Despite establishing a schedule of deaths reportable to the coroner, however, notification remains inconsistent. A research epidemiologist stated that on receiving notification of a death, the coroner alone decides whether to hold an inquest, resulting in inconsistency between districts: '*a huge variation around the country in terms of notifications to coroners … you can have five times as many in one district as you would in another and no real sense of why that would be. So practice is variable*'. There are further, '*excess variations, because if there are a lot of notifications in some districts it is unlikely that will follow through to having lots and lots of inquests*'.

Working part-time on a case-by-case basis, coroners receive remuneration for each case and are paid a flat-rate fee regardless of inquest length. There is little incentive to prolong cases beyond minimal consideration. The GSOC representative agreed:

There have been instances where matters in my

opinion haven't been inquired into in the same depth as they would have been elsewhere. Yeah, I can't say how widespread that is, and it depends on the circumstances, but it has been my experience that some inquests that maybe could have taken a full day have taken an hour, or maybe could have taken three or four days have been done in an afternoon or an evening … the level of inquiry varies depending on where you go.

He was uncertain regarding GSOC's authority to challenge a coroner's decision, stating '*it comes back to the jurisdiction … in what capacity GSOC are attending. If they're presenting* [how can they] *advise the coroner as to how long he should take in relation to us … it's not clear*'. GSOC does not have the authority to challenge a coroner's decision. This would require judicial review.

Inconsistency, Transparency and Investigation

As illustrated in the 2000 Review, *ad hoc* arrangements and inconsistencies between Districts undermine coherence across the jurisdiction. Scope and depth of inquiry, however, should not depend on where people live, nor on the availability of administrative support for coroners. An academic researcher considered '*a standardized system across all of the districts*' to be a priority, as '*people's experiences*' are '*determined by the coroner, the location, and sometimes the coroner is restricted by the district*'.

According to the GSOC representative, lack of consistency and standardised practice together with the complex '*logistics*' involved were consequences of part-time coronership:

You need full time coroners because in the current system … apart from the dedicated person in Dublin, they are usually going to be a doctor who has a private practice. So he maybe has to put aside a number of dates [when] *he is going to hold inquests and that is where it becomes problematic and where he has juries with a lot of inquests … Then he has the GSOC case which will create an extra day.*

Inconsistency is exacerbated by the number of coronial districts in Ireland, disproportionate to population. The research epidemiologist stated:

I think we have forty-eight coroner districts, maybe seventy, eighty coroners ... There are two hundred in England, and there is thirteen or fourteen times more people so we should have two hundred divided by thirteen or fourteen, so we would be down to small-numbers and a standardised system in place. We really don't seem to have enough attention on the system and that is then when people get very variable experiences.

Lack of transparency and delay are also significant, with sparse information or detail published. Regarding delay, the epidemiologist continued:

It always seemed to be such a slow process, but now it has got to the point where for us, as suicide researchers, we don't get reliable suicide data for several years. It seems increasingly in recent years that so many inquests are so late, death registered so late, the official statistics are published already.

Consequently, the published statistics do not reflect the totality of cases; '*it comes down to, the coroner system is not working well - and that's just from an efficiency point of view – if a person dies it shouldn't be three years to get their death finalised and registered with a cause*'. Variations in available data create inconsistent information regarding the categories of deaths. This is '*less so for maternal deaths because they are such major events*' and are '*so rare … that they will get much more attention and priority, because it is such a shocking thing to happen*'. However,

… more common causes of death such as suicide and possibly road traffic accidents … are just not being dealt with in the same way … There is an interdependency of guards notifying the coroners, coroners need to be then going on to have the post-mortems and the inquests, they feed the data back to registrars, it goes back to the CSO, back to the guards. There is a complicated enough system and if it is not working efficiently, then the data is out-of-date by the time it is finalised and reliable.

Lack of standardised processes and variations between districts have generated *ad hoc* procedures, creating inconsistencies and delays for bereaved families, who then face the circumstances of death '*being unearthed again over a year later and feeling re-traumatised*'. The lawyers interviewed considered the imperative of establishing a '*standardised system*' to lessen delay and to provide families with answers to their questions, enabling them to '*move on in their lives*' with a clearer '*understanding of what happened*'.

Concerns were also raised regarding legal representation. The spokesperson for a cycling NGO commented: '*all the inquests where I have been at involving a cyclist, the families have had no representation either legal or any professional*

representation. And that is appalling'.

In '*more contentious, more higher profile*' cases concerning deaths in custody, shootings and deaths following police pursuit, GSOC advises families to engage legal counsel:

You try to say … that going through the process it is always helpful to have a solicitor … We'd always advise them if there is an inquest it is in their interests to have a solicitor and there is provision there for legal aid that they can seek … I have to say, it is highly preferable to me if the family engage a solicitor or legal counsel.

The GSOC representative was concerned that in his experience, attending inquests and observing bereaved families, '*I have sat there thinking to myself, you are not getting here the service that you are entitled to or the information that you are entitled to because you don't know to ask the right questions or make the right representations*'. Legal representation calms '*emotion*' and from '*a practitioner's perspective*' families' representation '*would be optimal*'.

While GSOC assisted in jury selection in Dublin the process elsewhere was a cause for concern:

Elsewhere in the country it has been our experience that there is a panel of jurors that are used for each and every inquest, of local people, who may be retired and have time on their hands and come along and they rotate the foreman responsibilities. "Because I did it last week, it's your turn this week." And looking at them I'm not sure how representative they are of the communities that they are meant to represent … there seems to be a list of names that are used day-in day-out by certain coroners.

Further, local Gardaí '*certainly assist the coroners in impanelling the jurors in all areas actually, not just rural areas, but the guards give the coroners assistance in preparing*' the case. This close relationship is concerning, particularly in cases where GSOC investigate guards and Gardaí support to the coroner is provided by the station whose guards are under investigation.

Gardaí selection of the jury was also problematic for an NGOs representing the interests of cyclists, whose spokesperson considered the Gardaí consistently questioned cyclists' road safety: '*I don't trust the Gardaí, they have let people down left, right and centre in our society … in road safety, the Gardaí are the problem*'. He considered there was systemic failure in enforcing the law to protect cyclists.

The GSOC representative considered there exists a systemic problem with under-resourcing, with no dedicated support staff outside Dublin but '*a designated officer to work with the coroner*' who '*will, maybe, meet in the district court and usually will have* [selected] *the one jury panel that will hear all the cases*'.

Further, the lack of administrative support for coroners often led to GSOC adopting clerking roles during an inquest, '*almost on the verge of presenting the case*'. Part-time coroners '*tend to use local guards to assist them in their coronial duties*'.

Up the country … on occasion we have been asked to swear in, to administer the oath to jury members. We've got no legal standing to do so, we've got no authority to do so … we have been asked to present the evidence or read out the depositions, we've done that … We have been asked to prepare the depositions. Convert from what is normally a section 21 statement format into deposition format with a different heading ... We've been required to marshal the witnesses and, obviously, bring along the physical evidence as may be required.

These duties, however, '*have all become a cause of concern for us in recent years, as to our level of authority or entitlement to do any or all of those things*'. It is a concern also raised by the Ombudsman in submissions to the Department of Justice. The GSOC representative stated:

We've engaged with the department and we've had to say that the '62 Act does not make sufficient provision for GSOC. Until it does, we are providing services some of which we may or may not be entitled to provide and it's leaving you [GSOC] *and the procedures vulnerable to legal challenge. And until that legislative position is fixed, we won't be providing any of those services, or assistance any longer … not because we have no desire to help, quite the opposite. But we want a sound legal basis … the nightmare scenario would be … a contentious high profile case gets derailed halfway through or has to be reheard, or there is some other legal issue arising, simply because we've done something we weren't authorised or legally covered to do. We don't want to put ourselves, the families or the inquest or the coroners in those positions.*

GSOC identified inconsistency in process and procedures between Districts, resulting in markedly different experiences and outcomes for bereaved families:

We would prefer a consistent service regardless of

which county you're in, and established procedures and the administration taken care of by dedicated coronial administrative staff. There's that quote, isn't there, about 'how society treats its dead' and I think, certainly from what I've seen over the twelve years I've been involved in countless inquests, that the notion that I as a family could be experiencing a completely different level of service purely dependent on where my loved ones died - that can't be right.

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Coronial Legalism

Bereaved families and campaigners raised the appropriateness of formal settings and legalism governing inquests. The suicide researcher commented:

I just felt that the setting was wrong. It was actually in a courtroom. So obviously you kind of have the witness box, with the state pathologist or the pathologist who examined the body ... and it was just all very weird.

Formality impacted on vulnerable family members giving evidence, raising possible alternative methods:

Where statements are given ahead of time … why do they need to come back in at the inquest and stand up and verify? "Yes, I was the last to see him." "Yes, it was 9.15 in the morning." Or, "You know I received a text from him". Why can't all that be done in the presence of a guard at a different time? Because I mean, like, for anybody to stand up in front of a crowd is nerve-wracking but when you feel as if you are potentially on trial, the presence of the courtroom, the swearing on the Bible, all the legal aspects, really. It could potentially reinforce the feelings of guilt and blame that was there something I could have done differently … If only I had called them would this situation have been different? So, I do think it could reinforce those feelings of guilt.

The difficulties faced by bereaved families extended beyond the formal setting to failures in the provision of adequate accommodation. This was particularly difficult when more than one inquest was scheduled:

He said, like, for those family members who aren't first, maybe they would like to step out. There was like a mass exodus and myself and another girl from the NSRF were left on our own with the guards and maybe the family that were actually having the inquest … we felt really awkward. Because of the way the courthouse is set up, there didn't seem to be any, like, waiting area, and so they're actually just standing in the entrance doorway…there's no seats. It wasn't great.

At inquests when families attended without legal representation, they reported a climate of hostility emanating from representatives of state or private institutions that had full legal representation. This was evident in families' experiences of HSE deaths and road traffic accidents.

Delay

As in other jurisdictions, there were long delays in holding inquests with bereaved families waiting to have troubling questions addressed involving the circumstances of death. Regarding inquests examining the context in which individuals were assumed to have taken their own lives, the suicide researcher commented:

Some people had the inquest four months after the death, others had it over a year after the death. That was a serious issue for people. They were just waiting and waiting and waiting and they didn't know when it was going to be … For some people, if they hadn't been given a lot of information by the guards, or there was a sense of ambiguity about: 'Did the person take their own lives?' or, 'Was it like an accidental overdose?' And then the bereaved family is like, 'Well, we can't wait a year, we have to know'. I think then that it's important for it [the inquest] *to happen as timely as it can.*

As the following chapter addresses, when the circumstances of deaths were contested, delays could become significantly extended, with some families waiting over a decade for inquests. The prominent example of this is the inquest into the deaths of 48 people in the Stardust Fire. Significant factors explaining delay are the over-burdening and the under-development of the coronial system. A funeral director noted that in Ireland, because of a shortage of doctors to sign off a death, bodies unnecessarily are sent for post-mortems:

We have loads of people unnecessarily getting post-mortems who don't have to get post-mortems. I looked up the County Coroner's website where I used to work in America on their current deaths every year. So far, they have had one thousand and thirty-seven deaths this year, and they have only done fifty-one post-mortems and they have done fifty-four toxicology.

He considered that a lack of doctors available to certify deaths at home led to unnecessary referrals for post-mortem. A further burden on post-mortems resources was the persistence of invasive investigations:

England are moving with the times, to stop posting [Post-Mortems] *when you can take samples instead, and it is a huge cost saving … There is no reason why many PM cases couldn't be avoided. The families don't want them and if they really knew what went on in them it would be different. The coroner should be able to have an active role if there is nothing suspicious, to sign off on a death without a PM.*

Further, delays in processing bodies varied regionally:

If you have a body that has died in Wicklow after ten or eleven on a Friday morning, you might not get that body back until the following Tuesday or Wednesday if there are a lot of bodies, because they only do three post-mortems a day. We are blessed in Waterford, we could have the body back and embalmed by four or five o'clock.

Inquest delays result in delays to other preventative review mechanisms such as the HSE inquiries into maternal deaths.

Failure to Investigate Adequately

When a state institution is involved directly in a death, the potential for the inquest to interrogate fully the circumstances of the death can be compromised. As an epidemiologist stated: '*life gets very complicated in those cases because once the lawyers get involved then people become very cautious about what they say and it is not just the simple, "We are just trying to get to the facts".*' Further, rather than an inquest being a one-off legal process investigating a death, it also can be connected to criminal and civil proceedings. This represents a continuum of legal processes faced by families in the investigation of the circumstances in which their loved ones died. In situations where potential liability is an issue, institutions have the potential to become gatekeepers of the truth, despite inquests not being a court of criminal or civil liability. As the cyclist NGO representative commented:

The inquest sets the tone for any [potential] *civil action or any criminal case thereafter. And if the jury have been putty in the hands of the coroner or the system, then you know it will be misadventure when in fact it could have been death by design. In other words, road or traffic management design failure.*

In his organisation's view, cyclist deaths in Ireland are not taken seriously. This starts in the investigation of the criminal process:

Gardaí and the station commanders have a conscious anti-cyclist bias … They see cyclists as the architects of their own misfortune. And that's embedded; there's an institutional blindness. So they are not taken as seriously as a collision involving a HCV with a car, or a bus and a Luas for example. And that is serious.

This assertion appears confirmed by not employing forensic road collision investigators for all fatal accidents involving cyclists, and the Gardaí not immediately taking forensic samples or impounding vehicles for evidence. This failure to interrogate also extends to decisions regarding criminal prosecutions:

The DPP, acting on the advice of the Gardaí superintendent of the station investigating it [decides] *no prosecution of the driver, that's the pattern. Most of the ones that I have been at the inquest for … the driver ends up with a FPN [Fixed Penalty Notice] for not insuring or something like that. Two penalty points and 80 euro fine, and they have left someone paraplegic or they have killed somebody. And because there is not a sufficiently robust investigation of the nature of the accident. It's as if the State wants to just airbrush and move on … these were all inevitable when you've got traffic, people die as a result of traffic impacts, and it's the price we have to pay for progress.*

Campaigners and families stated that this view impacted on inquests, with coronial investigations carried out by those who criticise cyclists for placing themselves in danger. The NGO representative noted that while evidence-gathering had improved, its availability at inquests remained deficient:

I always want to see a very clear photograph or diagram of the debris field … a cyclist gets hit and generally they get thrown up in the air and they will do a parabolic trajectory in the air, whether hitting the windscreen, or flying over the roof and then hitting the ground, head first generally. And if you are not killed by the impact with the vehicle you are killed with impact with the ground, because you come down with speed. That evidence needs to be shown to the body of the court. And at that last inquest I was

at … none of that was shown to the body of the court.

Failure to investigate fully cyclists' deaths included not commissioning expert testimony from those whose knowledge could help prevent future deaths. He continued:

In any RTC where there is a cyclist, there has to be, should be by law, a road traffic engineer in attendance. That should be mandatory. Because it could be it could be the National Road Authority … it could be Transport Infrastructure Ireland, or it could be the local authority. So, whoever has jurisdiction over that particular road needs to have an engineer present, to say to the jury … anything about the road design here that might have led to this impact. I mean that just simple reform needs to be done.

Associated with this was the failure to call medical experts, who could provide informed evidence regarding the injuries suffered by the deceased:

The guard may have missed the impact. Was it the driver who impacted the rider or was it the rider impacted the vehicle. And you get that by looking at where the impact point was … You can get an idea about how the impact happened and the direction of the bicycle or the vehicle, and the same in multi-vehicle collisions. You need to see, where were the injuries. The pathology will generally deal with the proximal cause of death. You know, aortic rupture, or vena cava rupture ....

Failure to Prevent

Following inquests that recorded fault or error within institutions, it was difficult for bereaved families to reconcile such culpability with the lack of tangible outcomes. This created distress for families who sought changes in institutional practices to prevent recurrences of the death in similar circumstances of their loved one. As the suicide researcher commented:

Because they don't see potentially any change going forward in the health system, I think that can be very frustrating as well. They don't see any improvements to mental health services, to waiting times … inevitably there's going to be lots of other families going through this, because changes haven't been made…that the same situation that happened with 'my family member' is still happening.

Such situations were a consequence of deficits in the preventive function of the Irish Coroner System yet riders and recommendations can be delivered at inquests with the aim of preventing future deaths. A clear example of this is well-illustrated by the deaths of cyclists killed by motor vehicles. One commentator considered inquests as providing the opportunity to prevent future deaths:

To learn more about why cyclists were dying. Because I knew the Gardai had just about got forensic collision investigators team going by the mid-2000s, and I just wanted to see what's the quality of their evidence that they are presenting to the coroner. And from the international road safety research literature I have a reasonably good idea of what happens – how cyclists do get killed or seriously injured.

This preventive objective was echoed by all families, regardless of the institutional setting in which their loved ones died. The inquest is on a continuum of legal procedures and healthcare reviews experienced by families following the death of loved ones. It has the potential to prioritise families and their needs, performing a preventive function and ensuring that loss of life is not repeated in similar circumstances. Yet, reviews experienced by families have eroded confidence in the process, as a family solicitor noted:

Within the hospital there will be a team that does reviews of serious adverse events, and then there will be a discussion to see if they need an independent, hospital group team, separate system analysis, and that can take more than a year. That is independent of inquest, so you potentially have three reviews. So, there is definitely enough reviewing going on and it should be streamlined … because you will have situations where information comes to light and then maybe a different interpretation of the cause of death is given, and then the family are left thinking that they were lied to, or that something was going wrong.

Multiple death reviews create a range of outcomes which can result in impeding data collection and the knowledge necessary to prevent future deaths. Further, when inquests make recommendations they are not always enacted thus diminishing preventive potential. The research epidemiologist stated:

When there is a big case and the coroner has given recommendations and it comes out through the media, I don't really get a sense that it comes through the system in terms of the HSE, or that there is an implementation imperative … I don't think there is a role within the coroner system to kind of say, 'Let's collate our recommendations and review what we've been coming up with and see what we have to push via the Department of Justice through to other Departments so that they now have a role in saying,

these things need to be implemented. We've reviewed our recommendations from the last year and these are our priorities and now you have a responsibility'. We don't see any collation of recommendations or any kind of report that comes from the system, because you could at least then say that it could feed into the prevention of those kinds of cases.

In their investigations GSOC has the scope and capacity to present matters of concern to the coroner with the objective of preventing recurrences. They noted the failure to enact recommendations in several policing cases:

Our first public interest inquiry was an investigation into a death in custody, where a man was found hanging in his cell at City Central Garda Station and subsequently died. And following on from that there were Gardaí shortcomings but there were no contributing factors in his death. But there were recommendations that CCTV be put into Garda stations including the custody areas and that still hasn't rolled out across the country … Where I'm from they are in every single custody suite with audio … every angle covered … Here it is very patchy, very hit or miss … Again, following on from one of our cases there about three years ago, it was a recommendation that our Gardaí stations have defibrillators and I don't know that any of that has rolled out. That was in a rider on a jury inquest in a case we were involved with in 2016.

Regarding recommendations and riders, the topics prioritised by coroners are often inconsistent and regularly conservative. Reflecting on a range of contested deaths the research epidemiologist stated:

We have seen recommendations from coroners where they talk about addressing something that sounds like they have just become aware of this [issue] *like young people taking drugs … it seems like it is totally out of sync with where we are in society and maybe … they were shocked about what happened and they didn't realise the kind of things that are going on.*

Chapter 4

EXPERIENCES OF BEREAVED FAMILIES

Chapter 4

Experiences of Bereaved Families

In the immediate aftermath of sudden death, or when families have concerns about the death of their loved ones in hospital or care homes, grief can be all-consuming. Faced with the practical and emotional challenges of unexpected bereavement grieving families are confronted with Gardaí investigations, potential court cases, coronial processes and, in high profile deaths, media intrusion. Transition from routine normality to turmoil is immediate. Making funeral arrangements in circumstances when death is anticipated is always difficult, hence the significance of funeral directors. Sudden death circumstances, however, often result in delayed access to the body, post-mortems and police/ coronial investigations, each of which adds to families' pain. The realisation that the death is under investigation by the Garda and/ or other investigative agencies, that an inquest to ascertain how death occurred is necessary and that legal representation might be required, becomes apparent when families are at their lowest ebb. This chapter reflects the experiences of those whose loved ones died in contested circumstances.

Gardaí

Many families interviewed had involvement with the police due to the circumstances surrounding the death of their loved one. For some the relationship was straightforward. Several considered the Garda a pivotal support throughout the investigation. Others had no Garda involvement yet considered that there should have been a criminal investigation. A significant number of families, however, recounted their negative experiences of the police, exacerbated during the coronial investigation. They considered that investigations lacked transparency, the police apparently operating without adequate accountability or oversight. For them, lack of accountability persisted in the coroner's court, raising concerns about the impact of Garda investigations on inquest outcomes.

In one case relatives were concerned that the police investigation into two family deaths had been compromised by a garda's relationship with an involved third party. This concern had been raised by another serving officer. The family believed the case had not been investigated thoroughly and they had been misinformed about the investigation. This was exacerbated by shortcomings in the inquest proceedings, as their solicitor stated, '*It is probably best to draw a distinction in your own mind if you can, between the completely and perhaps deliberately botched investigation and then trying to undo that through the process of an independent inquiry that you can participate in*'.

Another family commented on the informality of the Garda investigation into the death of their family member and what they considered were shortcomings. They discovered '*through the grapevine*' that a police investigator on the case was at school with those involved in the death, '*but only left the case when he got a promotion. This was serious, he should have taken himself off the case*'. The family considered that the investigation had not been conducted in their best interests but by a '*dysfunctional police force who don't do their job for whatever reason. I would not trust them in future. They should be completely overhauled*'.

A family whose son had died in suspicious circumstances stated, '*for the last 16 years we've been trying to find the truth about what happened to him and we've been stonewalled by the Gardaí*'. He went missing following an assault by a well-known member of their rural community. They stated that the police refused to mount a search:

A search party was put together, ourselves, no Gardaí, no Gardaí help. We searched everywhere, we had nowhere left to search only the river. We searched the river and his body was found by his brother. The Gardaí never met us, we had no meetings with Guards, only when I went to the Garda station or my son went to the Garda station.

Samples taken during the autopsy were given to the police for testing but were delayed for sixty-seven days before submission to the State Laboratory, during which time some samples had deteriorated: '*There didn't seem to be anyone upset with what was in front of them*'. Further meetings created an expectation that the bereaved family would receive further significant information: '*I was always believing, 'This is going to tell us something today', but we never got to that point*'. The family believes a full investigation was never conducted, their search for answers frustrated. Garda meetings were not recorded and no minutes were taken. A witness to the assault was interviewed but the evidence was withheld from the inquest:

I never got that statement for 14 years … the coroner had it the day of the inquest and didn't release it to us. For 14 years, while they were telling us it never happened, they had this statement, which we have, that it did happen, and they had it from day one.

The family considered that the circumstances in which their son died were obscured by personal relationships within the community involving the alleged perpetrators.

In another case, the partner of the deceased considered that the investigation into his death was deficient because of his known Republican background. She became aware of his death via RTE Aertel: '*the Gardaí never knocked on the door to let me know what happened to him*'. There was confusion regarding his killing, '*it felt like Republicans were the enemy of the state*'. They felt marginalised and badly treated at the mortuary, their loved one left on a trolley in a corridor and the autopsy '*rushed*'. The body was returned two days after the killing, his belongings withheld. While this case concerned the death of a person who had a public profile connected to his political affiliation, it highlights the significance of differential treatment of families within communities based on local knowledge or personal circumstances of the deceased.

Failure to communicate the progression of cases was a significant factor in bereaved families' negative relationships with the Gardaí. The uncertainty of 'not knowing' was debilitating for grieving families:

There was a sergeant from Dublin. He was up interviewing us and taking our statements, after the inquest, yeah. Then all of a sudden, he's disappeared. We went up to the guard's barracks, 'Where is he?' 'We don't know where he is … gone away'. He told us he would look into the case after the inquest, and we were saying, 'This is it'. He sounded really positive: 'I'll show you notes, I'll show you every step of the way, I'm going to look into this'. And then nothing.

Another family also experienced deficits in Gardaí communication. First, the failure to release information about the investigation, and second, regarding the progression of the case and a date for the inquest. The latter remained unresolved: '*Ten years, we're used to waiting, there's no info and we're supposed to have a family liaison officer … We've asked and the Gardaí just don't reply*'.

Several families reported significant concerns or errors in the Garda investigation narratives regarding their loved ones' deaths. A solicitor stated: '*the guards gave the impression that* [she] *was at fault, but when they got their hands on that file, they realised that wasn't the case, and they were very angry*'. The family also was concerned about receiving detailed information at the last minute: '*You would be told everything was relaxed and not to worry about anything, and then when you were about to go in you could be told information that would throw you*'.

This impacted on the family's determination to pursue the case further:

I think they were afraid that I wanted to have the case completely reviewed. They said if you are going to do that it will delay things by up to a year and a half. And my sister didn't want delay. But I remember thinking, 'I don't have to decide this before we go in'. I don't think that was right. And they had months to tell us that before then.

From interviews with families and solicitors it was clear that the Gardaí viewed some deaths as inevitable, beyond prevention. Perceived failures to investigate loss of life created considerable anxiety for families.

In most cases, after a sudden death, An Garda Síochána was the first institution to engage with families and the Garda Liaison Officer (GLO) became the conduit for state/family communication throughout the investigation. For some, the GLO was an invaluable support. One family remained in contact with their GLO after the inquest: '*He has been brilliant, we've been so lucky…he was always at the end of the phone*'. Another family also recognised the support they received: '*The Garda Liaison Officer had lots to deal with. It's not just about losing a loved one – it's so public, shocking, sudden and trying to protect the young kids in school*'.

Some GLOs faced inconsistencies in how coroners

used their discretion, as one family outlined: '*There isn't a liaison appointed for each person, there is one guard and that is his job to deal with the coroner, and that was this man's job. And you know he said to me that it wasn't an easy job,* [the coroner] *was very difficult to deal with*'.

The GLO was the sole source of information for families as the inquest process progressed. For one family the GLO maintained a positive relationship throughout:

He was the main point of contact and he was the only real kind of contact that we had through it. I mean I don't know if he could have reached out or what else could have been done. He said, 'So the Coroner, he's a real nice guy, we can talk through it'. He dropped up to the house within the month and gave us a rough outline of what it would be and what it would involve. He would testify and that would be it. We would just go in, and it could be open, there could be people there. On the day we just met up and had a coffee before and walked in.

Another family was protected by their GLO from having to face unpleasant details of their loved one's death: '*He spared us having to formally go and identify the body – obviously the city morgue is a pretty grim place … it was quick and it was painless*'. His thoughtful protection, however, had unintended repercussions as, after receiving the coroner's report, the family noticed inaccuracies in the account and details of a gruesome death. While the intention at the inquest had been to prevent the family hearing disturbing details, the full reality of the death eventually was revealed, exacerbating and lengthening the grieving process. Further, the possibility of exploring specific details relevant to the death was denied. Typically, the inquest was the last contact that most families had with their GLO or with other state agencies, yet several expressed the necessity to have addressed important questions that had arisen at the inquest.

Health Service Executive

Given that people are hospitalised primarily because they are seriously ill or have suffered a serious accident, deaths in hospital are inevitable and assumed to be a consequence of those circumstances. Others are admitted for relatively routine or complex operations; and most babies are delivered in maternity wards. The assumption being that whatever the circumstances all patients receive the best available, most appropriate physical or mental health treatment. There are circumstances, however, when the care received falls below best practice standards, when the treatment administered is inappropriate or inadequate, or when a patient's needs have been misidentified or neglected.

Families interviewed included those whose loved ones had died while in the care of Ireland's Health Service Executive (HSE). For others, their relationship with the HSE was limited to attending the hospital after the death. Consistently, families raised the problem of minimal communication. Following a car accident which caused the death of their son, for example, one family was delayed in viewing his body without explanation: '*a whole 12 hours during the day, no-one is really coming and saying to you this is what is happening … what we were waiting for, I don't know*'. After the removal of his organs they were asked to identify the body: '*going back up there was absolutely horrific*'.

The death of another family's baby occurred in hospital and they felt their loss was minimized by the institution. The baby's body was transported in the boot of a taxi to a different hospital for a post-mortem. His distraught mother was *'brought out the back door, hidden from the other mothers so she wouldn't upset them'*. She was informed that her baby was stillborn, yet the pathologist found that he had died through oxygen deficiency and '*was alive for twenty-three minutes after he left the womb*'. Their consultant reported the death to the coroner. The family had believed their baby was stillborn until they received the case file confirming he had been born alive. At the inquest the HSE challenged this version and the family's lawyer questioned the evidence: '*Medical notes had been changed, hand-written changed.* [They] *silenced the alarms on the foetal alarm. Not discussed with the coroner*'.

The family raised concerns regarding systemic failures, claiming that the hospital, '*is not putting baby deaths on the registry, information is being hidden … the coroner is not getting the information*'. They considered that the inquest did not achieve preventive outcomes. Although it returned a verdict of medical misadventure and altering the records was criticised, there was '*no accountability in the health service*' and the consultant had '*no case against her to answer*'.

A husband recounted the circumstances in which his wife died:

I was told to go home and she'll be up having breakfast

in the morning. I said 'No, no there is something wrong, she is very weak. The doctor said 'No, its fine'. The nurse pulled me aside and told me there was a bleed on the brain. We knew there was no hope.

There was no hospital follow-up until the family engaged a solicitor and arranged a meeting at the hospital:

The consultant and nurses cried the whole way through it. They said nothing could be done, but that's not true. I asked the midwife – she didn't deliver the baby – I asked if she would have done anything different. She said she wouldn't have let her go into labour.

Inconsistencies between hospitals and districts were evident. Regarding staffing, the time of day or night was significant. One family had experienced problems over a Bank Holiday weekend: '*I feel they were understaffed and some of them were there for 12 hours. The Registrar started her shift at 7am and she was still there at 4am the next morning*'. They expected the inquest to deliver a medical misadventure verdict but believed that the HSE used the inquest to erode family resistance:

It's like they use the inquest to gauge for any further cases, for how much they will have to pay out, how far it will go, how strong the family are, how much they will fight to get the truth. They use it as a gauge and they'll just drag it out. They drag it out over years, and they don't mind that, they just hope the family will go away.

For some families their experience of the inquest was dominated by what they considered HSE defensiveness. The inquisitorial conduct of the process was eroded as lawyers transformed the inquest into an adversarial forum.

This was the experience of a family who had campaigned for five years to access the truth regarding the context of their loved one taking his own life. They stated, '*our anger was focused on the HSE*'. On arrival at hospital he had revealed his suicidal thoughts. He was given his notes '*in a brown envelope*' and, due to bed shortages, told to go to another hospital. On arrival at the second hospital he was not assessed by a doctor. Despite denial by the HSE, his belt had not been removed. The family claimed that the HSE concealed the truth until the inquest: '*The medics hid behind the shield of the HSE until in front of the coroner* [who] *asked questions and made sure he got answers. The consultant changed her story on the stand*'. Prolonging the family's grief, the hospital failed to apologise and accept accountability:

It's like they use the inquest to gauge for any further cases, for how much they will have to pay out, how far it will go, how strong the family are, how much they will fight to get the truth. They use it as a gauge and they'll just drag it out. They drag it out over years, and they don't mind that, they just hope the family will go away.

If I had received an apology or an acknowledgement straight afterwards, I would not be here today talking about it. 'The making of our own misfortune', the HSE's solicitor said. All I wanted was an apology.

Pathology

State pathologists have a central professional role in the coronial process. Some families reported positive experiences as '*it meant it* [the death] *was being taken seriously*'. Others considered pathologists were barriers to accessing the truth, their examinations compromised by police and/or the HSE interpretation of events thereby shaping investigations and outcomes. One family stated that the pathologist approached the post-mortem with a preconceived cause of death: '*There was a big degree of a priori reasoning, because* [the deceased] *had been under management in the local hospital for a cardiac condition and somebody puts two and two together and* [the pathologist] *concluded that it was natural causes*'.

They contested this narrative by seeking alternative expert evidence:

[The pathologist] *had to deal with a professional colleague, saying that actually, 'No, these injuries are not all explained by the version of heart attack first, and a fall and an injury' … and much more likely, in his opinion, there was some incident that caused stress that led to the heart attack.*

Having also made fundamental errors, wrongly recording the colour of the deceased's eyes and hair, the State pathologist was compelled to change her position including the possibility that death had been caused by an assault.

Another family was concerned that in their case the pathologist had failed to send samples for testing. They considered that the inquest verdict, '*death by immersion in water*', had failed to take into account other injuries sustained by their son. The family, whose second opinion found a cause of death to be brain injury, believed the initial pathology examination had been influenced by the Garda version of events:

[The pathologist] *went to do an autopsy based on what he had been told by the guards … he did not examine* [my son's] *hands, his fingernails, and when he was queried about the parts of the body that he didn't examine, the answer you get is, 'Well if it is not in the report I didn't do it'. We believe that this man was told, 'You are coming down to do this but really it is a suicide case'.*

A bereaved family was concerned that a clear narrative regarding how their loved one died had been formed prior to the inquest and this had repercussions for the cause of death delivered. They believed that the HSE consultant and the pathologist were friends, often '*walking together, they went for coffee together*'. The family stated they had been told prior to the inquest that, '*events in the lead up to the time of the birth would not be listened to, yet in our opinion, they were very, very pertinent because there was proof of neglect on a large-scale leading up to it*'. They considered their concern was justified when, at the opening of the inquest, they were informed that the consultant had conferred with the pathologist regarding the cause of death. Further inconsistencies emerged at the inquest, not least the order of the pathologist's findings.

Coronial Process

Pre-inquest

As previously stated, the coronial process begins once the local coroner receives notification of a death and decides to proceed with a post-mortem. At this point bereaved families are most emotionally vulnerable as they await details of the circumstances of their loved one's death while enduring the shock of their loss. Invariably, their primary objectives are to view the body while being reassured that a thorough investigation of the circumstances of the death is being progressed. As the following case demonstrates, their priorities are not always recognised.

The body of one family's son could not be located for a weekend. They had been told on a Friday evening that all procedures had been completed and the body could be released to the family. Yet throughout the weekend they were unable to locate his body: '*the reason why we want to talk about this, it's not to hang anyone out to dry, it's prevention for the next family … that weekend was absolutely more horrendous than it ever needed to be*'. The only explanation for the lack of information '*was that something wasn't signed*'.

I think they should be able to issue an interim certificate … accounts were frozen, her life insurance couldn't move forward, her mortgagers were getting anxious, and wouldn't talk to us because we were not the mortgage holders, and the letters for legal action kept on coming because she was falling into arrears … They even had photographers coming to take pictures of the house to repossess it … And all of this for the death certificate, and all of this for eighteen months, because we had to wait for the inquest. Talk about adding pain on top of pain. We didn't have time to breathe the amount of pressure from things like that.

A similar issue was raised by another family whose experience was particularly distressing:

I think they should be able to issue an interim certificate … accounts were frozen, her life insurance couldn't move forward, her mortgagers were getting anxious, and wouldn't talk to us because we were not the mortgage holders, and the letters for legal action kept on coming because she was falling into arrears … They even had photographers coming to take pictures of the house to repossess it … And all of this for the death certificate, and all of this for eighteen months, because we had to wait for the inquest. Talk about adding pain on top of pain. We didn't have time to breathe the amount of pressure from things like that.

Another family raised concerns following the death of their loved one in a road traffic accident. They received scant official information during the investigation, adding to their grief: '*the* [police] *liaison officer wasn't fully aware, he didn't have the exact details and only had a brief outline, at that stage…when you are not told what happens, it makes it a lot worse*'. These

experiences illustrate a broader issue of the failure to inform bereaved families of the details of the death and the investigation process throughout the pre-inquest period, particularly when long delays then occur.

Understanding the Process

Families had no knowledge of the significance, conduct or consequences of inquests, thus were unsure what to expect: '*We wouldn't have known the importance of the inquest. I think in our minds the inquest was just going to get a death certificate. We didn't know*!' After being briefed on the process, their view changed and they recognised the significance of accurate information to allay their concerns and answer their questions:

Even if they weren't the answers that you wanted to hear, it was an opportunity. It's your last chance. You're never going to see these people again. You're never going to get to do any of this again. And that's why inquests are important, if you do have questions. But you need to know that you can ask them. If you don't know, it's gone, forever … and you'll find the rest of your life more tortured than you need to be.

Some families were aware of the potential for finding truth and pursuing accountability regarding the death, '*it was my pain, I just wanted the truth*'. One family simply wanted transparency following the death of their relative while in the care of the HSE: '*I wanted to know what had happened and I wanted the doctors to discuss it and make sure it didn't happen again*'. Families were driven by the desire to establish and understand the facts contextualising deaths: '*If you can't get accountability for your loved one you will never get healing*'.

Some families recounted negative experiences with other state institutions, impacting on their understanding of the process and diminishing their confidence that the coroner would conduct a thorough investigation:

Even if they weren't the answers that you wanted to hear, it was an opportunity. It's your last chance. You're never going to see these people again. You're never going to get to do any of this again. And that's why inquests are important, if you do have questions. But you need to know that you can ask them. If you don't know, it's gone, forever … and you'll find the rest of your life more tortured than you need to be.

I knew once that head cop was involved, there was going to be a cover up. At an inquest, they'd have to get a report from the guards and the whole lot. And I know that they wouldn't get a proper report.

At their inquest, however, they had legal representation: '*We were very optimistic going into the inquest because we had* [solicitor] *on our side and because we had a man over from England who was brilliant*'.

Another family doubted they would achieve a positive outcome from the investigation due to their previous experiences:

We got word in 2002 that there was an inquest organised. I objected. We knew there was no investigation. We knew what was going on was a complete and utter sham. We put in an objection.

The date was cancelled, and the inquest delayed for a further two years. No-one liaised with the family nor familiarised them with the process.

Other families campaigned for an inquest, learning about the process as they waited:

If I had of let it be I'd have been no wiser. We fought for the inquest, pushed on, week after week, nothing, eventually got it. A lot of people said, 'Don't do it'. I was pushing on, a farm to run, mortgage, kids etc. Looking back, I don't know how I did it. I did it all myself, no help.

Another woman, pregnant and now widowed, had no knowledge of inquests, nor was any effort made to inform her. The inquest was held just months after her partner was killed and eleven years later a further hearing examined the circumstances of his death. '*I was like most people, completely ignorant of the whole inquest and didn't realise it was a functioning court*'.

Some families acquired partial understanding prior to their inquest. Non-statutory groups provide support to families, informing them of their rights and options both before and during their inquests. PARC, for example, is a support group for families of road traffic victims*: 'without them we genuinely would have thought we were going that day for a death certificate, we wouldn't have known it's a jury, witnesses. The most important thing is, the person who killed* [X] *would have been there*'. Clearly,

families' understanding of proceedings, together with informed legal representation, make a marked difference to their experience and the outcome.

Legal Representation

As stated above, bereaved families are impelled suddenly into an unfamiliar and complex process that then is often delayed. Unlike criminal courts where the parties are legally represented, bereaved families are not necessarily aware that their interests might require legal representation, not least because other 'interested parties' involved directly in the death will be represented. Families also are unaware of the often prohibitive costs of legal representation.

Many families confirmed that initially they were unaware of the possibility and significance of legal representation. A family member stated, '*No, it wasn't suggested. I mean is that a normal thing?*' Another was told representation was unnecessary: '*the state was prosecuting* [sic] *the case so we didn't need representation*'. Yet, legal representation is crucial in interrogating the facts and asking vital questions of expert witnesses. Having met with the HSE a family member was concerned that he '*should have brought legal representation in with me, because I didn't even know if there was a failure in a duty of care*'. The inquest was completed within minutes:

We didn't have legal representation there with us, we didn't think it was necessary, we thought it was just a formality going in to get it done. So, there was no way once we were put on the spot that we could have really challenged anything, like we wouldn't have known.

Another family sought legal advice because they '*knew something wasn't right*' and '*the solicitor was brilliant, no stone unturned*'. Yet another family was advised by a former police officer to seek legal representation: '*He knew my brother, he said 'Sorry to hear the bad news, it is a cover-up, go and see a solicitor, a good solicitor*'.'

Legally represented families considered their lawyers had been crucial prior to the inquest, then in questioning witnesses and affecting the eventual outcome. One family member concluded: '*You can't have an inquest without legal representation*'. For many, however, without the provision of legal aid, costs were prohibitive. While some families were represented *pro bono*, that was rare. This raises the issue of inequality of arms as powerful institutions invariably have full legal representation.

A further issue raised by families was whether lawyers were familiar with coronial procedure or, in some cases, were adequately prepared: '*The barrister had not read the brief.* [Name, family member] *had to stand up and say that the barrister was incorrect*'.

Another family member stated her concern that their solicitors were focused on taking a civil case and neglected the inquest: '*I reckon it happens all the time, because people are so upset and traumatised, and people believe what they are told, and very few people question the system*'.

Delay

Long delay between the moment of death and the eventual inquest has become institutionalised within the coronial system. While inquests cannot be held until criminal prosecutions have been decided, this does not explain long delays experienced by so many families: '*There's a sixteen month waiting list in Dublin. It's all you wait for to hear your loved one's name*'. While the criminal prosecution proceeds, the inquest is suspended:

It took over a year for anything to get to [criminal] *court, and the waiting was just you know, unbearable. When you're turning up in* [coroner] *court, knowing that they are waiting on this and they are waiting on that, and it's not going to go ahead, and you're sitting there saying what the hell are you playing at here? It was up for mention how many times? Four. I know the inquest can't happen until after the criminal. But we found it really hard having to go in.*

This experience was echoed by another family who *'went to the coroner court appearances, we kind of went even though it was just adjourned to get another date, because it made you feel, at least someone was there, you know?*'

Another family had been told by the police that the process would take a year, but *'every month we'd contact and be told, no, it's going to be the next month, and then the next month, it's going to be the next month ended up stretching out to fourteen and sixteen and, finally, twenty months*'. Other families experienced longer delays. One family waited five years for their inquest, another waited a decade. The latter was explained by the failure to locate witnesses to the death, exacerbated by administrative cancellations: '*They just kept on coming up with excuse after excuse. We were prepared and ready the whole time*'. Dissatisfied with the inquest and its outcome, their campaign has continued over two decades: '*You're just so worn down that you don't*

know what, or you just reach a point where it's now just hopeless … I'm 81 now, I'll never see justice'.

One family's inquest was held eleven years after a murder. There were three years of adjournments, biannual hearings, and a Judicial Review to access Gardaí files. Another family had an unsatisfactory inquest five months after their loved one's death and waited over a decade for the follow-up inquest. Delays not only exacerbated families' suffering but also delayed probate: '*the day of the inquest, I just said it was such a long drawn out process, and that there were bills to be paid, and he said most inquests take a lot longer*'.

The failure to understand bereaved families' anticipation is clear in the following account, the family having waited eighteen months for their inquest:

We were prepared for an inquest lasting two to three days, so we travelled down from Mayo and we would have told our respective jobs and arranged accommodation, to be there on site, and the inquest opened. On the very first day the barrister for the HSE came in and stood up and said 'I won't be available tomorrow', and the coroner said 'That's fine we'll organise that, we'll put it off until September'.

Coronial Discretion and Proceedings

Coronial discretion creates inconsistencies in requesting post-mortems and progressing cases to inquest. It extends to the conduct of inquests, calling witnesses, summarising evidence and offering verdicts to juries; determining whether a narrative is added and to whom it is directed. The decision to hold an inquest is often discretionary. Following a death in childbirth one bereaved family, '*rang the coroner and drove the case ourselves … we had to prove the case … it is horrible that the inquest is not automatic*'. Another family stated that an inquest should always be held following maternal deaths: '*We had to fight. Kept writing and kept annoying them and eventually got it. Sometimes people said, don't do it – I wanted to try – at least if I lost I can say I tried*'. The family considered that media interest was the reason their case gained traction.

Bereaved families have neither experience nor knowledge of the coronial process. Regarding location, duration, jury selection, accommodation and public access, inquest proceedings vary significantly between districts. Families expressed concern about the formal setting of courts: '*it was the last place you want to be … a dark court room, we were up the back looking down on it … it was intimidating'; 'awful, upsetting'; 'needs to be more informal'*. They felt that their loved ones were lost in legal formalism including, '*the lack of reference to my son once by name'*.

In contrast, another family had been invited to meet the coroner prior to the inquest and had been familiarised with the court setting. They were, '*the only people who were in the coroner's court … no strangers … just us and the people that needed to be there*'. Other inquests were held in informal settings, including hotel function rooms or local halls. While families questioned the suitability of these venues, one family considered a private hotel function room had been preferable to the formality and '*chaos*' of a courtroom.

On arrival at the inquest most families felt they were '*cast adrift*', with no formal liaison person allocated to them: '*There is no-one to tell you about the process. No-one spoke to us on the day*'. Often, there was no dedicated accommodation or seating area for families, who were expected to wait alongside the general public:

You don't know who you are sitting beside, this is in the ante-room before you are brought into the actual body of the court. You know, so you can't really say anything because you don't know who is who and that's wrong.

One family's ordeal was exacerbated by HSE officials who were responsible for the circumstances under which their loved one had died:

The HSE were disrespectful – eating in the gallery. They didn't care that it was my son! It was very adversarial. It was not about the truth, it was about the show. I felt poisoned.

Families attending inquests, openly grief-stricken, experienced the difference between how they were treated in contrast to the professionals from the institution involved:

At break times there were no rooms for us. It was comfortable for the HSC. They had coffees and pastries but there was nothing for the family who are grieving, we were left in the corridor. My husband got upset during the inquest and the entire court-house was looking at him.

Another bereaved family experienced similar feelings of alienation, including tensions when families were forced to mix with witnesses:

We weren't even told where to sit. It was a very tense atmosphere. We felt on top of each other … we were sitting beside witnesses who were lying. No-one was telling us anything, you were left by yourself.

Another family stated, '*we just walked in as if we were someone in off the street … we were just in with everyone else, no recognition of who we are, or of what's taking place, or of what way you should or shouldn't react. You're just put in this mix*'.

Typically, bereaved families considered their inquests were not family-centred and this compounded their stress:

What I really wanted to say was that I felt it [the inquest] *was unnecessary. But it is intimidating, because he* [the coroner] *is austere looking, and just the whole set up in the courthouse is quite austere.*

Families raised concerns regarding scheduling several inquests on one day. This anticipated that cases would be uncontroversial and evidence uncontested: '*I just think that's insulting … doing a few cases together shows the disregard for the victims*'. One family stated the court was a '*conveyor belt … we were the first, but the three inquests were you know, bang, bang, one after the other*'. Their inquest lasted just thirty minutes, adding significant pain and frustration to their experience.

Another family likened the proceedings to '*an exam, you've been waiting for so long and you're just in and out and it all goes in a bit of a blur. I think it was over in about fifteen or twenty minutes. It's hard to even tell but it seemed to go so quickly*'. For another, '*it was only a minute or so after the deliberations, we were only out the door and they called us back in*' and the verdict was delivered.

Evidence

Some families were unaware they could be legally represented or, with the agreement of the coroner, that they could question witnesses. They felt that some of the evidence presented at the inquest raised issues requiring further examination. Others, advised by campaign groups and/ or solicitors, were able to prepare questions thus gaining a clearer understanding from witnesses of what had happened. This included examination of evidence given by investigators and professional experts.

Coroners regularly advised bereaved families that they might not want to hear the medical evidence contained in pathology reports '*particularly in a violent death of any sort, be it traffic or with a weapon*'. Hearing such evidence caused one family '*a huge amount of stress*' as '*there was a lot of stuff I didn't know*'. For a family whose baby died in childbirth, the mother, '*was so embarrassed. It was about her body and her labour. She was afraid that they were going to say that there was something wrong with her*'.

The family of a cyclist killed in a collision with a car considered the inquest minimised the motorist's role, placing responsibility on the deceased. They stated that the forensic evidence, '*highlighted what a cyclist is supposed to do, it didn't go into what a driver is meant to do … it sort of puts the person who is dead on trial, which is upsetting for the family*'.

Members of another family were distressed in court on hearing, for the first time, details of their loved one's death, particularly as the inquest was covered by the media:

I knew what the cause of death was. As far as I was concerned there was nothing else to be found out. But I found the statement quite raw. I felt like this person's dignity had already been taken away by her disease [illness] *and here it was being spoken about openly. Let her rest in peace, she has suffered, we have all suffered. There was no need, it was taking away whatever little dignity she had left.*

For some families the inquest provided an opportunity to contest official versions of the death by introducing expert opinion that they had commissioned: '*our coroner at least allowed you to call your own pathologist to give evidence*'. Others criticised coronial discretion regarding specific evidence: '*the coroner originally said no, but following further requests from* [our] *lawyer, it was allowed … it was the coroner's choice*'.

Not calling witnesses and the failure to present their statements was a further concern:

And then half the witnesses that the guards had interviewed didn't turn up. And some of them were really crucial to the argument … I don't think that people realise, that day when we were sitting there, and we're looking for these people. I remember everytime we hear the door, we're waiting for these people to come in, to do justice for my dad.

Despite long delays in holding inquests families occasionally heard evidence for which they and their lawyers had been unprepared:

And then when we did get there [our solicitor] *pulled*

us to one side to tell us that [the pathologist] *had brought in new information … and then he asked would I go up onto the stand, which I wasn't prepared for because we were literally just in, and I had to go up then and do a statement … it was brought in after ten years … never an issue until inquest day.*

Questions that families had sought to have addressed remained unanswered: '*we are still nowhere… I would have preferred for the two* [witnesses] *that were there to stand up and answer what happened, or their version of events that night*'. Another family commented, '*Lots of people who should have been there, and who had more genuine information, were left out*'. A further family recounted a witness being called on the insistence of the Gardaí who, it was claimed, had been in a relationship with their deceased son. When asked about her unsigned statement she denied ever making it: '*the coroner discharged her, and told the jury to disregard everything she had said*'.

Lack of evidence, or the failure to reveal evidence held by investigators, were issues raised by several families. This included 'self-inflicted' deaths. One family was told at the inquest that their son had suffered serious depression prior to dying in suspicious circumstances. There had been long delays in the investigation, yet the circumstances were not raised until the day of the inquest:

The coroner refused to hand over the documents to my legal team. If we had the documents, we could scrutinise them, if they are genuine we have to accept it, but it was hidden from us, and the person who hid this was the coroner.

Another family was concerned about inconsistencies in statements:

The Medical Council came up with different statements. The coroner knew they were lying and had to keep reminding the Medical Council that they were under oath. They will blatantly lie under oath. We knew what happened and our story didn't change.

While families considered the main purpose of the inquest to be discovery of the truth surrounding the circumstances in which their loved ones died, institutional defensiveness particularly regarding disclosure created an adversarial climate: '*It was not fact-finding, the HSE wouldn't let their own report be used*'. The family involved also raised concerns about the evidence presented by HSE expert witnesses when it was their professional practices that were under scrutiny.

In one case a family criticised senior HSE staff for leaving nursing staff to face adversarial questioning: '*In fact, the nurses* [had] *worked very hard and they were on the stand crying and everything … They had no power*'.

Failure to call key witnesses or seek their written testimony was a concern raised by many families. In one case a guard who had gathered key evidence regarding the death and was listed to appear had taken a vacation. The family's solicitor had not been informed, yet '*the coroner decided to roll on*'. The guard's statement was not presented as '*the coroner was of the view it was not relevant*'.

Many families were critical of the failure to provide information explaining coroners' decisions regarding the prioritisation and presentation of evidence. They considered that restrictions placed on evidence affected the thoroughness of the inquest:

There was no investigation into the time before [our baby] *was born and if there had been we would have been able to investigate all of his* [the consultant] *actions before her death or before he was born. It was just neglect, after neglect. If we had our way, we would be including all the information. In my opinion, the inquest was to look at all of the facts, and they didn't, the coroner ruled half of the facts out. It was clear that the midwives and the consultant had different stories. They were blaming each other.*

The family was concerned that they had been treated differently to the professional witnesses, the coroner allowing HSE lawyers greater scope in examining witnesses. What compounded their '*hurt*' was observing HSE witnesses '*coming down from the dock, and being patted on the back by their colleagues. They were sitting right behind us, smiling at each other saying, 'Well done, you got through it'.*' Another family considered that HSE witnesses: '*were not respecting the process … they were high-fiving each other at the inquest*'.

Not being informed about details of a death prior to the inquest had significant consequences. Attending a '*fifteen minute*' inquest, '*the coroner's findings were read out, and the cause of death was incised wounds to the neck and wrists. That completely took me aback, I didn't know it was the wrists*'. The Garda had informed the family that their loved one had died quickly, this was then challenged by the pathology report. It had serious personal consequences:

That opportunity to go through the finding of rigor

mortis and what it meant at the time, it probably would have given me and mam the opportunity to explore it whereas now it has become this huge thing between myself and her and now there is no way I can broach it. It's changed everything now for me particularly. Just knowing the last minutes of his life, what would have happened. So yeah, I can't move on from those years now. I'm trapped. I have to find a way to move on from it but I don't know if there is.

Juries

Bereaved families had contrasting experiences and divided opinions about juries. While some considered juries provided a detached assessment of the evidence, others were circumspect. Concerns focused on selection, lack of diversity and subjectivity: '*the jury are not really expert in their job … you know, they were just pulled off the street*'. In less-populated areas, jurors could be known to bereaved families, raising the issue of their independence.

One family was surprised that the jury was all male, all but three over 70. The verdict was reached in fifteen minutes: '*At least five were shaking hands with the Gardaí, patting them on the back in front of the family. It made us feel horrid. Three slept through the whole process*'. Jury selection was clearly an issue: '*they have a few businesses they generally pick people from, and some places they just pick them off the street on the day*'.

Coroners' direction of juries and the influence of the Gardaí investigation troubled families. One family believed the misadventure verdict in their case should have been accidental death: '*my view from reading the statements was that she had no part in her own death*'.

Challenging the necessity of a jury, a family thought the decision in their case was '*bizarre*' given that the cause of death was '*obvious*' from the post-mortem: '*it wasn't as if someone had to be guilty of something or something had to be deliberated on*'. Another family was distressed by what they perceived as the intrusiveness of a public court: '*They are strangers listening to really intimate details about your loved one … witnessing your sorrow and your pain*'.

Concerns extended to jury independence:

The jury is only doing what the coroner tells them … I don't see the need for them to be honest. They are going on the coroner's instructions, so they are only repeating what the coroner has asked them to do … It's just ticking the boxes really.

This was also the view of a family member who had attended several inquests: '*I think the jury is superfluous, I just don't see any role for the jury. In the inquests I have been at they have never uttered a word*'.

Juries, however, can offer bereaved families an independent and informed collective appraisal of the circumstances in which their loved ones died. From that appraisal, formed on the evidence heard and discussed between themselves, they reach a determination in the form of a verdict offered by the coroner. However, it is a concern that several families interviewed considered that jury independence was undermined by less than robust processes of selection, over-familiarity with those directly involved-particularly the Gardaí, and strong direction by coroners.

Competing Interests

Inquests can and should provide a forum in which families ask troubling questions and receive a thorough account of how loved ones died. This locates families at the centre of the coronial process. As discussed, some families were well prepared and considered their interests had been prioritised.

I had everything, all the files, all the documents. It was daunting, but I was relieved. I wanted to read my statement, I didn't need to read off it, I had learnt it. I had been to one [an inquest] *before and wanted to give my evidence last for impact. I wanted to represent my son.*

Some families, however, felt marginalised: '*You had no real indication at any stage what was going to happen next, and therefore you had no real ownership of the process*'. Several families stated that the death of their loved one seemed marginal to the proceedings particularly when competing interests were clearly evident. While their priority was to access 'the truth' of the context and circumstances of the death, they experienced tensions between institutional interests creating an adversarial atmosphere.

One family considered the professional defensiveness of a psychiatrist involved in their loved one's death highlighted an adversarial context. Another family was shocked by the level of HSE presence at the inquest into their loved one's death caused by Methicillin-Resistant Staphylococcus Aureus (MRSA). A family whose loved one's death reflected complex medical issues, considered the coroner appeared not to understand key '*medical terms*' underpinning '*the complexity of the case*'.

Bereaved families were concerned particularly by

the role of the Gardaí in establishing a narrative, influencing pathology examinations/reports and guiding the coroner. Their concerns included the gathering, use and elimination of witness statements. One family considered the Gardaí servicing their inquest were '*obstructive*', supporting the interests of what they considered to be a '*dysfunctional police force*'. Another family concluded that the coroner and Gardaí showed '*no sympathy; thanked the family and walked out. Very cold, like you didn't exist*'.

A further family believed the inquest, '*was not run by the coroner*' but '*by Garda and set up by the Garda and the coroner did not facilitate us in any way, especially when it came to looking for documents, or statements or any other help – either before the inquest, certainly during the inquest, and for the last number of years since the inquest*'.

Media Coverage

While families accepted there would be a media presence in high profile or controversial cases, they drew a distinction between reporting the facts and intruding on bereaved families' grief. Examples of intrusion included taking photographs and filming without asking permission and misquoting families' statements at the conclusion of inquests: '*I felt confident that we were going to get justice, we were going to get the truth out and it took every ounce of courage I had to read a three-page statement to the media when we got out of that inquest*' but '*they printed their own slant on it*'. This family's concern focused primarily on '*graphic detail*' causing additional pain and suffering to '*those who were involved and the people* [friends and family] *who were present at the inquest*'. Their questioning was echoed by other families when inquest findings were reported without the context and circumstances of the death being considered:

What is the purpose of the inquest? It's to get the truth or to get to the heart of the matter about what happened, so the press shouldn't even be involved. There should be some stipulation, or don't let rags in that are going to sensationalise it and print all of this stuff. You have this awful loss, and the whole world is aware of it, and what for? It's gossip.

Some families, however, considered that informed media coverage had the potential to make a significant contribution to preventing deaths in similar circumstances. Responsible, in-depth coverage by journalists committed to understanding and reporting the details of deaths in contested circumstances, together with bereaved families' accounts, can raise public awareness while encouraging necessary policy and institutional reform.

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Outcomes

Bereaved families were clear in their expectation of what the inquest should provide: an account of the background to and context of the death; truthful, accurate accounts of the circumstances of the death from those directly involved; exploration of systemic errors or failures; an informed verdict that would prevent deaths occurring in similar circumstances; institutional reform. An example of the realisation of the first four criteria was an inquest verdict of medical misadventure following a maternal death.

However, in another case, a family considered hospital staff had failed to answer questions adequately, claiming that they had '*got away with lying*'. The family had expected the coroner to make comments on the hospital's procedures and '*identify patterns*'. Yet the verdict appeared to be presented as specific to the case, '*not feeding into any other process*'. Another family stated:

The verdicts are not really good enough. An open verdict was the best outcome under the circumstances. Recommendations are only recommendations. They are hardly ever implemented … because once psychiatry gets involved nothing happens.

Regarding the classification of verdicts, a family took issue with '*medical misadventure*' arguing that systemic failure could not be defined as an unexplained sequence of events beyond the knowledge or control of those responsible for the care of a patient. They considered '*many more categories to explain a death*' should be introduced.

All families interviewed considered that inquests provide an opportunity to initiate systemic change:

I wanted to get the HSE to cop on. I just thought I would play my part in trying to bring about change. And that's really what it was about, as simple as that. An acceptance that there is something radically wrong in the training of health professionals, to understand the spread of infection and to deal with it.

One family's account of an inquest into a death in hospital was consistent with the experiences of others interviewed. Issues they considered should have been examined were eliminated by the coroner who, without question, accepted evidence given by hospital staff. The family believed that '*he had already made up his mind*' and in his summing-up, '*he said to the jury, this is what you will find*'. Their criticism was scathing: '*We were expecting some level of justice, truth, and what we got instead was a whitewash, controlled by the coroner. It seemed like a circle of close friends*'.

The family's concern led them to investigate further practices at the hospital where their loved one had died. They concluded that in several other cases, in which settlements had been reached and apologies made, '*new practices*' had not been adopted as promised. A family member stated: '*I feel strongly that medical negligence needs to be added as a verdict option*'. They were also concerned that riders additional to the verdict had not been followed-up:

But who is to know? Is this part of the coroner's role as well to follow up on this? There is no point in handing out riders if you have no effectiveness check. The coroner should follow up on this and make sure these things are happening in the hospital in question and in other hospitals. If recommendations are enforced that would help, go a long way to prevent similar things happening.

In another instance, a family had been advised that they could submit recommendations to the coroner. Their recommendations were accepted prior to the inquest, one of which related to coroners' communication on releasing bodies to families. At the inquest, while the jury was deliberating, a woman working for the coroner told the family not to raise their concerns regarding inadequate communication or the return of the body to the family. She had said, '*there was a really good reason why and she would tell me after*'. Eventually they were told: '*we have had family members in here, and when they get their chance to speak at the end they could be effing and blinding. And I said you don't have to worry about that with us, we're not those people, we want to try and get something good out of today, something positive so another family doesn't have to suffer the way we did*'. Effectively, therefore, a restriction had been placed on what the family might have stated in court.

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Another family struggled following delivery of an open verdict:

We were optimistic, when we had [our solicitor] *and the expert … and we thought, Jesus, that's it now, it's all going to open up now, we're going to have a proper investigation. Still nothing. Still not a thing. We're wondering why did we have an inquest then, if you can't get anything out of it? We were expecting an investigation afterwards. We'd gone through this whole process. It seems like you're not allowed to question it. I approached the Minister for Justice, and still, even the Minister for Justice couldn't do it.* [Our solicitor] *was in touch as well, but still we were getting nothing. It was just like a closed door.*

One family had taken a judicial review against their coroner, delaying their inquest for several years. The judicial review went against them and they did not appeal: '*We were out of time. We would need to go to the Supreme Court and then Strasbourg. It's a lot of money. I've raised five kids with this and it would take ten more years of the same*'. Their objective had been to access all relevant documents from the investigation, previously withheld, to establish '*the truth*'.

Another family considered their inquest had led to greater confusion, revealing '*no new information and we felt we got nothing. It was all rushed. I was really angry I waited eleven years for that*'. They had anticipated an open verdict:

We knew it wasn't going very well. Quick verdict, we felt they had gone to the toilet and just came back, back-slapping. The only thing we got out of it was a death certificate. You feel your loved ones are on trial.

Like other families, they considered they were defending the reputation of their loved one. They felt that their loved one's reputation was under scrutiny. Summarised by one family as '*a class system in operation*', this was an issue for families who believed that such negative labelling influenced the process and limited HSE investigations.

A family whose loved one had taken his own life believed the verdict of suicide failed to recognise that he '*died because he wasn't looked after; he killed himself, but no-one was asking why … death by misadventure does not even tell the truth, but it would have been a better verdict, more honest*'. While the coroner made four significant recommendations, the family were aggrieved that institutional reforms did not follow.

While some families considered the coroner had shown empathy, a family member stated:

The coroner doesn't take into account what the death has done to a family. He should have acknowledged that the HSE caused grief. When the case against HSE was finished, I had to start grieving again. There is no such thing as closure. I hate that word. You learn to live with it.

Others were concerned that their experience of their inquests fell short of expectations: '*Our hope was to try and get justice but in my opinion we didn't anyway. I didn't get justice there*'; '*We got no answers*'; '*We didn't get any answers*'.

A bereaved family considered that the DPP's decision not to prosecute in the case of a road death had a direct impact on the inquest narrative and the jury's verdict:

They tend to fob you off, the guards. The impression I would have about cycling accidents and road deaths is that it is easier for everyone concerned if there is no criminal case involved. And that impacts on the inquest and on the jury, because I think that they automatically assume that if somebody has been killed on the road and there is not a criminal case, that they [the deceased] *are probably at fault.*

Frustration regarding lack of accountability was shared by all families interviewed:

There is no accountability, for [sic] *the coroner in Ireland. Our particular coroner is quite arrogant, he knows he is outside anything as such, he is protected in his name and his title and who he is … nobody has the right to challenge him. So, if you ask questions of the coroner, like we have down through the years, it goes through the justice department who send it directly back to the person you are querying for him to answer.*

Records

Following inquests, families were frustrated by being denied access to files on their loved ones. For some there had been a failure to record *verbatim* the proceedings, for others documents had been lost or access denied:

We sought it, we sought access, we pursued the Gardai. [Our solicitor] *pursued them on our behalf, to get the reports. We asked for paperwork to verify what had been said by the state pathologist, and we weren't allowed it. We went through all the channels. We were not allowed that. They would not, and they still won't, give it to us.*

Access to records and transcripts of proceedings is significant particularly in seeking resolution to contested cases. The only record of one family's inquest was in local media as no transcripts were taken. A crucial element of the case focused on the consequences of an alleged assault and the pathological evidence presented. The journalist, however, no longer had their notes.

The absence of written or audio transcripts of proceedings was a consistent criticism raised by bereaved families: '*The fact that he didn't take a record of everything that was said is a really bad thing*'. Where records did exist they were limited in scope and detail:

There was no stenographer there. We took our own notes. Finding the script from the inquest has proved difficult, the report from the inquest, she had a good bit of trouble trying to get it and I think what she did get [was] *one or two pages, no recording of it … we don't have money for that* [stenographer] *and the HSE knew that.*

One family recalled approaching the Justice Minister who informed them that inquest records had been lost in a fire. Following their persistence, they stated, '*all of a sudden they* [the files] *resurfaced*'.

Support

The majority of families were dismayed by the lack of official support afforded to them throughout the inquest process. Their primary concerns were: deficiencies in the information and guidance provided in the preparation for and conduct of their inquests; lack of recognition of their need for emotional

support in dealing with the impact of the inquest. As stated previously, many families were unaware of their entitlement to legal support.

Failure to recognise and respond to the needs of the bereaved was institutionalised. This extended to the experiences of marginalisation before, during and following their inquests. A few families considered that the inquest had provided answers they had required and had contributed positively to coping with grief.

Post-inquest support, however, was lacking:

Even when you come out of an inquest, there should be someone to guide you through, someone there to talk you through what is going to happen next. Because we all left, going out with that feeling that we're going to get our justice now. You never think you're going to wait for another eight years, and still be trying to fight the fight.

Further, the trauma of the inquest, particularly hearing in a public forum the disturbing details of sudden death, required emotional support, in this case a death during childbirth:

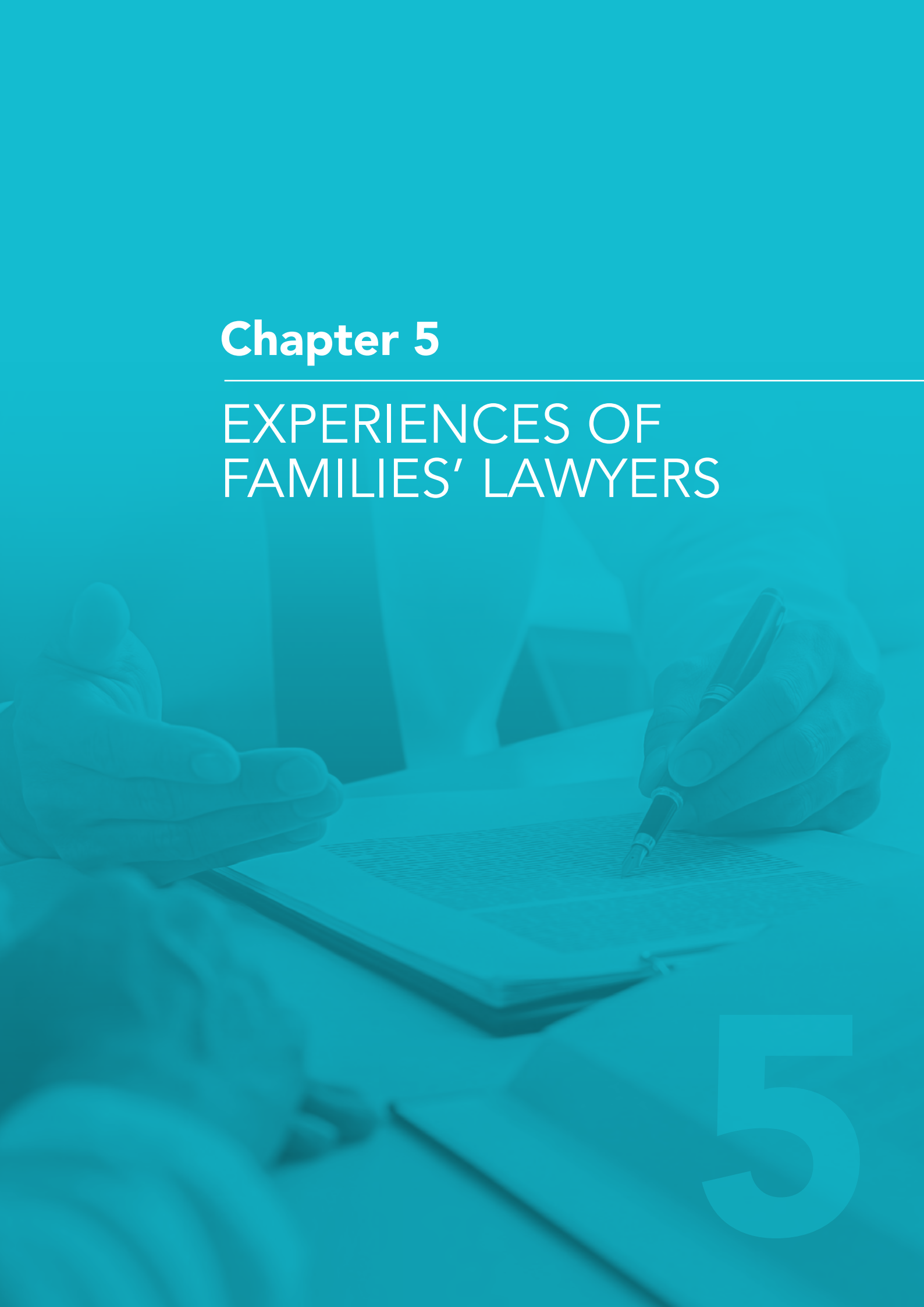
Families should have support and counselling. Its traumatising and embarrassing, particularly sensitive when its childbirth because it is so intimate. You feel excluded. It was very lonely and very difficult.

Families considered that detailed information about the inquest process and what to expect, together with the availability of independent family liaison, was required to humanize the process and respond to their needs: '*It would have probably been a helpful thing if they said, 'You know, this is difficult and you can phone this number to get some support'. There was definitely nothing like that*'.

Without exception, interviews with families demonstrated that they required further support during the immediate aftermath of inquests and throughout the weeks that followed. Once the inquest ended, however, they were left alone, dealing with their grief, the often frustrating experience of the inquest and the impact of the verdict.

Chapter 5

EXPERIENCES OF FAMILIES' LAWYERS



Chapter 5

Experiences of Families' Lawyers

The solicitors interviewed had considerable experience representing bereaved families at inquests. Research interviews followed a similar structure to those conducted with families to ascertain whether their criticisms and concerns were consistent with lawyers whose experience of the coronial system was extensive and across a range of Districts.

The Gardaí and Coronial Investigation

As discussed in the previous chapter, the Gardaí are integral to the coronial process. In direct contact with bereaved families, they are the primary death investigators initially establishing the grounds for prosecutions and then servicing the coronial investigation. Discussing the discretionary powers of the investigators, a solicitor commented that '*quite often the investigative failings happen long before the coroner can do anything about it*'. However, another solicitor suggested that as an institution the Gardaí's reputation is derived in '*the tradition of protecting the State*'. Consequently, '*unless there was grievous wrong-doing*' they would be trusted in '*doing their job*', affording them immunity from what would be viewed as '*invasive investigation*'.

Further, '*in the absence of paid staff and a structure to deal with families*' they fulfilled a range of essential roles: '*liaison … advisory … jury selector … evidence gatherer … general investigator, and then sometimes they come to the inquest and they also give evidence*'. Their investigative function, however, was considered flawed:

If the Coroner's position was full time and professional and the coroner had legal authority to direct areas of investigation … they might be better carried out. But the current situation is the coroner is only asking the guards to go and take statements from, shall we say, the medical professionals in a hospital death situation. But they are not question and answer statements. They are prepared by professionals assisted and submitted to a guard who doesn't have expertise in the areas anyway. So, it is not an investigation, it is a delivery service.

Another solicitor stated that in his experience guards' involvement in an investigation was arbitrary, '*insofar as they happen to catch a particular case*'.

If the Coroner's position was full time and professional and the coroner had legal authority to direct areas of investigation … they might be better carried out. But the current situation is the coroner is only asking the guards to go and take statements from, shall we say, the medical professionals in a hospital death situation. But they are not question and answer statements. They are prepared by professionals assisted and submitted to a guard who doesn't have expertise in the areas anyway. So, it is not an investigation, it is a delivery service.

He considered if '*there is no crime involved then the levels of enthusiasm drop considerably*' with non-criminal deaths perceived as inevitable:

Like in suicide for example, a person killed themselves, 'But it was a tragedy. What can you do?' The idea that they were horribly neglected by a medical establishment, or kept waiting for six months for an appointment, or prescribed the wrong medication … that never, never, gets investigated.

A solicitor stated that police investigations into deaths, '*can only be described as ad hoc, but it is ad hoc at the control of the police*'. The proximity of the Gardaí to the coroner's office was problematic unless coroners asserted their independence.

Pathology

As discussed previously, bereaved families raised concerns regarding Gardaí accounts of the circumstances of deaths directly influencing

pathologists conducting post-mortems. A solicitor with considerable experience of inquests stated:

A pathology report, I have learnt over the years, is very often based on the anecdotal information a pathologist received from police officers doing the investigation. That anecdotal information is, as often as not, omitted from the report because the pathologist says they based it on their own observations, but their observations are built on what they are told. Change the initial information slightly and you change the conditions of the analysis, and that can sometimes lead to a very different result.

Consequently, he questioned the independence of the '*pathology service*'. Deficits in state pathology, he stated, reflected the culture and context in which pathologists routinely worked:

If you examine a body … for the purposes of catching bad guys who may have caused that death, pretty soon your general approach is a law enforcement orientated approach, which is a conservative sort of statist approach. The idea that you are going to be able to turn that off someday, when asked to examine a body [whose death] *may have been caused by a police officer ill-treating a suspect at a police station, I think is a little naïve. You have to get somebody independent in.*

Another solicitor emphasised the shortcomings of a process in which, '*there is a wilful ignorance of this by people who put themselves up as impartial*'. Clearly, in contested cases, the repercussions of evidence presented by pathologists as impartial, objective and scientific having been influenced in its gathering by vested interests or partial interpretation was a matter of serious concern. As stated in the previous chapter, this led some families to seek a second, independent pathology examination resulting in a different outcome, thereby altering the possible circumstances of death.

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Legal Representation

As families stated, access to legal representation was not universally sought, some assuming the inquest was simply a formal process to access a death certificate. This had repercussions for legal representation at inquests:

I think [it's] *broadly true to say that bereaved families only end up with legal representation … if they go and get it themselves. The typical feedback I get from people I have represented was that when they ask the question, if they ask the question, 'Should we get a lawyer?' they are typically told, 'You don't need one'. They are often told that by the Gardaí, the police.*

Another solicitor objected strongly to this practice: '*they should not be told by some well-meaning cop, 'Oh you don't need a lawyer, it is very relaxed, and the coroner will be very nice about it'*. While the Coroner Service web-site provides some information regarding legal representation, the initiative is placed on families to seek this out: '*If they don't go and look for it, it is not necessarily automatically provided for them*'.

Solicitors interviewed considered that information encouraging relatives to '*seek some legal advice*' and informing them of the legal aid scheme, '*should be part of their general communication*'. Rather, it was left to families of the deceased '*to go and find out if they need legal advice or not*'.

A solicitor considered the information offered did not provide an objective overview of the adversarial potential of inquests and, therefore, the significance of legal representation:

You get these anodyne, blasé information leaflets produced by the Government … 'You may want this, and you may want that'. Whereas anybody who had been through the process would say if you do nothing else go and find yourself a lawyer … if you think this system is capable of finding out what happened to your relative because it is a really good system and you can put your faith in it, think again. And that is the information leaflet you would really write.

As the previous chapter discussed, many families campaigned for an inquest and considered legal

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representation as crucial. Solicitors stated this was vital for deaths that had occurred under HSE care. Still-births were a particular concern because of an assumption that such deaths were inevitable. Yet, as a solicitor stated, '*it is very unusual that the coroner will have an inquest where there has been a still-birth*', although coroners '*are getting more proactive*'.

Another solicitor considered that multiple factors informed coroners' decisions not to have inquests for still-births not least, '*a patriarchal attitude … towards families that it's a lot better for them that they don't have to go through this*'. Further inhibitions, he stated, included the '*burden on the health system … and it is going to cost the tax-payers' money*'. Ultimately, solicitors agreed that many coroners '*just don't want it. It is an easy death to stamp and write off and* [they assume] *there is no need to have an inquest into it*'.

Barriers to seeking a second inquest because of concerns raised by bereaved families regarding the initial outcome are significant. A solicitor stated:

We had to go to the Attorney General to say look, we have come across new evidence, so we need to have this re-opened … We had contacted the coroner and he was having none of it, so we went to the AG and he re-opened.

In complex and contested cases, families' access to solicitors who had significant inquest experience was important as institutions invariably were represented by senior counsel. A solicitor commented: '*you have an inequality of power, an inequality of true justice. When you have inequality of arms you don't have true justice*'. Another solicitor agreed:

There is no parity of arms. Usually, they are up against either the Guards or the state in some form, or if it is not the state … it is an insurance company … the family are there usually by themselves or with one solicitor, and then you have the insurance company coming in with a battalion of solicitors … it is a very intimidating procedure for families to have to face.

Identifying a solicitor with expertise necessary to represent families in complex and contested cases is not straightforward. A solicitor stated, '*we have no training ... you can do CPD courses on the coroner's court … that's about the extent of it*'. Another solicitor commented: '*it is peripheral in law school, you just learn by doing them*'. Further, there was no incentive for solicitors to take coronial cases, '*it is completely voluntary whether you do this or not and it is all down to you whether you acquaint yourself with the processes of the law*'.

This had consequences for the standard of legal representation: '*it is a lottery*'. Some families would '*prefer to be with somebody familiar to them … even if that person may not be qualified*', while some solicitors were '*happy to take a case and try to educate themselves as they go along*'. In some cases, however, solicitors informed bereaved families that legal representation was not necessary:

That's because inquests are horrible and unrewarding, financially unrewarding, and they just don't want to do them … Most solicitors would avoid them like the plague and that is a big problem for families, because they are going in on their own.

Others, however, took cases to the civil court, influenced by fees: '*interested in making money … but not a lot of them interested in making change*'.

There is no parity of arms. Usually, they are up against either the Guards or the state in some form, or if it is not the state … it is an insurance company … the family are there usually by themselves or with one solicitor, and then you have the insurance company coming in with a battalion of solicitors … it is a very intimidating procedure for families to have to face.

The Inquest Process

One solicitor considered that the coroner's court lacked the professionalism and standing of other

courts. Cases in the criminal courts offered better remuneration than the '*ad hoc scheme in the coroner's court*'. Criminal cases were heard before '*a professional judge* [with] *scheduled hearings*' and the proceedings, '*fully recorded*'. While in the coroner's court, '*there is nothing*'. There was agreement among the solicitors interviewed that '*the inquest process itself is completely outdated*', using '*what is effectively a court room for what is an inquisitorial process*'. In their view, '*it is too abrupt and it's not collaborative enough and not thorough enough*'. Consequently, there was a failure to investigate all deaths rigorously: '*it needs to be more inquisitorial; it needs to dig deeper to find not just the how, but the why*'.

As the historical context chapter demonstrates, the deficit in the inquest process is both structural and organisational, requiring reform:

The state is obviously primarily economically minded, and if they felt that the alternative was to be fending off litigation for years, they would do something about it … as practitioners we have to take our share of the blame that we let the system feed off our own complacency.

Persistent institutional failings indicate a conflict between the State's responsibility to the bereaved and the protection of established interests. As a solicitor stated:

I think the legal framework in Ireland does not equip relatives with the means to find out what they want to find out. It equips vested interests with the means to prevent information being revealed.

Coronial practice is determined by '*a great degree of cultural influence, the traditional practices of certain agencies and actors*' which can '*over-ride the legal requirements*', thereby undermining the integrity of the process. The defensiveness of '*established interests*' was evident in many inquests:

As a general rule, the people who are not in the driving seat are the bereaved relatives … they are met with complaints and objections from quite extensive legal teams representing the State, if it is, for example, a police death or a prison death. They encounter a similar army of lawyers who are briefed on behalf of the medical establishment who protect things just as fiercely, if not more, than people who are tasked on behalf of State agencies.

Consequently, bereaved families were '*met with lip service*', especially in contested cases:

It's like, when they are dealing with substantive rulings, they always seem to go against the family, but they are always mentioned and addressed during the course of the hearing. 'You know we are very sympathetic, sorry for your loss, but no you are not getting any paperwork and yes, we are going ahead with the inquest'.

Solicitors interviewed considered that the effectiveness of the coronial process was subverted by a controlling dynamic of institutional protectionism and defensiveness. In this context, families required lawyers to resist this dynamic, identify and reveal the facts of the case and release information that might otherwise be withheld:

The pattern of litigation in Ireland around coroners' inquests has that real feel of a restrictive spiral … you are constricted more and more, and restrained from asking questions that are often obvious … It has got to the point where the outcome of the inquiry provides no reassurance or redress for relatives.

Solicitors identified the HSE as being particularly defensive, often hiding '*behind confidentiality, even when the person is dead, to prevent an investigation into the circumstances of the death*'. This institutional defensiveness raised, '*questions of relevance, questions of appropriateness, whatever that means … questions as to whether something comes within the ambit of the inquest or not, or whether it is ultra-vires*'.

Disclosure of evidence, and all relevant material held by the prosecution, to the defence well in advance of a criminal trial is a contentious and persistent issue in many jurisdictions. Disclosure underpins a defendant's right to a fair trial. At inquests full disclosure has proved problematic:

I've done a few deaths in custody, police stations, a few deaths in prisons and a few cases where there was a killing and there was no criminal trial and then we had an inquest … I found that difficult because it seemed to me that the medics and the prison people had got their ducks in a row … I certainly felt that the disclosure I got was very nicely synchronised.

Further, a solicitor with considerable inquest experience proposed that medically-trained coroners protected HSE witnesses:

If you have a coroner who is a doctor there is kind of a built-in resistance to let a colleague be mauled by some over-zealous lawyer in a coronial setting … it just seems the chances of an interruption from the coroner are much higher if you are having a go at the doctor rather than having a go at a policeman.

Such institutional defensiveness and protection of professional interests suggests a coincidence of interests: '*there doesn't have to be a great conspiracy, because these people inherently know to protect the system and each other. It's just learned behaviour*'. This included '*evidential statements*' containing and possibly restricting access to '*a huge amount of information*', particularly regarding police and prison officers when, regularly, '*the language is so uniform*'.

The advice that the medical people get is never apologise for anything; you did nothing wrong … that's the lawyers fault I would say, because that is the advice they are given. I think there is on the medical legal side, an entrenched position.

The solicitors interviewed considered that in contested cases inquests were transformed by institutional defensiveness and focused not on ascertaining the truth but on protecting against the possibility of a future civil case. This was described as an '*inquisitorial process in an adversarial wolf's clothing*'. Consequently, defensive institutions arrived, '*lawyered up to the eyeballs for an inquest into someone's death in a hospital*' anticipating '*what is going to happen later on further down the river*' in civil proceedings.

One solicitor considered that such embedded defensiveness inflicted further harm on bereaved families: '*shot down every time they try to get an answer to something that really they have a right to know, or should have a right to know*'. It was '*an awful thing to put a family through after they have had that loss*'.

Such a '*counsel of despair*' was anticipated by solicitors managing the intensity of family expectations. It had repercussions for families' experiences of the inquest process, particularly regarding lack of redress following proceedings. A solicitor stated, '*because it looks like a court process, I say, 'No. I know it looks similar with a judge and the witness box, but this is just an investigation, nobody is going to get blamed'*. This is difficult for families to accept because they '*want someone to bear the brunt of their pain, the brunt of their anger; they want someone to be punished and that is never ever going to happen … you do have to work to manage their expectations*'.

As demonstrated in the previous chapter, the investigative process consistently fell short of families' reasonable expectations for a rigorous examination of the context of their loved ones' deaths. This was evident at inquests conducted at speed and of short duration. A solicitor stated that the longest inquest he had experienced was three days: '*It's very short here, in England and Wales you have Article 2 inquests, we don't have those Article 2 inquests here…and each inquest is not compliant at all with Article 2 which is a big concern*'.

As discussed, contested inquests often became forums for institutional defensiveness, obfuscating the truth of the death, particularly when there was the possibility for civil action. Families, therefore, need to be made aware of this potential development and its impact:

Isn't it that classic thing, you are talking to someone who has clearly been the victim of a wrong … and you just say to them look, this is what litigation involves, are you ready for this, do you want this? What could you gain, you could possibly gain x, y and z, right? But if you don't do it you can walk out of here and that part of your life is over. You won't have any expense; you won't have any stress. And some people will say, no I'm just happy to move on.

Coronial Disparities

Three distinct but related concerns were identified by solicitors: uneven resourcing, the process often informal; variations in coronial expertise; inconsistencies in the use of coronial discretion. Interviews with families also revealed inconsistencies between coroners across the Districts. Given the lack of central, institutional leadership and training, local discretionary practices had evolved and consolidated. As a solicitor commented: '*the institution is not up to the job because there isn't one really, it's a decentralised system*'.

Inconsistencies were exacerbated by regional disparities in resourcing:

What you have is a person tasked with the job, who is given a certain amount of resources to do the job, and those resources, I would imagine, tend to be consumed with the absolutely necessary tasks: paying staff, maintaining basic admin facilities. They seem to be subsumed into local government offices an awful lot of the time and what you have is a great deal of ad hoc fulfilling of roles.

Such disparities could be improved by adequate resourcing, '*certainly around the country there should be one lawyer attached to each coroner, there should be much better communication, that may be where the coroner being properly staffed would come in*'.

Solicitors agreed that coronial discretion produced inconsistencies often reflecting the particular coroner presiding over the inquest:

Now it depends a lot on the coroner you get. There are coroners who simply want to rubber stamp everything, brush it under the carpet, they don't want any controversy, and I assume it is either because they are very busy, or they don't want to do the work. So, you can come up against coroners who are just uncooperative. But luckily they are few and far between.

Another solicitor stated, '*what passes for expectation is completely different depending on where you are*'. This variation affected how lawyers prepared families for their inquests: '*you can't say, on my experience this is how the inquest will develop, because your experience divorced from knowledge of the individual coroner is pretty useless*'. It also had consequences for coroners, '*as they don't have a centralised support system that would assist them in achieving best standards and there is nobody mandating them saying this is our approach to be followed*'.

Solicitors drew a distinction between coroners who were conflict averse and those who were direct interventionists:

If a coroner has a significant strength that he is a genuine, nice, compassionate man, and a significant drawback is that he is conflict averse … if anything looks like it is a disputed death it is not going to be anywhere near the top of his list of priorities.

In contrast, others '*are so conceited about their own knowledge of the subject, that they make the process excruciatingly bad*'. Coroners' professional discretion and the lack of a centralised system of professional training was summarised by a solicitor as follows:

Discretion, in my experience of Ireland and judges and decision-makers generally, is that they just bring so much of their individual personality into a process that certain things can be uniform but there will always be big differences in terms of how each individual coroner runs their particular court.

Solicitors considered the coronial appointment process to be '*problematic*', one commenting that '*the way most of them are appointed is if they are deputy coroner, usually the deputy becomes the coroner after the coroner retires*' with no transparent '*public process*'.

The professional background of coroners, their training and professional expertise were concerns shared by families and their lawyers. In Ireland, general practitioners form a significant cohort, a process questioned by one solicitor: '*an inquest is not a medical forum, it is a legal forum, and the skills of a person that is presiding over that forum are not medical skills, they are legal or investigative*'. Should an inquest require medical input, '*get a doctor in to provide you with that evidence. You don't need a doctor sitting in judgement*'.

Another solicitor agreed:

An inquest is an investigative mechanism. If you are gathering information and investigating a case then you either need to have made significant effort to acquire those skills in addition to your medical skills or you need to be an investigator/ analyst in the first place.

Solicitors raised further concerns regarding what they considered to be a significant deficit in investigative expertise which had implications particularly for those families not represented:

So, a family appearing at an inquest on their own, putting their entire faith in the system without the benefit of a legal representative of their own, the Irish system will not serve them well. If you go into an inquest in Ireland … you do need to bring your own lawyer if you want any guarantee that you are going to get a proper investigation.

Despite the State's '*responsibility to investigate, it cannot be left to the families under their own steam*'. Further, the State's duty to act was '*very must observed in the breach in Ireland*'. Consequently, bereaved families could not depend on inquests to resolve their unanswered questions: '*If you don't have an overtly clear set of circumstances, that show an overt position on the state to do something, then they will step away and do the minimum*'.

Finally, deficits in coronial accountability and oversight were shared concerns:

They are not really answerable to anyone, so this is a big part of the problem. The only thing you can do with them is judicially review them. And really, they have nothing to fear from judicial review; the tax-payer ends up paying for it. I don't think there are any sanctions on a coroner if they get judicially reviewed, so they really are a law unto themselves.

Delay

As discussed in the previous chapter, bereaved families often experience persistent, unacceptable delays waiting for inquests. On occasion, family members have died before the inquest into the death of their loved one was held. Solicitors considered delay to be endemic within the system, summarised as follows: first, '*if they do have a solicitor, we will have to research the case first, so some delay is down to us*'; second, '*getting all of those people* [witnesses] *together on the same day is going to be a challenge*'. Consequently, '*I can't think of any inquest that was done and dusted quickly*'.

Further, the process lacks transparency and communication is poor: '*You don't get an opening date and accountability as to why it doesn't proceed on subsequent dates*'. This contrasts to civil courts where, '*the practice of judges being able to reserve their decision without having to explain after a period of time why they haven't yet delivered is a bad practice*'.

Unaccounted-for delays potentially leads to omissions in the evidence heard, exacerbated by the institutional interests and defensiveness of state agencies and medical institutions:

Where it is a state party that is potentially culpable, they are past masters at delaying the lie. And if you can achieve a non-hearing by simply saying, 'Oh we can't have all our witnesses available at that date' … you wouldn't get away with it in a criminal court … then they do exhaust families. I can think of a case where by the time you get to a point where it would really be actionable to pursue that coroner for not convening that inquest, the couple are no longer a couple. So, the last thing in the world they want is to find themselves back in [in court] *together.*

Disclosure

Conflict regarding disclosure of evidence, blocking access to contextual information, witness testimonies and documentation, was a regular occurrence and had become institutionalised. This extended to witnesses evading disclosure:

You may get, 'Sorry I can't recall', or 'Sorry I don't have that in my notes', or some of them … they dance around it and you can't get a direct yes or no answer because if you keep going back at them, what the coroner will do and say is, 'That's already asked and answered'. So, it's very easy for witnesses to fudge answers, or not give straight answers, or tell outright lies ... And I have seen doctors lie.

A concern raised by solicitors was the acceptance by coroners of the reliability and truthfulness of evidence given by medical professionals whose actions or inaction were under scrutiny:

There was one particular case I did, the coroner … couldn't give a natural causes verdict, but he was not going to give a medical misadventure verdict even though this poor woman had obviously been killed due to negligence on the part of the staff.

As discussed earlier, disclosure of documents was a persistent problem: '*you may only get the statements a couple of days in advance, and at that stage they are not much good to anyone*'. Inhibition on disclosure was raised by families and solicitors as a persistent feature of interactions with the HSE. According to one solicitor: '*they are very, very reluctant to open doors …* [in one case] *we battled with them to release medical records and notes for about two* years'. The failure to disclose could result in litigation, '*because there is no openness*'. He continued:

One of the main reasons premiums are going up is because there is a reluctance among insurance companies, estate agents, you name it, to co-operate and release information to plaintiff solicitors, applicant solicitors, to try and move the cases forward, because they are afraid of admitting culpability, and that's constant.

Further hindrances to the timely progression of inquests involved the coroner/ Gardaí working relationship: first, through '*depositions which are essentially not given in person by the individual, they are lifted from the police statement and pasted onto coroner documents*'; second, through potential witness details being withheld.

What I don't know and I'd only have to guess, is whether the police were saying to the coroner, 'No', or the coroner was making up his own mind and was saying 'No' … whether the police were saying, 'No, we are not giving them to you, coroner' or 'Yes, we will give them to you, but we don't think they are relevant'.

The Gardaí could deny access to key statements citing privilege, a process which, in the view of one solicitor, required legal reform:

When there is a proper statutory framework, everybody knows that there are legislative

provisions that have to be adhered to and complied with, and as long as the coroner is acting intra vires, he should be allowed to make those requests for disclosure from the police. There should obviously be safeguards of public interest, privilege and perhaps integrity of investigation. I can understand that. But if safeguards like that are there for the police, they should be very robustly examined if they are claimed … to avoid non-disclosure under those two headings. I mean you have rights to disclosure, we have got that far, and thanks to the European Court really … the default position was just to say no, but obviously the European trends and the trends in England were very much going towards giving people some disclosure … that has become more regular now … but there is no proper framework.

According to another solicitor, inhibited disclosure was not reducible solely to administrative protectionism, but a prevailing culture across and within State departments:

If you get into a situation where you are dealing with an inquest, for example a death in police custody, and you start saying, 'Well, we want disclosure', that rings a bell with policemen. And they are familiar with it. They understand how it works, they are comfortable with it and that cultural familiarity takes over … that is not a problem anymore, I think, when you are dealing with police or prison cases.

However, this was not the experience with the HSE:

Flip that over to a medical situation, start talking to them about disclosure and the shutters come down. Because they are not used to disclosure and they are not comfortable with it in the same way the police are. What they are comfortable with is discovery … and discovery you have to pull from the back teeth of medical people, with a very strong set of pliers, usually after an excruciating court exercise, affidavits being exchanged, tons of legal advice, medical defence union people coming in and saying. 'Well, we will give you this but we won't give you that' … and we haven't even got to what questions are you allowed to ask, assuming you get to the discovery at all.

While the organisational context and professional culture within a particular institution could, and should, enable a positive inquest experience for families, neither was evident in contested cases:

What should be happening is that you should be able to point to a particular rule or a particular law or a particular requirement … the law says if my relative is dead, I should have this information. I think having been up against both the State and the medical establishment in inquests, I think the medical establishment is ten times more pernicious when it comes to hiding information, refusing to disclose, not admitting anything even approaching liability and generally doing its best to prevent any kind of publicity or publication of the circumstances surrounding a death because of the potential consequences legally.

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Recording the Inquest

As discussed in previous chapters, bereaved families expressed concern that inquest proceedings were neither recorded nor available for scrutiny. These across-the-board deficiencies have been explained by coroners as a consequence of under-resourcing. They have serious implications, identified by a solicitor: '*You go through the process that is meant to be the coroner's inquiry … matters are established, but you can't subsequently use them because there is no record of what is established*'.

While another solicitor stated he had not been inhibited from the lack of a stenographer, he

considered that widespread recording would provoke defensiveness among coroners: '*some may be difficult to get around having a recording because it is literally making them accountable, but I don't think we should give them a choice, that is the only proper way to go forward*'. Another solicitor asked why would, '*a jury take things seriously when they can see that none of the questions they ask are being written down*?'

Regarding the discretionary selection of juries, a solicitor stated:

I think they are just drawn from a pool of the same people … it is usually a few local people who are retired, and you'd see the same ones over and over again at inquests … at least they know the process and are interested. But I'm not sure the jury system in the coroner's court is fit for purpose … some of them are very good, but it is not well regulated, it has not been looked at properly and it is not properly constructed.

Verdicts and Riders

As discussed previously, in addition to short-form verdicts, riders provide an opportunity to make recommendations arising from the circumstances of death to prevent recurrence; yet bereaved families consistently doubt the realisation of this objective. A solicitor interviewed was more cynical: '*they are not legally binding, they are just recommendations, they are usually just a soundbite for the media and nothing else*'. While some coroners pursued their recommendations by engaging with the appropriate institutions, this was not consistent:

The whole notion of follow through … some coroners are good, they at least take the trouble to write to an agency or department or bureau, or a hospital. Not that that is binding and there isn't even a record of it as far as I know. But at least some coroners say, 'I'll do it' and they will do it. Other coroners, kind of go, 'Well that is terrible, my condolences to the family. Next case please'.

Another solicitor considered the main objectives of the inquest are discovery of information to satisfy the concerns of bereaved families alongside making a positive contribution to the avoidance of deaths in similar circumstances:

The only success one can achieve really is through the means and the process of putting information in the public domain. So, establishing, for example, that police officers in Ireland are not routinely expected to learn and update their CPR [Cardiopulmonary Resuscitation] *skills for example, was something I encountered twenty years ago in an inquest that pretty much hasn't changed. There have been improvements, but they are improvements that always feel like they are designed to make the state agency or the medical agencies' job easier as opposed to improving the experience of the prisoner, or the patient or the detainee or whomever. It's always the bird's eye view, never the worm's eye view.*

The follow-up necessary to ensure recommendations are enacted remains deficient, leaving bereaved families and their legal representatives concerned that lessons arising from inquests are not learnt.

As established in the previous chapter, for bereaved families, the inquest's most important function is access to the truth regarding the context and circumstances of their loved one's death. While they accepted that inquests cannot directly establish liability, to them the relationship between 'how' they died and 'why' they died is more significant than establishing the medical cause of death.

Most of the time you find out what the family want … what it is they need to know absolutely, and then you go in and try to raise that … the pathologist report is normally 95 per cent of the time correct, on whatever the cause of death was. But it's the circumstances surrounding the death that are important … the family is entitled to find out what were the circumstances.

However, when an individual takes their own life, their recent experiences and state of mind should be focal considerations enabling a deeper understanding of the circumstances surrounding the death:

A lot of the coroner's court work … it is just based on the bare fact of what happened in an individual case. John was in a cell, we checked him at 8.50, he was fine; we checked him at 9.30, he was dead. And that is it. They are not big into their backstories, they are not big into contextualisation of why he was there, what happened beforehand, and that's a problem.

It was suggested that reticence to inquire more deeply was due to a prevailing conservative culture within the profession: '*I think that they can't cope with a lot of these things, because to do that would open up agents of the state to criticism. And I think they are afraid of that*'. Of particular concern was the assertion made by one solicitor that on occasion bereaved families were left to shoulder responsibility for a death beyond their control: '*attempts will be made to shift the blame, whether on the person who is dead, ideally because*

they can't defend themselves, or on some external circumstance that is beyond everyone's control'.

Inquests and Civil Cases

As previously discussed, inquests often form a significant element of a process which includes criminal investigation, decisions taken regarding prosecution and the possibility of civil actions. In this process, over a significant period of time and involving multiple delays, an additional layer to the problems families experienced were the prohibitive costs involved, including commissioning specialist reports: '*that report, it cost them the guts already of 3000 Euro and then to bring the expert over from England will cost another 2000 Euro as well*'. Legal representation was also expensive: '*I know one of the Dublin firms, they will look for £20,000 upfront for an inquest*'. On the other hand, however, '*there are only so many inquests a solicitor can do for free*'.

The relationship between the inquest and civil cases is due, in part, to the structural and discretionary limitations placed on the coronial process:

If you really want to do something about a death then the accepted method through culturally established ways and means, is that you get yourself a lawyer, you extract as much information as you can from the inquest process and then head off to the high court and file your proceedings and sue … civil litigation is seen as the real remedy.

Progressing claims was considered a rational response to a prevailing institutional climate in which, '*people don't give a damn about health and safety and that is running from the government down*'. Further, systemic institutional change was inhibited by the legal process:

You seem to go down the road of an awful lot of civil action, compensation, move onto the next case. The idea that you would actually use the experience to improve the system doesn't really seem to have filtered through. The inquest should be a mechanism for forcing the state to rectify its systems by process of investigation, but at the moment the legal landscape does not permit an inquest to do that in Ireland.

Regarding the relationship between inquests and civil proceedings, a solicitor stated, '*It is really only in recent times that people in Ireland have adopted the idea that an inquest, as an investigative mechanism in and of itself, can satisfy their demands*'. It is a significant shift, as families do not have the finance to pursue civil actions: '*the costs implications in the Irish system are too great for many people, if not most people, to risk*'. Without access to legal aid, families have '*little means for insulating yourself against a cost order if your civil action fails*'. Yet families who were represented considered the inquest offered a '*fact-finding exercise … a bare minimum moving through the motions*', before progressing to '*a sustainable civil case against either the state or a private actor*'.

The possibility of a civil action also motivated insurance companies to affect the outcomes in an inquest as the verdict could lead directly to further court action.

Should they have a right to be present at these inquests or should their solicitors have a right to be there? Because if you have someone there testifying who might have been the reasons for the deaths of somebody and their insurance company might be there, not defending them but effectively telling them what they can and can't say, it is intimidating for the people giving the testimony and it is intimidating for the family who are there.

Insurance companies benefitted from the '*balance of power between the families and whoever is trying to come between them and the correct verdict*'. Overall, regarding civil action, '*the only impact is information* [when] *you might get admissions out of doctors or whoever … that's really the only value an inquest has to a civil process*'.

The Broader Context

In-depth interviews with solicitors who regularly represent the interests of bereaved families at inquests demonstrate clearly the contextual issues regarding deaths in contested circumstances. For bereaved families, the deaths of their loved ones are situation-specific and the investigations and inquests that follow are unique to them. This extends into the inquest, not least their knowledge and means to acquire legal representation. Yet, as the interviews with the bereaved and their lawyers show – and is evident throughout the research – there are common issues that collectively reveal fundamental, institutionalised concerns. More broadly, yet related to situation-specific and institutionalised issues, is the wider issue of societal ambivalence regarding deaths in contested circumstances.

Criticisms levelled by solicitors who represented bereaved families at inquests focus on institutional

concerns in terms of policy and practice. They echo the experiences of bereaved families and reflect the profound concerns that underpinned and informed the 2000 Report which had anticipated fundamental reforms. A solicitor with considerable experience of civil cases identified the persistent failure to regulate state institutions or to implement oversight and accountability regarding the harms endured by: those on the margins of society; those suffering deficits in mental health support; those without safe and regulated accommodation; those falling foul of the drugs epidemic; those dying in custody.

As families withdraw cases or settle rather than face further personal and economic stress there is limited support in wider society for their plight. Focusing on deaths in prison, a solicitor stated that the prevailing attitude is: '*Prisoners are in prison for a reason. They forfeited their entitlements and rights*'. Consequently, '*that is reflected then in the whole middle-right conservative attitude of the big majority of people in Ireland*'.

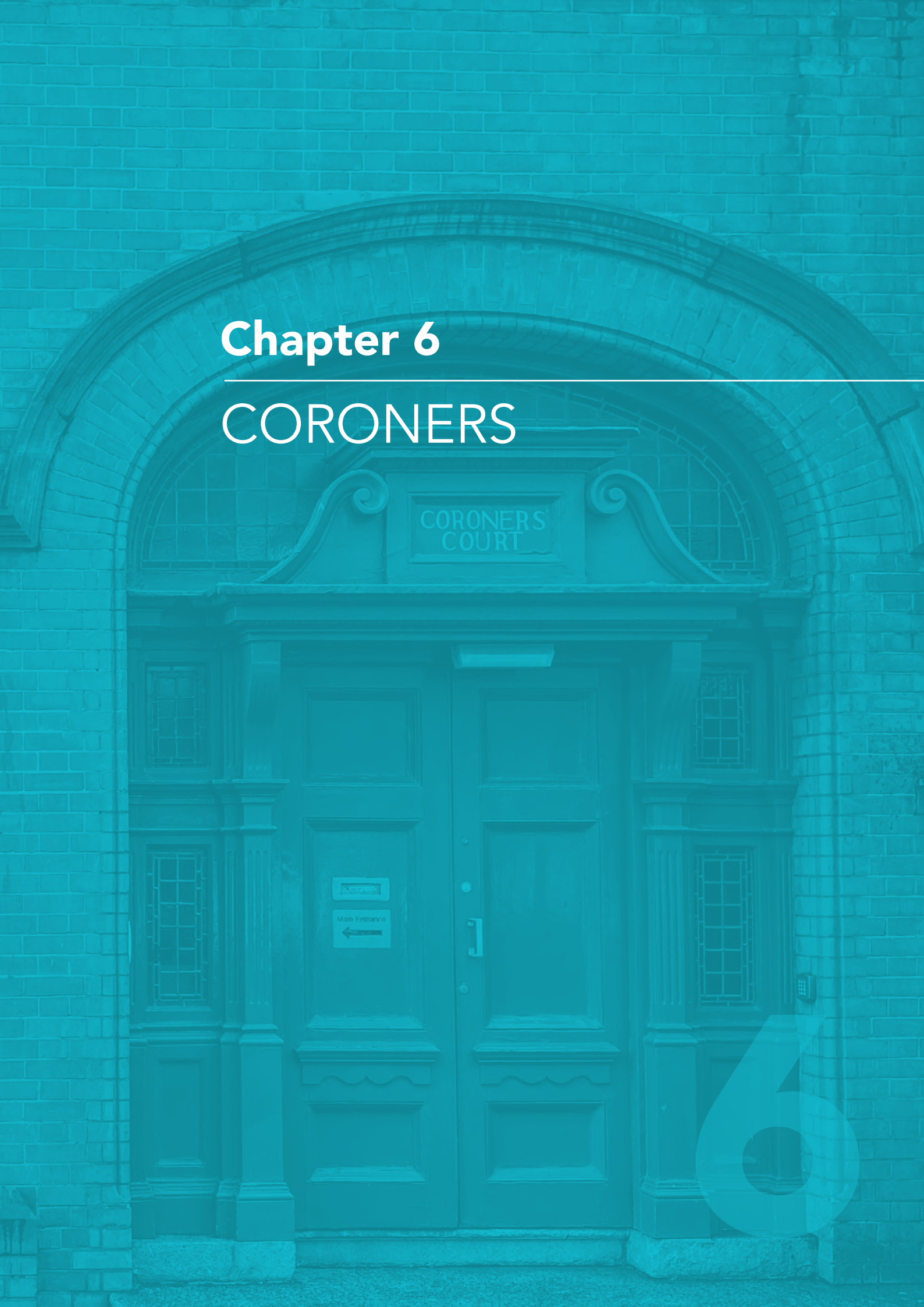
He identified significant disjuncture between those who worked in the courts and those they represented: '*top QCs coming out of the back of the forecourts and stepping over the homeless people … the dichotomy of those who live in leafy suburbs, coming in and working among these people who have been forgotten*'. Further, the organisational culture within criminal justice agencies reflected a lack of diversity while reproducing a narrow representation of civil society: '*there is such a network of people who have been there generation upon generation, if your grandfather was a guard and your father was a guard, you're a guard*'. This resulted in closing ranks when the profession was scrutinised or subjected to criticism: '*an institutionalised attitude that we will not expose anyone in our organisations at any level. Because to do so will be to expose the establishment*'.

Another solicitor reflected on the wider social, cultural, political and post-colonial context that has shaped Ireland's criminal justice system, in which coronial processes had been '*subsumed into wider political interests*':

In Ireland, the establishment, the legislative establishment, I think took a strong view that the inquest forum should be limited as much as possible, and that wider questions, even of responsibility never mind liability, ought not to be considered.

Historically, '*Ireland has been left with bureaucracy and process … changing the process because the process is unsatisfactory is the hardest thing you can do*'. This hindered '*public examination*' of the inquest's function and its potential, creating a '*huge amount of obstacles*', through '*resistance to change, resistance to improvement*'. A '*robust inquest system, with properly sceptical coroners, fully resourced and equipped, and mechanisms and assistance for relatives to scrutinise the narrative well*', he argued, is required. It would transform the current coronial system into '*an extremely valuable institution*' with the ability to challenge, '*policemen, doctors, lawyers and … other people who wield a lot of influence and have a huge stake in keeping the status quo*'.

Explaining why his experiences representing bereaved families at inquests had been consistently negative, a solicitor noted that coroners often had no interest in the case, or they protected the interests of fellow professionals: '*they don't want a public examination*'. In that context, '*if you are lucky enough to get hold of somebody to represent you in an inquest, you can do really good things, but unfortunately it is too often down to luck and circumstances and the individual initiative of the bereaved relative … it can come good, but only if a lot of things align in their favour, whereas really, that should be the system's job*'.



Chapter 6

CORONERS

Chapter 6
Coroners

Concerns raised by bereaved families and their lawyers regarding the coronial system echoed the findings of the 2000 Review. Inevitably, therefore, interviews with senior coroners focused on the lack of progress towards implementation of the Review's extensive recommendations, the stalled development of accommodation that would bring together the State pathology service and the central coroner's offices, and the envisaged professionalisation of the Service including the appointment of full-time coroners. In-depth interviews were recorded and, consistent with previous empirical chapters, they are anonymised.

The Role of the Inquest

A coroner affirmed that the purpose of an inquest is, '*inquire into the facts, allow evidence within scope, within jurisdiction, allow questions to be asked in a proper manner, and sometimes full and frank and robust questioning, without in any way going over that thin line of liability or exoneration*'. His colleague noted that the process, '*is along the path to some serenity rather than closure … the inquest is still part of the pathway rather than the final destination*'.

Inquests, he continued, '*must also deal with the system, it's about a public inquiry*'. Unlike courts of liability, an inquest was '*of its own type*':

It has a purpose. It is neither civil nor criminal. However, if it assists people in gathering facts, by way of evidence and examination, that will help them address whether or not there should either be a civil case or, for the authorities, a prosecution … that in itself is an extremely important purpose of the inquest.

The inquest is '*the only forum that fulfils most if not all of the* [Article 2] *criteria, including that there be a public hearing and that the family be involved*'. In this unique context its function is not to '*apportion blame*' but '*to be present and be examined and give answers … if the accountability also requires culpability, it's a different concept*'. As discussed previously, for bereaved families this is a difficult concept to grasp.

Ireland's coronial system was described as '*superior to most other death investigation systems in Europe*' despite '*its imperfections*'. In England and Wales, he continued,

… perhaps knowingly or unwittingly, they went beyond the scope and jurisdiction and almost ultra vires [beyond their powers]. *The coroner's court can hold, to a certain extent, accountability by examination … but it cannot go either to exoneration or blame by culpability and I think that is an extraordinary difficult task for a coroner's inquest.*

Another coroner stated that in Ireland:

I don't think we're equipped to do that sort of approach. You would need a major retraining. It would need a major restructuring, because you would need to have independent investigative staff.

The 'philosophy' of the coronial process was identified as encompassing, '*law, medicine, sociology, and humanity*' thereby creating *'an awfully big burden for a system that is under-resourced, restricted by ancient laws and always striving to reform and improve*'. Its core is *'the value of life…that's why we're there. We're there for the dead person*'.

Legal Representation

Coroners were reticent to advise families about seeking legal aid or legal representation: '*the coroner must be extremely careful, because we cannot be seen nor should we be giving advice, to any interested person over another*'. However, '*if a person is not legally represented there is a greater onus on the coroner to make sure that they are informed, that they are encouraged, not just invited, to participate in asking questions, without having to have legal knowledge*'.

Legal representation was considered as '*assisting the court … explaining to the family who mightn't otherwise understand what are the parameters of an inquest*'. Yet representation often generated an adversarial context, potentially creating '*greater*

difficulty' for families '*because the free flow of the inquest is very different to that in an adversarial setting*'. A coroner stated that '*hospitals and others generally will not send in a legal team unless it is a major issue*', as they are '*pragmatically aware*' that representation appears defensive.

While '*the tone and the manner in which persons conduct themselves may be adversarial*', the procedure '*remains inquisitorial, in that it is the coroner who calls witnesses, the coroner who examines, the coroner who permits others to examine*'. Maintaining the inquisitorial form while tempering an adversarial tone was part of the coronial role:

I remind them it's not semantics, you examine the witness, you do not cross-examine the witness … by permission of the coroner … because barristers live in adversarial fora every day and, on occasion, they actually start treating the coroner as the adversary.

However, when '*institutions of the state*' were involved in a death often they were defensive throughout the subsequent inquest: '*we had sometimes to fight, we fought more with institutions than we fought with families*' because '*we always felt we had to do our best for the families*'. This fight '*to get to the truth*' was often contested by institutions and their employees:

I've been in the Supreme Court, the High Court, I think twenty times. Some of them were families, but there were institutions that were blocking us as well. What we were trying to do was make sure we had a really good hearing, and that was really my priority in my practice.

Disclosure of Documents

As discussed in the previous chapters, bereaved families and their lawyers consistently raised concerns regarding difficulties in obtaining full, timely disclosure of relevant documents. Responding to these concerns coroners identified several factors that influenced their decisions:

It must be relevant, admissible and necessary for the purpose and aims, and within the scope and jurisdiction of the coroner's inquest. And I will apply that test … there may be some things that are not relevant or necessary and there may be some things that are not admissible.

Equal disclosure to all parties, however, was identified as '*very, very important for families*':

I have been criticised as a coroner for having preliminary hearings. But the reason I do that is I don't want to be dealing bilaterally in multiple and serial correspondence, and some people asking for a, b and c and others asking for d, e and f. I want you all to come, even if it is an extra inconvenience. You will apply and I will give the same thing to everybody. And if that is slightly more formalised and inconvenient, my apologies, but in the end I think it is a proper, fair and open way.

Disclosure was informed by prior judgments and rulings:

I apply the rulings of the Supreme Court but I also apply – I've extracted this partly from High Court judgments and partly from my own – what is disclosable … [but] *because it is in the possession of the coroner doesn't mean it is to be disclosed.*

Decisions to disclose, he continued, are informed by European Court judgments, therefore '*there is very little issue with release of documents now*'. Factors influencing coroners' decisions to disclose were illustrated as follows:

The family wanted to see all the material that I had from the police. Now there is an issue about that, because I have managed to get the police … to agree that we see all the evidence. So then if I disclose it without reason, the guards … say, 'We are only agreeing that you use that in the public domain if it is germane to the hearing'. So that is what I was doing. But the barristers kicked up hell and it went to the High Court. The judge agreed with the practice and procedure that we adopted as not being unfair or wanting in regard to fairness of procedure.

Responding to the issue of regularising access, a coroner stated:

Well, I suppose it could be regularised through statute. But the thing is, a lot of what the guards give me is intelligence, or maybe if the evidence was disclosed someone would have to go into the witness protection programme. If we put it all on the record, then we will lose the confidence of the police.

Disclosure of sensitive documents also has emotional impact on family members, particularly suicide notes and medical records:

I am extremely careful about notes left by people who have taken their own lives. I will not disclose them. I will tell about the existence, I will ask and try and make sure that the people to whom it was addressed are aware and have read it in advance. I will not read it out, because in my view something like that is to help me to apply the legal test as to whether there is

sufficient evidence to bring in a verdict that the person took their own life, the contents are not necessary to be read out for me to draw that conclusion.

Regarding suicide and disclosure coroners faced complex, sensitive decisions:

Sometimes there are accusations which exist back and forth. And that's why I have to say, is it relevant? Its existence is relevant. Is it admissible? It may or may not be. Is it necessary? Necessary to note its existence. Sometimes I will say this was a very warm and wonderful note and other times I will say nothing because it is a huge burden and should not be in the public domain. Which of course goes against the principle that it is a public hearing, but I would say that the fact it is a public hearing doesn't mean that everything has to be put into the public domain, and particularly if it is of a sensitive and personal nature and goes beyond what is necessary. Because I still believe there is a duty to the deceased in terms of their life and their privacy and their sensitive information.

Another coroner adopted similar practice, but this was not universal:

In the court room I would never read out, 'the note', I would simply say for the purposes of standard of proof for suicide which is beyond a reasonable doubt, that we have a note … 'Members of the family, you can have the note, you can have a copy now', or they may have had it before … a lot of notes have scandalous allegations or untrue allegations, or hurtful allegations and we couldn't have a hearing with all that background angst in there. So, I would just say we have sufficient evidence, I have read the note.

Regarding medical cases and records, disclosure could assist in pre-inquest preparation:

I don't want a family coming in without healthcare records. I don't want doctors and nurses coming in not knowing what the family have said in their statements. It's a draft deposition, they can change their evidence, but everyone is coming in prepared better [and] *it may help people … I'm not saying emotions are bad or wrong, but sometimes an open court is not the optimum forum for people hearing things for the first time.*

Clearly, the content of post-mortem records could be distressing for families:

A lot of people do not realise what they are asking for. They do not realize they are going to get the details of a dissection. So, I put a seal around it and tell people that I am going to seal it, so that you don't open it without knowing what is in it … You may wish to open it yourself, that's your choice, or you may wish to bring it to a doctor … your legal advisor, or whoever. So, disclosure is not straightforward.

Coroners also balance the deceased's right to confidentiality:

Maybe eighty per cent of what is in a medical record is relevant in the inquest, but twenty per cent may involve social history, personal history and they are not for open disclosure because they are not necessary for the purpose of the inquest and I don't believe I have the right to breach the privacy even of a deceased person. For their memory, their reputation, because they still have living relatives. Sometimes what comes out, in terms of taking their life, or drugs, intoxicants or other issues, of its nature it is distressing. It is hurtful, but there is no other way.

Juries and Jury Recommendations

Juries were viewed positively, '*very wise most of the time*', providing '*the expertise of the layperson that even the coroner lacks*'. Jury selection, however, was a concern: '*in most cases the guards will organise a jury for me … I get a number of very familiar faces … it is very hard to get people who are prepared to commit to jury service*'. Return jurors were considered acceptable:

… because they are experienced [they] *will ask a number of pertinent questions … which surprises me from time to time, I'll be directing them towards a very clear verdict, and they will come back to me with something else, but they'll have a rationale for it. There are pros and cons for having a small panel of jurors as distinct to going out to the population at large. And with us, the jurors don't get paid.*

The addition of riders to short-form verdicts was considered positive. A '*good example*' cited was a well-publicised inquest in which the jury made nine recommendations regarding maternal healthcare. However, while bereaved families stated their frustration regarding the failure to implement jury recommendations, to place follow-up responsibility on coroners would expand their remit:

Some of them fall to statutory bodies, so it is really up to them to enforce. And if they are not enforcing them you are going to be stretching me or the role of coroners exponentially to make sure they are enforced. I think it is better to put it out there, it now becomes an issue for the department, or whatever organisation that is involved … and if they ignore it

there will be consequences down the line.

The consequences, however, were not clarified.

Coronial Inconsistency

As the previous chapters demonstrate, the relative autonomy afforded to coroners in Ireland creates inconsistencies in practice and procedures. Accommodation for inquests is a particular concern, as two coroners commented:

It is not appropriate to hold courts in hotel rooms, not because of any sense of over importance or aggrandisement … my view is there must be some form of court, perhaps a friendlier type of family court … the inquest is about sensitivity for the bereaved and dignity and respect for the deceased.

I have never felt that [hotels] *were a great alternative. We use one of the smaller court rooms which is more intimate unless we have a really big case and then we use one of the big ones … it gives a certain air of solemnity, which you do require for this sort of thing, but at the same time it is more user-friendly.*

Available resources could determine the level of Gardaí involvement in an inquest: '*we don't have coroner's officers, we are very much dependant on the local Gardaí, I am blessed to have a sergeant who more or less acts as my coroner officer*'.

Regarding discretion, there are '*inevitable inconsistencies … that happens in all courts*', however:

We may differ in our approach, we may even differ in the way we analyse. But we must always turn our mind and be aware of what we should know in terms of the law, the facts, and applying it. And being human, every judicial officer, every judge, will apply slightly differently. But the consistency has to be in procedures. I do believe we are improving, but I believe we have a distance to go. But compared to … when I started as a coroner, we do have more consistency, partly because it has been demanded … and we have had more complex cases and, for better or for worse, the coroner's court which was slightly in obscurity thirty years ago is now much more to the fore.

Discretion is significant in the decisions concerning death investigation and holding an inquest:

I will get a call, say if someone dies in hospital, and I'll get a brief outline of the circumstances, and some of them will be statutory calls, for example if someone is sent in from a nursing home and dies, then it must be reported to me, but if we have a clear cause of death and its natural, then I'll sign off on it at that stage. Others that report to me from hospital, I'll send forward for post-mortem … I'll decide whether to proceed to inquest or not … I have about 1,300 deaths reported to me a year. Three hundred, maybe three hundred and fifty, will actually go to inquest. Some will be dealt with as naturals off of the phone-call and the information I get. Others then will proceed to post-mortem and on receipt of the post-mortem reports they are treated as natural.

Apart from circumstances when there is a statutory obligation to hold an inquest, there are other occasions when coroners take into consideration the family's wishes:

I have [a death] *just at the moment that I was prepared to treat as a natural, but the family have raised certain issues. I will, I suspect, have an inquest just to allay suspicion rather than anything else. They have a concern so I think it is fair to have an inquest to allay those concerns and put everyone's minds at rest as much as one can.*

While aware of remaining disparities in the process, it was suggested that greater consistency had been achieved:

Over the last ten years the Coroner Society of Ireland meets twice a year for educational meetings. We also meet for our conference [it] *is all about self-education … a significant number, not all, will attend the education meetings and one of our aims is to improve our consistency, while still allowing, depending on the size, locality, that there will be some difference, the same as there are for district judges or magistrates' courts or even up to the next level of circuit court. So I would say that it is hopefully improving.*

Another coroner, however, was less optimistic about progress:

The Coroner Society does its best, we have an education programme. But there is no OJT [On-the-Job Training] *for coroners. The Department of Justice … used to send around circulars from time to time, to include new case law for example. Now there isn't much case law. But in those days we would get a missive from the Department and it would include any new legislation that was bearing on the coroner's practice. That has never happened really for the last quarter of a century.*

The Department did not provide initial training, and in-service training was infrequent:

During my 25 years I think we had one meeting organised by the DoJ … now we have tried on an ad hoc basis to do it in the Coroner Society, and by joining our colleagues in other disciplines, but you know that was all on our own initiative, we had nothing organised by the Department.

While the Coroner Society updated members on new rules, implementation was undermined by the workload:

There is only so much you can do … the workload keeps going up all the time. You are trying to keep up with the work and then you can't meet as often as you would like to, so I just feel we haven't made as much progress as we ought to have.

Consistency across different and distinct cases was considered integral to professional integrity and positive family outcomes:

You really need a professional approach, that is what the public want and it is what they deserve. So, it is not just the big cases, or just the small bread and butter cases of an open and shut car accident or suicide, though they can be difficult to. It's their day in court for the families and you've got to do it to the same standard.

Coroners exchanged information, shared their experiences and '*behind the scenes*' sought support '*without ever going into a particular case*'.

During my 25 years I think we had one meeting organised by the DoJ … now we have tried on an ad hoc basis to do it in the Coroner Society, and by joining our colleagues in other disciplines, but you know that was all on our own initiative, we had nothing organised by the Department.

Over-burdened and Under-resourced

Coroners operate within a complex, multi-disciplinary and seriously under-resourced process. Appointments had become '*a real cause for concern*':

It's not known in the public domain that half of our coroners are acting, without any assessment as to their suitability … I'm sure they are doing their best. But they have never been assessed.

We did recommend in the review in 2000 that we would reduce the number of coroners … amalgamate the Districts and have one regional office, so that the coroner or coroners would be staffed properly and would also be getting more cases so that they could increase their experience. So, there is a huge structural issue there.

This would create a structure of full-time coroners and deputies supported by dedicated staff:

… the last ten years, every time I came into the office, five days a week, I was never out of court. So that means you can't go to meetings, or do other things, the administrative side … You can't be in court all the time, trying to do your best with each case, and have a good hearing, and then trying to move the whole office along and the whole structure. You can't do everything. You are at the pin of your collar trying to keep things going and doing the best you can.

Coroners are local authority appointments, yet the Department of Justice oversees their work and has part responsibility for their financing:

The DoJ pay me a stipend towards the running costs which doesn't even cover the costs of my registrar, let alone rent. I get some contribution to the rent from City Hall. I have been trying to get a meeting with city hall to discuss the staffing requirement for the last seven months without success.

Local councils responsible for part-funding do not meet the requirements of or demands on the office: '*they are not funding adequately, now they are giving me other support … I have IT support and they are very good like that. But I need extra staff and I haven't got them so far*'. Underfunding, particularly evident in staff shortages, limits coroners' participation in preventive work:

We have had to cut back on access time. We used to be nine to five, but now it is much more restricted, which is not our desire but we have no choice. It means we cannot assist in certain research. For example, suicide research … I don't have the staff or the time to be able to give information because you would have to dig it out. And I find that particularly upsetting because we deal with a lot of suicides, and anything we could do to facilitate or lessen the number of suicides we would be very keen to do, as would my staff.

Complex cases make exceptional demands on the Service, resulting in delays across all cases: '*with the Stardust inquiries now, there is already a two-year backlog*'. Even '*uncomplicated cases take too long … nine months or a year*'.

Under-resourcing includes the lack of transcription: '*the coroner's court has no facilities for stenography, we have no funding*'. Even when coroners grant an application for a stenographer, it is '*on the understanding that the applicant, i.e. the family, had to bear the cost*'. Stenographers are particularly important in contested cases but, '*it costs a significant amount of money to engage a stenographer, to engage them on an hourly or daily basis, and to have the print-out and records produced*'. Regarding documentary disclosure, '*the coroner's office bears the entire* cost'. The coroner's fee for each case, '*about five hundred and fifty Euro*', includes disclosure costs, basic administration and '*practical facilities*'.

Structural Factors

From the interviews with coroners it was clear that under-resourcing of their role is symptomatic of deeper structural under-resourcing:

There are practice and procedures issues, there are leadership issues, I suppose they meld together. You need a chief coroner or maybe a committee, like in England and Wales, where you have the chief coroner from time to time giving missives on practice and procedure.

It was their view that by resolving structural factors, '*a lot of the other issues would be ironed out in relation to practice and procedure*'. However, progress was inconsistent between districts and, as raised by the 2000 Review, lack of centralised training undermined consistency throughout the State:

It must be difficult for a coroner being appointed with no experience. We know it is an issue because we get phone calls. And we are happy to help out, but without any training at all just seems really hard on them.

The impact of inter-agency tensions, including '*other investigating agencies …not sharing evidence*', was identified as a significant inhibition on progressing a case. Deaths involving institutional interests were considered to be significantly more complex, therefore taking more time:

If I have an inquest involving a death in hospital or, particularly, deaths involving babies … you would have a number of days preparation so you can get to understand the issues. You would have a number of submission hearings, and then your hearing itself can take three or four days.

Cases involving institutional liability were '*getting more complex*', particularly regarding medical evidence. Thus, '*for the legal coroners I think a little bit of training in the medical, and vice versa, wouldn't go amiss*'.

Informal conversations between bereaved families and hospital staff were considered to raise unrealistic expectations:

One of the big problems with the hospitals and the consultants, and this is a very difficult area because it touches on duty of candour, is when they meet with the family immediately post-death. I won't want them giving too much information until we have had a chance to investigate. If they give information, what can happen when you get to inquest, is that has built up a certain understanding of events in the family. So, they believe certain things happened which are not subsequently borne out by the evidence.

Coronial Independence

As discussed in previous chapters, regarding their institutional independence the relationship between coroners and the Gardaí is crucial. In deaths directly involving the police, '*all matters have been strengthened in the 2019 Act*', and GSOC takes responsibility for the investigation. Cases progressed by GSOC had provided '*frank and full examination … with which An Garda Síochána were not comfortable and it led to recommendations*' and a '*review of training in certain methods*'.

A distinction was drawn between shortcomings in Gardaí investigations and officers' direct involvement in the circumstances of a death:

… sometimes people mix that up. They say, 'We don't believe the Gardaí investigated this properly'. That is a legitimate and justifiable concern to be brought to the attention of the coroner, or later for a review. But that versus, [a claim that] *the Gardaí were somehow involved in the circumstances bringing about the death of the deceased … they are two separate questions. Therefore, certainly in the second case, there is a strong case to be looked at for GSOC to take over the investigation … I'm not saying it is perfect. But I believe that is the answer.*

Regarding the contrast between Coroners' Courts in cities and those in the Districts, Dublin had full-time registrars: '*the Department has been very supportive, especially with the new staff and these are all lay people, there are no police officers who act in that capacity here*'. Given limited resources, '*you couldn't have somebody appointed to do that work*

in every coroner's District in Ireland'. District coroners, therefore, were '*only too delighted to use the services of the local inspector of the guards who help them out around the country*'. However, this could give '*the wrong impression*' particularly in cases where '*you have a police officer standing up in uniform … I always used to say to them, if they are coming in to do a police report, get them to come in in their civvies!*'.

Guards were involved '*except in cases where the Gardaí have been directly involved*', including cases of prison deaths where *'funnily enough, there is no love lost between the prison officers and the Gardaí*'. As coroners had become '*much more integrated with the DoJ*', efforts had to be made to '*retain our independence*'.

Families' Concerns

Coroners recognised that bereaved families had disparate and, in some cases, negative experiences of the coronial process. On hearing that bereaved families collectively had raised concerns, a senior coroner stated:

I was appalled at some of the things families were saying that they had experienced. Well, I have no doubt that is what they had experienced, because things happen. Nobody means it, but it is the way it happened. Either people were insensitive, or not understanding, or didn't do this, that or the other.

While negative experiences could be explained by inadequacies in training or local custom and practice, coroners considered that most families were more likely to have had a positive, rather than negative, experience. One coroner stated that families, '*who go to the ICCL or the HRC, are those who either have concerns about the way the inquest was conducted, or because the outcome has not been won which has satisfied all of their understandable needs*'. His colleague cautioned against '*the impression that all families are not satisfied … while we can't satisfy them in everything of course, we get a lot of positive response … a lot of families are satisfied*'.

Further, families' concerns contributed significantly to institutional reform:

Now that does not for a moment suggest that the people who had concerns or dissatisfaction should not be listened to. I think they must. Was it the late Senator Feargal Quinn [who said] '*Customer feedback is actually one of the least expensive ways of improving*'. *You listen, you consider, and you say 'yes', or sometimes, 'no' they need to understand. But sometimes 'yes' - I need to improve on that practice.*

The 2000 Coroner Service Review team had consulted families:

When you are doing a review, the ones who are not satisfied are a lot more vocal than the ones that are satisfied. I know we should be doing a lot more for families but don't get the impression that we are not doing anything for families. And I know you'll hear a lot of stories, because I've heard them all before, about things happening here and around the country, and when I hear them, I think, 'God, how is that happening?' But I suppose it may be the same everywhere, I don't know, you can't satisfy everybody. There is a lot of difficulty with families sometimes with unreasonable expectations, and family issues that are thrown on top of us to solve. This is a complex interaction.

Acting on family concerns necessitated recognising those that were historical:

It may be the case that, without diminishing their concerns or the legitimacy of their questions, we may say, 'Ah, that was then'. But, in part, thanks to those families raising those concerns, we have looked at, and the Government has looked at, and improved the legislation to say, 'Yes, this is something we need to improve on'. So, I think perhaps they have got to be placed in that context.

Families' concerns regarding delay had to be balanced by taking the time necessary to achieve precision and thoroughness in the investigation:

Oh there is no doubt that timeliness is a big issue. You have one full time coroner here. There are five hundred, six hundred inquests a year. There are five thousand five hundred deaths. They are much more complicated. You have to wait for the toxicology to come through. You've got to investigate the cases. There is going to be a backlog. While I was aware that families would have liked the inquests earlier I was more concerned with making sure we had a good investigation and we gave them a proper hearing, and that they understood the reasons why there was a delay. So, in other words, timeliness had to give way to quality of the investigation.

Ensuring that families were kept informed and understood the reasons for delay was important, but not always possible:

I felt, the families, if you did keep them informed that they did understand. This is where family liaison officers would come in. They'd meet the families and say, 'Look, this is what we are doing at the

moment'. But again, it is difficult to do that, and do your day's work, and to be also hitting the quality that you want to.

Also, coroners agreed that holding inquests too soon after the death of a loved one could be a negative experience for the bereaved:

We did a pilot study on the time limits of the inquests. We decided we would have the inquest within four to six months of the deaths. And it didn't really work. Because if you were hitting four months the family was still bereaved and it was often going over their heads. And sometimes they were worried that we might not be investigating all the angles or were looking at it properly. So, I would say the time limits, for a routine case it should be around six months.

Families also raised concerns about how the inquest narrative, specifically what was included and what was excluded, had been shaped by witnesses. Coroners considered that it was their responsibility to balance uncertainties of memory and concerns over credibility:

Sometimes I will actually say where there is a difference, 'Look I believe each of the witnesses has given their recollection to the best of their ability. There are simply variations that are irreconcilable, I must take them on board'. Very occasionally I will remind the witness three or four times that they are under oath, which is my way of saying that there is a credibility issue here. But again, I think that is where the coroner's skill must come in, weighing up the evidence.

Coronial discretion is significant also in allowing witnesses to construct their narratives:

The coroner has a certain amount of discretion and I will generally watch, particularly if it is an institution, if their legal representatives are allowing it because they are making a pragmatic decision. But on the other hand, if someone actually does stand up and say, 'Coroner, I believe this is beyond the scope', then I must actually stop and hear the implications for and against continuing that line. So that is the discretion of the coroner, which I think is reasonably exercised provided the coroner is aware and is fair to everybody.

It was considered preferable to address evidential concerns as they arose, rather than allowing issues to stagnate and possibly result in judicial review:

At the end you may see I actually ask, 'Is there anybody who believes that the coroner has made an error in law or has conducted any part of the inquest in a manner that they have concerns over? Please say so now, and I will consider it and if it is a legitimate point of concern I will address it'. There is, of course, no guarantee there will not be a judicial review, but I can say everybody is given the opportunity to bring up any issue where the coroner may have inadvertently, in their view, strayed in one way or the other, or didn't set his mind to something he should have. Do it now. Why put a family through judicial review? This is the forum, let's do it now.

Demonstrating humility, another coroner concluded: '*So yes we're all fallible, dreadfully fallible.*'

Coronial Reform

Coroners considered that inconsistencies in the system and Gardaí interference, to an extent, had been reformed on their initiative:

We are all together, we are all trying to learn, we are all trying to improve the system with its many weaknesses, with its under-resourcing. And some of the changes in the law are very helpful and some are crying out to be met.

They had committed to change, especially recently: '*I think it came about because there were a lot of high profile judicial reviews and the public were becoming more involved'*. However, the 2007 Bill had been an opportunity lost:

We actually produced coroner's rules and they have never been enacted. This is what we have been banging away at. We ended up with a much more restricted piece of legislation, having been promised a much wider Bill ... There are a lot of issues around the way legislation is managed in this country.

The 2007 Bill had addressed issues raised by judicial reviews throughout the preceding decade, but '*things were done on a needs basis rather than a planned basis*'. A wider range of reportable deaths was introduced, including maternal deaths which were '*always reportable under a rule of practice, but they have been put in as a rule of law just now. It's sort of very piecemeal*'.

We are all together, we are all trying to learn, we are all trying to improve the system with its many weaknesses, with its under-resourcing. And some of the changes in the law are very helpful and some are crying out to be met.

As discussed in Chapter Two, the Government's failure to deliver the promised coronial and medical-legal facilities on one site in Dublin was a low point:

The biggest disappointment of my career is that we lost the medical-legal centre … We had terrific plans drawn up, architects, we spent a hell of a lot of money. We got the first floor, the second floor built, would you believe. We had this magnificent centre out in the fire brigade headquarters out in Marino. And we were going to amalgamate and have the autopsy rooms for homicide and non-homicide cases. We were going to have teaching facilities so we could have not only coroners but, maybe, doctors who are interested in pronouncing death, you know, forensic physicians. The state pathologist was moving in with us. So we got to the second floor, and the builder went bust in 2000 … I think it was around 2009, and the building stood there for two years and by the time we began to move on it again it had deteriorated and it had to be demolished … So, there have been huge disappointments.

Family Support

As discussed in Chapter Four, the experiences of bereaved families demonstrated the lack of institutional support in advance of inquests and during proceedings. The coroners interviewed, however, recognised that families required significant support throughout the death investigation process, from first receiving distressing information through to post-inquest aftercare.

Regarding provision, a coroner commented, '*Sure we have been talking about this for years*'. When he began his career, in the City '*families had no room to go into*' but now had '*three or four meeting rooms*' available. '*Some leaflets and booklets*' are provided for '*support in relation to their bereavement and all of that*'. He continued, '*my staff have a huge interaction with the public, so we are kind of counselling the public all of the time … the phones are just flying all day long with families ringing up*'. Further, '*we now have the facilities to bring families in and talk to them, in here*'.

Bereaved families, however, continued to experience problems accessing information:

We have been engaging with lawyers, doctors, trying to talk to them, explain about the coronial system. There needs to be some way that we can let families know. I suppose they are the ones that pick up the phone and know they can do it, but I suppose we should get out more information to families but I'm not sure how to do it. There must be better ways of publicising the service and letting families know their rights.

Another coroner commented:

My registrar would be in touch with them. She's rung a representative of the family and explained the situation. And she'd be asked, 'Should I have a solicitor there?' She'll go through all that, so it is more personalised that way. And they will get a leaflet too, explaining the coroner system. We would like to have a website but we just haven't the time to put it up. We would ask the families, 'What are their issues?'

The Media

Families revealed how the inquest as a public forum created further suffering. Recognising this, coroners stated their commitment to protecting families' privacy. Multiple inquests could be held on any given day, each attended by bereaved families and friends. Consequently, a coroner pre-warned families: '*it is an open forum but you may not wish to be present for other than your own* [inquest] … *Why sit through the distress of someone else?*' Thus, '*ninety-five per cent of the time, everybody leaves apart from the people involved*'. Yet, '*I think it is important that it is held in public because certain issues may come out which need to be open to the public at large or for people to be informed about things that are happening*'.

As inquests are public forums, they are often reported in the media. Reports focus on the deceased, the circumstances in which they died and, often, the lifestyle they were assumed to be leading. Such judgements, both implicit and explicit, created distress for bereaved families. Coroners felt they had little influence on the insensitivity of media reporting:

I have a specific request to the media to be aware of sensitivity, and to be aware of dignity and respect. I refer them to guidelines from the press council. Can we stop media reporting? No, but I have to say the majority respect the sensitivity. But we are not there yet, nor do we have the power to censure. I have reprimanded the media recently because of what they published … and I did say now that, 'You are on notice, if this happens again I will have to take steps'. The steps I can take are very limited, even as a coroner. I think I have only twice issued public statements in relation to inquests and that's over maybe 2,000 inquests. The coroner, like a judge, must not comment but I think it is our duty to ask the media to be responsible.

Chapter 7

THE CASE FOR REFORM

Chapter 7

The Case for Reform

A significant objective of this research, as outlined in the Introduction, has been to focus on the Public Sector Duty as presented in Section 42 of the Human Rights and Equality Commission Act 2014. The Act requires public bodies to identify and 'eliminate discrimination' in all its forms, promote 'equality of opportunity and treatment' and 'protect the human rights' of staff and those 'to whom it provides services' (Sec 42.1). To meet their obligations, public bodies are required to publish 'an assessment of the human rights and equality issues it believes are relevant to the functions and purpose of the body and the policies, plans and actions in place or proposed … to address these issues' and to record their compliance annually (Sec 42.2). To assist in achieving these objectives the Irish Human Rights and Equality Commission 'may give guidance to and encourage public bodies' in their policy development, 'good practice and operational standards' (Sec 42.3).

This research has consolidated profound concerns regarding the investigation, examination and inquiry into deaths in contested circumstances. As discussed in previous chapters, concerns include: the role and function of An Garda Siochána in servicing coronial investigations and inquests; the informality of, and delays in, the procedure from the death through to the inquest; the under-resourcing of a system that requires a nationally co-ordinated professional service including full-time staff; a human rights-based approach in training and service delivery to coronial practice; fully integrated public bodies whose collaboration is necessary to achieve best practice in death investigation and inquiry. Central to this project has been identification of bereaved families' priorities and expectations alongside the reforms necessary to their realisation.

Families' 'Best Interests'

It was stated repeatedly in the personal accounts of the bereaved, in the interviews with their lawyers and in international, comparative literature on the coronial process, that the 'best interests' of families and others close to the deceased are ill-served by current death investigation and inquest procedures. In seeking the contextual and immediate details of 'how' their loved ones died, a fundamental commitment made at inquests by coroners in their opening address is to acknowledge families' priorities for disclosure and acknowledgement of any contributory acts or omissions relevant to the death. Whatever short-form verdict is reached, 'suicide' in prison for example, riders added by the coroner or the jury provide the opportunity to identify procedural deficiencies or institutional failings that contributed to the death. Clearly, the broader scope given to a verdict by the narrative indicates liability which is why institutions and individuals, whose acts or omissions could be reflected in the long-form verdict, engage lawyers to protect their interests.

Once a criminal investigation has recommended there is insufficient evidence to proceed to prosecution, or a prosecution ends without a conviction, the inquisitorial process invariably becomes adversarial. Inquests into deaths that occur while the deceased is in the care of the state, whatever the institutional setting, provide bereaved families with the only opportunity to have witnesses called, their testimonies examined and the consequences progressed to inform changes in institutional policy and practice. As illustrated earlier in bereaved families' accounts, and those of their solicitors, these priorities were paramount. They are well illustrated by the comment from a bereaved mother, versions of which were heard repeatedly by the researchers: '*I want to know the full story, the truth, I want lessons to be learnt so that no other*

family has to go through what we have been through'.

The research reflects a duality central to Ireland's coronial system: a culture of informality in the implementation, location and conduct of inquests, together with an archaic, overly legalistic and paternalist approach framing its processes and procedures. Consequently, evidence is discounted because it is not perceived as being within the coroner's legislative remit and investigations are hampered by serious under-resourcing. Long-delayed, local district inquests are presided over by part-time coroners who often have full-time law or medical practices within the community. Inquests are held in local court houses or other community facilities that offer, at best, limited accommodation or support for the bereaved who attend distressing hearings alongside news reporters, Gardaí and/or others who have a direct involvement in the death.

Further, not all bereaved families who attend inquests are represented by a lawyer. Apart from a lack of understanding about what to expect, bereaved families assume that the coroner system is value-neutral and the inquest is a court of inquiry rather than a court of liability. In fact, as many cases in Ireland and in the UK and Northern Ireland have demonstrated, the inquest is not necessarily a non-adversarial process. Inquests can become courts of intense, occasionally hostile, contestation regarding the 'facts' of a death, the interests of powerful institutions represented by highly-experienced, senior lawyers. Further, in rural Ireland, coroners who work and live in local communities, are expected to navigate the evidence presented to the court and direct juries known to those involved.

Families coping with the death of loved ones face further adversity in their engagement with the processes of investigation in the aftermath. Confronted by unfamiliar procedures of coronial investigation, they experience a lack of information and unacceptable delays, often for several years, to their inquests. The families interviewed had been bereaved in quite different circumstances. Yet they had unity of purpose in seeking detailed, factual and truthful accounts revealing the context and circumstances in which their relatives had died. They recognised that this was a complex objective, not necessarily reducible to a single act or omission. Their common goal had two dimensions: to achieve a thorough examination of the circumstances of the death through which their questions and concerns were answered; to learn lessons from the death with coroners' riders making recommendations that would contribute to death prevention.

In advanced democratic societies there is growing recognition that inquests have not served well the best interests of bereaved families. Their invaluable contribution to this research demonstrates clearly the necessity of recognising their rightful location which should extend to accessing full and thorough information on the circumstances of the death at the earliest opportunity. Failure to achieve this objective has serious and lasting repercussions, not least raising concerns regarding the efficacy of inquests, the selection of evidence, the attendance and questioning of key witnesses and the factors influencing eventual verdict. At the heart of this process are questions regarding the thoroughness and independence of the pre-inquest investigation. As families' accounts demonstrate, this involves maintaining regular, meaningful contact with them and providing clear information on the progress of the investigation.

As high profile inquests now demonstrate, it is no longer appropriate to claim that inquests operate solely as courts of inquiry. Questions regarding liability simmer below the surface, occasionally breaking out in sharp exchanges between lawyers and coroners. The inquests discussed in families' testimonies, show clearly that deaths in contested circumstances place expectations on the process to establish facts which, inevitably, involve the personal behaviour and/ or professional responsibilities of individuals and, if appropriate, their employers. In that sense, there is open acknowledgement of competing interests and this is reflected in the extent and seniority of legal representation in contested cases. What follows in court, therefore, invariably amounts to an inquisitorial intention over-shadowed by an adversarial reality. To ensure the fundamental principle of 'equality of arms', it is crucial that bereaved families receive legal aid to engage lawyers with knowledge and experience of the coronial process.

As is evident from families' testimonies, many attend inquests unprepared for proceedings held in unfamiliar surroundings without basic accommodation or hospitality. Waiting areas are inadequate and little attempt is made to accommodate their needs and ensure their comfort. While the environment and its processes are familiar to professionals regularly involved with the coroner's court, they are intimidating environments for those attending for the first time following a long, painful wait. Given that context, families' experiences of exclusion, exacerbated both

in and outside the inquest by failures to receive and accommodate them with sensitivity, is unacceptable. Their marginalisation often extends to media intrusion by reporters who neither understand nor appreciate the significance of the case.

Beyond the inquest, families require immediate and short-term support. Many state that their post-inquest experience is akin to re-living the trauma they experienced at the time of their bereavement, exacerbated by apprehension, uncertainties and unexplained delays. Often struggling to deal with the explicitness of the evidence heard, discovering difficult details for the first time, reflecting on the suffering of their loved one and believing that the investigations and inquest were inadequate, families were left to readjust without support or guidance. While some felt defeated in their quest for truth, others were determined to continue.

It was clear from the interviews conducted with coroners that inquests, as evident in the 2000 Review, provide bereaved families with the opportunity to have examined the facts that contextualised the deaths of their loved ones. While not a court to establish criminal liability, coroners are well aware that when deaths occur in contested circumstances the robust examination of the witnesses they call inevitably will be adversarial. As one coroner stated, in such cases the inquest provides '*accountability by examination*'. To bring Ireland's coronial process in line with other jurisdictions, however, requires '*major retraining*' and '*major restructuring*' delivered via significant financial investment. As Chapter Two demonstrates, this is not a new proposal. It echoes the findings of the 2000 Review, blunted and compromised by delayed, piecemeal reform.

In the current situation, as the interviews revealed, coroners are well aware of the inconsistencies in coronial practice between Districts, exacerbated by a less than transparent appointments process, inadequate training and chronic under-resourcing. It is a system under immense pressure resulting in unacceptable delays and inadequate record-keeping with proceedings not transcribed. The structure of the Service, judged seriously inadequate in 2000, has remained largely unreformed. Coroners emphasise the need for structural change, particularly the establishment of a new agency overseen by an Inspectorate, the appointment of a Chief Coroner, reconfiguration of Districts and the appointment of full-time coroners throughout Ireland. Restructuring would also enable the appointment of full-time support staff, emphasising the importance of the office of coroner while reaffirming its independence.

Coroners were concerned that fundamental reform and revised Rules, reflecting the programme for change in the 2000 Review and central to the abandoned 2007 Bill, had not been realised by subsequent changes in legislation. A further concern raised by coroners is the failure to deliver the much-anticipated 'state-of-the-art' accommodation combining medical, legal and coronial services.

Justice Delayed

Reflecting on contrasting approaches to death investigation, this final section contrasts the different responses to deaths of economic migrants killed by organised people smugglers with deaths of citizens in circumstances involving statutory services or corporate bodies.

In late December 2001 inquests were held in Dublin into the deaths of six Romanian men and two children who had suffocated in a sealed container that entered Ireland via Waterford unknown to the lorry driver. He discovered the tragedy in a business park outside Wexford town. There were five survivors. The coroner called for those responsible for the deaths to face murder charges and for new legislation to search all containers passing through Ireland's ports. Yet, the trade in people continued unabated.

On 5 February 2004, twenty-three cockle-pickers were drowned in Morecombe Bay, England, caught by the incoming tide on a notorious stretch of water. All were Chinese, undocumented and employed illegally, on less than minimum wages and housed in multi-occupancy accommodation. Subsequent inquests returned a verdict of unlawful killing. In October 2019, thirty-nine Vietnamese people suffocated in a refrigerated trailer discovered in an Essex lorry park. Three drivers and the haulier, all from Northern Ireland, were convicted and imprisoned.

These distinct tragedies are related because they were the consequence of organised people smuggling and undocumented arrival, but also because of the thoroughness and alacrity of the criminal investigations that followed. Of international significance, the investigations resulted in timely criminal prosecutions. Revealing the harrowing circumstances of the deaths, the inquests were significant for the bereaved in receiving and comprehending the facts.

In marked contrast, however, other high-profile inquests into deaths involving the responsibilities

of *domestic* public and private institutions have frustrated, even deterred, bereaved families' endeavours to achieve the full investigation and interrogation of the facts to which they were entitled. Their marginalisation has led directly to long-running campaigns exposing flawed investigations and conflicts of interest. Eventually they achieved new inquests, the conduct and thoroughness of which contrasted starkly with the inadequacy of the initial inquests. Decades on from the initial event, second inquests are fraught with difficulties given the passage of time, the deaths of key witnesses and bereaved family members, and memory clouded by publicity and campaigning. They reveal, however, the necessity of ensuring that coronial investigation and inquests are thorough and informed in the initial instance.

Hillsborough, Sheffield

On 15 April 1989 in Sheffield, England at a high-profile football match held at Hillsborough Stadium a fatal crush on the terraces led to the deaths of 96 men, women and children. Following the disaster, a judicial inquiry was appointed. While it found that failure in policing the crowd was the main reason for the overcrowding that caused the deaths, no prosecutions followed. This placed the initial inquest under immense and inappropriate pressure. Having held unprecedented 'mini-inquests' with bereaved families, the Sheffield Coroner held a generic hearing between November 1990 and March 1991. All official interested parties were represented and the families pooled resources to afford one barrister and his support team. The majority jury verdict was 'accidental death'. Families won leave to appeal to the High Court and a Judicial Review before three appeal judges followed. They rejected the families' submission that evidence had been suppressed.

The Hillsborough families' campaign continued, an Independent Panel was convened in 2010 to review all existing documents. Reporting in 2012, its 153 findings demonstrated deep-seated failures in the police investigation and all previous inquiries. The UK Government ordered: a new criminal investigation into the police; an IPCC (now the Independent Office for Police Complaints) investigation; and a review of emergency services, hospital responses and medical pathology. The Attorney General applied to the High Court to quash the accidental death inquest verdicts. On 19 December 2012, the Lord Chief Justice ruled that in the interests of justice there would be new inquests into all who died. He stated that 'within the limits of the coronial system' reinvestigation and reanalysis would reveal 'the truth'. Between April 2013 and February 2014, the Coroner received submissions from fourteen legal teams representing organisations and individuals designated 'interested parties' each of whom received full legal aid.

In late March 2014, the new inquests opened before a senior judge and a jury. The families were represented by multiple barristers. While the Coroner stated that the inquest would not degenerate into an 'adversarial battle', the questioning of police officers was clearly adversarial. Two years later, the jury verdict was delivered. It comprised a yes/ no answer to a series of complex questions set by the coroner in consultation with the legal teams. Over 25 serious errors or omissions were identified by the jury, most against the police but also the stadium safety engineers, the owners of the stadium, the ambulance service, and the city council. 'Are you satisfied, so that you are sure, that those who died in the disaster were unlawfully killed?' 'Yes'.

Ballymurphy, Belfast

In Belfast, Northern Ireland, second inquests were held between November 2018 and March 2020 into the deaths of ten civilians killed by British Army sniper fire while walking in the Ballymurphy estate over three days in August 1971. The initial inquests were brief, resulting in open verdicts. In November 2011, following families' long and sustained campaign, the Northern Ireland Attorney General ordered new inquests. They were delayed and five years later the Lord Chief Justice of Northern Ireland stated that new inquests were necessary. A further two years passed before they opened. Having heard extensive evidence from over sixty soldiers, thirty civilians and a range of experts, they concluded in late March 2020. A year later, ten years on from the Attorney General's decision and fifty years since the killings, the Coroner is yet to deliver her verdict.

Stardust, Dublin

On 14 February 1981, a fire in the Stardust night club caused the deaths of forty-eight mainly young people. In the immediate aftermath, a High Court Judge was appointed to head a tribunal of inquiry assisted by three assessors to provide technical advice. Its six objectives were comprehensive and over 122 days it heard evidence from 363 witnesses, approximately half of whom were survivors. The report into the fire was published in June 1982. It was highly critical of the owner, the Dublin Corporation and the Department of the Environment. Fire doors had been kept locked,

exits blocked, fire safety regulations breached and inadequate. However, 'probable' responsibility was attributed to an unknown arsonist with an unknown motive. No inquest verdict was recorded.

In September 2019 the Attorney General ordered new inquests in both the public interest and the interest of justice. In his judgment he made direct comparison to the Hillsborough disaster, stating that the bereaved families were entitled to 'public revelation of the facts' and that the wider community should have confidence that 'there should be sufficient inquiry at any inquest to maximise the chances that the truth should emerge'. sufficiency of inquiry. The Stardust inquests are scheduled to open in mid-2021. At a preliminary hearing the Coroner affirmed the Attorney General's statement that the 'scale and horror of the tragedy' amounted to the 'greatest such disaster to have occurred in the history of the State'.

Cumulative Deaths

A strength of the coronial process is that coroners occupy a unique position to identify consistencies in circumstances of recurrent deaths. Unlike disasters, such deaths are not a consequence of a single, obvious cause but have sufficient similarities that, over time, a coroner is uniquely placed to identify a clear pattern. In November 2020 Sean Horstead, deputy coroner for Cambridgeshire, delivered a narrative verdict almost eight years after the death of a 19-year-old student. The young woman who suffered from anorexia had been referred to a trainee psychologist without experience of her condition. The deputy coroner concluded that Norfolk and Norwich University Hospital failed to provide nutrition, a dietician and or psychiatric support, amounting to a gross failure in care. Having been admitted to hospital, it was a further three days before she was examined by a specialist in eating disorders. She died three days later.

The deputy coroner was praised by the family's solicitor for holding such a detailed public investigation, calling many witnesses and seeking expert evidence. Also, he had considered the institutional failure to provide appropriate care so serious that an Article 2 inquest was necessary. Under examination, clinicians' testimonies contradicted those made in their witness statements and no records existed to show that the young woman had been monitored appropriately.

During the period from her death to her inquest, four other young women in the area, all patients registered with the Cambridge and Peterborough Foundation Trust, died from anorexia. The deputy coroner stated publicly his intention to write a 'prevention of future deaths report' to raise the necessity of appropriate training for medical staff dealing with anorexia nationally.

The deputy coroner stated that five deaths from anorexia in his jurisdiction demonstrated the significance of the 'absence of a formally commissioned monitoring service in primary or secondary care'. While each occurred in specific circumstances, he identified consistent serious deficiencies in medical treatment thus exposing systemic failures. Lack of education and training, together with ignorance among medical practitioners regarding anorexia and its treatment, remained prevalent. He recommended urgent, necessary changes in medical practice. This example illustrates the potential of inquests as vehicles for institutional reform, while meeting the bereaved family's expectations of a full and thorough exposition of the facts.

Final Comment

While the primary aim of this project was to focus on Public Sector Duty within the coronial process, specifically regarding the rights of bereaved families, the research expanded the remit. This is evident in the research findings and is reflected in the wide-ranging yet specific recommendations that have evolved from the analysis. Further research is imperative given that the coronial institution within the justice system remains marginal and misunderstood. As acknowledged above, high profile cases across jurisdictions demonstrate the potential of inquests in preventing future deaths. At the opening event of this project Caoilfhionn Gallagher QC stated that, following the police response in the immediate aftermath of the 7/7 bombings in London, ambulance crews did not check all people who, before they arrived, had been assumed dead and covered by blankets. She stated, 'we got a prevention of future death report in that case, which has now changed the way ambulance services deal with multiple fatalities'.

Other key, under-researched concerns have been identified in the course of the project. A priority for future research is to analyse the circumstances in which people take their own lives, particularly in prisons and other custodial settings. Bereaved families, often fraught with guilt that they might have prevented the death of their loved one, do not readily seek further information on the context, particularly whether there was a failure in an institution's duty of

care. The identification and elimination of 'all forms of institutionalised discrimination' is a key objective, in line with the proposed Charter's commitment to in-service training 'on class, race, gender, sexuality, culture, age and ability' within all State agencies 'involved with the reporting, analysis and investigation of deaths'.

Finally, a long-standing yet neglected priority for reform throughout Ireland's public services is to eradicate the harms inflicted on the Traveller community by institutionalised racism. Failure to make specific, appropriate provision for those whose cultural identity is distinct from the assumed identity of the majority population exacerbates exclusion, reinforces cultural apartheid and sustains a political-ideology of cultural superiority. Further research is essential to ensure that the human rights of all people in Ireland – citizens, refugees, asylum seekers – are protected, particularly in circumstances of death investigations.

Appendices

Appendix

The Research

The ICCL research was supported by the Irish Human Rights and Equality Commission under its 'Human Rights and Equality Grant Scheme'. The Project, initially entitled 'The Public Sector Duty: A Pathway to Implementing Human Rights within the Coroner System', commenced work with a one-day conference, 'The Coroner: Fit for Purpose?' held in Dublin on 7th February 2019. Dr Vicky Conway, Associate Professor of Law at Dublin City University was lead investigator, supported by Professor Phil Scraton, School of Law, Queen's University, Belfast. Following the early progression of the research its progress was suspended due to ill-health of both researchers. It resumed in August 2020 under COVID restrictions with Professor Scraton taking over as lead investigator supported by Dr Gillian McNaull.

As discussed in the Report's introduction, secondary research - particularly regarding the significance of the detailed 2000 Review - provides the background to the empirical data. It focuses on the political debates and policy proposals over two decades, not least the failure to deliver the 'root and branch' reforms recommended by the Review, and eventual minimal legal reform.

The primary research involved interviews with bereaved family members (25), solicitors regularly representing bereaved families at inquests (4), senior coroners (3), and representatives from agencies and campaign groups. Interviews other than those with bereaved families were taped and transcribed. Interviews with family members were taped and transcribed or written by scribes attending alongside interviewers.

Interviews with families focused on: their loved one: how they were informed of the death; information provided regarding the investigation; information provided regarding the role and function of the coroner and what to expect at an inquest; legal representation; attendance at the coroner's court including accommodation and reception; the conduct of the hearing and whether their questions were answered; the role of the police; whether the inquest satisfied their concerns and met their perceived needs; whether the outcome was satisfactory, recommendations made and their implementation; considerations for change. Bereaved families were asked to sign an informed consent form. All interviews have been anonymised for consistency.

Author Profiles

Dr Gillian McNaull

Dr Gillian McNaull is a Postdoctoral Research Fellow in the School of Social Sciences, Education and Social work at Queen's University Belfast. She is currently working on an ESRC project examining the impact of Covid in prisons across the HMPPS estate and co-facilitates the QUB *Learning Together* project in Hydebank Wood Secure College. Her previous research in the School of Law critically examined the institutional reform of the Northern Ireland Prison Service, locating the change programme within the broader context of devolution and the political economy; her doctoral research used original empirical research to examine the gendered experience of custodial remand. She has published several articles on this research. Gillian has a background in suicide prevention and was previously the Regional Prison Support Officer for Samaritans Ireland, overseeing their suicide support across prisons in Ireland and contributing to the NI Ministerial Safer Custody Forum and the IPS National Suicide and Harm Prevention Steering Group. She currently sits on the Executive Committee of NIACRO and is an organiser with Larne House Visitor Group and Abolitionist Futures Belfast.

Phil Scraton

Phil Scraton PhD is Professor Emeritus in the School of Law, Queen's University Belfast. Widely published, his books include: *In the Arms of the Law - Coroners' Inquests and Deaths in Custody; Prisons Under Protest; Hillsborough The Truth; Power, Conflict and Criminalisation; The Incarceration of Women; Women's Imprisonment and the Case for Abolition*. He was a member of the Liberty Advisory Committee on deaths in custody and led the Hillsborough Independent Panel's research team and was principal author of its ground-breaking 2012 Report, *Hillsborough*. In 2018, with Rebecca Scott Bray at the University of Sydney, he co-convened a community-based international Critical Death Investigation Lab' focusing on deaths in controversial circumstances. He was a member of the JUSTICE Working Party into inquests and public inquiries whose Report, *When Things Go Wrong: The Response of the Justice System*, was published in 2020. Also in 2020 he edited *'I Am Sir: You Are A Number': The Report of the Independent Panel of Inquiry into the Circumstances of the H-Block and Armagh Prison Protests 1976-1981*. Having refused an OBE, he was awarded the Freedom of the City of Liverpool in recognition of his Hillsborough research.

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