INFORMATION NOTE

Information on the **Rights of Families at Inquests**

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

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The Irish Human Rights and Equality Commission was established under statute on 1 November 2014 to protect and promote human rights and equality in Ireland, to promote a culture of respect for human rights, equality and intercultural understanding, to promote understanding and awareness of the importance of human rights and equality, and to work towards the elimination of human rights abuses and discrimination.

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Introduction

1. The Irish Human Rights and Equality Commission ('IHREC') is an independent public body charged with the protection and promotion of human rights and equality in Ireland. Established by the Irish Human Rights and Equality Commission Act 2014 (the '2014 Act'), IHREC has extensive powers, including providing information to the public in relation to human rights and equality.

2. This information note has been prepared by IHREC with the consultation and cooperation of relevant organisations and stakeholders.

3. This information note seeks to provide information to bereaved families in their engagement with the inquest (death investigation) process conducted by a coroner under the Coroners Acts 1962-2020. It seeks to give families a roadmap of the law, standards and procedures that apply at inquests, with a particular emphasis on the protection of human rights and equality.

4. This information note provides bereaved families with information on inquests having regard to Irish law (both Acts of the Oireachtas and the limited Irish case law on inquests). Where there is no relevant Irish case law, reference is made to case law in the UK and the European Court of Human Rights in Strasbourg.

5. This information note does not impose any legal obligation on any person concerned with the inquest process. It is not an authoritative statement or interpretation of the law - that can only be provided by the courts.

What is an inquest?

6. An inquest is a public inquiry that is held by a coroner. The purpose of the inquest is to establish:

   - the identity of the person in relation to whose death the inquest is being held;
   - how, when and where the death occurred; and
   - to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred, and to make findings in respect of those matters.

7. Inquests are conducted by a coroner, who is an independent office holder. There is a coroner appointed for each district in Ireland.

8. It is not the role of the inquest to decide if any person was responsible for the death, nor if a crime was committed. Questions of civil liability - that is

legal responsibility for the harm alleged by an individual and the damages suffered and a potential right to obtain redress from another party, e.g., compensation – cannot be considered at an inquest. Neither can questions relating to criminal liability – that is legal responsibility for an illegal act or failure to act, which constitutes a crime in law and where a finding of criminal liability can result in a criminal conviction by a court, and may also lead to a fine or a prison sentence -be considered or investigated at an inquest.[1]

9. A coroner is required to hold an inquest following a death, where they are of the opinion that the death may have occurred in a violent or unnatural manner, suddenly or from unknown causes[2] or where an inquest is otherwise required by law.[3] For example, an inquest will be held in cases of deaths following road traffic accidents, deaths resulting from accidents in the workplace, deaths of prisoners or deaths of persons in Garda custody.

10. The conduct of inquests in Ireland is governed by the Coroners Act 1962, which has been amended over the years and most recently in 2020.[4] Court judgments have also impacted on the conduct of inquests.

11. Under Article 2 of the European Convention on Human Rights (the 'ECHR'), the State has (in broad terms) a duty to protect the right to life. As well as a duty not to take life without justification, this includes a duty to ensure that laws, systems and procedures are in place in Ireland to protect life to the greatest extent reasonably practicable. Therefore, where inquests take place into a death following contact with the State, for example where a prisoner dies in State custody, the inquest may form part of Ireland's legal duty to provide an independent investigation.

When is an inquest required?

12. The holding of an inquest will be required when the coroner for the district where the body of the deceased is lying, is of the opinion that the death may have occurred in a violent or unnatural manner, suddenly and from unknown causes or where an inquest is otherwise required by law.[5]

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1 Sections 30 and 31 of the Coroners Act 1962, as amended.

2 Section 17 of the Coroners Act 1962, as amended.

3 For example, certain statutes require an inquest to be held in certain circumstances e.g. where a prisoner dies in prison [Section 56 of the General Prisons (Ireland) Act 1877]. Certain statutes merely require notification to the coroner leaving the coroner a discretion to refuse to hold an inquest where satisfied that the death is due to natural causes e.g. death of patients in mental institutions [Section 268 of the Mental Treatment Act 1945].

4 The Coroners Amendment Act 2005, the Civil Law Miscellaneous Provisions Act 2011, the Courts and Civil Law (Miscellaneous Provisions) Act 2013, the Coroners (Amendment) Act 2019 and the Civil Law and Criminal Law (Miscellaneous Provisions) Act 2020.

5 Section 17 of the Coroners Act 1962, as amended.

13. With the passing of the Coroners (Amendment) Act 2019, inquests are also required in the following cases:

- Where the deceased was, at the time of his or her death, or immediately before his or her death, in State custody or detention;
- Where the death of the person is a maternal death[6] e.g. where a pregnant woman dies in childbirth as a result of the mismanagement of the delivery;
- Where the death is a late maternal death;[7]
- A coroner may also hold an inquest into a stillbirth in certain circumstances;[8] and
- A coroner may also hold an inquest where a medical certificate of the cause of death cannot be obtained or where the coroner is of the opinion that the certificate is not completed in a satisfactory manner to facilitate the registration of the death and the coroner is unable to ascertain the cause of death.[9]

For more information on terms and definitions used at an inquest, see **Appendix 1**.

Deaths reportable to the coroner

14. The Coroners (Amendment) Act 2019 significantly clarified the concept of "reportable deaths". These are deaths that require certain specified people[10] to report a death to the coroner.[11]

15. Reportable deaths to a coroner include the deaths of persons that occurred or may have occurred, either directly or indirectly:

- in a violent or unnatural manner or by unfair means,
- by misadventure,

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6 See definition of maternal death in Appendix 1.
7 See definition of late maternal death in Appendix 1. Section 16A of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019.
8 See definition of stillborn child in Appendix 1. Section 2A of the Coroners Act 1962, as inserted by Section 3 of the Coroners (Amendment) Act 2019.
9 Section 18 of the Coroners Act 1962, as amended by Section 11 of the Coroners (Amendment) Act 2019.
10 Section 16B of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019.
11 This duty may also be discharged by reporting the death to the Gardaí, who in turn must report the death to the coroner. Section 16B (5) of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019.

- unexpectedly and from unknown causes or in an unexplained manner,
- as a result of negligence,
- from any cause other than natural illness or disease for which the person had been seen and treated by a registered medical practitioner within one month before his or her death,
- misconduct or malpractice on the part of others or in such circumstances as may, in the public interest, or
- under provisions in that behalf in any other enactment, require that an inquest should be held.

16. The Coroners (Amendment) Act 2019 provides a lengthy list (or schedule)12 of types of deaths that must be reported to the coroner. These include various forms of homicide, suicide, maternal deaths and deaths of infants.

    For more information on reportable deaths to a coroner, see **Appendix 2**.

Persons who must notify the coroner of a reportable death

17. Since 2019, certain specified people are required to report 'reportable deaths' to the coroner for the district where the deceased's body is located.[13] The specified people include various types of medical personnel, paramedics, undertakers and persons who had care of the deceased person.

    For more information on those persons who must notify the coroner, see **Appendix 3**.

18. Where the family of a deceased person believes that the death is a reportable death, and should have been reported to the coroner, they are entitled to ask of the relevant specified person if this death has been reported to the coroner.

19. If they are not satisfied that the coroner has been informed of a death, they are entitled to contact the relevant coroner themselves and make the coroner aware that the death has occurred and the family's belief that the death is a reportable death.

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12 Section 16A of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019. See Appendix 2 - Reportable Deaths.

13 Section 16B of the Coroners Act 1962, as inserted by Section 9 of the Coroners (Amendment) Act 2019. See Appendix 3 - Specified Persons in relation to Reportable Deaths.

20. Any person can report a death to a coroner. While the law obliges certain specified people to report a death, this in no way limits the right of any other person to notify a coroner or give information in relation to a death.

Post-Mortem examination

21. A coroner may direct a doctor to carry out a post-mortem examination of the body of the deceased person for the purposes of inquiring into the death.[14]

22. Where a decision is taken to hold a post-mortem examination, the coroner is required to make arrangements to inform a family member of the deceased person of this decision. The family member is also entitled to be informed that material may be removed from the body and retained for the purposes of a post-mortem examination or an inquest.[15] The law does not permit a family member to prevent a post-mortem examination directed to be held by a coroner.

23. The law also provides that, in respect of certain categories of death or where certain persons request the coroner so to do, the coroner must direct a post-mortem examination.[16] The relevant circumstances include, for example, where the coroner is of the opinion that the death may have occurred in a violent or unexplained manner; where the deceased person was in State custody or detention at, or immediately before, death; or where senior Garda or Defence Forces officers, or a duly authorised officer of a statutory body who is empowered under another enactment to investigate accidents, incidents or diseases resulting in death in a case in which the body is investigating the accident, incident or disease resulting in the death concerned, or designated offices of the Garda Síochána Ombudsman Commission, make a written request.

24. A post-mortem report must be provided to the family by the coroner as soon as practicable (this may take some time as it will be dependent on the nature of the tests to be undertaken). The family of the deceased person is entitled to request and receive a copy of the report.[17] However, the coroner may not provide the report to a family member if they think that it is not proper to do so, because it may have an unfair influence on criminal proceedings in relation to the death of the deceased person that are being considered or have been instituted.[18]

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14 Section 33 of the Coroners Act 1962 as inserted by Section 21 of the Coroners Act (Amendment) 2019.
15 Section 33 of the Coroners Act 1962 as inserted by Section 21 of the Coroners Act (Amendment) 2019.
16 Section 33A of the Coroners Act 1962 as inserted by Section 21 of the Coroners Act (Amendment) 2019.
17 Section 33E of the Coroners Act 1962 as inserted by Section 21 of the Coroners Act (Amendment) 2019.
18 Section 33E of the Coroners Act 1962 as inserted by Section 21 of the Coroners Act (Amendment) 2019.

25. The body of the deceased will usually be released by the coroner to the next-of-kin shortly after the post-mortem examination. However, cases can arise where it is necessary to retain the body for a longer period, e.g. where there is an ongoing criminal investigation into the death. In such cases, it may be necessary to carry out further investigations or to undertake a second post-mortem examination.

Notification of the inquest to the family of the deceased

26. Where a decision is made by a coroner to hold an inquest into the death of a person, the family who are next-of-kin will be informed of the date and place of the inquest.[19]

27. The family is entitled to be notified of the date, time and place of the inquest at least 14 days before the date of the hearing.[20]

28. In practice, it may be the coroner's office or the Gardaí who contact a member of the family of the deceased. The extent to which any particular coroner will have their own support staff, or will rely upon administrative support from the Garda Síochána or the Garda Ombudsman, varies across the State. Both the Garda Síochána and the Garda Ombudsman have personnel who are trained to act as Family Liaison Officers, whose role is to provide support and information in a sensitive and compassionate manner to the family of the deceased.

29. There is no standard procedure for identifying who within a family should be contacted, and this may give rise to the question of whether all appropriate family members have, in fact, been made aware of the inquest. Any family member (or other person) who wishes to be present and/or involved at the inquest is entitled to contact the coroner. In that event the person should write to the coroner as soon as possible setting out their interest and desire to be notified of the time, date and place of the inquest.[21]

30. It is desirable that inquests are not unnecessarily delayed, and that all relevant witnesses and evidence is available to the coroner at the inquest. Therefore, it is important that interested persons make the coroner aware as soon as possible, and well in advance of the inquest wherever possible, of any witnesses and/or evidence that they believe may be of relevance to the inquest, so that the coroner can take a decision on whether to call such witnesses or evidence.

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19 See the Coroner Service's Website at https://www.gov.ie/en/publication/inquest-an-inquiry-held-in-public-/

20 Section 18B of the Coroners Act 1962, as inserted by Section 13 of the Coroners (Amendment) Act 2019. See Appendix 4 - Draft Letter of Interest. In Irish law, the failure to notify the family of the deceased of the inquest, whether by the coroner himself or herself or the Garda Síochána, might amount to a departure from the rules of natural and constitutional justice. See for example State (McKeown) v Scully [1986] 1 IR 524 at 526.

21 See Appendix 4 - Draft Letter of Interest.

Inquest on order of the Attorney General

31. Section 24 of the Coroners Act 1962 provides for the possibility whereby the Attorney General has reason to believe that a person has died in circumstances, which, in his or her opinion, make the holding of an inquest advisable. This applies regardless of whether an inquest has been held before. For example, this may arise where new facts or evidence came to light that raised doubts as to the correctness of the earlier verdict.[22]

32. It is open to the family of a deceased person to write to the Attorney General to present an argument as to why the holding of an inquest, or a fresh inquest, may be advisable. Significant justification would require to be put forward to the Attorney General.

Participation at the inquest

33. Inquests are held in public and any person may attend.

34. It is important, at the beginning of any inquest, that the coroner has in his or her possession all relevant witness statements and evidence. If a family member believes that this is not the case, this should be made known at the beginning of the hearing so that the coroner can determine whether the inquest should proceed or whether it should be adjourned in order to seek out the missing witness or evidence.

35. As regards the precise procedures to be followed at an inquest, the legislation provides limited guidance and the procedure is informed to a large extent by the established practice and some guidance provided by the Irish Courts.

36. While there is no legal provision setting out who may or may not examine witnesses, the Coroner Service[23] provides a list of what are described as "properly interested persons", which includes:

- The next-of-kin of the deceased;
- Personal representatives of the deceased;[24]
- Representatives of a board or authority in whose care the deceased was at the time of death e.g. hospital, prison or other institution; and

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22 Farrell v Attorney General [1998] 1 IR 203 at 226.

23 See the Coroner Service's website https://www.gov.ie/en/campaigns/coroner-service/ The Coroner Service is a network of coroners located throughout the country.

24 These include the executor or administrator of the deceased's estate - See Farrell Coroners: Practice and Procedure Dublin; Roundhall Sweet and Maxwell (2000) at page 338.

- The driver of a motor vehicle involved in a fatal collision, representatives of insurance companies and certain specified persons where death resulted from an accident at work.[25]

The coroner will decide who may examine witnesses at an inquest.

37. Again, any family member (or other person) who wishes to be present and/or involved at the inquest is entitled to contact the coroner. They should write to the coroner as early as possible setting out their interest and desire to be notified of the time, date and place of the inquest.[26] There is no requirement for families, or other properly interested persons, to have legal representation and they are fully entitled to attend and participate in the inquest without being legally represented.

38. Where the coroner determines that a person (or corporate body, such as a company that employed the deceased person or the hospital where they died) is a properly interested person, they may examine witnesses themselves or have legal representation in order to ask questions of witnesses on their behalf.

Legal aid and legal advice at an inquest

39. Where an inquest is to be held and a family member[27] of the deceased wishes to apply for legal aid or legal advice or both, they may apply to the coroner for a request to be submitted by that coroner to the Legal Aid Board on behalf of the family member in relation to the granting of legal aid and/or legal advice.[28] Any such request should be made as early as possible and before the inquest commences.[29]

40. Requests for legal aid and/or legal advice can only be made in certain circumstances. These are where the deceased was, at the time of his or her death or immediately before his or her death:

- In the custody of the Garda Síochána;

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25 I.e. representatives of trade unions, the employer of the deceased and inspectors of the Health & Safety Authority.

26 See Appendix 4 - Draft Letter of Interest.

27 Family member is defined under Section 60(7) of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013 as follows: a parent, grandparent, child, brother, sister, nephew, niece, uncle or aunt, whether of the whole blood, of the half blood or by affinity, of the person, a spouse, civil partner or cohabiting partner, any other person who is ordinarily a member of the person's household, any child who has been placed in foster care with the person or any person referred to above and any such member of his or her family who is adopted.

28 Section 60 of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.

29 Section 60(2) of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.

- In custody in a prison;
- Under arrest or confinement by the Defence Forces;
- Involuntarily detained under the Mental Health Act 2001;
- Detained in a designated centre under the Criminal Law (Insanity) Act 2006;
- Remanded in a remand centre under the Children Act 2001 or detained in a children detention school;
- A child in care; or
- Where the death was a maternal death or a late maternal death.[30]

41. Requests for legal aid and/or legal advice, may also be made where the coroner is of the opinion that the person's death occurred in circumstances, the continuance or possible recurrence of which would be prejudicial (or harmful) to the health or safety of the public or any section of the public such that, there is a significant public interest in the family member of the deceased person being granted legal aid or legal advice, or both, for the purposes of the inquest concerned.[31]

42. Legal aid and/or legal advice is not provided at all such inquests. The granting of such is subject to the family member who applied satisfying requirements in respect of financial eligibility and the payment to the Legal Aid Board of a contribution towards the cost of providing the legal services.[32]

43. If granted, legal aid and/or legal advice will usually be provided in the form of a legal aid certificate granting the services of a solicitor in private practice. The family member can then choose from a panel of solicitors maintained by the Legal Aid Board. Once engaged, the solicitor may apply to the Legal Aid Board for the services of a barrister (junior and/or senior counsel), and this may be granted in appropriate circumstances.

44. Where legal aid and/or legal advice is granted by the Legal Aid Board to a family member in respect of an inquest, no further applications

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30 Section 60(5) of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013 and as amended by Section 34 of the Coroners (Amendment) Act 2019.
31 Section 60(5) (h) of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.
32 Section 29 of the Civil Legal Aid Act 1995 and the Regulations made under Section 37 of the Civil Legal Aid Act 1995. A consolidated version of these regulations is available from the Legal Aid Board's website at www.legalaidboard.ie.

may be made by another family member in respect of that inquest.[33] This means that where the deceased has multiple family members if legal aid and/or legal advice is granted for one family member, then another family member is not entitled to a separate grant.

45. A family member who wishes to apply for legal aid and/or legal advice in relation to an inquest should make an application in writing to the coroner at the earliest opportunity, and in any event prior to the inquest.[34] The coroner will decide whether a request should be made to the Legal Aid Board that legal aid and/or advice be provided. If a request is made, the Legal Aid Board will require the family member to complete an application form for the purpose of establishing their financial eligibility for legal services and determining the contribution payable by them.

46. It is also important to note that a family, or any family member or other interested party, may also engage their own private legal representation to engage with the coroner on their behalf and attend at the inquest.

Disclosure of documents in advance of the inquest

47. In order to meaningfully participate at the inquest, a family member who intends to attend the inquest may request the coroner to provide them, in advance of the inquest, with copies of the draft depositions (or witness statements) and other documentation that will be considered at the inquest. Such a request should be made to the coroner as early as possible.[35]

48. Draft depositions are statements that are usually based on witness statements taken by the Garda Síochána or other State agencies (e.g. the Garda Ombudsman or the Health and Safety Authority).

49. Family members (and other properly interested persons) are entitled to make representations to the coroner where they believe that other relevant persons should be called to give evidence or that other documentation should be sought and examined at the inquest. However, the choice of witnesses and evidence to be called is at the discretion of the coroner.

50. While the coroner has discretion to refuse the release of depositions or other documentation, the family of the deceased

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33 Section 60(6) of the Coroners Act 1962 as inserted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.

34 See Appendix 5 - Draft Letter on Legal Aid.

35 In Ramseyer v Mahon [2006] I IR 216 at 225 the Supreme Court found that - "The governing criterion is whether the party seeking the material can show that he or she will be prejudiced in participation in the inquest in its absence." See Appendix 6 - Draft Letter seeking Disclosure.

is entitled to participate effectively in the inquest and to be furnished with sufficient information to do so.[36]

51. Where disclosure of depositions or other documentation is being provided by a coroner, the family is entitled to receive this information in good time, in order to allow them (and their legal representatives if appointed) adequate opportunity to consider the documentation and issues arising.

52. There is no system prescribed in law as to how draft depositions are to be prepared, or how witness statements taken by the relevant investigating agencies (e.g. the Garda Síochána) should be edited to form draft depositions for use at the inquest.

53. Nor is there a provision prescribed in law to challenge the withholding of documents from properly interested parties (including families) at an inquest, on the basis that the party holding them is entitled to assert privilege (i.e. to invoke the legal right to refuse to produce a document in certain circumstances).

54. Any family member (or other properly interested party) participating at an inquest should, when requesting access to depositions and other documentation, also seek an indication of any information that has not been disclosed or has been otherwise redacted (or edited)[37] so that they are in a position to fully engage in the inquest.

55. Where information or documentation is not provided, or is edited or redacted, on the basis that it is privileged or for another reason, parties are entitled to be made aware of this fact in advance so that they can properly address the issue with the coroner if they are dissatisfied with the approach being taken. If the question of disclosure, or privilege, is not addressed to the party's satisfaction, they may take legal advice and legal action.

Notification of witnesses

56. Witnesses may appear at the inquest having been notified or requested by the coroner or following the issue of a summons.[38] Failure to answer a summons and to attend the inquest, without reasonable excuse, at the specified time and place is a criminal offence.[39]

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36 Ramseyer v Mahon [2006] I IR 216 at 227.
37 See Appendix 6 - Draft Letter seeking Disclosure.
38 Section 26 of the Coroners Act 1962, as amended.
39 Section 66 of the Coroners Act 1962 as substituted by Section 1(b) of the Coroners (Amendment) Act 2005.

Notifying the coroner of necessary accommodations and services

57. While inquests are often held in courthouses around the country or, at the dedicated Coroner's Court in Dublin city centre, they are sometimes held in less formal settings, such as hotel conference or meeting rooms.

58. If a family member of the deceased person requires any special arrangement, in order to access and/or fully participate in the inquest (e.g. wheelchair access, interpretation services etc.), they should make the coroner aware of this fact as early as possible so that they can ensure that any necessary actions are taken in advance of the hearing.[40]

The scope of inquest

59. Questions of civil or criminal liability cannot be considered or investigated at the inquest.[41] In other words, the inquest cannot find that any person, or organisation legally responsible, or not responsible, for the death.

60. These limitations do not mean, however, that the inquest cannot consider the facts of the case where those facts might, in court proceedings, give rise to a finding of civil or criminal liability.[42]

61. Where interested persons, including family members, are present and/or represented at an inquest, they are entitled to fair procedures. They are entitled to be present, to call witnesses and to cross-examine. However, the coroner has a responsibility to ensure that these rights are subject to the overriding consideration that interested persons are present to assist the inquest and are not responding to, or making a charge against, any other person.

62. The coroner is entitled by law to conduct the hearing at his/her discretion, while respecting the legitimate interest of interested persons to pursue lines of inquiry.[43]

63. The coroner may, whenever they consider it appropriate to do so, apply

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40 See Appendix 7 - Draft Letter seeking Special Arrangements.

41 Sections 30 and 31 of the Coroners Act 1962, as amended.

42 In Eastern Health Board v Farrell [2001] 4 IR 627 at 637 the Supreme Court held "...the prohibition on any adjudication as to criminal or civil liability should not be construed in a manner which would unduly inhibit the inquiry. That would not be in accord with the public policy considerations relevant to the holding of an inquest to which I have referred. It is clear that the inquest may properly investigate and consider the surrounding circumstances of the death, whether or not the facts explored may, in another forum, ultimately be relevant to issues of civil or criminal liability."

43 Ramseyer v Mahon [2006] I IR 216 at 225.

to the High Court for directions (or clarity) on a point of law regarding the performance of his or her functions in relation to the death of any person.[44]

Adjournment of inquest

64. While a date may be fixed for the inquest within a relatively short period after the death of the deceased person, for a variety of reasons the inquest may not be able to take place on the specified date and may be adjourned to a later date.

65. In certain situations, the coroner must by law adjourn the inquest when requested to do so by specific officials – e.g. where a member of the Garda Síochána (not below the rank of inspector), a member of the Defence Forces (not below the rank of commandant), or a designated officer of the Garda Ombudsman requests the adjournment on the ground that criminal proceedings in relation to the death are being considered or are underway.[45] In such situations, the coroner would usually admit basic information concerning the death, e.g. identification.

66. However, while adjournments may be required in specific situations (e.g. where results of post-mortem examinations or toxicology or other tests are pending), the inquest should be held as expeditiously as possible.[46]

67. Where an inquest is adjourned, or is otherwise not being held, families may seek clarification from the coroner as to the reason for such a decision. Where a family is dissatisfied with the decision to adjourn the inquest, they can write to the coroner asking that they would set out the basis for the adjournment. If the family remain dissatisfied with this outcome, they may wish to seek legal advice as to possible remedy.

Inquests with or without a jury

68. Inquests can proceed with or without a jury.[47]

69. The inquest is required by law to be held with a jury if the coroner is of the opinion that the following circumstances apply:

    - The death was caused by murder, infanticide or manslaughter;

44 Section 62 of the Coroners Act 1962 as inserted by section 36 of the Coroners (Amendment) Act 2019.
45 Section 25 of the Coroners Act 1962, as amended by section 16 of the Coroners (Amendment) Act 2019.
46 Eastern Health Board v Farrell [2001] 4 IR 627 at 644.
47 Section 39 of the Coroners Act 1962, as amended.

- The death arose in circumstances in which inquests are required by law;
- The death was caused by accident, poisoning or disease, in respect of which legislation requires that notice be given to a Minister or Department of State or to an inspector or other officer of a Minister or Department of State; or
- The death occurred in circumstances the continuance or possible recurrence of which would be prejudicial to the health or safety of the public or any section of the public.[48]

70. The decision to hold an inquest with a jury, other than where required by law (as set out above), is within the discretion of the coroner in question.

71. However, where that discretion is not properly exercised, or where a decision is made to hold an inquest without a jury where the law requires one, then the decision may be susceptible (or open) to challenge before the coroner or subsequently before the High Court by means of judicial review.

72. Where an inquest is proceeding with a jury, the jury is sworn in before the coroner.

73. While there are no standard procedures for selecting jurors and empanelling (or forming) a jury, jurors who are disqualified or otherwise ineligible, or who may have a conflict of interest, should not participate.

74. There does not appear to be any formal procedure for objecting to jurors at an inquest. However, the coroner should be made aware if any party believes that a juror is disqualified, ineligible or is otherwise conflicted.

How an inquest proceeds

75. At the commencement of the inquest hearing, all persons taking part (whether they be family members, other interested persons or any legal representatives on their behalf) should identify themselves.

76. Where the coroner is satisfied that the various persons are properly interested persons, they are entitled to have the witnesses cross-examined on their depositions, to make submissions and to offer to make available to the coroner further evidence that might be of assistance at the inquest.

77. There is no specified order for the calling of witnesses and,

48 Section 40 of the Coroners Act 1962, as amended.

subject to the coroner's decision: this usually begins with a witness to identify the deceased followed by other witnesses who can give evidence relating to the circumstances of the death.

78. Once the witness is called, the usual procedure is that their deposition is read aloud by the coroner's registrar and then the various interested persons present may examine (or question) the witness. The range and nature of questioning of a witness may not extend beyond the scope of the inquest allowed by law, and cannot extend to questions of civil or criminal liability. Once the witness has concluded his or her evidence, the practice is that all material evidence is recorded in the deposition and is then signed by the witness and the coroner.[49]

Role of the coroner

79. Coroners may examine witnesses at an inquest on oath and may direct a witness to answer questions.

80. It is an offence for any person to give evidence to an inquest knowing it to be false or misleading.

81. The coroner may direct the production by any person of any document, article, substance or thing in his or her possession or under their power or control. They may inspect, copy and keep, for such period as they consider necessary, any document, article, substance or thing produced at the inquest or give any other direction that the coroner considers necessary.[50] Failure to comply with any such direction may result in an application by the coroner to the High Court seeking to order compliance.

82. The coroner also has the power to enter premises, with the consent of the occupier or under search warrant issued by the District Court.[51] Where the coroner considers that they require the advice or assistance of an expert for the purposes of his or her inquiry into a death, they may engage the services of such a person.[52]

Evidence at an inquest

83. The strict rules of evidence, which may apply in other types of litigation or legal cases, do not necessarily apply at inquests.

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49 In accordance with the standard form set out in the schedule to the Coroners Act 1962 (Forms) Regulations SI94/1962.

50 Section 38 of the Coroners Act 1962 as inserted by Section 24 of the Coroners (Amendment) Act 2019.

51 Section 49A of the Coroners Act 1962 as inserted by Section 30 of the Coroners Act (Amendment) 2019.

52 Section 53A of the Coroners Act 1962 as inserted by Section 31 of the Coroners Act (Amendment) 2019.

84. For example, while hearsay evidence (i.e. statements based on what a witness has heard from another person, rather than on direct personal knowledge or experience) is not normally admissible in court cases, the coroner may admit such evidence where they believe it is reliable and relevant.[53]

85. That said, inquests are required to be held in accordance with natural justice and fair procedures.[54]

The summing up by the coroner

86. Following the hearing of the evidence, it is the practice of the coroner to sum up the evidence and direct the jury on the verdicts available to them.

87. If there is any disagreement by the family of the deceased or any interested party with the way in which the evidence is summed up, this should be addressed with the coroner in advance of the jury withdrawing to consider their verdict.

The inquest verdict

88. Following the summing up by the coroner, the jury or coroner (where there is no jury, as the case may be) will consider the verdict.

89. Where the inquest is sitting with a jury, the decision may be unanimous or, where the jury fails to agree on a unanimous basis, by majority.[55]

90. It may be the case that only one verdict is open to the jury based on the evidence given and, in that event, the coroner directs the jury accordingly.

91. However, there may be a number of possible verdicts open to the jury based on the evidence and, in that case, these can properly be left for the jury to consider.[56]

92. The form of the verdict requires the identity of the deceased to be recorded as well as how, when and where the death occurred.[57] Questions of civil or criminal

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53 Kiely v Minister for Social Welfare (No. 2) [1977] IR 267 at 281.

54 See for example Morris v Dublin City Coroner [2000] 3 IR 592 in which the Supreme Court held that "... provided the respondent (coroner) complies with the requirements of the Act of 1962 and observes the requirements of natural justice and fair procedures, he is entitled to conduct the inquest in the manner which he thinks best adapted to serve the grounds of public interest...".

55 Section 44 of the Coroners Act 1962, as amended.

56 See Farrell Coroners: Practice and Procedure Dublin; Roundhall Sweet and Maxwell (2000) at page 338.

57 As set out in the schedule to the Coroners Act 1962 (Forms) Regulations SI94/1962.

liability cannot be considered.[58] The verdict, or any rider or findings attached to the verdict, must not contain a censure or exoneration of any person.[59]

93. The record of the findings made and the verdict returned at an inquest will be signed by the coroner holding the inquest and, where they are sitting with a jury, by the foreman of the jury. [60]

94. There is no definition of "verdict" in the Coroners Act. Coroners avail of a range of verdicts at the conclusion of an inquest to best describe their investigation into the death of the deceased person. The Report of the Coroner Rules Committee 2003 – available on the www.coroners.ie website – provides information on verdicts.

95. Possible verdicts at inquest include:

- Accident - means an unintended act or event which has a fatal outcome;
- Misadventure - means an intentional act that resulted in a mishap or misfortune causing death;
- Suicide;
- Natural causes;
- Unlawful killing - means a death that is a result of unlawful or felonious homicide (murder, manslaughter or infanticide); or
- An open verdict -- means that the evidence does not fully or further disclose the means by which the cause of death arose or where the cause of death cannot be ascertained by the post-mortem examination.

Riders and recommendations

96. Sometimes the coroner or the jury attaches what are known as "riders" or "recommendations" to the inquest verdict. These riders or recommendations are normally of a general character and may be designed to help prevent further deaths.[61]

97. As with the verdict, any riders or recommendations should not determine civil or criminal liability, nor contain a censure or exoneration of any person.[62]

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58 Sections 30 and 31 of the Coroners Act 1962, as amended.
59 Section 31 of the Coroners Act 1962, as amended.
60 Section 32 of the Coroners Act 1962, as amended.
61 Section 31(2) of the Coroners Act 1962.
62 Section 31 of the Coroners Act 1962, as amended.

98. Where it is likely that a rider or recommendation is going to be made, both the coroner and the parties should be made aware of this before the announcement of the verdict. This is to ensure that there is no conflict with the requirements of the law (in terms of not determining civil or criminal liability) and, where necessary, to allow any submissions to be made to the coroner on the nature of the rider or recommendation to be made.

The maintenance of records after the inquest

99. The coroner has obligations to preserve every deposition or note of the names and addresses of witnesses taken at an inquest, every report of a post-mortem examination made and every record of the verdict returned at an inquest.[63]

100. Any person who applies for a copy of such documentation is entitled to receive them from the coroner on the payment of a fee. However, certain organisations are exempt from the fee.[64]

The inquest and Article 2 of the European Convention on Human Rights

101. Article 2 of the ECHR provides protection for the right to life. Under Article 2 the State has (in broad terms) a duty to protect the right to life. This includes a duty not to take life without justification, as well as a duty to ensure that laws, systems and procedures are in place to protect life to the greatest extent reasonably practicable. Examples of where Article 2 might be engaged (or apply) include the death of a person following contact with the Garda Síochána or the death of a psychiatric in-patient in a State institution.

102. In cases where Article 2 is engaged, the State has a duty to ensure that the investigation of the death is:

- Independent of the persons/organisations being investigated;
- Adequate – i.e. capable of gathering evidence to determine whether any actions were unlawful and, where appropriate, to identify and punish those responsible;
- Prompt – i.e. conducted in an expeditious manner;

63 Section 29 of the Coroners Act 1962, as amended.

64 Section 29(3) of the Coroners Act 1962, as substituted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.

- Open and transparent; and
- Allows the family of the deceased to engage meaningfully in the process.

103. In respect of cases where Article 2 ECHR is engaged, the State has a positive duty to ensure an independent investigation. This might be met in a number of ways, but the circumstances may mean that the coroner's inquest is the intended mechanism, even though the State's Article 2 obligation requires a broader inquiry than might otherwise be envisaged at an inquest.[65] For example the inquest may need to identify any systemic deficits (e.g. whether officers in charge of prisoners were properly trained in first aid). In some cases, this could potentially come into conflict with the legal prohibition on the determination of civil or criminal liability at inquests or of making findings which censure or exonerate any person.

104. In light of this, it is possible that where Article 2 ECHR is engaged, a coroner's inquest, in and of itself, may not always be sufficient to comply with the requirements of Article 2.

105. In other words, in a limited number of cases it may be that a more substantial inquiry, including a Commission of Investigation, is required in order to fulfil the requirements of Article 2.[66]

106. In this regard, families are entitled to make representations to the coroner on the adequacy of the inquest, where Article 2 ECHR is engaged, in order to ensure that the Article 2 requirements are being fully met.

Dissatisfied parties

107. Where family members or interested persons are dissatisfied with the outcome of an inquest, they may first wish to consider the formal documents. There is a right for any person to copies of every deposition or note of the names and addresses of witnesses disclosed at an inquest, every report of a post-mortem examination and every record of the verdict returned at an inquest.[67]

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65 For example, in an English context the decision of the House of Lords in Middleton [2004] 2 AC 182 where it was found that an Article 2 inquest will seek to elicit the jury's factual conclusions in relation to the following "where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death" and such conclusions may also be "judgmental".

66 See for example, the case of NicGibb v Ireland ECHR 17707/10 in which the State accepted that it was in breach of Article 2 of the ECHR, in respect of the investigation of a Garda Síochána operation to prevent a robbery, which resulted in the shooting dead of Ms NicGibb's partner. The State established a Commission of Investigation under the Commission of Investigation Act, 2004 to independently investigate the death in question.

67 Section 29(3) of the Coroners Act 1962, as substituted by Section 24 of the Courts and Civil Law (Miscellaneous Provisions) Act 2013.

108. There is no provision in law for a dissatisfied party to appeal the outcome of an inquest. There is a limited power for the Attorney General to direct a coroner to hold an inquest in relation to the death of a person, whether or not they or any other coroner has previously held an inquest in relation to the death. The power must be exercised reasonably[68], for example, where new evidence emerges casting doubt on the result of the original inquest.

109. Where the family of the deceased believe that there has been some significant irregularity in relation to the inquest or some significant absence of fair procedure, it is open to them to apply to the High Court for judicial review of the inquest.

110. Once the inquest is concluded (and save for the potential for a fresh inquest at the order of the Attorney General or by way of a judicial review by the High Court), the coroner's jurisdiction is at an end and the matter cannot be reopened. The only exception to this is the coroner's power to correct certificates issued following an inquest to the Registrar of Births and Deaths and where there is an error in such a certificate. A coroner may issue an amending certificate to the registrar and the error shall be corrected by the registrar in the register of deaths.[69]

68 See Farrell v Attorney General [1998] I IR 203

69 Section 50(3) of the Coroners Act 1962.

Appendix 1 - Terms and Definitions relevant to the inquest coroner

Direct maternal death	means the death of a woman resulting from obstetric complications of the pregnant state whether arising during pregnancy, labour or puerperium and whether from obstetric interventions, omissions, or incorrect treatment or from a chain of events resulting from any of them.
Indirect maternal death	means the death of a woman resulting from a pre-existing disease, or a disease that developed during pregnancy, and which was not the result of direct obstetric causes, but which was aggravated by the physiological effects of pregnancy.
Late maternal death	means the death of a woman occurring more than 42 days and less than 365 days after the end of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes and, without prejudice to the generality of the foregoing, includes a direct maternal death or an indirect maternal death occurring during that period.
Maternal death	means the death of a woman while pregnant, or within 42 days of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes and, without prejudice to the generality of the foregoing, includes a direct maternal death or an indirect maternal death occurring during that period.
Stillborn child	means a child of not less than 24 weeks' gestation, or of birth weight of not less than 500g, who is delivered without signs of life.

Appendix 2 - Second Schedule of the Coroners Act 1962

1. Any death that may be murder, manslaughter or infanticide.

2. Any death that appears to be connected with a crime or suspected crime.

3. Any death, whether or not accidental, caused wholly or partly by stabbing, drowning, poisoning, hanging, electrocution, asphyxia or a gunshot wound.

4. Any death where the deceased person is dead on arrival at a hospital.

5. Any death which may be by suicide.

6. 6. Any death where the body of the deceased person is unidentified.

7. Any death where no family member of the deceased person can be traced within a reasonable time of the death.

8. Any death where the body of the deceased person is found or recovered in circumstances that indicate that the death may have occurred a considerable period of time previously.

9. Any death (other than in circumstances to which paragraph 8 applies) in respect of which the date of death may not be ascertainable.

10. Any death caused wholly or partly by any of the following:

    - an incident, whether or not accidental, resulting in any physical injury, including a cut, fracture or contusion;
    - a fall;
    - self-neglect;
    - an eating disorder;
    - exposure or hypothermia;
    - burns.

11. Any death which may be by assisted suicide.

12. Any death caused wholly or partly by any of the following:

    - an accident arising out of the use of a vehicle in a public place;

- an incident occurring on a railway;
- an incident arising on a train, aircraft, ship or other vessel.

13. Any death caused wholly or partly by any of the following:
    - a notifiable disease or condition that is, under provisions in that behalf in any other enactment, required to be notified to a Minister of the Government, a Department of State or a statutory body or to an inspector or other officer of a Minister of the Government, a Department of State or a statutory body;
    - an adverse reaction to any drug;
    - a drugs overdose or the presence of toxic substances;
    - in the case of an infant death, maternal drug addiction;
    - an infection contracted as a result of previously contaminated blood product administration;
    - a lack of care or neglect;
    - starvation or malnutrition.
14. Any death which may be due to a prion disease.
15. Any death caused wholly or partly by an accident at work or due to industrial or occupational injury or disease.
16. Any death occurring in a hospital or other health institution —
    - that is unexpected,
    - within 24 hours of presentation or admission, whichever is the later, or
    - of a person transferred from a nursing home.
17. Any maternal death or late maternal death.
18. Any death of a stillborn child, death intrapartum or infant death.
19. Any death occurring in a hospital or other health institution that is directly or indirectly related to a surgical operation or anaesthesia (including recovery from the effects of anaesthesia) or to any other medical, surgical or dental procedure, regardless of the length of time between the procedure and death.

20. Any death which may be due to any healthcare acquired infection.

21. Any death where an allegation is made or a concern has been expressed regarding the medical treatment provided to the deceased person or the management of his or her healthcare.

22. Any death which may be as a result of an unconventional medical procedure or treatment.

23. Any death occurring in —

- an institution for the care and treatment of persons with a physical or mental disability, or
- any public or private institution for the care of elderly or infirm persons, including a nursing home.

24. Any death where the deceased person was at the time of his or her death, or immediately before his or her death, in State custody or detention.

25. Any death of a child in care.

Appendix 3 - Specified Persons in Relation to Reportable Deaths to a coroner

Any medical practitioner, nurse or midwife who had responsibility for, or involvement in, the treatment or care of the deceased person in the period immediately before his or her death or who was present at his or her death.

Section 16B Of the Coroners Act 1962, as amended, requires a range of specified persons to report a death to the coroner for the district in which the body is lying, as soon as practicable after becoming aware of a reportable death and unless he or she has reasonable grounds for believing that the death has already been reported to the coroner by another specified person.

The obligation imposed on a specified person is deemed to be discharged if he or she reports the death as soon as practicable after becoming aware of it to a member of the Garda Síochána. It shall be the duty of a member of the Garda Síochána, on becoming aware of a reportable death to report the death as soon as practicable to the coroner.

Specified persons

1. Any medical practitioner, nurse or midwife who had responsibility for, or involvement in, the treatment or care of the deceased person in the period immediately before his or her death or who was present at his or her death.

2. Any registered medical practitioner who examines the body of the deceased person after death.

3. Any paramedic or advanced paramedic, registered with the Pre-Hospital Emergency Care Council under the Pre-Hospital Emergency Care Council (Establishment) Order 2000 (S.I. No. 109 of 2000), who had responsibility for, or involvement in, the care of the deceased person in the period immediately before his or her death or who was present at his or her death.

4. The funeral undertaker responsible for the disposal of the body of the deceased person.

5. The person in charge of a mortuary in which the body of the deceased person is lying or comes to lie.

6. An occupier of a house or other dwelling, including a mobile dwelling, in which the deceased person was residing at the time of his or her death.

7. The person in charge of any public or private institution or premises, or a part of such institution or premises, in which the deceased person was

residing or receiving treatment or care at the time of his or her death.

8. A person who had care of the deceased person immediately before his or her death.

9. Where the deceased person was in State custody or detention immediately before his or her death, a person who, pursuant to an enactment or otherwise, had responsibility for the deceased person.

10. The person in charge of an aircraft, ship or other vessel landing or arriving in the State on which the deceased person was travelling at the time of his or her death.

11. A registrar of deaths within the meaning of the Civil Registration Act 2004 to whom particulars of the death of the deceased person are given for the purposes of the performance by the registrar of deaths of his or her functions under that Act.

12. If the reportable death concerned is that of a stillborn child or a death intrapartum, any medical practitioner, nurse or midwife who had responsibility for, or involvement in, the treatment or care of the woman concerned in the period immediately before or after the delivery of the stillborn child, or who was present at the delivery, is required to report, or cause to be reported, the death to the coroner concerned.

Appendix 4 - Draft Letter of Interest

Insert address of the relevant coroner

Dear Coroner,

I/we am/are the *[Insert relationship to the deceased]* of the deceased *[Insert name of deceased]* and understand that a decision has been made to hold an inquest.

I/we am/are writing to ask that we be notified in writing of the time, date and place of the proposed hearing of the inquest, so that I/we may be able to attend the inquest and to fully engage in the proceedings.

I/we request that as much advance notice as possible be provided and that notice be given at least 14 days in advance of the holding of the inquest in accordance with the Coroners Act 1962, as amended.

Yours sincerely,

(Note: use of this template letter is not a statutory requirement under the Coroners Act 1962).

Appendix 5 - Draft Letter on Legal Aid or Legal Advice

Insert address of the relevant coroner

Dear Coroner,

I am the *[Insert relationship to the deceased]* of the deceased *[Insert name of deceased]* and understand that a decision has been made to hold an inquest.

I am writing to apply for a request to be submitted by you to the Legal Aid Board in relation to the granting of legal aid or legal advice, or both, to me pursuant to the Civil Legal Aid Act 1995.

Yours sincerely,

(Note: use of this template letter is not a statutory requirement under the Coroners Act 1962).

Appendix 6 - Draft Letter on Disclosure

Insert address of the relevant coroner

Dear Coroner,

I/we am/are the *[Insert relationship to the deceased]* of the deceased *[Insert name of deceased]* and understand that a decision has been made to hold an inquest.

I/we am/are writing to formally apply for all documentation in relation to this inquest, to include a list of all witnesses, a copy of the post-mortem report, a copy of all draft depositions and a list of any other materials relevant to the inquest.

If any materials that are relevant are not being disclosed, or are otherwise being edited or redacted (on the grounds of privilege or otherwise), please identify what materials are not being disclosed, or otherwise being edited or redacted, and the basis for same.

I/we would be most grateful if you would please ensure that the above are provided as soon as possible to allow me/us the opportunity to fully consider same in advance of the inquest.

Yours sincerely,

(Note: use of this template letter is not a statutory requirement under the Coroners Act 1962).

Appendix 7 - Draft Letter on Special Arrangements

Insert address of the relevant coroner

Dear Coroner,

I/we am/are the *[Insert relationship to the deceased]* of the deceased *[Insert name of deceased]* and understand that a decision has been made to hold an inquest.

I/we am writing to formally notify you that in order to properly participate at the hearing of the inquest, I/we require the following facilities/ accommodations be made available to me: *[Insert relevant requirements]*

Please confirm by return that same will be provided.

Yours sincerely,

(Note: use of this template letter is not a statutory requirement under the Coroners Act 1962).

Glossary

Civil liability	Legal responsibility for the harm alleged by an individual and the damages suffered. A finding of civil liability gives an individual rights to obtain redress from another party, for example, compensation for damages.
Criminal liability	Legal responsibility for an illegal act or failure to act, which constitutes a crime in law. A finding of criminal liability can result in a criminal conviction by a court, and may also lead to a fine or a prison sentence.
Hearsay evidence	Statements given by a witness based on what they have heard from another person, rather than on direct personal knowledge or experience.

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

The Irish Human Rights and Equality Commission

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