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Introduction

The Coroner Service is one of the oldest public services in existence and has evolved over time to a position of significance in today's society. The Act under which the Coroner currently functions is the Coroners Act, 1962. Today the Coroner has a wide range of duties involving investigatory, administrative, judicial, preventative and educational functions. Operating as an independent judicial officer, he must establish the "who, when, where and how" of unexplained death. The coroner is not permitted to consider civil or criminal liability. His function is to establish the facts, in other words his court is inquisitorial rather than adversarial.

This evolution has taken place without any real evaluation of its structure and direction and indeed, apart from the introduction of the Coroners Act in 1962, no reform of the Coroner Service has taken place in modern times.

Against this background, the Minister for Justice, Equality and Law Reform decided to initiate a comprehensive review of the service and established a broad-based Working Group on the Review of the Coroner Service to carry out that task.

Establishment

The Working Group on the Review of the Coroner Service was established in December 1998 to examine the role of the Coroner Service, its needs and the appropriate framework for its development. The final Report of the Working Group contained over 100 recommendations and was published in December 2000.

In the context of drafting and rewriting a new Coroners Act, the Working Group on the Review of the Coroner Service had recommended that the concept of regulation-based Coroners Rules should be an essential part of a new legislative environment for the new Coroner Service. The report added

"Rules should be established by statutory regulation and be capable of being amended. They should cover the various procedures and options available to coroners throughout the cycle of their functions from death reporting right through to the carrying out of formal inquests."

Recommendation No. 12 (section 3.3.1) of the Report of the Working Group) recommended the establishment of a Rules Committee. Recommendation No. 13 (section 3.3.1 of the Report of the Working Group) went on to say that the Committee should devise Coroners Rules in accordance with the recommendations in the report and on the basis of the Outline Coroners Rules set out in Appendix J.

The Rules Committee was comprised of representatives from the following organisations:

- The Coroners Society of Ireland
- The Department of Justice, Equality and Law Reform
- The Faculty of Pathology of the Royal College of Physicians of Ireland
- The Department of Health and Children
- The Office of the Attorney General
- An Garda Síochána
- The Samaritans

A full list of membership is at Appendix A.

Methodology

The Rules Committee met 12 times in plenary session covering a total of 48 hours of discussion. In addition, specialist subgroups were established to examine specific issues.

Invitations for submissions to the Rules Committee were publicly advertised in February 2002. A copy of the advertisement is shown in Appendix B. A total of 32 written submissions were received. The Committee also heard a further 5 oral submissions. Details are shown in Appendix C.

The Rules included in the Committee's report as laid out below have followed the notes set out in Appendix J of the main Working Group Report in relation to the area to be addressed. The Committee did not re-examine the core recommendations of the Working Group Report except insofar as an examination of the details of the issues suggested some refinements of the original proposals. In some cases these refinements arose from a more detailed consideration of the full legal implications of a proposal. In other cases the incorporation of the Working Group's ideas into statutory rules had to await progress in setting up appropriate infrastructure. Items which did not translate directly from Appendix J into Coroners Rules are identified and the Committee's conclusions are set out further on in this Report.

The Rules Committee were conscious that changes in the work and practice of the coroner are inevitable as the complexity and demands of modern society increase. It felt however that the changing nature of the service is best served by a rules-based approach which will deliver the flexibility and level of detail needed for the new coroner service.

The Committee would like to especially acknowledge the contribution made by the Samaritans who, building on their work with the Working Group, have again added their unique experience to what have been very detailed deliberations.

Coroners Rules

Part 1 - Definition of Terms

1.1 Post-mortem examination

A detailed examination involving:

- the dissection of the cranium, thorax and abdomen
- the noting and description of marks or injuries on the body
- ancillary investigations where appropriate to include toxicology, histopathology and microbiology investigations.

1.2 Histopathologist

A qualified pathologist who has training and experience in the performance of post-mortems and microscopic examination, and who is a Registered Medical Specialist on the Register of Medical Specialists (Division of Histopathology) of the Medical Council of Ireland.

1.3 Preliminary inquiry

A preliminary inquiry includes everything that occurs between a death being reported to the coroner and a Medical Certificate of the Cause of Death becoming available or between a death being reported to the coroner and a decision by a coroner as to how to proceed with the next step.

1.4 Jurisdiction

A coroner's jurisdiction is founded on the presence of a dead body lying within his district or where a body otherwise within his district is lost or irrecoverable or where a body comes to lie in his district by repatriation from abroad.

1.5 Inquest

An inquest is a public inquiry into death which is held to establish the identity of the deceased, the date and place of death and the circumstances surrounding the death (including the medical cause of death).

1.6 Interested persons

An ‘interested person’ should be determined by the coroner in the light of all the circumstances of the inquest. Parties to be considered by the coroner may include:

- Spouses/former spouses, partners/former partners, including same sex partners
- Next of kin of the deceased
- Personal representatives of the deceased
- Representatives of the Board or Authority in whose care the deceased was at the time of death e.g. hospital, prison or other institution
- Those responsible for the death in any way e.g. driver of a motor vehicle
- Representatives of insurance companies
- Properly interested persons under the provisions of the Safety, Health and Welfare at Work Act, 1989
- Other persons arising from the circumstances of the particular case.

1.7 Post-mortem report

A post mortem report should include:

- Basic demographic details
- A brief clinical summary
- Description of external and internal examinations
- A report of histology or other investigations, where appropriate
- A summary of findings
- A concluding commentary
- A “cause of death” in the standard international form for the “medical certificate of the cause of death”.

1.8 Toxicology

Toxicology is the examination of specimens for the detection and quantification of alcohol, drugs and poisons.

1.9 Histopathology

Histopathology is the microscopic examination of human tissue for the diagnosis of disease.

1.10 Microbiology

Microbiology is the examination of specimens for the isolation and identification of micro-organisms.

1.11 Certificate of fact of death

A statute-based certificate which is a record of the fact of death and which makes no reference to the cause of the death.

1.12 Verdict

A short summary of the circumstances of death and a conclusion on the means by which death occurred.

1.13 Recommendation

A note of a general character designed to prevent further fatalities, to be appended to the verdict at the inquest. The recommendation must not contain a censure or exoneration of any person and the coroner should ensure that it is framed in accordance with coroner law.

1.14 Body

- The complete body of a dead human being
- The body of a foetus or of a stillborn child
- Old human remains
- A partially destroyed body or an essential part or parts of a body
- Calcined remains or ashes.

Part 2 - Deaths Reported to Coroners

2.1 Deaths reportable to a coroner

- All sudden deaths
- Any case where the cause of death appears to be unknown
- Any accidental death
- Where there are suspicious circumstances, violence or misadventure
- Suicide, suspected suicide or suspected assisted suicide
- If the deceased has not been seen and treated by a registered medical practitioner within the 28 days before death

  In cases of the above, where a coroner, having considered the circumstances of the case, authorises the issue of a Medical Certificate of Cause of Death, the medical practitioner involved must carry out an external examination of the body
- Death due to possible negligence, misconduct or malpractice
- Death occurred within 24 hours of admission to hospital
- Any death that may have occurred during an operation, or before recovery from the effects of anaesthetic, or from a diagnostic or therapeutic procedure regardless of the length of time between the procedure and death
- Any death which may have occurred from a non-conventional medicine or procedure
- Any maternal death that occurs during or following pregnancy (up to a period of six weeks post-partum) or that might be reasonably related to the pregnancy
- Any death of a child in care
- Infant deaths which fall under the normal categories for reportable deaths, to include Sudden Infant Death (SID) syndrome and non-accidental injury
- Unnatural stillbirths and intra-uterine deaths

- Death of any mentally ill or intellectually disabled person who, at the time of death, resides in a place of care, including an institution or a community care residence
- If the deceased was in prison or in Garda or military custody at the time of death
- Deaths due to want of care, exposure or neglect
- Any death due to accident at work, occupational disease or industrial poisoning
- Where a body is to be removed from the State
- Where a body is to be repatriated to the State
- Where a body is unidentified
- Where the next of kin cannot be traced
- Where human remains are “discovered”
- Deaths in a nursing home
- Deaths resulting from acute alcohol poisoning or other poisoning
- Any death which may be due to Transmissible Spongiform Encephalopathy (TSE) - for example Creutzfeldt-Jakob Disease (CJD)
- Where a funeral director, proposing to carry out a burial, is unable to secure proof that a medical certificate of the cause of death is procurable from a registered medical practitioner.

2.2 Who must report a death?

- Every medical practitioner, nurse, registrar of deaths or funeral director, every occupier of a house or other dwelling, and every person in charge of any institution or premises in which a deceased person was residing at the time of death
- Any member of the Gardaí who becomes aware of a reportable death in the coroner’s jurisdiction

2.3 When is it necessary to hold a post-mortem?

- All unnatural deaths
- All unexplained deaths
- Where the deceased was in prison or in Garda or military custody
- Deaths due to industrial disease or industrial accident.

Part 3 - Post-mortem Examinations

3.1 Who may carry out a post-mortem?

- A suitably qualified Histopathologist
- A trainee Histopathologist under his/her direction
- In the absence of a suitably qualified Histopathologist, a qualified pathologist with suitable experience in post-mortem techniques.

3.2 When should a pathologist not carry out a post-mortem?

- The coroner shall not request a pathologist to carry out a particular post-mortem if he is of the opinion that a possible conflict of interest may arise
- In the case of a hospital pathologist, where there are substantive allegations against another member of staff in relation to the death in question and the coroner is aware of this fact.

3.3 Preservation of material and records at post-mortem

- Materials and records to be retained should include the following:
  - ✔ Items that may be of evidentiary value to the coroner that are recovered from the post-mortem
  - ✔ Notes
  - ✔ Post-mortem report
  - ✔ Toxicology and other reports

- ✔ Organs (until no longer required by the coroner but in any event, in accordance with the procedures outlined in the Review Report)
- ✔ Blocks and slides.

- Blocks and Slides should be kept in accordance with the Royal College of Pathologists' recommendations

- Records should be kept *ad infinitum.*

3.4 Organs and body parts - removal, retention and disposal

- The coroner has the right, through the pathologist who acts as his or her agent in performing the post-mortem, to authorise the removal and retention of organs, body parts and ante-mortem samples. This right applies solely in the context of establishing the cause of death.

3.5 The post-mortem report

- The pathologist must submit the report to the coroner

- Families have a right to see the post-mortem report if no inquest is to take place

- A copy of the post-mortem report should on request to the coroner be made available to the Gardaí

- All requests from interested parties for copies of the post-mortem report must be addressed directly to the coroner.

3.6 Toxicology

Toxicology tests are mandatory in the following cases

- All unnatural deaths
- All unexplained deaths
- Drug overdoses or suspected drug overdoses
- If the cause of death cannot be established clearly from the post-mortem examination.

Part 4 - Post-mortem by State Pathologist

- The coroner should be empowered to request the State Pathologist directly to undertake a post-mortem examination.

Part 5 - Certificate of Fact of Death

- The issue of a 'certificate of fact of death' should be in accordance with the provisions of the new Coroners Act.

Part 6 - Inquests

6.1 When should a coroner be disqualified from carrying out an inquest?

- Where there is a potential conflict of interest such as:
  - ✔ when there has been a personal or professional relationship with the deceased
  - ✔ when there is a professional relationship with an interested person or witness, such as a doctor in the same practice or hospital
  - ✔ where the coroner has a pecuniary or proprietary interest in the outcome of the inquest.

6.2 Circumstances where flexibility of jurisdiction are required

- Coroners and deputies should have concurrent jurisdiction
- Where two or more deaths result from one incident and the bodies come to lie in different districts, the relevant coroners may agree amongst themselves which coroner shall have jurisdiction to investigate the deaths
- Where the deputy coroner may also be disqualified, compromised or is otherwise unable to conduct the inquest.

6.3 Notice of an inquest

- The coroner should arrange to notify the next of kin regarding the holding of an inquest. A minimum period of two weeks notice should be given.

6.4 Circumstances where a jury must be used

- In cases of suspected murder, manslaughter or infanticide
- A death where an accident, poisoning or disease was involved and which requires reporting to a relevant authority
- If the coroner is of the opinion that the circumstances of death could recur and such recurrence would be prejudicial to public health and safety
- Where other enactments which require juries at inquest are applicable or where death is otherwise reportable to a relevant authority.

6.5 Empanelling the jury

- Jurors should be selected from the Circuit Court list or the County Registrar's list
- It will be the duty of the coroner, with the assistance of the Gardaí if necessary, to assemble and issue summonses to potential jurors.

6.6 Records to be kept

- All records submitted to the inquest shall be kept. These include:
  - ✓ Depositions
  - ✓ Exhibits (inc. photographs and maps)
  - ✓ Expert reports
  - ✓ Copy of hospital notes or notes extract
  - ✓ Post-mortem report (appendix F)
  - ✓ Verdicts
  - ✓ Recommendations
  - ✓ Copy of the coroner's certificate of cause of death
  - ✓ Any other document presented at inquest.

6.7 Taking and requesting documentary evidence at inquest

- The coroner may admit non-contentious documentary evidence provided

  (a) interested parties have been notified that such evidence will be admitted

  and

  (b) the coroner announces that he intends to admit the evidence.

- If there are any objections to material evidence being admitted solely in documentary form, then the coroner should not proceed and the inquest should be adjourned.

6.8 Expert evidence

- Documentary evidence of an expert nature which is critical to the establishment of the cause of death may be sought and submitted by the coroner.

6.9 Coroner's discretion for non-release of documents before inquest

- The coroner should have discretion with regard to the release of documents prior to an inquest. This discretion should in general be exercised in favour of release.

6.10 Witness anonymity

- Witness anonymity may be granted in the following circumstances:

  - ✔ If there is a threat to the personal security of a Garda or member of the Defence Forces or their families

  - ✔ If there is a threat to the personal security of any witness, or their family

  - ✔ If there is a threat to national security.

6.11 Protocols for examining witnesses

- Only the coroner has the power to call a witness at inquest
- The witness will be examined first by the coroner
- Interested persons should be permitted to ask the witness questions through the coroner
- Interested persons can make a request to examine a witness but the coroner retains the final discretion in the matter.

6.12 Inquest adjourned due to criminal proceedings

- Where a Garda Inspector applies to the coroner for an adjournment on the basis that criminal proceedings are being contemplated or a criminal inquiry is ongoing, the coroner shall adjourn the inquest, but may take evidence of identification and the medical cause of death for the purpose of issuing a coroners' certificate for death registration purposes.

6.13 Mandatory inquests

- An inquest must be held where
  - ✔ a coroner believes that the death occurred in a violent or unnatural manner
  - ✔ a death occurs in Garda, Military or prison custody
  - ✔ where it is required under another enactment.

Part 7 - Verdicts

7.1 What verdicts are available at inquest ?

- Accidental death
- Death by misadventure
- Medical misadventure

- Suicide/self-inflicted death/deceased took his own life

  In declaring a verdict of suicide the coroner/jury must be sure:
  - ✔ The deceased took his or her own life
  - ✔ The deceased was intent on taking his or her life
  - ✔ There is proof beyond reasonable doubt that the injuries sustained were self-inflicted and the deceased had such intention.

- Unlawful killing

  In returning a verdict of unlawful killing the coroner/jury must confirm that:
  - ✔ There are no criminal proceedings
  - ✔ Unlawful killing is proved beyond reasonable doubt
  - ✔ The investigation by the Gardaí has ended
  - ✔ No person is, expressly or by implication, named for the killing.

- Want of attention at birth

  In returning such a verdict the Coroner/Jury must confirm that the:
  - ✔ The child was abandoned
  - ✔ The child's mother was never found
  - ✔ No other person is under criminally identifiable suspicion of the death
  - ✔ Proof of the above three items is secured beyond reasonable doubt.

- Stillbirth

- Occupational disease

- Industrial accident

- In accordance with the findings of a criminal court

- Death by natural causes

- Open Verdict - an open verdict should be returned if there is insufficient evidence to record any other specified verdict.

7.2 Findings

Findings may be applied in the following cases:

- Where a person is killed by a member of the Defence Forces or Garda Síochána acting in the course of their duty

- Where a burglar has been killed by the occupant of a premises

- In certain circumstances where criminal proceedings took place but there was no conviction or where criminal investigations took place but there was no prosecution.

Part 1: Definition of Terms

Final Rules (Committee's Report)	Notes
Post-mortem examination A detailed examination involving: • the dissection of the cranium, thorax and abdomen • the noting and description of marks or injuries on the body • ancillary investigations where appropriate to include toxicology, histopathology and microbiology investigations.	
Histopathologist A qualified pathologist who has training and experience in the performance of post-mortems and microscopic examination, and who is a Registered Medical Specialist on the Register of Medical Specialists (Division of Histopathology) of the Medical Council of Ireland.	

Final Rules (Committee's Report)	Notes
Preliminary inquiry A preliminary inquiry includes everything that occurs between a death being reported to the coroner and a Medical Certificate of the Cause of Death becoming available (see 1, 2 and 3 of notes) or between a death being reported to the coroner a decision by a coroner as to how to proceed with the next step (see 1, 2 and 4 notes).	"Preliminary inquiry" is a useful term which enables a distinction to be made between (a) inquiries usually made immediately after a death is reported and (b) inquiries represented by the inquest itself. (1) coroner is notified or the death is reported to the Gardaí (2) the coroner notifies the Gardaí of the death, or if the death has been reported to the Gardaí, the Gardaí notify the coroner (3) if a medical certificate is available then this is issued by a doctor (in some cases the coroner may need to notify the Registrar of Deaths using the'pink form') and the preliminary inquiry is at an end (4) if there is no medical certificate available then the coroner must decide which of the following categories applies and the preliminary inquiry is at an end: - Unknown cause - the coroner has discretion to hold a post-mortem/inquest - Sudden and unknown cause - post-mortem may suffice in lieu of inquest - Violent or unnatural or legislatively prescribed-inquest mandatory - Garda investigation requiring State Pathologist.
Jurisdiction A coroner's jurisdiction is founded on the presence of a dead body lying within his district or where a body otherwise within his district is lost or irrecoverable or where a body comes to lie in his district by repatriation from abroad.	In the case of a repatriated body 'comes to lie' means the district into which the body is consigned by the next of kin for the purpose of burial or cremation.

Final Rules (Committee's Report)	Notes
Inquest An inquest is a public inquiry into death which is held to establish the identity of the deceased, the date and place of death and the circumstances surrounding the death (including the medical cause of death).	The general purpose of an inquest is to be as follows: • To determine the circumstances surrounding death (including the medical cause of death) • To allay rumours or suspicions • To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths • To advance medical knowledge • To preserve the legal interests of the deceased person's family, heirs or other interested parties.
Interested persons An 'interested person' should be determined by the coroner in the light of all the circumstances of the inquest. Parties to be considered by the coroner may include: • Spouses/former spouses, partners/former partners, including same sex partners • Next of kin of the deceased • Personal representatives of the deceased • Representatives of the Board or Authority in whose care the deceased was at the time of death e.g. hospital, prison or other institution • Those responsible for the death in any way e.g. driver of a motor vehicle • Representatives of insurance companies • Properly interested persons under the provisions of the Safety, Health and Welfare Work Act, 1989 • Other persons arising from the circumstances of the particular case.	There is a wide range of interested persons within the coroner system and the identification of an interested person will depend on the part of the coroner cycle reached when the concept is being applied. Determining an "interested person" is essentially a matter for the coroner but the Rules set out the considerations which should apply. It will be important to have regard to the way in which the law is developing in this area as modern legislation tends to take a wider view of an "interested party" reflecting changes in social groupings in our society.

Final Rules (Committee's Report)	Notes
<u>Post-mortem report</u> A post mortem report should include: • Basic demographic details • A brief clinical summary • Description of external and internal examinations • A report of histology or other investigations, where appropriate • A summary of findings • A concluding commentary • A "cause of death" in the standard international form of the "medical certificate of the cause of death".	The post mortem report is an extremely important document and should be comprehensive and consistent in its contents. A sample form (designed by the Committee in consultation with the Faculty of Pathology (Royal College of Physicians of Ireland) and the Coroners Society of Ireland) is included in Appendix F.
<u>Toxicology</u> Toxicology is the examination of specimens for the detection and quantification of alcohol, drugs and poisons.	It should be noted that toxicology tests can be both routine and quantitative **Routine toxicology** A mainly qualitative test that indicates the presence of a drug (or drugs) but may not indicate the levels involved. **Quantitative toxicology** A quantitative test that gives the precise level of the drug present in the specimen together with therapeutic, toxic and lethal ranges for the drug identified.
<u>Histopathology</u> Histopathology is the microscopic examination of human tissue for the diagnosis of disease.	
<u>Microbiology</u> Microbiology is the examination of specimens for the isolation and identification of micro-organisms.	

Final Rules (Committee's Report)	Notes
Certificate of fact of death A statute-based certificate which is a record of the fact of death and which makes no reference to the cause of the death.	A sample copy is set out in Appendix D. The certificate is required to facilitate the claiming of death benefits and can be issued by the coroner at an early stage of the coroner cycle. It is not an interim certificate in the sense that it is a final certificate of the fact of death as opposed to a coroners' certificate of the cause of death.
Verdict A short summary of the circumstances of a death and a conclusion of the means by which death occurred.	
Recommendation A note of a general character designed to prevent further fatalities, to be appended to the verdict at the inquest. The recommendation must not contain a censure or exoneration of any person and the coroner should ensure that it is framed in accordance with coroners law.	
Body A body may be defined as follows: ● The complete body of a dead human being ● The body of a foetus or of a stillborn child ● Old human remains ● A partially destroyed body or an essential part or parts of a body ● Calcined remains or ashes.	Clearly, the complete body of a dead human being, whether newly-born child or fully-grown man falls within the term "body". But the more or less special cases listed must also be considered.

Part 2: Deaths reported to coroners

Final Rules (Committee' Report)	Notes
2.1 - REPORTABLE DEATHS	
All sudden deaths.	The Committee felt there was no need to differentiate between types of sudden deaths. Sudden deaths may include the following categories: Sudden and expected Sudden and unexpected Sudden and not unexpected A sudden death can be defined as death within an hour to 24 hours from onset of illness.
Any case where the cause of death appears to be unknown.	This term "appears to be" unknown merely reflects the degree of uncertainty associated with not knowing the cause of death.
Any accidental death.	There is no requirement to differentiate between types of accidents.
Where there are suspicious circumstances, violence or misadventure.	
Suicide, suspected suicide or suspected assisted suicide.	These situations may vary from being fairly obvious to vaguely suspicious. The presence of a reasonable doubt should be sufficient to make a death reportable. It should be noted that "assisted suicide" is also included.

Final Rules (Committee's Report)	Notes
If the deceased has not been seen and treated by a registered medical practitioner within 28 days before death.	The term '28 days' was used for purposes of clarity. The desirability of reducing this period to 14 days was examined but following detailed discussions and research on this topic with other jurisdictions and in particular the UK, the Committee concluded that the 28 day period was appropriate. In cases of the above, where a coroner, having considered the circumstances of the case, authorises the issue of a medical certificate of the cause of death, a medical practitioner involved must carry out an external examination of the body.
Due to possible negligence, misconduct or malpractice.	
Death occurred within 24 hours of admission to hospital.	
Any death which may have occurred during an operation, or before recovery from the effects of anaesthetic, or from a diagnostic or therapeutic procedure regardless of the length of time between the procedure and death.	Therapeutics is the branch of medicine that deals with the different methods of treatment and healing, particularly the use of drugs in the cure of disease.
Any death which may have occurred from a non-conventional medicine or procedure.	This category is intended to cover all aspects of 'alternative' and 'complementary' medicine. Some examples of non-conventional therapies include acupuncture, faith healing, herbal remedies, homeopathy, hypnosis etc.

Final Rules (Committee's Report)	Notes
Any maternal death that occurs during or following pregnancy (up to a period of six weeks post-partum) or that might be reasonably related to pregnancy.	
Any death of a child in care.	A child is deemed to be a "child in care" in the following circumstances: (1) A Child in voluntary care (2) A Child who is placed in emergency care (3) A Child placed under a care order (4) A Child who under The Child Care Act 1991 (as amended by the Children Act, 2001) is detained in a special care unit. These are children in respect of whom there is concern about their physical/health welfare. The Health Board provides care in one of the following ways: (1) By placing the child with a foster parent (2) By placing the child in residential care whether in a children's residential centre registered under part viii of the Child Care Act 1991 in a residential home maintained by a health board or suitable place of residence (3) In the case of a child who may be eligible for adoption under the Adoption Acts,1952 to 1988, by placing him/her with a suitable person with a view to adoption (4) By making such other suitable arrangements (which may include placing the child with a relative) as the Health Board deems proper (5) By placing him/her in a special care unit pursuant to part iv (a) of the Child Care Act 1991 (as amended by the Children Act, 2001).

Final Rules (Committee's Report)	Notes
Infant deaths which fall under the normal categories for reportable deaths, to include Sudden Infant Death (SID) syndrome and non-accidental injury.	While this category duplicated the natural death reporting categories, the Committee felt that it deserved emphasis particularly in relation to the following two categories of deaths - SID and non-accidental injury of infants. Infant deaths are defined as perinatal (stillbirths and deaths in the first week of life) and neonatal (deaths in the first 4 weeks of life).
Unnatural stillbirths and intra-uterine deaths.	The Committee discussed the differences between unnatural stillbirths and intra-uterine deaths and agreed they would need to be differentiated. Unnatural stillbirths include those which may have arisen from neglect or through injury to the mother. **Note:** • A stillbirth is a foetus weighing over 500g and born post 24 weeks • Intra-uterine deaths are those where the foetus is unable to maintain independence outside the womb.
Death of any mentally ill or intellectually disabled person who, at the time of death, resides in a place of care, including an institution or a community care residence.	The Committee acknowledge that there are sensitivities involved in reporting the deaths of those who are mentally ill or intellectually disabled. There are concerns that by so doing, such people are stigmatised and set apart as a separate group. A balance, therefore, lies between avoiding stigmatisation on the one hand and protecting vulnerability on the other. Following extensive discussions on the topic, the Committee concluded that the balance should be in favour of protection. Accordingly, reportable deaths should include the death of any mentally ill or intellectually disabled person who, at the time of death, resides in a place of care. Community care can include residences which involve either part-time or full-time staff support.

Final Rules (Committee's Report)	Notes
If the deceased was in prison or in Garda or military custody at the time of death.	
Deaths due to want of care, exposure or neglect.	The term 'neglect' encompasses self-neglect (starvation, chronic alcoholism) and 'third party neglect' (communities and institutions).
Any death due to accident at work, occupational disease or industrial poisoning.	Non-industrial poisoning is included under the separate heading 'acute alcohol and other poisoning'.
Where a body is to be removed from the State.	In these cases a coroner should sign a certificate (The Coroners Act 1962 (Forms) Regulations 1962 (S.I. No. 94 of 1962) Schedule 5, prescribes the Coroner's Certificate to be issued) confirming that there is no reason why the body may not be removed from the State.
Where a body is to be repatriated to the State.	The place where the body comes to lie will dictate which coroner has jurisdiction in these instances. 'Comes to lie' for the purposes of repatriation will be the district into which the body is consigned by the next of kin for the purpose of burial or cremation.
Where a body is unidentified.	
Where the next of kin cannot be traced.	
Where human remains are "discovered".	This is to cover a situation where a body can still be identified as human remains.
Deaths in nursing homes.	Persons residing in nursing homes are considered to be in a 'vulnerable' category.
Deaths due to acute alcohol poisoning or other poisoning.	

Final Rules (Committee's Report)	Notes
Any death which may be due to Transmissible Spongiform Encephalopathy (TSE) - for example Creutzfeldt-Jakob Disease (CJD).	If CJD is a possible or probable cause of death, a serious public health issue can arise hence its inclusion as a reportable death.
Where a funeral director, proposing to carry out a burial, is unable to secure proof that a medical certificate of the cause of death is procurable from a registered medical practitioner.	
2.2 WHO MUST REPORT A DEATH	
Every medical practitioner, nurse, registrar of deaths or funeral director, every occupier of a house or other dwelling, and every person in charge of any institution or premises in which a deceased person was residing at the time of death.	This category identifies those who are obliged to report a death. However, it should be noted that any person who has reasonable grounds to believe that a reportable death has not been reported may inform the coroner. An occupier may be defined as a person residing in a property as its owner or tenant.
Any member of the Gardaí who becomes aware of a reportable death in the coroner's jurisdiction.	
2.3 - WHEN IS IT NECESSARY TO HOLD A POST-MORTEM	
1. All unnatural deaths 2. All unexplained deaths 3. If the deceased was in prison or in Garda or military custody 4. Deaths resulting from industrial disease or industrial accident.	The Committee felt that mandatory post-mortems should be confined to these four distinct situations.

Part 3: Post-mortem examinations

Final Rules (Committee's Report)	Notes
3.1 - WHO MAY CARRY OUT A POST-MORTEM	
A suitably qualified Histopathologist.	
A trainee Histopathologist under his/her direction.	
In the absence of a suitably qualified Histopathologist, a qualified pathologist with suitable experience in post-mortem techniques.	While the Committee felt that a qualified Histopathologist should carry out post-mortems, it was also agreed that a Histopathologist may not always be available. A third category was, therefore, added to avoid a situation where a post-mortem could not be carried out because a Histopathologist was not available.
3.2 - WHEN SHOULD A PATHOLOGIST NOT CARRY OUT A POST-MORTEM	
The coroner shall not request a pathologist to carry out a particular post-mortem if he is of the opinion that a possible conflict of interest may arise.	Some examples of situations where a conflict of interest may arise are as follows: • Where there is a professional relationship with the deceased • Where there is a personal relationship with the deceased • In the case of a hospital pathologist where there are substantive allegations against another member of staff in relation to the death in question • Where the pathologist may have had previous medical involvement with the deceased. The Committee felt that the next of kin should not have an automatic right to object to a particular pathologist but that any objection expressed should be assessed by the coroner in each case.
In the case of a hospital pathologist where there are substantive allegations against another member of staff in relation to the death in question and the coroner is aware of this fact.	

Final Rules (Committee's Report)	Notes
3.3 - PRESERVATION OF MATERIALS AND RECORDS AT POST-MORTEM	
Materials and records to be retained should include the following: ✔ Items that may be of evidentiary value to the coroner that are recovered from the post-mortem ✔ Notes ✔ Post-mortem report ✔ Toxicology and other reports ✔ Organs (until no longer required by the coroner but in any event, in accordance with the procedures outlined in the Review Report) ✔ Blocks and slides.	The pathologist, on behalf of the coroner, may retain any item(s) of evidentiary value which he finds in or on the body of the deceased.
Blocks and slides should be kept in accordance with current Royal College of Pathologists recommendations. Records are to be kept *ad infinitum*.	This is to ensure that blocks and slides are kept as part of the post-mortem record.
3.4 - ORGANS AND BODY PARTS - REMOVAL, RETENTION AND DISPOSAL	
The coroner has the right, through the pathologist who acts as his or her agent in performing the post-mortem, to authorise the removal and retention of organs, body parts and ante-mortem samples. This right applies solely in the context of establishing the cause of death.	This Rule is to ensure that coroners have a legal entitlement to retain organs/body parts as part of the process of establishing the cause of death.

Final Rules (Committee's Report)	Notes
3.5 - THE POST- MORTEM REPORT	
The pathologist must submit the report to the coroner.	
Families have a right to see the post-mortem report if no inquest is to take place.	Due to the nature of the contents, it may be preferable to have the report forwarded to the family's General Practitioner.
A copy of the post-mortem report should, on request to the coroner be made available to the Gardaí.	
All requests from interested parties for copies of the Post-mortem Report must be addressed directly to the coroner.	
3.6 - TOXICOLOGY	
Toxicology tests are mandatory in the following cases: • All unnatural deaths • All unexplained deaths • Drug overdoses or suspected drug overdoses • If the cause of death cannot be established clearly from the post-mortem examination.	New provision.

Part 4: Post-mortem by State Pathologist

Final Rules (Committee's Report)	Notes
The coroner is empowered to request the State Pathologist directly to undertake a post-mortem.	This item is also to be included in primary legislation. The criteria on which such requests can be based should include: • where the circumstances of a death are questionable or may be suspicious • where a body is found with unexplained marks or injuries.

Part 5: Certificate of Fact of Death

Final Rules (Committee's Report)	Notes
The 'Certificate of Fact of Death' should be issued in accordance with the provisions of the new Coroners Act.	It was agreed that the certificate should be called a 'Certificate of Fact of Death'. Once the coroner is in possession of a C71 form, he may issue a Certificate of Fact of Death on foot of a request from an "interested person". A sample certificate is shown at Appendix D. C71 form - On a death being reported to the Garda Síochána, Form C71 (Report to the Coroner) will be completed and forwarded to the coroner's office and also to the District Officer of the Gardaí and the Commissioner, Crime Investigation Branch. The information provided includes particulars of the deceased, the circumstances of the death and the identification of the deceased.

Part 6: Inquests

Final Rules (Committee's Report)	Notes
6.1 - WHEN SHOULD A CORONER BE DISQUALIFIED FROM HOLDING AN INQUEST	
Where there is a potential conflict of interest such as: • When there has been a personal or professional relationship with the deceased • When there is a professional relationship with an interested person or witness, such as a doctor in the same practice or hospital • Where the coroner has a pecuniary or proprietary interest in the outcome of the inquest.	The third category has been added to reflect an additional potential source of conflict of interest.
6.2 - FLEXIBILITY OF JURISDICTION	
Coroners and deputy coroners should have concurrent jurisdiction.	
Where two or more deaths result from one incident and the bodies come to lie in different districts, the relevant coroners may agree amongst themselves which coroner shall have jurisdiction to investigate the death.	
Where the deputy coroner may also be disqualified or compromised or is otherwise unable to conduct the inquest.	

Final Rules (Committee's Report)	Notes
6.3 - NOTICE OF AN INQUEST	
The coroner should arrange to notify the next of kin regarding the holding of an inquest. A minimum period of two weeks notice should be given.	
6.4 - CIRCUMSTANCES WHEN A JURY MUST BE USED	
In cases of suspected murder, manslaughter, or infanticide.	Apart from these mandatory categories, it should be left to the discretion of the coroner as to when a jury should be used. (Under the new rules, a jury will not be required in cases of road accidents but the coroner may decide to use a jury in particular circumstances).
A death where an accident, poisoning or disease required reporting to a relevant authority.	
If the coroner is of the opinion that the circumstances of death could recur and such recurrence would be prejudicial to public health and safety.	
Where other enactments which require juries at inquest are applicable or where death is otherwise reportable to a relevant authority.	These enactments include: • Safety, Health and Welfare at Work Act 1989 • Prisons Acts 1877-1947 • Mental Treatment Act 1945.

Final Rules (Committee's Report)	Notes
6.5 - EMPANELLING THE JURY	
Jurors should be selected from the Circuit Court list or the County Registrar's list.	The Committee favoured the more simple approach adopted in Recommendation 71 of the Review Report of giving access to the Circuit Court list rather than those procedures under the Juries Act, 1976.
It will be the duty of the coroner, with the assistance of the Gardaí if necessary to assemble and issue summonses to potential jurors.	
6.6 - DOCUMENTS/RECORDS TO BE RETAINED AT INQUEST	
All records submitted to the inquest shall be retained. These include: • Depositions • Exhibits (inc. photographs and maps) • Expert reports • Copy of hospital notes or notes extract • Post-mortem report (Appendix F) • Verdicts • Recommendations • Copy of the Coroner's Certificate of Cause of Death • Any other document presented at inquest.	The concept of "documents submitted at inquest" is particularly critical since the Rule obliging a coroner to decide in favour of release (rule 6.9) applies only to documents submitted or to be submitted at inquest.

Final Rules (Committee's Report)	Notes
6.7 - TAKING DOCUMENTARY EVIDENCE AT INQUEST & REQUESTING DOCUMENTARY EVIDENCE	
The coroner may admit non-contentious documentary evidence provided (a) interested parties have been notified that such evidence will be admitted or (b) the coroner announces that he intends to admit the evidence.	It was agreed that this was a procedural matter and should not be included in the rules. It should be noted that of the Report of the Working Group on the Review of the Coroner Service the taking and requesting of documentary evidence part 6.7 and 6.8 of Appendix J is now amalgamated under Rule 6.7. Not all of the Garda report may be admissible in evidence and it is the coroner's responsibility to prepare an extract of the report which will be admissible. The obtaining of any additional or new statements will be the responsibility of the coroner.
If there are any objections to material evidence being admitted solely in documentary form, then the coroner should not proceed and the inquest should be adjourned.	In general, non-contentious evidence will be evidence which does not relate to issues likely to arise for the parties involved. In general, parties to an inquest have a right to hear the evidence of those making statements orally. While in many cases, documentary evidence can be deemed acceptable, an inquest may need to be adjourned if an interested party wishes to hear the witness in person.
6.8 - EXPERT EVIDENCE	
Documentary evidence of an expert nature which is critical to the establishment of the cause of death may be sought and submitted by the coroner.	This new provision is to reflect the fact that coroners require expert views on specialised aspects of inquests.

Final Rules (Committee's Report)	Notes
6.9 - CORONER'S DISCRETION FOR NON-RELEASE OF DOCUMENTS BEFORE INQUEST	
The coroner should have discretion with regard to the release of documents prior to an inquest. This discretion should in general be exercised in favour of release.	The coroner's discretion should be exercised in favour of release especially in the following circumstances: • Hospital deaths • Prison deaths • Killings by security forces.
6.10 - WITNESS ANONYMITY	
Witness anonymity may be granted in the following circumstances: • If there is a threat to the personal security of a Garda or member of the Defence Forces • If there is threat to the personal security of any witness, or their family • If there is a threat to national security.	
6.11 - PROTOCOLS FOR EXAMINING WITNESSES	
Only the coroner has authority to call a witness at inquest.	
The witness will be examined first by the coroner.	There is no provision governing sequence of examining a witness other than that the coroner examine the witness first.
Interested persons should be permitted to ask the witness questions through the coroner.	
Interested persons can make a request to examine a witness but the coroner retains the final discretion in this matter.	

Final Rules (Committee's Report)	Notes
6.12 - INQUEST ADJOURNED DUE TO CRIMINAL PROCEEDINGS	
Where a Garda Inspector applies to the coroner for an adjournment on the basis that criminal proceedings are being contemplated or a criminal inquiry ongoing, the coroner shall adjourn the inquest but may take evidence of identification and the medical cause of death for the purpose of issuing a Coroners Certificate for death registration purposes.	
6.13 - MANDATORY INQUESTS	
An inquest must be held where: • a coroner believes that the death occurred in a violent or unnatural manner • a death occurs in Garda, Military or Prison custody • where it is required under another enactment.	Apart from the mandatory categories, the Committee felt, in keeping with the general focus of the Review Report, that an inquest should generally be held in any situation where the coroner believes that the cause of death has not, for whatever reason, been satisfactorily established.

Part 7: Verdicts

Final Rules (Committee's Report)	Notes
7.1 - WHAT VERDICTS ARE AVAILABLE TO THE CORONER?	
Accidental death.	
Death by misadventure.	The verdict of misadventure is applied to a wide variety of deaths which might generally be described as the unintended outcome of an intended action. For example, a heroin addict injects him/herself with heroin and unintentionally overdoses. It also includes those whose deaths arise from engagement in potentially dangerous sports or activities.
Medical misadventure.	Medical misadventure is where there is an unintended outcome of an intended action in a medical context or where complications arising from a medical procedure cause death.
Suicide/self-inflicted death/deceased took his own life. In returning a verdict of suicide the coroner/juror must be sure: ✔ The deceased took his or her own life ✔ The deceased was intent on taking his life ✔ There is proof beyond reasonable doubt that the injuries sustained were self-inflicted and the deceased had such intention.	In addition to "suicide" it was agreed that the term 'self-inflicted death' or a narrative such as 'deceased took his own life' are acceptable wordings of this verdict.

Final Rules (Committee's Report)	Notes
Unlawful killing. In returning a verdict of unlawful killing the coroner/jury must confirm that: ✔ No criminal proceedings are pending ✔ Unlawful killing is proved beyond reasonable doubt ✔ The investigation by the Gardaí has ended ✔ No person is named for the killing, expressly or by implication.	
Want of attention at birth. In returning such a verdict the coroner/juror must confirm the following: ✔ The child was abandoned ✔ The child's mother was never found ✔ No other person is under criminally identifiable suspicion of the death ✔ Proof of the above three elements is secured beyond reasonable doubt.	
Stillbirth.	
Occupational disease or accident.	It was agreed that "occupational" is a broader term than "industrial" and should be used instead.

Final Rules (Committee's Report)	Notes
In accordance with the findings of a criminal court.	A coroner's court may not reach a different verdict.
Death by natural causes.	
An open verdict should be returned if there is insufficient evidence to record any other specified verdict.	It was agreed that an open verdict may be recorded if there is insufficient evidence to record any of the foregoing verdicts. This would arise: ✔ If the evidence does not fully disclose the means by which the death occurred ✔ Where the verdict returned would otherwise impute a censure or exoneration of a person in the matter of civil or criminal liability ✔ Where the standard of proof has not been reached ✔ Where the evidence is inconclusive and the DPP may have to re-examine the case ✔ Where there is insufficient evidence to record another verdict.
7.2 - FINDINGS	
Findings may be applied in the following cases: ● Where a person is killed by a member of the Defence Forces or Garda Síochána acting in the course of their duty ● Where a burglar has been killed by the occupant of a premises ● In certain cases where criminal proceedings took place but there was no conviction or where criminal investigations took place but there was no prosecution.	The coroner or jury is not empowered to return a verdict of 'lawful killing'.

Items listed in Appendix J of the Report of the Working Group on the Review of the Coroner Service which did not translate into Coroners Rules

The Committee used Appendix J of the Report of the Working Group on the Review of the Coroner Service as an outline of the minimum areas to be covered by Coroners Rules. In the course of their deliberations it became apparent that some of the areas could not be translated directly into Coroners Rules. These areas are identified below.

Part 1: Definition of Terms

- ***Appropriate post-mortem facilities***

  The Committee felt that a formal definition of this term was not appropriate in the context of Coroner Rules. It did, however, concur with the view that post-mortem facilities need to be upgraded urgently but considered that this must take place in the context of a planned availability of the appropriate resources and the general provision of the infrastructure of the new Coroner Service.

Part 2: Deaths reported to coroners

2.1 - Reportable deaths

- ***In certain circumstances where a body is to be cremated***

  Since the rules need to be specific, the Committee declined to use the term "certain". The idea of reporting all cremations to the coroner was not favoured since (a) such broadly based notification criteria were beyond the coroner brief envisaged both by the main Review Group and the Rules Committee, and (b) all the other categories of reportable death could be relied upon to ensure that the overall objectives of the coroner system are met.

  Cremation does, however, have implications for the standard of death certification since the immediate destruction of the body leaves no opportunity for any subsequent investigation which might be required. The Committee therefore took note of the current crucial role of the medical referee in this regard and felt that the medical referee system was more appropriate in the certification for cremations. Indeed, the Committee felt that the medical referee system should be put on a statutory basis in view of its crucial role and the general increase in the use of cremation facilities in Ireland.

- ***The death of persons in vulnerable groups to be defined by the Rules***

  The Committee felt that this is now redundant. Persons who would be listed under this category are already covered.

Part 3: Post-mortem examinations

3.4 - Organs and Body Parts - Removal, Disposal and Retention

- ***Clarification of circumstances and procedures for removal, disposal and retention***

  The Committee endorsed the original proposals of the Working Group (section 3.3.2 of the Report of the Working Group) in this matter and in particular the right of the bereaved person to make a choice in relation to the context and timing of information about organs and body parts. It further concurred with the proposed arrangements for a "designated person" to liaise with the bereaved. The Committee felt, however, that the rights of the next of kin should be matched by a corresponding obligation to deliver on those rights and that such rights should be incorporated into the primary legislation. Given that the coroner is central to ordering of the post-mortem in the first instance, that the duty should be assigned to the coroner. The Committee was also very mindful of the impracticality of such obligations being exercised on a personal basis due to the complex set of logistics which surround the holding of a post-mortem. Accordingly, any legal obligations assigned to a coroner should be expressed in terms which allow the coroner to take steps to ensure the appropriate arrangements are in place.

  The Committee noted that the work of the Post-Mortem Inquiry is still ongoing and in view of its terms of reference, may bear impact on any future arrangements for addressing the issues involved in organ retention.

3.5 - Standardise the Post-mortem Report

- A sample post-mortem report agreed by the Committee is shown at Appendix F. It is recommended that this is used as best practice by pathologists.

Part 6: Inquests

6.12 - Inquest adjourned due to criminal proceedings

- It must be made clear to families that the reopening of the inquest cannot produce a finding or a verdict of any civil or criminal liability or an outcome which conflicts with that of a criminal court.

Part 8 - Review

- **Review**

  The Committee noted that the proposal for a Review Board was a relatively innovative one and accordingly would benefit from a detailed legal evaluation. A special subgroup was established to carry out this assessment. The overall conclusion of the subgroup was that there are no legal or constitutional impediments to establishing the Review Group as proposed. Refinements proposed by the subgroup and agreed by the Committee were as follows:

  - The Board should be referred to as an "Advisory Board" as the term more accurately reflected its function in relation to advising the Attorney General as to whether an inquest or inquiry is to take place. The Attorney General has the final say in the decision.

  - While noting the case law where new (second) inquests are confined to the availability of new evidence, the Committee felt that discretion should be given to the Attorney General to recommend a new inquest on the basis that he might "consider it advisable". This would continue the sentiments expressed in the 1962 Coroners Act.

  - A resolution of any appeal could depend on a point of law - in which case the advice of the Board might be the seeking of judicial review.

  - The grounds for the review as set out in recommendation No. 75 of the Report on the Review of the Coroner Service should be placed in primary legislation rather than in Coroners' Rules. These grounds can be prefaced by a legal reference to a situation where the Attorney General has "reason to believe" that the following situations exist...

  - The range of the recommendations as set out in recommendation No. 78 of the Report on the Review of the Coroner Service which can be made by the the Advisory Board to the Attorney General should also be set out in primary legislation.

- The procedures to be used in lodging and processing an application for review should be agreed between the Advisory Board and the Office of the Attorney General rather than being set out in advance in Coroners' Rules. Flexibility of procedures would, it was felt, enhance the overall effectiveness of the Board. When establishing the Board on a statutory basis, it would be sufficient to merely state that the Board should apply such procedures as it sees fit.

- **Consultative case-stated**

  While the Committee noted that the consultative case-stated needed further consultation it endorsed the concept and the rationale for its inclusion in the Review Group's report.

  Some refinements were however agreed:

  - There should not be a requirement to channel an application for consultative case-stated through the Attorney General who should not be involved in giving direct legal advice to coroners.

  - Co-ordination of applications could be ensured through the proposed Coroner Agency.

  - As a corollary of the above, there is a need to provide a facility for a coroner to seek legal advice.

  - The Committee emphasised the need to provide specifically in primary legislation for a case-stated procedure for coroners.

Part 9: Removal from Office

- Procedures for removal from office by the Minister and the circumstances under which coroners can be removed from office.

  The Committee felt that these references should be reinstated into primary legislation since they represented the taking of a very serious step by the Minister. The Committee felt that this provision should only be used in the most unusual circumstances. Furthermore, in restating the provision in legislation, the opportunity should be taken to make some changes in the interests of natural justice. Specifically, there should be some mechanism whereby the Minister can establish the facts of the case for him/herself (i.e. form a basis for an opinion) before formally sending an opinion to the coroner. The formation of the opinion would, the Committee felt, require initial contact with the coroner.

The formation of an opinion by the Minister that a coroner should be removed from office should be based on appropriate procedures (based on natural justice) for establishing the facts of the case before delivering such opinion to the coroner involved.

Subject to the above, a coroner can be removed from office by the Minister for Justice, Equality and Law Reform in the following circumstances:

- ✔ Misconduct or neglect of duty
- ✔ Unfitness for duty because of mental or physical infirmity
- ✔ Permanent disbarring arising from professional misconduct.

Part 10: Procedures for clearance for burial

- The Committee agreed that there is a need to ensure that the burial of bodies does not proceed in the absence of a death certificate or appropriate proof of the procurability of a death certificate. It was agreed in consultation with the Association of Funeral Directors that the funeral director should satisfy himself that the medical certificate of the cause of death is procurable, by creating a record of contact with the relevant Registered Medical Practitioner involved which confirms that such certificate is, in fact, available.

  The Committee felt that it was not within its remit to address this issue in the context of the Coroners' Rules. It recommends, however, that the whole funeral direction system should be put on a statutory basis in view of its crucial role.

Section 4 - Best Practice Notes

Apart from the need for statute based procedures as set out in the Rules, the original Working Group felt that some areas of coroner procedure could benefit from the development of codes of best practice. These should cover areas where consistency of approach rather than a statutory obligation would benefit the service as a whole. As recommended in the Report (section 3.3.1 of the Review Report) such procedures should be set out as "best practice notes" and would be best devised by coroners themselves with assistance from the new Coroner Agency.

In addition to the suggestions made by the original Working Group, the Rules Committee identified some further areas for inclusion as 'best practice notes'.

The outline below includes the minimum areas to be covered by "best practice notes" and provides some notes for the assistance of the proposed new Coroners Agency.

- **A generic information leaflet should be developed as a matter of urgency to clearly explain the coroner service, to identify the rights of relatives and to point to any restrictions placed on them in the course of their contact with the coroner service. The same leaflet should be used to supplement the dialogue recommended in the context of the arrangement for a designated person. The new leaflet could be modelled on that currently provided by the Dublin City Coroner and should be made available, in the initial phase at least, in coroners' offices, hospitals and Garda stations. (Recommendation 18)**

  It was felt that there was a general deficit in the public's knowledge of the coroner service. This, coupled with a lack of uniformity in conveying information to relatives at time of death, means that misunderstanding and needless trauma can occur which could be remedied through adequate information provision. Initiatives are required both at a general level, where the public are made aware of what coroners do, and at a specific level, where the public are involved in a particular case.

- **The generic information leaflet as described above should provide an appropriate insert at coroner district level to identify local support and bereavement groups. (Recommendation 19)**

- **A protocol should be developed in consultation and agreement with all the parties involved in coroner cases, in relation to how, by whom and when the leaflet and preference document and other information is given to relatives. (Recommendation 21)**

The availability of easily-interpreted information is paramount particularly where, as is mostly the case, the relatives will be dealing with a wide variety of other parties involved in coroner cases such as the Gardaí, general practitioners, medical consultants, pathologists, nursing staff, pathology technicians and funeral directors. Great attention should be given not only to the type of information to be provided but also to the choice of person to provide the information and the timing of its provision. This is particularly so in situations where organs or body parts must be retained in the context of establishing the cause of death.

- **Liaison between coroners and those responsible for reporting deaths should be improved through training for all relevant parties and the development of best practice procedures. (Recommendation 35)**

- **The practice whereby coroners or juries can make general recommendations to prevent further fatalities should be continued. (Recommendation 53)**

In relation to the public service aspect of coroner work this function has importance and should be continued in the new legislation. Every effort should be made by relevant authorities to follow up on such recommendations. The proposed Coroner Agency could take a particular interest in ensuring that coroner recommendations were appropriately considered by the relevant authorities. The phrasing of recommendations could be very important and could be the basis of "best practice" notes.

- **An appropriate code of practice should be adopted by the media to govern inquest reporting. (Recommendation 73)**

It is considered that the adoption of a media code of practice for the reporting of inquests would be the most sensitive and appropriate way to respond to the bereaved.

- **Full recording of complex inquests should be facilitated on the certification of the coroner. (Recommendation 74)**

It was considered that the recording of all inquests through tape recording or stenographer would be excessively expensive and unnecessary. Some very complex cases may merit the use of some recording method, which could be used on the certification of the coroner.

Section 5 - Appendices

A **Group and subgroup membership**

B **Public advertisement for Submissions**

C **List of Submissions**

D **Certificate of Fact of Death**

E **Coroner's Certificate**

F **Coroner's Post-mortem Report**

Appendix A - Group Membership

Main group

Chairman, Haskins, John	Department of Justice, Equality, and Law Reform
Cullinane, Dr. Myra	Coroners Society of Ireland
Farrell, Dr. Brian	Coroners Society of Ireland
Howard, Supt John	An Garda Síochána
MacNamara, Brendan	Department of Justice, Equality, and Law Reform
McDonagh, Dr. Gerard	Coroners Society of Ireland
Ní Dhuinn, Máirín	Department of Justice, Equality, and Law Reform
Ó Dubhghaill, Feargal	Office of the Attorney General
Ó Floinn, Angela	Department of Health and Children
O'Keane, Dr. Conor	Faculty of Pathology Royal College of Pathologists of Ireland
Synnott, Noel	Department of Justice, Equality, and Law Reform
Thomas, Rosaleen	The Samaritans

Replacements, substitutes and specialist contributors

Supt. O'Donohoe, Kevin	An Garda Síochána

Secretariat

Airlie, Justina	Department of Justice, Equality, and Law Reform

Appendix B - Public advertisement for Submissions

Coroners Rules

Public Advertisement for submissions

The Department of Justice, Equality and Law Reform is preparing new legislation arising from the publication of the Report of the Review Group on the Review of the Coroner Service (the Review Group). A Rules Committee has been established to develop detailed standardised procedures (Rules) for the work of the coroner. In accordance with the recommendations of the Review Group, the detailed Rules developed by the new Committee will be incorporated into regulations to be appended to the new legislation.

The Rules Committee's work will include matters relating to:

Definition of interested persons
Definition of "sudden death"
Deaths which must be legally reportable
Persons who must report a death
Preservation of post mortem records
Post mortem reports
Certificates of death
Inquest jurisdiction
Notices of inquest
Circumstances where juries should be used
Access to post mortem reports
Records to be retained at inquest
Procedures for documentary evidence
Access to inquest documents
Calling of witnesses
Range of verdicts findings available

A full list of matters for consideration is set out in **Appendix J** of the Report of the Review Group, a copy of which is available by accessing the Department of Justice, Equality and Law Reform web site, **www.justice.ie.** A hard copy is available on application to the Secretary of the Rules Committee at the address below.

The Rules Committee now invites submissions from interested groups and persons in relation to their work. Submissions should be confined to the matters set out in Appendix J and should arrive **not later than Tuesday 12 March 2002**

Submissions in writing should be sent to:

Ms Justina Airlie
Secretary to the Rules Committee
Room 520
Department Justice, Equality and
Law Reform
72-76 St. Stephen's Green
Dublin 2

Submissions can also be made by email to:

submissions@justice.ie

Appendix C - List of Submissions

Written Submissions

1. **East Coast Area Health Board,**
   Newcastle, Co Wicklow.

2. **Fanagans Funeral Directors**
   54 Aungier Street, Dublin 2.

3. **Post Mortem Inquiry,**
   Parnell Square East, Dublin 1.

4. **Mary. T. Glynn,**
   Terenure, D6W.

5. **C.N Pidgeon, Beaumont Private Clinic,**
   Beaumont, D9.

6. **Dr. Brídin Brady, Senior Chemist,**
   State Laboratory, Abbotstown, Dublin 15.

7. **Parents for Justice,**
   Templeogue, Dublin 6W.

8. **Medical Protection Society,**
   33 Cavendish Square,
   London, WIG OPS.

9. **John Harrington, Dublin 2.**

10. **Irish Water Safety Association.**

11. **Rosbrien Suicide Awareness Group,**
    215 Ballinacurra Gardens Limerick.

12 **South Eastern Health Board.**

13. **Health & Safety Authority,**
    10 Hogan Place, Dublin 2.

14. **Kevin & Vera Duffy**
    Clontarf, Dublin 3.

15. **Caroline Gillespie,**
    Donegal Town, Co Donegal.

16. Marguerite Sommers,
Foxrock, Dublin 18.

17. Anne Docherty, Dublin 18.

18. Noel & Rosemarie O'Flaherty,
Wicklow Town, Co Wicklow.

19. Eugene O'Connor, acting coroner of Laois,
Portlaoise, Co Laois.

20. Medical Defence Union
230 Blackfriars Road, London.

21. Central Statistics Office,
Skehard Road, Cork.

22. Dr John Callaghan, Consultant,
UCG, Galway.

23. Dr John Ryan, Consultant pathologist,
Our Lady of Lourdes Hospital
Drogheda, Co Louth.

24. Mental Health Ireland,
Dun Laoghaire, Co Dublin.

25. National Suicide Review Group,
Oranmore, Galway.

26. National Suicide Research Foundation
College Road, Cork.

27. Department of Pathology,
Cavan Gen Hospital, Cavan.

28. National Newspapers Ireland,
15 Clyde Road, Dublin 4.

29. Rotunda Hospital, Dublin 1.

30. Anne O'Loughlin
Social worker
Alverno
Castle Avenue, Clontarf, Dublin 3.

31. **Mid-Western Health Board**

32. **Victim Support**

33. **Irish Association of Suicidology**

34. **Acute Hospital Services**
North Eastern Health Board

Oral Submissions

1. **Irish Association of Funeral Directors**
54 Aungier Street, Dublin 2

2. **Health and Safety Authority**
10 Hogan Place
Dublin 2

3. **Irish College of General Practioners**
Grange Mount, Naul, Co Dublin

4. **Civil Registration Modernisation Programme.**
Department of Health and Children, Department of Social Community and family Affairs.

5. **Central Statistics Office**
Skehard Road, Cork.

Appendix D

Certificate of Fact of Death

Coroner Details

Name: _____

Coroner for area:_____

Address: _____
_____
_____

Contact No: _____

Date and Place of Death: _____

Details of Deceased

Surname: _____

Forename: _____

Address: _____
_____
_____

Date of birth: _____ Sex: _____

Occupation: _____

Please tick appropriate box	**Y**	**N**
The cause of death has yet to be determined -	**[ ]**	**[ ]**
A death certificate will issue in due course -	**[ ]**	**[ ]**
An inquest will be held in the near future -	**[ ]**	**[ ]**
A decision on the cause of death will be made as soon as possible -	**[ ]**	**[ ]**

I certify that I am inquiring into the death of the above named, and have taken evidence of the facts set out above.

Signed: _____ Date: _____

Appendix E

Coroner's Certificate - Part 1

Part 1 to be completed and signed by the Coroner

To the Registrar of Births and Deaths for the District of _____

in the County of _____

I hereby certify that in pursuance of the Coroner's Act, 1962, I, on the _____

Strike out whichever two are inapplicable

(a) held an inquest

(b) adjourned an inquest at which evidence of identification and any medical evidence as to the cause of death were given

(c) decided, as a result of post-mortem examination held on the _____ not to hold an inquest on the body of _____ and I found as follows:

Date of Death_____ day of_____ Pronounced Dead on_____ day of _____

Place of Death (Full Address) _____

_____

Sex of Deceased _____

If the deceased was female, was she known to have been pregnant at the time of death, or within the previous 42 days ? _____

Cause of death and duration of last illness		Approximate interval between onset and death
I. Disease or Condition directly leading to death	(a)_____ due to (or as a consequence of)	_____
Antecedent causes	(b)_____ due to (or as a consequence of)	_____
Morbid conditions, if any giving rise to the above cause stating the underlying condition last	(c) _____	_____
	_____	_____
II. Other significant conditions contributing to the death but not related to the disease or condition causing it.	_____	_____
	_____	_____

Witness my hand, this _____day of _____

Signature _____

Coroner for District of _____

Address _____

_____

Registrar's Stamp

Coroner's Certificate - Part 2

Part 2 To be completed and signed where possible by the nearest available relative of deceased

Particulars of Deceased:

First Name(s) _____ Surname _____

Age of Deceased _____
(Age to be stated in hours if under one day, in completed days, if under one month, in completed months if under one year, otherwise in completed years last birthday)

PPS Number _____

Sex _____

Marital Status _____
(State whether bachelor, spinster, married, widowed or divorced)

Occupation _____
The occupation should be described as accurately as possible; if the deceased was retired state "retired" and previous occupation

If married, occupation of spouse _____

_____

Full Name of Relative _____

Address _____

_____

_____

Relationship to Deceased _____

Date _____

Signature _____

This form, when completed and signed by the Coroner and relative of the Deceased, is to be forwarded immediately from the Coroner's Office to the Registrar of Deaths for the registration of the Death.

Appendix F

Coroner's Post-mortem Report

Particulars of deceased

Name: *Enter text*

Address: *Enter text*

Date of Birth: *Enter text*

Occupation: *Enter text*

Gender: *Enter text*

Marital Status: Enter text

(State whether bachelor, spinster, married, widowed or divorced)

Date of Death: *Enter text*

Time of Death: *Enter text*

Place of Death: *Enter text*

Coroner: *Enter text*

Post-mortem No: *Enter text*

Clinician/GP: *Enter text*

MRN: *Enter text*

Date of Post-mortem: *Enter text*

Time of Post-mortem: *Enter text*

Place of Post-mortem: *Enter text*

Pathologist/Prosecutor: *Enter text*

Supervisor/Consultant: *Enter text*

Technician/Attendant: *Enter text*

Others in attendance: *Enter text*

Identification: *Enter text*

SECTION A: Circumstances of Death/Medical History

Source of information:

Coroner's authorisation form: *Enter text*

Hospital chart: *Enter text*

A/E notes: *Enter text*

Other: *Enter text*

SECTION B: External Examination

(1) Height: *Enter text*

(2) Weight: *Enter text*

(3) Build: *Enter text*

(4) Nutrition: *Enter text*

(5) Lividity: *Enter text*

(6) Rigor: *Enter text*

(7) Racial origin: *Enter text*

Significant external findings:
(Injuries, Scars, Bruises, Operation sites, IV access sites, Tattoos, Other)

Enter text

SECTION C: Internal Examination

Cardiovascular System

Pericardium: *Enter text*

Heart: *Enter text*

Weight_____(g)

Ventricular wall thickness - Left_____cms Right_____cms

Coronary Arteries: *Enter text*

Atheroma/% occlusion

Left anterior descending artery
Left circumflex artery
Right coronary artery
Other *(grafts, stents etc)*

Myocardium: *Enter text*
(Interstitial fibrosis (extent), Infarct (size), Valves, other)

Aorta and main vessels: *Enter text*
(Atherosclerosis (severity), aneurysm)

Respiratory System

Pleural cavities: *Enter text*
(Pneumothorax, effusions, other)

Larynx, trachea, main bronchi: *Enter text*

Lungs: *Enter text* Weight - Right_____g Left_____g
(Oedema, consolidation, contusion, thromboembolism, infarct, tumour, other)

Pulmonary arteries: *Enter text*
(Embolus, other)

Gastrointestinal System

Mouth: *Enter text*

Teeth: *Enter text*

Tongue: *Enter text*

Oesophagus: *Enter text*
(Inflammation, ulceration, varices, tumour, other)

Stomach: *Enter text*
(Inflammation, ulceration, tumour, stomach contents (inc tablets))

Small and large intestines: *Enter text*
(Infarct, inflammation, tumour, obstruction, perforation, melena)

Liver: *Enter text* Weight_____(g)
(Fatty change, nutmeg change, cirrhosis, tumour, other)

Gallbladder and biliary tree: *Enter text*

Pancreas: *Enter text*

Endocrine System

Adrenals: *Enter text*

Thyroid: *Enter text*

Other: *Enter text*

Genitourinary System

Kidneys: *Enter text* Weight - Right_____g Left_____g
(Pyelonephritis, nephrosclerosis, tumour, other)

Renal vessels: *Enter text*

Ureters: *Enter text*

Bladder: *Enter text*

Prostate: *Enter text*

Uterus and Ovaries: *Enter text*

Lymphoreticular System

Spleen: *Enter text* Weight_____(g)

Lymph nodes: *Enter text*

Musculoskeletal System
(Fractures, scoliosis, arthritis, other)

Enter text

Central Nervous System

Scalp: *Enter text*

Skull: *Enter text*

Meninges: *Enter text*
(Haemorrhage (extra dural, sub dural, sub arachnoid, other), inflammation, tumour)

Brain: *Enter text* Weight_____(g)
(Haemorrhage, infarct, tumour, contusion)

Cerebral vessels: *Enter text*

SECTION D: Additional Examinations

Toxicology: *Enter text*
(Blood, urine, stomach content, other)

Histology: *Enter text*
(Blocks of tissue from main organs (heart, lung, liver, kidney, brain, other))

Other relevant investigations: *Enter text*
(Where appropriate)

Organs retained: *Enter text*
(Here list organs retained for further examination by Coroner)

Summary of pathological findings: *Enter text*

Clinicopathololological correlation: *Enter text*
(where appropriate)

Cause of Death

I		**I**
Disease or condition directly *leading to death*	(a)	*Enter text here*
	due to (or as a consequence of) (b)	*Enter text here*
	due to (or as a consequence of) (c)	*Enter text here*
II		**II**
Other Significant Conditions: *(contributing to death but not related here to disease or condition causing it) (if none, write none)*		*Enter text*

Signed: _____

Date: _____