19th January 2024

Submission to the Public Consultation on the Reform of the Coroner Service

Consultation Part 2, Part 4: Inquests

4.1 What functions/duties should A Garda Síochána have in the Coroner death investigation process? Please give reasons for your response.

MPS believes that An Garda Siochana should continue to carry out their important functions to include body identification. However, we believe that they should not be responsible for the first notification of an inquest to witnesses. MPS represents doctors who are the most frequent group required to attend an Inquest; it can be a distressing experience to have a Garda approach or contact them directly to notify them of a pending Inquest or to request a statement. This is frequently misunderstood in terms of the Garda involvement as a representative of the Coroner and instead it is often seen as a matter that has attracted a personal criminal investigation. We therefore suggest that the Coroner always makes initial contact with witnesses, making it clear that future contact will be on their behalf and may involve contact with Garda X so that there can be no misunderstandings. We suggest that there should be an initial template letter from the Coroner to a proposed witness clearly setting out the role of the Coroner, scope of the coronial process and including the fact that the Inquest is an independent process. The initial template letter from the Coroner should give the witness an opportunity to prepare and submit a witness statement without being subject to interview by a member of an Garda Siochana. Where the witness is a medical witness, it would also be helpful if the letter suggests that the proposed witness consider obtaining advice.

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

MPS do not have a strong view on this, however we believe that a Coroner should continue to inform the Gardai to identify members of a relevant jury. It is best that jurors are not merely selected by availability on the day or relationship to the judge. MPS also believes it would be beneficial to have a limit on how often a jury member should be permitted to sit on a jury in a given year.

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

MPS believes that the preference of a courthouse as a location for a Coroner's Inquest is quite a challenging environment for all witnesses. This includes doctors, who often inform us that they have not experienced a Court appearance previously and believe that they are effectively "in the dock" for the care they provided to the deceased. A move away from the courthouse environment may help reflect the non-adversarial nature of an inquest to all parties and we believe potentially manage expectations regarding the

purpose of an inquest and the respectful cross examination of professional witnesses, who are present to assist the Coroner in carrying out their functions.

4.4 What alternative supports could be provided to families to minimise the need for legal representation?

MPS suggests that key to minimising the need for families to have legal representation is ensuring that families fully understand the purpose of an inquest - it is intended to be inquisitorial in nature and not adversarial. We suggest that this could be achieved through the provision of a step-by-step guide to the scope of the inquest for families and other witnesses. The allocation of dedicated administrative support to all coroners would also assist by providing families with access to someone, other than the coroner or an Garda Siochana, to whom they could address any queries or concerns they have in relation to the inquest process.

4.5 What is the best approach to recording and monitoring Coroner recommendations?

MPS supports efforts for uniformity in relation to recording and monitoring of Coroner recommendations in the interests of patient safety. However, whilst some recommendations, if implemented, would enhance patient care and prevent further deaths, it is our experience that not all recommendations made by juries and coroners are suitable for implementation. We suggest that if all recommendations made by coroners were recorded centrally and reviewed for common themes, focussed recommendations could be made in the interests of system improvements for the benefit of patients.

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

a. Yes **X** [see 4.7 below]
b. No ☐-Please give reasons for your response

4.7 If the answer to 4.6. above is "yes":

a. What form should this review process take?

We do not have a strong view on reviews on a legislative level. It is our opinion that Coroners should have an opportunity to review other Coroner's cases as a support and learning mechanism for future decisions. The process of working in silos with no opportunities for audit and review can be impactful on those undertaking coronial duties. MPS have been made aware that a system similar to this, a 'wash up' opportunity, is currently employed within the field of pathology, where pathologists meet monthly to review case notes and decisions. A chance to review cases that other Coroners have worked on, either in person in a roundtable style, or online through a regularly updated and monitored monitoring system, would increase support for those working in the system as well as improving parity across the country.

b. What "decisions" should be subject to review?

N/A

4.8 Please provide any other views, opinions, or proposals on how a reformed Coroner Service should be structured and operated.

MPS suggests that a standardisation of the Coroner's process would help to ensure uniformity across all Inquest hearings throughout Ireland. We also suggest that enhanced training is provided to Coroners to help achieve this uniformity, and the introduction of a Chief Coroner to oversee same would be welcome.

We believe that a Guidance Document aimed at the Coroner around the Coronial process including practical considerations before and during an Inquest hearing should be drafted and would be relevant to all parties attending an inquest. The Guidance can be referenced by the Coroner (in conjunction with the legislation) in justifying directions/decisions, if faced with allegations of unfairness of the procedures. The aim of this Guidance document would be to help promote transparency and consistency in decision making.

In MPS' experience, Inquests appear to be becoming akin to a high court civil action with requests from legal representatives for a large number of medical personnel to attend the Inquests. This has a significant impact on our member's clinical duties and on the delivery of medical services to patients while they attend Inquests. In our experience, in appropriate cases, a pre-Inquest meeting between legal representatives and the Coroner remotely would allow the Coroner the opportunity to identify the core witnesses who are able to provide the essential evidence required to facilitate the Coroner reach a verdict.

Our members are also frustrated with delays in getting an inquest date and would like to communicate their evidence as quickly as possible to the Coroner and the family. Inquests should be held whilst doctors and medical professional's memory of events is recent, in order to achieve closure for the family and themselves. We believe that a Guidance document suggested above, and pre-inquest administrative remote meetings, would greatly assist bringing all parties back to the fundamental purpose of an inquest in terms of investigating who died, where, when and the cause of death. We also believe that an automatic alert system could be considered where an inquest awaiting a hearing date for one year for example, could be expedited, re-assigned or transferred to a priority list.

About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals with more than 300,000 members around the world.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

MPS is not an insurance company. We are a mutual non-for-profit organisation and the benefits of membership of MPS are discretionary as set out in the Memorandum of Articles of Association.

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact us.

Megan Ball, Policy and Public Affairs Manager (megan.ball@medicalprotection.org)

The Medical Protection Society Limited
Level 19, The Shard
32 London Bridge Street
London SE1 9SG
United Kingdom

Tel: +44 (0)20 7399 1300
Fax: +44 (0)20 7399 1301
info@medicalprotection.org
medicalprotection.org