Value for Money Unit

Local Government Audit Service

Report on the Coroner Service in Local Authorities

Value for Money Study

A Value for Money Study on the control of expenditure and financial management procedures within local authorities relating to the Coroner Service and the appointment of coroners.

Report No. 31 **February 2018**

An Roinn Tithíochta, Pleanála agus Rialtais Áitiúil
Department of Housing, Planning and Local Government

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The sectoral goals of the LGAS are to:

- carry out the audits of local authorities and other bodies in accordance with the Code of Local Government Audit Practice thereby fostering the highest standards of financial stewardship and public accountability.

- promote the achievement of value for money in local authorities by undertaking Value for Money audits and publishing reports thereon.

It is the responsibility of local authority management to ensure that value for money is achieved by establishing and maintaining sound arrangements including procedures for planning, appraisal, authorisation and control of resources.

This report was prepared on the basis of information, documentation and explanations obtained from the public bodies included in this report. The draft report was sent to all local authorities and relevant Government departments for factual accuracy and where appropriate the comments received were incorporated in the final version of the report.

The website of the Department of Housing, Planning and Local Government is the primary means of publishing reports of the Value for Money Unit of the Local Government Audit Service. Should any errors arise they will be corrected and noted in the report published at http://www.housing.gov.ie/en/publications/localgovernment/auditservice/

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Report No. 31

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Department of Housing, Planning and Local Government

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Foreword

The Value for Money Unit of the Local Government Audit Service, in my Department, has prepared this comprehensive report on the Coroner Service in local authorities. Coroners are independent office holders charged with the legal responsibility for the investigation of sudden, unexplained, violent and unnatural deaths in his or her district. Local authorities fund the operation of the Coroner Service in each district from their own resources as there is no central funding for the financing of this service.

This report arises from a Value for Money review undertaken by the Local Government Audit Service on the Coroner Service and its related expenditure. The review focused on the management and oversight of the Coroner Service at the local authority level, from the appointment of the coroner and their related expenditure, together with the costs of the other support services that are required by the coroners in performance of their duties.

The report provides detailed data analysis on the actual expenditure incurred by local authorities over a three year period to 2015. It highlights areas for improvement and makes recommendations on best practice for the reform of existing procedures, practices and systems, thereby promoting economy, efficiency and effectiveness in the management and oversight of the Coroner Service in local authorities.

Some of the recommendations may be outside the control of local authorities. The Department of Justice and Equality has primary responsibility for policy and legislation with regard to coroners. The current legislation that governs the activities of coroners is the Coroners Act 1962. Local authorities now perform functions across a wide range of sectors which come within the remit of a number of different government departments and state agencies, including the Coroner Service.

I have asked the Value for Money Unit of the Local Government Audit Service to monitor the implementation, by local authorities, of the recommendations in this report relevant to them.

Eoghan Murphy, T.D.,
Minister for Housing, Planning and Local Government
February 2018

Executive Summary

Overview

A coroner in Ireland is an independent quasi-judicial office holder charged with the legal responsibility for the investigation of sudden, unexplained, violent and unnatural deaths in his or her district. This may require a coroner's post mortem examination, to establish the cause of death, sometimes followed by an inquest. The post mortem is normally carried out by a pathologist who, although usually attached to a hospital, acts independently of the hospital as the "coroner's agent" for the purpose of the post mortem. The State Pathologist's Office conducts a certain number of post mortems into violent deaths.

Local authorities now perform functions across a wide range of sectors which come within the remit of a number of different government departments and state agencies, including the Coroner Service. At central government level, the Department of Housing, Planning and Local Government has responsibility for a range of certain specific functional or service areas in the local government sector such as planning, housing and fire services.

However, the responsibility in relation to policy, funding, legislation, and general oversight and accountability at national level in respect of the numerous other activities and functions undertaken by local authorities can rest with other relevant departments and state agencies. This cross-departmental position is further outlined in the policy document "*Action Programme for Effective Local Government – putting people first*". Chapter 2.5 in the document deals with the determination of local authority functions, and strengthens the principle that responsibility at central level remains with the relevant department or agency.

The Department of Justice and Equality legislates for and determines policy for the Coroner Service in Ireland. The principal legislation is the Coroners Act 1962. The Coroners Bill 2007 provided that funding and general oversight and accountability at national level should also rest with the Department of Justice and Equality.

As at 2016, there was a network of 38 coroners operating in 40 coroner districts (2014: 41 coroners in 45 coroners districts) with effectively two full time coroners (Dublin and Cork City). The remaining coroners are employed in a 'part-time' capacity as they continue to work in their professional medical and law practices. As coroners, they are available and on call every day of the year on a 24 hour basis. Currently, the coroners' network is 55% doctors and 45% solicitors and over 80% are male with less than 20% female.

Local authorities fund the operation of the Coroner Service in their district. There is no central funding provided to local authorities for the financing of this service and the service must be financed from their own resources. The Coroners Bill 2007, proposed a major reform with a new national service under the auspices of the Department of Justice and Equality and an end to the involvement of local authorities, however this Bill was never enacted.

The net expenditure incurred by local authorities for the operations of morgue and coroners' expenses (after additional income in 2015 of €1.19m is recouped from four local authorities for their contribution to the Coroner Service) was €9.81m (**2014**: €10.36m, **2013**: €10.32m). See Appendix 4 for the actual expenditure breakdown by local authority.

The coroners' annual return 2014-2016 records the number of deaths reported to each coroner in their district and the category of report as follows;

	Report[1] only	Report with Post mortem[2]	Report with Post mortem & Inquest[3]	Total No of Cases	Dublin Cases	All other Districts
2016	11,419	3,287	2,109	16,815	4,835	11,980
2015	11,144	3,566	2,046	16,756	4,974	11,782
2014	10,359	3,421	2,053	15,833	4,740	11,093
[1]**Report only: Reports that did** not proceed **to Post Mortem/Inquest**						
[2]**Report and Post Mortem: Post mortems that did** not proceed **to inquest**						
[3]**Report/Post Mortem/Inquest: Inquests held**						

Source: Department of Justice and Equality - Annual Returns data

The Study

The study examined the operation of the Coroner Service in all local authorities. It includes the appointment and profile of the coroner in each local authority district, and all coroner related expenditure incurred by local authorities over a three year period.

A Value for Money (VFM) study on the current service, based on our mandate, can only examine the service delivered at local authority level. It highlights areas for improvement in the current practices and procedures, some of which may be outside the control of the local authorities, as policy and legislation for the Coroner Service is under the remit of the Department of Justice and Equality. It has studied best practice as outlined in various reports and the Coroner Service provided in the UK.

A draft report was circulated to all 31 local authorities for their confirmation of the factual accuracy on the data included relating to their local authority and/or feedback comments on the above report. This confirmation was received from all of the local authorities circulated.

Findings

The following is a summary of the findings from the study:

- **Legislation**

  The study found that the Minister for Justice and Equality is currently conducting a comprehensive review of the coroners' legislation and specifically the Coroners Bill 2007. In the review, the Department of Justice and Equality is looking at the reform of coroner structures to reflect the current economic environment and the new or amending legislation needed to implement the recommendations of the 2000 review to reform the Coroner Service.

- **Profile of the Coroner - Appointment**

  Under the 1962 legislation, local authorities are responsible for the appointment of coroners on the recommendation of the Public Appointments Service. However this study found that

no appointments have been made by any local authority since 2000. There is a lack of knowledge or expertise in the local authorities around the appointment of new coroners when positions become vacant.

The study examined the profile of the coroner network and found that over half of the coroners appointed in coroner districts are carrying out the role in an acting capacity. The approach of appointing only 'acting' coroners was linked to the policy approach adopted by the Department of Justice and Equality in the context of reform of the Coroner Service, with a likely move to a full time service as outlined in the Coroners Bill 2007.

This may be partly due to some anticipation of swifter pace of reform as set out in the Coroners Bill 2007 and to the requirement under the Civil Law (Miscellaneous Provisions) Act 2011 to re-structure and amalgamate coroner districts.

The study found that not all appointments in an acting capacity were due to amalgamation of districts. There were other local authorities with only one coroner district and therefore no requirement to amalgamate. A competition should have been held for the vacant position arising on retirements and this was not carried out. The outgoing coroner recommended that the deputy coroner carry on the role in an acting capacity pending the new appointment. No competition or selection process was ever held.

The study found that three coroners carry out their role in more than one coroner district. In these cases, a retainer fee was paid to the coroner for both districts.

- **Administration & Liaison with Department of Justice and Equality**

The Civil Law (Miscellaneous Provisions) Act 2011 provides for the amalgamation of coroner districts on a phased basis with a reduction in the number of coroners in a county.

The study reviewed a number of amalgamations that had taken place and found that, with the exception of the reduction in the retainer fee paid, there is no resulting savings for the local authority as a result of the amalgamations of the district. Local authorities continue to pay one coroner the fee amounts that the previous three to four coroners would have received.

- **Coroner Annual Returns**

Under Section 55 of the Coroners Act 1962 there is a requirement that every coroner submit, on or before 1 February every year, a written return to the Minister for Justice and Equality of the post mortem examinations directed, the inquests held and the number of cases dealt with during the year ended 31 December.

` This study found that there were certain discrepancies in the majority of counties between the cases published by the Department of Justice and Equality and the death reports from coroners that were processed by the local authority. See section 6 Annual Returns, Exhibit 9. These discrepancies likely arise due to the number of cases still on going at the end of the year. There will invariably be cases where post mortems have been ordered but not yet reported on, inquests opened and adjourned etc.

- **Coroner Remuneration**

  - **Retainer Fee**

The study found that the rates for coroner retainer fees, which are sanctioned by the Department of Public Expenditure and Reform, had not been reviewed since 2003 for the majority of coroners. Since 2014 amended retainer rates have been applied to certain districts following amalgamations. The three graded rates paid are based on a range of reported deaths. It was found that the current rate being paid for the number of reported deaths may not be in line with the actual number of reported cases dealt with in the period for some coroners.

  - **Fee income per death report**

The study found that, in addition to the retainer fee, the fee income per death report category is currently paid through the payroll system for the majority of local authorities. While this is in line with coroner legislation for the retainer fee, it may not be the correct procedure for the fee income per death report category.

With the exception of Dublin and Cork city, all coroners hold the office on a part time basis, and are also engaged in medical or legal practice. This fee income is deemed to be professional fees under the 2009 regulation and subject to professional service withholding tax. Therefore this practice may not be in line with Revenue Commissioner guidelines.

- **Funeral and Undertaking Expenditure**

The study found that there was a lack of consistency in approach to the payment of funeral and undertaking services in connection with coroners' death investigation. The 'coroner hearse' transports bodies to and from (as required) to the post mortem facility which is normally located in a regional general hospital. Some local authorities were not charged by the undertaker for the service for any of the years examined, while others were only recently invoiced e.g. in late 2015. Some local authorities negotiated with a panel of suppliers a fixed price for the transport element of the service, while others negotiated a fixed price for all of the service.

The study found that local authorities were not in compliance with procurement and tendering rules for the funeral and undertaking service for the coroner. No tender process was carried out in any of the local authorities, with the exception of one. A full tender process had been undertaken in this local authority, while it was planned that the service will be tendered in three other local authorities.

- **Pathology and Laboratory Expenditure**

The study found that the classification and coding of the financial system for pathology and laboratory fees in connection with the coroner's investigation was not standardised or consistent across all local authorities. This presented difficulties in extracting and analysing the pathology related expenditure category for the study.

The study also found that for the majority of local authorities, it was usual for the pathology service to be paid to a specific pathologist. However in one local authority the payment was made to the specific hospital at which the service was carried out.

- **State Laboratory Expenditure**

There is a considerable amount of expenditure incurred for pathology and toxicology testing on behalf of the coroner by local authorities and paid to the State Laboratory. When payments were analysed, it was found that over 60% of the expenditure was incurred in the Dublin and Leinster region.

A further analysis highlighted that there was an increase in the expenditure in 2014 and this was due to a delay in receiving samples that had built up during 2013. The issuing of invoices by the State Laboratory was delayed as a result. In this instance it was difficult for individual local authorities to control and monitor the budgets in this area year on year.

- **Attendance at Inquests**

There were no material findings in this area as the amounts paid under this heading in regard to experts, witnesses or jurors were not significant.

- **Mortuary Fees**

The study found that for the majority of local authorities, mortuary facilities in respect of the coroner's investigation were provided by the Health Service Executive (HSE) on a regional hospital basis, and there was no payment for this facility with the exception of Cork City Council, who pay an annual fixed fee to the HSE for the service. In the case of the Dublin district the coroner has a dedicated mortuary facility and all costs are paid by Dublin City Council for the facility.

- **Overall Costs of the Coroner Service including other costs not included above**

The overall expenditure incurred for the Coroner Service is disclosed in the Annual Financial Statements of all local authorities under 'Miscellaneous division H05' in a single line item. The study found that the classification and coding of the coroner related expenditure was not standardised or consistent across all local authorities. This resulted in difficulties analysing and extracting specific categories of expenditure for the study. This was particularly the case for pathology services and fees.

The study also found that the recoupment arrangement with some local authorities is based on a fixed annual amount which is not reflective of actual coroner related expenditure or activity in the relevant period.

Recommendations

Recommendation 1 - Legislation

It is recommended that a definitive decision should be made as to the future organisation of the Coroner Service in the context of the comprehensive reform planned by the Department of Justice and Equality. New legislation will allow for a more coherent organisation of coronial work and appointment process for coroners, than is currently in place.

Recommendation 2 – Appointment of the Coroner

As a selection process for the filling of coroner vacancies has not been carried out at any local authority since 2000, it is recommended that, in consultation with the Public Appointments Service and the Department of Justice and Equality, detailed guidance on the appointment and selection process for any new coroner positions should be drafted and issued.

Recommendation 3 – Coroner Payments - Standard Template Invoice

It is recommended that a standard template invoice should be devised by local authorities for coroners to include details of the death reports under each certification category. This template invoice can be used to submit to the local authority and to complete the annual returns to the Minister for Justice and Equality as required under the 1962 legislation. This will ensure that the annual returns and invoicing process are in agreement and fees paid to both the coroner and other stakeholders during the year are based on the published annual returns information.

Recommendation 4 – Coroner Returns - Annual Report

It is recommended that an annual report on the Coroner Service is prepared on the cases and activities of the coroner network. The report should be based on the calendar year to 31 December and submitted to the Minister for Justice and Equality within an agreed timeframe.

Recommendation 5 - Coroner Remuneration - Retainer Fee

It is recommended that the retainer fee is reviewed to ensure that it is consistent with the current number of death report certifications for each coroner district. The majority of the rates paid have not been updated since the last review in 2003 with the exception of individual coroners/local authorities that have negotiated updated fees following the amalgamation of districts.

Recommendation 6 - Coroner Remuneration - Fee per Case

It is recommended that the rate for the fee per case is reviewed as the last review was in 2009. The appropriateness of paying the fee through the payroll system should be reviewed by local authorities, to ensure that the nature of the professional service is reflected in the payment and that the procedure used is in line with Revenue Commissioners guidelines.

Recommendation 7 - Coroner Remuneration - Guidance

It is further recommended that guidance material should be drafted for local authorities with clear instruction to all local authorities on the payments to coroners and the interpretation of the legislation and its application. This would ensure that there is a consistent and integrated approach for all coroner and related expenditure.

Recommendation 8 - Funeral and Undertaking Service

It is recommended that all local authorities comply with procurement and tendering rules for the provision of funeral and undertaking services in an open or restricted competition. (A restricted competitive process can be used where there is a particular specialist skill or expertise required to carry out the service).

Recommendation 9 – Pathology Services - Financial Management System

It is recommended that the coding of pathology expenditure is reviewed to provide improved analysis of the costs incurred for pathology and other services and to monitor the budget of coroner related expenditure to achieve greater value for money.

Based on the findings in this study in relation to pathology services, there is a lack of consistency and standardisation of coding and classification in the financial management system used in the majority of local authorities. For this reason, the study found that it is difficult to identify with accuracy the total amount of expenditure incurred for pathology services.

Standard coding will ensure that payments to the pathologist relate to cases dealt with by the relevant coroner and are in accordance which the fees regulation currently in place.

Recommendation 10 – Pathology Services - Standard Template Invoice

In line with recommendation 3, it is recommended that a standard template invoice, on which fee income is paid to pathologists, should be created similar to that of the coroner. The template invoice should contain identifying details of the post mortem, with a unique case number, created initially by the coroner on report of death and order of the post mortem.

It should be verifiable with the annual returns submitted by each coroner to the Minister for Justice and Equality, as required under the 1962 legislation.

Recommendation 11 – Pathology Services - Memorandum of Understanding

It is recommended that the Department of Justice and Equality consult with coroners and the HSE to create a suitable memorandum of understanding for coroners in their districts for the provision of pathology services. This should ensure that all of the requirements for a quality service are included in the memorandum, and better value for money achieved as a result.

Recommendation 12 – State Laboratory - Centralised Service

It is recommended that payment arrangements for this service should be centralised within a shared service to achieve better value for money rather than through individual local authorities.

Based on the findings in this study in relation to the payments to the State Laboratory there is a considerable amount of expenditure incurred for pathology and toxicology testing for local authorities.

It is also recommended that in consultation with the service provider, a suitable service level agreement or memorandum of understanding be developed for coroners in local authority coronial districts. This would ensure that all of the requirements for a consistent quality service are included as part of the agreement and better value for money achieved as a result.

Recommendation 13 – Coroner Service Expenditure - Financial management system

It is recommended that local authorities review their financial IT systems to provide better analysis and coding of the expenditure relating to the overall cost of the Coroner Service. This will ensure that the local authorities will be able to monitor coroner expenditure and budgets to achieve better value for money.

Recommendation 14 – Coroner Service - Shared Service

It is recommended that the Coroner Service should be considered as a shared service with a central lead local authority paying for all coroner related expenditure. This single point of contact would provide standardised practices for payments to coroners and other service providers with improved financial information on coroner related expenditure. The arrangements for some local authorities for the recoupment of coroner related expenditure could be updated with this improved financial information.

This would provide additional administrative support to the coroner in the performance of their duties and ensure better coordination of the service and service providers and greater liaison with the Department of Justice and Equality on specific matters arising on the service.

1. Introduction

1.1 Background

Local authorities perform functions across a wide range of sectors. These functions fall within the remit of a number of different government departments and state agencies, the Coroner Service is an example of this. At central government level, the Department of Housing, Planning and Local Government (DHPLG) is responsible for a range of specific functional or service areas in the local government sector such as planning, housing and fire services.

However, local authorities also undertake numerous other activities and functions, whose responsibility in relation to policy, funding, legislation and general oversight and accountability at a national level rests with other relevant departments and state agencies, not just the DHPLG. The policy document *"Action Programme for Effective Local Government - putting people first"* provides further explanation on this cross-departmental approach. In particular, chapter 2.5 of the document deals with the determination of local authority functions, and strengthens the principle that responsibility at central level remains with the relevant department or agency.

The Department of Justice and Equality legislates for and determines policy for the Coroner Service in Ireland. The principal legislation that established the role and responsibilities of coroners in Ireland is the Coroners Act 1962. The Coroners Bill 2007 provided that funding and general oversight and accountability at national level should also rest with the Department of Justice and Equality.

Local authorities fund the operation of the Coroner Service in their district and are responsible for the appointment of coroners on the recommendation of the Public Appointments Service. Local authorities do not receive any specific central funding for the financing of this service. There is a network of 38 coroners operating in local authority districts throughout the country.

The Coroner Service is only a small percentage of the overall budget that local authorities manage and this Value for Money study sought to ascertain the total expenditure incurred for coroner related services for the entire country for each of the three years to 31 December 2015. The study included a review of the management and oversight of the Coroner Service from the appointment of the coroner and their related expenditure, together with the costs of the other support services that are required by the coroner in performance of their duties.

As the service is demand led with fee regulation set by statute, it is difficult for each local authority to budget for and ensure value for money for the Coroner Service. The study highlights shortfalls in the service and makes recommendations on best practice for the reform of existing procedures, practices and systems, thereby promoting economy, efficiency and effectiveness in the management and oversight of the Coroner Service in local authorities.

1.2 Scope of the Study

The study examined the operation of the Coroner Service in all local authorities. It includes the appointment and profile of the coroner in each local authority district, and all coroner related expenditure incurred by local authorities for each of the three years to the 31 December 2015.

A review of the Coroner Service in operation in the UK was undertaken in order to establish international best practice, and to identify areas of reform that could be applied to the Coroner Service in Ireland.

1.3 Basis for Selection

In order to obtain a full and accurate assessment of all coroner related expenditure in the Republic of Ireland, it was appropriate for the Value for Money study to select all of the 31 local authorities.

While the study surveyed all local authorities, we found that there were four locations (Dún Laoghaire-Rathdown, Fingal, South Dublin County Councils and Galway City Council) that did not have specific coroner related expenditure. There is an arrangement whereby a fixed annual amount for the coroner related expenditure is recouped from that local authority to the local authority with the appointed coroner district in their county i.e. Dublin City Council and Galway County Council.

1.4 Advisory Group

As part of the study, an advisory group was established comprising representatives from the Department of Justice and Equality, local authorities and the Local Government Finance section within the Department of Housing, Planning and Local Government. The group met on a number of occasions throughout the study process and has provided important additional insights to the scope and methodology of the study.

1.5 Methodology

A detailed questionnaire was prepared with the assistance of the advisory group and a number of local authorities. This questionnaire was issued to all 31 local authorities. The questionnaire requested information on the following:

Summary Information

- Profile of the coroners and deputy coroners in each of the coroner district(s) of the relevant local authority

Detailed Questions

- Appointment of the coroner and deputy coroner
- Administration and liaison with the Department of Justice and Equality
- Coroner and deputy coroners - cases and fees (including retainer fees)
- Pathology and laboratory fees
- Funeral and undertaking costs
- Attendance at inquests
- Mortuary fees
- Overall total expenditure of the Coroner Service (including other costs not included above).

In addition to the questionnaire, all local authorities were required to provide a soft copy transaction listing of the coroner related expenditure incurred for each of the three years ended 31 December 2015. As part of the study, a sample of local authorities were visited to document the coroner system and verify the data supplied in the questionnaire. The responses to the questionnaire were also validated with the assistance of each of the Local Government Auditors located in the local authorities.

On completion of the study, a draft report was circulated to all 31 local authorities for their confirmation of the factual accuracy on the data included relating to their local authority and/or feedback comments on the above report. This confirmation was received from all local authorities.

2. Legislation

2.1 Coroners Act 1962

The principal legislation that governs the role and responsibilities of coroners in Ireland is the Coroners Act 1962.

The coroner is an independent office holder who operates in the public interest in a quasi-judicial capacity, coordinating the medico-legal investigations into certain deaths. A coroner must inquire into the circumstances of sudden, unexplained, violent and unnatural deaths. This may require a post mortem examination, sometimes followed by an inquest. The coroner's inquiry is concerned with establishing whether or not death was due to natural or unnatural causes. If a death was due to unnatural causes an inquest must be held.

A coroner's court is an inquisitorial court rather than an adversarial one. There are no "parties" in the coroner's court, and all depositions, post mortem reports and verdict records are preserved by the coroner and are available to the public. The coroner may summon a jury and may call witnesses. The inquest is confined to ascertaining the identity of the person in relation to whose death the inquest is being held and how, when, and where the death occurred.

2.2 Coroners (Amendment) Act 2005

The Coroners (Amendment) Act 2005 repealed the prohibition on the calling of more than two registered medical practitioners to give evidence during an inquest and also empowered a coroner to issue witness summonses to persons essential to the inquiry. It also increased the punitive sanctions in the event of non-attendance of witnesses and jurors.

2.3 Civil Law (Miscellaneous Provisions) Act 2011 (Part 9)

The Civil Law (Miscellaneous Provisions) Act 2011, Part 9, amended the Coroners Act 1962. It provided for the amalgamation of the Dublin coroner districts in order to ensure the best use of resources in the Dublin area. As of 2 August 2011, pursuant to Section 32 of the Civil Law (Miscellaneous Provisions) Act 2011, the coroners' districts of the city of Dublin and the county of Dublin were amalgamated into one district, to be known as the coroner's district of Dublin.

This involved centralising the Coroner Service under Dublin City Council, and provides for a recoupment of a percentage of the costs from all of the other Dublin local authorities. The 2011 Act provides for the appointment by the Minister for Justice and Equality of a Dublin coroner when a vacancy occurs in the coroner's district of Dublin. This is an exception to the general position whereby, under the Coroners Act 1962, coroners are appointed by the local authority. The Dublin coroner retired in June 2016 and a temporary assignment has been made to the position by the Minister for Justice and Equality, pending a new appointment.

3. Review of the Coroner Service

3.1 Background

A review of the Coroner Service was conducted by a working group appointed by the Minister for Justice, Equality and Law Reform in 1998. The working group included representation from the Department of Environment and Local Government and the County and City Managers Association.

The group reported in 2000 and the report stated that the weakness in the current system is that there is no overarching agency providing oversight and governance to the Coroner Service together with any consistency of service provision throughout local authorities. The current system is outdated and needs reform. The seemingly high number of coroners in the country dates back to a time of poor communications and transport, rather than to any analysis of service needs requirement in each district.

The report issued 110 recommendations and those relevant to local authorities included that:

- The number of coroners should be reduced over time, evolving to a regional structure with one or more coroners in each region
- A new post of coroner's officer should be introduced at regional level to act as a general support to both coroners and relatives
- A new statutory agency should be established, to reflect the core concept of service to both coroners and the public and its central role in shaping the future of the new service
- Funding relating to the administration of the coroner service should be moved into the control of the proposed new central coroner agency.

These main recommendations have not been implemented. As mentioned below, the Coroners Bill 2007 sought to provide for a comprehensive reform and restructure of coroner organisation and structures, but was not progressed due to the major challenges confronting public finances. A review of the Coroners Bill is currently under way with a view to progressing necessary reforms. This review of the Coroners Bill has involved an extensive examination of the text of the Bill addressing both the legal and medical issues in detail. This work has been undertaken by the legislation section of the Department of Justice and Equality with a group from the Coroner Society of Ireland.

However, three recommendations were initially implemented pending the enactment of the Coroners Bill 2007, as follows;

1. Coroner Service Implementation Team

A Coroner Service Implementation Team (CSIT) was set up to implement the administrative provisions of the 2007 Bill when enacted. The currently reduced staff of that unit, acts as the primary liaison for the Department of Justice and Equality and the network of independent coroners throughout the country.

The team operates under the provisions of the Coroners Act, 1962 and deal with requests from coroners provided for under Sections 21, 23, 33 and 47 of the Act.

They are also responsible for the collection and publication of Annual Returns in accordance with Section 55 of the Coroners Act 1962. Functions provided by CSIT under the Coroners Act, 1962 include:

- Processing of requests under Section 21 of the Coroners Act, 1962. Where the bodies of two or more people, whose deaths appear to have been as a result of the same incident, are lying within the districts of different coroners, the Minister may, direct that one of those coroners shall hold an inquest in relation to all of the deaths.
(Usually in the case of fatal road accidents, where one party dies at the scene of the crash and another party subsequently dies in a hospital in another coroner's coronial district).

- Processing of requests under Section 23 of the Coroners Act, 1962. Where a coroner has reason to believe that a death has occurred in or near his district, and that the body has been either lost or is irrecoverable, the Minister may direct an inquest in relation to the death.

- Processing of requests under Section 33 of the Coroners Act, 1962. Where the services of the State Pathologist are required to perform a forensic post mortem examination on the body of a deceased person, the Minister makes a direction to the office of the State Pathologist to perform such a post mortem.

- Processing of requests under Section 47 of the Coroners Act, 1962. Where a coroner has been informed by a senior member of An Garda Síochána that, in his opinion, the death of any person whose body has been buried in the coroner's district may have occurred in a violent or unnatural manner, the coroner may request the Minister to order the exhumation of the body by An Garda Síochána.

The team also keeps a record of the retirement due dates for coroners and processes the administrative steps involved in the amalgamation of districts under Section 7 of the 1962 Act as amended by Section 32(b) of the Civil Law (Miscellaneous Provisions) Act, 2011.

2. Coroner Rules

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."*

A Rules Committee was established, and through a consultation process, involving the network of coroners and regular meetings, the committee developed 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 have been published and are expected to be updated as needed and will be placed on a statutory footing in the context of any new coroner legislation. The Coroner Society of Ireland is currently undertaking a review of the draft rules.

3. Restructuring of the Coroner Districts

The recommendation that the number of coroners should be reduced over time, evolving to a regional structure with one or more coroners in each region, was implemented under the Civil Law (Miscellaneous Provisions) Act 2011 (Part 9).

The implementation is carried out by the CSIT in the Department of Justice and Equality. If a vacancy arises in a coronial district, and that district is within the area of a local authority in which there is more than one coroner district, the Minister for Justice and Equality may, following consultation with the local authority concerned, direct that a coroner holding office in respect of a neighbouring coronial district within the local authority area, shall also hold office as coroner in respect of the vacated coronial district.

The process is as follows:

- The Department of Justice and Equality will establish that an existing coroner in the coronial district is prepared to assume the duties of the outgoing coroner.
- When the coroner indicates his/her willingness to take on the extra duties, the Department then writes to the local authority, pointing out the provisions of Part 9 of the Civil Law (Miscellaneous Provisions) Act, 2011 and indicating that consideration is being given to the amalgamation of two coronial districts within their jurisdiction.
- Confirmation is requested of the local authority that they have no objection to the amalgamation.
- If the local authority has no objection, the Minister issues a direction to the existing coroner that, as of the date of the vacancy, he or she shall also hold the office as coroner for the vacated coronial district, and that the two coronial districts shall stand amalgamated.

This section of the Act is only relevant where there is more than one coronial district within a local authority's administrative area.

3.2 Follow up on Recommendations of the Review

A. Coroners Bill 2007

The Coroners Bill 2007 provided for a comprehensive reform of the Coroners Act 1962 and of the existing coroner system, including the establishment of a new national Coroner Service, the appointment of a Chief Coroner, full time coroners and the appointment of a Director of the Coroner Service. It incorporated many of the recommendations made by the Coroner Working Group in 2000, and by the Coroners Rules Committee in 2003, as well as a detailed review of reforms to coroner systems in other common-law jurisdictions (particularly New Zealand and Northern Ireland).

The Bill envisaged the Coroner Service operating on a regional basis with each region allocated:

- A minimum of two coroners
- A minimum of one assistant coroner and
- A minimum of two coroner officers.

The Bill completed Second Stage in the Seanad in October 2007 but has not progressed further, for the reasons indicated above. It was not restored to the Order Paper of the 32nd Dáil.

On 2 November 2016, the then Minister for Justice and Equality indicated in a response to a parliamentary question that:

"the Coroners Bill 2007, which was on the Order Paper in the previous Dáil, was not restored to the Order Paper in the current Dáil, as it needs to be fully examined and revised before an updated Bill is brought forward. I had already asked my Department to carry out a review of the 2007 Bill, as a number of elements have become outdated and need review in the light of:

- legal and forensic developments
- the changed public finance
- increased emphasis on delivering leaner, better integrated and more customer-focused public services.

That review is continuing and the intention is that new proposals will be brought forward in 2017." (See Section C – Coroners (Amendment) Bill 2017)

B. Coroners Bill 2015

In December 2015, a Private Members' Bill, the 'Coroners Bill 2015' was presented to the Dáil, and it completed Second Stage of the legislative process on 11 December 2015. This Coroners Bill 2015 effectively reintroduced in its entirety the Coroners Bill 2007, and introduced into that Bill three new sections on investigation of any 'maternal death', including a requirement for a mandatory inquest to be held into any maternal death. (A maternal death is defined as the death of a pregnant or post-partum woman while she is in the care of a hospital, maternity unit or other location where births take place, or within 6 weeks after discharge).

The Coroners Bill 2015 was not opposed by the Government at Second Stage. The Minister for Justice and Equality recalled that the Coroners Bill 2007 was fundamentally outdated, and was already the subject of a comprehensive review in her Department. The Minister indicated that the Government would therefore be proposing very substantive amendments to the Private Members' Bill at Committee Stage, but that she appreciated the intention behind the Private Member's Bill, and was sympathetic to considering within that review the important and complex issues raised regarding maternal deaths, in consultation with the Minister for Health.

The Coroners Bill 2015 was restored to the Order Paper by resolution of the Dáil on 1 June 2016 and referred to the Select Committee on Justice and Equality on 5 July 2016.

C. Coroners (Amendment) Bill 2017

The Minister for Justice and Equality obtained Government approval in May 2017 to prepare as a matter of urgency a Coroners (Amendment) Bill 2017 which will address the related maternal death issues included in the Private Members Coroners Bill 2015. The Bill, when enacted, will provide for a number of legislative procedural sections as follows:

- Mandatory inquests for maternal deaths - As there were no objections to this section in the previous bill in 2015, it was felt that progress should be made on its enactment
- Updating the Coroner Act 1962 on coroner procedures to ensure that the holding of inquests is in line with ECHR (European Convention of Human Rights) and
- Other additional procedural powers provided to the coroner.

3.3 Current status of the Review

The Minister for Justice and Equality is currently conducting a comprehensive review of the coroners' legislation and specifically the Coroners Bill 2007. As part of this study the Value for Money Unit met with the Department of Justice and Equality officials in order to obtain information on the progress of this review. The meetings were very informative.

The aim of the Minister's review is to:

- Identify how best to deliver an integrated, reformed structure that will support coroners more effectively, within the Government's current financial possibilities
- Bring the 2007 Bill up to date for legal and forensic developments, and in particular to ensure full compatibility with the European Convention on Human Rights
- Put in place improved support to ensure that bereaved families receive a prompt, responsive, and effective service.

In the review, the Department of Justice and Equality is looking at the reform of coroner structures to reflect the current economic environment and the new or amending legislation needed to implement the recommendations of the 2000 review to reform the Coroner Service.

This review of the legislation is ongoing and the intention is that new proposals will be brought forward in 2017.

Recommendation 1 - Legislation
It is recommended that a definitive decision should be made as to the future organisation of the Coroner Service in the context of the comprehensive reform planned by the Department of Justice and Equality. New legislation will allow for a more coherent organisation of coronial work and appointment process for coroners, than is currently in place.

4. Profile of the Coroner

The Coroner Service is a network of independent coroners located throughout the country. There is no central organisation. The coroners' core function is to investigate sudden and unexplained deaths so that a death certificate can be issued.

4.1 The work of the Coroner

The work undertaken by coroners generally falls into three categories:

1. Cases where the coroner investigates the death following receipt of report and information, which do not require a post mortem
2. Cases that are concluded with a post mortem and other medical information but do not require an inquest
3. Cases giving rise to an inquest.

1. Cases that are reported to the coroner (and that don't give rise to a post mortem or inquest) usually arise in circumstances where a death occurs unexpectedly, or say at home, where it has to be ascertained if a cause of death can be identified and who will issue a medical certificate on the cause of death.

An illness or some condition may be identified and under treatment but it may not be appropriate for the hospital doctor or the attending GP to certify on these cases until there is an exchange of information. These include deaths in care or nursing homes.

The coroner will be informed and will inquire to ensure that a cause of death is identified and/or that a medical practitioner is available, and in a position to confirm the cause of death. These cases also include referrals from the Registrar of Births, Deaths and Marriages where the medical certificate on the cause of death is completed but clarification of that certification is required through the coroner's office.

2. Post mortem cases will for the most part comprise of cases where there is a sudden or unexpected death and where a medical practitioner is not in a position to issue a medical certificate on the cause of death either because the cause is not known or because of uncertainty due to the possibility of multiple possible causes.

In these cases, on receipt of the relevant reports, the coroner will liaise with one or all of the family, the family GP and in some cases the relevant consultant who attended the deceased. Sometimes additional expert reports are required e.g.

(i) confirmations from the deceased's GP

(ii) confirmations from other parties, including statutory bodies

(iii) An Garda Síochána

before the case can be concluded, in addition to meeting the family, before a certificate is completed under Section 41 of the Act.

3. Inquest Cases vary considerably and can be divided into a number of categories:

(i) Inquests that are mandatory under the 1962 Act

(ii) Inquests which are mandatory but also require a Jury under the Act and

(iii) Inquests which are considered necessary by the decision of the coroner.

Practise on the management and administration of inquests has considerably changed over the past twenty years involving:

- the distribution of material to parties pre inquest
- pre inquest hearings
- preliminary inquest hearings and
- the mutual exchange of substantial documentation relevant to the case pre inquest.

This is in order to identify the issues and to have the parties fully informed.

Practices have also changed and become more elaborate in order to comply with the requirements of the European Court of Human Rights (ECHR) and also arising from the requirement of varying statutory bodies such as the Health and Safety Authority and Garda Síochána Ombudsman Commissioner (GSOC).

In 2016, there were 38 coroners in 40 coroner districts which includes two full time coroners in Dublin city and Cork city. All of the other coroners provide the Coroner Service in addition to their role as solicitor or medical doctor in their own practices, but as coroners they are available and on call every day of the year on a 24 hour basis.

See Appendix 1 for a listing of all the coroner districts. Currently there are 82% male and 18% female coroners in the coroner network.

The jurisdiction of the coroners is limited to the district where they are appointed and they must also reside in that district, unless Ministerial approval is obtained to do otherwise. They are independent in the conduct of their function in the investigation of death.

Section 14(1) of the Coroners Act 1962 states that, to be appointed, the coroner must hold at least one of the following qualifications:

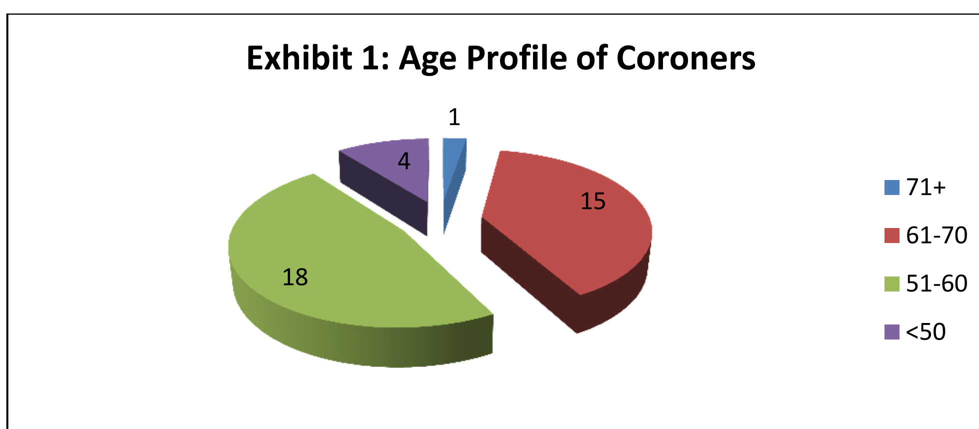
- A practising solicitor/ barrister of at least five years' standing
- A registered medical practitioner who has been registered, other than provisionally or temporarily, under the Medical Practitioners Acts, 1927 to 1961, in the Register of Medical Practitioners for Ireland, or who has been entitled to be so registered, for at least five years.

The study found that all of the coroners appointed held one of the above qualifications, with the split currently 55% medical doctors and 45% solicitors/barristers.

4.2 Age Profile

Section 11 of the Coroners Act 1962 provides that every coroner appointed shall hold office until he reaches the age of seventy. In order to obtain an age profile of the network of coroners, all local authorities were surveyed and asked to provide information on the profile of the coroner(s) in their districts. This information was corroborated with the information held by the Department of Justice and Equality on the coroner network throughout the country.

Exhibit 1 is an analysis of the age profile of coroners in all local authorities and the findings show that there are 33 coroners aged between 51 and 70 years with only five coroners outside of this age range.



The age category 71+, highlighted in the Exhibit above, relates to a coroner appointed prior to the Coroners Act 1962. Section 11(2) provides that, as the appointment was prior to the commencement of the 1962 Act, there was no requirement to retire at age 70 years. The Civil Law (Miscellaneous Provisions Act 2011) also provides for continuation to act as coroner, where the person may already have retired from legal or medical practice.

4.3 Retirement Profile

Section 11(1) of the Coroners Act 1962 states 'Every coroner appointed after the commencement of this Act shall, unless he sooner dies, resigns or is removed from office, hold office until he reaches the age of seventy years.' The study reviewed the coroner network and based on the responses from the survey questionnaire and the data collated in the Department of Justice and Equality, Exhibit 2 shows the profile of future retirements in the coroner network.

Exhibit 2: Future Retirement profile

No. of Years until retirement	No. of Coroners	%
Within 10 years	16	42%
Within 20 years	18	47%
Over 20 years	4	11%
Total	**38**	**100**

Source: Department of Justice and Equality

The study found that as at June 2016 there have been a total of 11 coroner retirements since 2011 as set out under Exhibit 3. The majority of these retirements required the amalgamation of some coroner districts, with the agreement of the Minister for Justice and Equality and the local authority.This is explained under section 5.1 'Amalgamation of coroner districts'. However there are three coroner districts listed below where no amalgamation took place, as the retirement was in a county with only one coroner district.

Exhibit 3: Retirements from 2011-2016

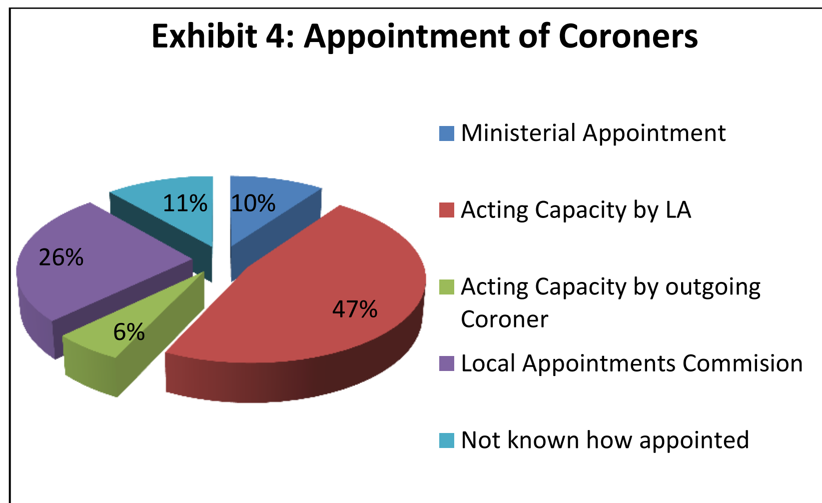
City and County	Coroner District	2011	2012	2013	2014	2015	2016	Total
Donegal County Council	DONEGAL NE	0	0	0	0	0	1	1
	DONEGAL NW	0	0	0	0	1	0	1
	DONEGAL SW	0	0	0	0	1	0	1
Dublin City County	DUBLIN CITY	0	0	0	0	0	1	1
	DUBLIN COUNTY	1	0	0	0	0	0	1
Limerick City and County Council	LIMERICK SE	0	0	0	0	0	1	1
	LIMERICK WEST	0	0	0	0	1	0	1
Mayo County Council	MAYO SOUTH	0	0	0	0	0	1	1
Meath County Council	MEATH	0	0	1	0	0	0	1
Sligo County Council/Leitrim County Council	SLIGO/LEITRIM	0	0	0	1	0	0	1
Wexford County Council	WEXFORD SOUTH	1	0	0	0	0	0	1
Total		**2**	**0**	**1**	**1**	**3**	**4**	**11**

Source: Department of Justice and Equality

4.4 Appointment

Regarding the appointment of the coroner, Section 8(2) of the Coroners Act 1962 states that 'The coroner for the coroner's district shall be appointed by the local authority in whose area the district is situated'. This means that under the 1962 legislation, local authorities are responsible for the appointment of coroners on the recommendation of the Public Appointments Service.

The survey asked all of the local authorities how their current coroner was appointed, and Exhibit 4 is an analysis of the appointments in the current coroner network.



From a review of the responses received, the study found that no appointments have been made by any local authority since 2000 and there is a lack of knowledge or expertise in the local authorities around the appointment of new coroners when positions become vacant.

Exhibit 4 shows that over half of the coroners operating are in an acting capacity. In the case of four local authorities, they were not aware how their coroner was appointed, as they had been in the role for several years.

When asked why coroners were appointed in an acting capacity, local authorities provided the following reasons:

(i) The impact of the restructuring of the coroner districts under the Civil Law (Miscellaneous Provisions) Act 2011
(ii) The pending legislation that was envisaged under the Coroners Bill 2007, which would have resulted in a number of radical reforms, was imminent
(iii) Over half of the local authorities surveyed were not aware that they were required to carry out the appointment for the vacant positions under the legislation.

All of these issues have resulted in a lack of open competition at local authority level for any coroner vacancies that have arisen since 2000, even where there was no requirement to amalgamate coroner districts within the local authority i.e. the local authority only had one coroner district prior to the retirement.

The Department of Justice and Equality explained that many of the acting appointments were made pending the new coroner legislation, and it was thought at the time that this legislation was imminent. The primary concern was for continuity of the service in each coroner district, and therefore it was not envisaged that the acting appointment would be a long term arrangement.

However the new legislation was never enacted and all of the acting appointments have continued in over half of the local authorities.

As the retirement age for a coroner is 70 years under the current legislation and, given the current retirement profile of the coroner network (See Exhibit 2, Page 25), the appointment process will be required to be conducted more frequently over the coming years to assist with the filling of vacant positions.

Recommendation 2 - Appointment of the Coroner
As the selection process for the filling of coroner vacancies has not been carried out at any local authority since 2000, it is recommended that, in consultation with the Public Appointments Service and the Department of Justice and Equality, detailed guidance on the appointment and selection process for any new coroner positions should be drafted and issued.

5. Administration & Liaison with Department of Justice and Equality

5.1. Amalgamation of Coroner Districts

The Civil Law (Miscellaneous Provisions) Act 2011 provides for the amalgamation of coroner districts on a phased basis with a reduction in the number of coroners in a county. The process is, that in the event of a retirement, agreement is reached to amalgamate the vacant district with the appointed coroner in the district closest to this vacant district. The coroner takes on the deaths reported in this additional geographical area and the two coroner districts are amalgamated with the consent of the local authority.

5.2. Impact of the Amalgamations of Districts on Local Authorities

Case Study Example
As at 2011, there were four coroners operating in Donegal (North East, North West, South East and South West). Following two retirements in mid 2015 and a further retirement in July 2016, the remaining coroner located in the South East district agreed to act as coroner for the entire county. Exhibit 5 below sets out the number of cases dealt with by each district over the years 2013 to 2016.

Exhibit 5: Annual Return of Cases 2013-2016

Donegal	2016	2015	2014	2013
Donegal North East		135	119	96
Donegal North West		260	348	357
Donegal South East		368	133	122
Donegal South West		86	140	117
Donegal County	879			
Total	**879**	**849**	**740**	**692**

Source: Coroner Annual returns 2013-2016

In Exhibit 6 below, the study calculated the fee income figure based on the rates per the regulation. This may differ from the amount actually paid due to accruals and additional PRSI included in the payment. The current coroner dealt with 122 cases in 2013 increasing to 368 in 2015. In 2016 the actual number of cases was 879 and the increase in reported deaths resulted in an increase in fee income for the remaining coroner at €150,356.

Exhibit 6: Post Amalgamation Fee Income 2013-2016

Donegal	2016	2015	2014	2013
Reported Deaths	**No.**	**No.**	**No.**	**No.**
Donegal South East		368	133	122
Donegal County	879			
Fee Income	**€**	**€**	**€**	**€**
Donegal South East		62,584	23,813	22,938
Donegal County	150,356			

Source: Coroner Annual returns 2013-2016 and Survey Questionnaire

The implication of the amalgamation of all of the Donegal coronial districts is, that while the fee income of the coroner is increasing considerably from €22,938 in 2013 to income of €150,356 in 2016, there will be no resulting savings (excluding the retainer fee changes below) for the local authority as a result of the amalgamations of the district. They continue to pay one coroner the fee amounts that the previous four coroners received.

5.3 Savings arising from the retainer fee

Exhibit 7 below highlights that retainer fee savings were achieved by the local authority as a result of the reduction in the number of coroners in receipt of the retainer fee.

Exhibit 7: Annual Retainer Fee[1] 2013-2016

Donegal	2016 €	2015 €	2014 €	2013 €
Donegal North East		12,807	12,807	12,807
Donegal North West		8,966	17,932	17,932
Donegal South East	21,774	21,774	12,807	12,807
Donegal South West		6,403	12,807	12,807
Total	**21,774**	**49,950[2]**	**56,353**	**56,353**

1. Retainer fee excludes any tax or ER Prsi paid over by local authority on behalf of coroners
2. The retirements for 2015 occurred mid year, 50% retainer fee applies.

Source: Coroner Annual returns 2013-2016

Based on the retirements over the four year period, the retainer fee has been reduced by over 60% from €56,353 in 2013 to €21,774 in 2016 resulting in a savings of €34,579 for the local authority as a result of the amalgamations of the coronial districts in the county.

5.4 Other potential savings

There is no provision in the 2011 legislation whereby, following the amalgamation process, that there is;

(i) a limit on the fee paid per deaths reported requiring an inquest, or
(ii) a requirement to carry out the role in a full time capacity even where the numbers of deaths reported increase.

In the absence of this legislative provision, the amalgamation process did not provide for a voluntary arrangement, similar to the current arrangement in the Dublin district where both of these arrangements are in place. The office is held in a full time capacity and the coroner fees paid is limited to the fee per deaths reported requiring an inquest plus an annual retainer fee.

6. Coroner Annual Returns

6.1 Returns to the Department of Justice and Equality

Under Section 55 of the Coroners Act 1962 there is a requirement that every coroner submit, on or before the 1 February every year, a written return to the Minister for Justice and Equality of the inquests held and the number of cases dealt with during the year ended 31 December.

The coroners' annual return records the number of reported death certifications dealt with in each coroner district for the year as per Appendix 2. This information is collated by the CSIT in the Department of Justice and Equality and published on the coroner website (www.coroner.ie).

The total number of reported deaths under the above returns in 2016 was 16,815 (**2015**: 16,756, **2014**: 15,833). It should be noted that the reported deaths outlined in the coroner review in 2000 was just over 7,000 deaths reported for the year 1999.

Exhibit 8 below provides a breakdown of reported deaths between all of the provinces together with the population figures for each province. Cork city and Dublin are separately identified as the office is held in a full time capacity in these districts and approximately 30% of cases are reported in Dublin. The exhibit shows that the number of reported deaths in Dublin is greater than the number of deaths reported in the other provinces.

Exhibit 8: Coroner Annual Return of Reported Deaths 2014-2016

Province	Population[1]	2016	2015	2014
Connacht	542,547	2,260	2,347	2,216
Cork City	119,230	1,098	945	917
Dublin	1,273,069	4,835	4,974	4,740
Leinster	1,231,745	3,504	3,513	3,353
Munster	1,126,858	3,889	3,785	3,519
Ulster	294,803	1,229	1,192	1,088
Total[2]	**4,588,252**	**16,815**	**16,756**	**15,833**

Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report.

Source: 1. Central Statistics Office-Census 2011 – Population by County
2.Coroner Annual returns 2014- 2016

6.2 Local Authority reconciliation

For the years 2014 and 2015, the survey asked local authorities if reported deaths per invoices paid and processed by local authorities were ever reconciled to the information collated by the Department of Justice and Equality as per Appendix 2 of this report. None of the local authorities had ever completed this reconciliation. They stated that they were not aware that reported deaths by coroner districts were published annually on the coroner website.

The study then reviewed the returns information supplied under the survey questionnaire and found that there were discrepancies in the majority of counties between the published information and the death reports that were processed by the local authority. The differences are set out in Exhibit 9 below for each province.

Exhibit 9: Reported Deaths per Questionnaire V.s Annual Returns 2014-2015

	Questionnaire		Annual Returns		Difference	
Province	2015	2014	2015	2014	2015	2014
Connacht	2,443	2,174	2,347	2,216	96	-42
Cork City	944	914	945	917	-1	-3
Dublin	4,974	4,740	4,974	4,740	0	0
Leinster	3,371	3,413	3,513	3,353	-142	60
Munster	3,709	3,651	3,785	3,519	-76	132
Ulster	1,393	1,240	1,192	1,088	201	152
Grand Total	**16,834**	**16,132**	**16,756**	**15,833**	**78**	**299**

Source: Department of Justice and Equality/Survey questionnaire

The study examined the discrepancies and found that they were likely to occur because of;

- timing of the submission to the Department of Justice and Equality - There are a number of ongoing cases where certain death reports with post mortem and/or inquest were not completed at year end. There will invariably be cases where post mortems have been ordered but not yet reported on, inquests opened and adjourned etc.
- consistency in coroner approach - Some on-going cases may have been reported in the annual returns to the department but they may not have been included in local authorities figures as they have yet to be invoiced if the case is still open.
- invoicing - The frequency of invoicing by coroners can vary with some quarterly in arrears while others monthly or annually.

In the absence of the source and supporting data for the deaths reported under the annual returns and information submitted to the Department of Justice and Equality, it was not possible to identify specific reasons for the differences at coroner district level.

Recommendation 3 - Coroner Expenditure - Standard Template Invoice
It is recommended that a standard template invoice should be devised by local authorities for coroners to include details of the reported death under each certification category. This template invoice could be used to submit to the local authority and to complete the annual returns to the Minister for Justice and Equality as required under the 1962 legislation. This will ensure that the annual returns and invoicing process are reconciled and fees paid to both the coroner and other stakeholders during the year are based on the published annual returns information.

6.3 Analysis of coroner report categories

Exhibit 10 analyses each of the report categories issued by the relevant coroner over the three years and it is broken down by province as follows:

- Death reports only
- Death report following post mortem and
- Death report following post mortem and inquest.

Exhibit 10: Analysis of Coroner Death Reports 2014-2016

	2016			2015			2014		
Province	Report only	Report & Post mortem	Report & Post mortem & Inquest	Report only	Report & Post mortem	Report & Post mortem & Inquest	Report only	Report & Post mortem	Report & Post mortem & Inquest
Connacht	1,489	471	300	1,537	488	322	1,398	526	292
Cork City	637	208	253	590	148	207	566	159	192
Dublin	2,970	1,195	670	3,054	1,305	615	2,838	1,236	666
Leinster	2,502	614	388	2,316	829	368	2,297	650	406
Munster	2,879	645	365	2,732	646	407	2,454	685	380
Ulster	942	154	133	915	150	127	806	165	117
Total	**11,419**	**3,287**	**2,109**	**11,144**	**3,566**	**2,046**	**10,359**	**3,421**	**2,053**
Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report.									

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2016

6.4 Percentage breakdown of report categories

The study also analysed the percentage breakdown between the types of reports issued by the coroners of the cases reported on in 2015 and 2014 as follows;

- Report only
- Report following post mortem and
- Report following post mortem and Inquest.

Exhibit 11 below sets out the percentages for each of the reports and highlights the variations between the provinces. In England and Wales the breakdown by case type for 2014 was 60%, 28% and 12% respectively, compared with the average percentages shown below for the Republic of Ireland.

Exhibit 11: Percentage breakdown of report categories 2014-2016

	2016			2015			2014		
Province	Report only	Report & Post mortem	Report & Post mortem & Inquest	Report only	Report & Post mortem	Report & Post mortem & Inquest	Report only	Report & Post mortem	Report & Post mortem & Inquest
Connacht	66%	21%	13%	65%	21%	14%	63%	24%	13%
Cork City	58%	19%	23%	62%	16%	22%	62%	17%	21%
Dublin	61%	25%	14%	62%	26%	12%	60%	26%	14%
Leinster	71%	18%	11%	66%	24%	10%	69%	19%	12%
Munster	74%	17%	9%	72%	17%	11%	70%	19%	11%
Ulster	77%	12%	11%	76%	13%	11%	74%	15%	11%
Total	**68%**	**19%**	**13%**	**67%**	**21%**	**12%**	**65%**	**22%**	**13%**

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2016

We can see from the results above that there is a wide variation in the % range in each category and this can be summarised as follows;

Type of Report	2016	2015	2014
	% Range		
Reports only	58-77	62-76	60-74
Report following post mortem and	12-25	13-26	15-26
Report following post mortem and inquest	9-23	10-22	11-21

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2016

6.5 Comparison with other jurisdictions

Using the data from the number of deaths reported to the coroner in each report category for the three years 2014 to 2016, the study compared this data with the statistics provided for Northern Ireland for 2015/16 and 2014/15.

The results are set out in the Exhibit 12 below and for 2016 shows a significant difference in the following areas:

- The percentage of post mortems per deaths reported is at 19% in the Republic of Ireland and in the Dublin coroner district is 25% compared with 30% in Northern Ireland for 2015/16.
- The average percentage of inquests per deaths reported is at 13% in the Republic of Ireland and in Dublin coroner district is 14% compared with only 2% in 2015/2016 in Northern Ireland

Exhibit 12: Comparison of Deaths Reported to the Coroner in Republic of Ireland and Northern Ireland 2014-2016

	Dublin			Republic of Ireland			Northern Ireland	
Category	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2015/2016**	**2014/2015**
No of deaths reported to the Coroner	4,835	4,974	4,740	16,815	16,756	15,833	3,895	4,006
No of deaths reported to the Coroner that did not require a port mortem	2,970	3,054	2,838	11,419	11,144	10,359	2,083	2,014
No of post mortems held	1,195	1,305	1,236	3,287	3,566	3,421	1,149	1,092
% of post mortems per deaths reported	**25%**	**26%**	**26%**	**19%**	**21%**	**22%**	**30%**	**27%**
No of Inquests held	670	615	666	2,109	2,046	2,053	85	115
% of Inquests per deaths reported	**14%**	**12%**	**14%**	**13%**	**12%**	**13%**	**2%**	**3%**

Source: Department of Justice and Equality /Northern Ireland Courts and Tribunals Service Annual Report and Accounts 2015-16

It should be noted that the total number of cases reported in Northern Ireland included other categories such as 'Other disposals' that have not been included in Exhibit 12 above for comparable purposes. This information is set out in section 10 Other Jurisdictions 'Exhibit 24'.

The study found that the Coroner Service in Northern Ireland approach to post mortems and inquests was very different to the Republic of Ireland. This was due, in part, to the historical background of the Northern Ireland jurisdiction and the increased volume of cases during this time.

The number of inquests held is much less than in the Republic of Ireland, as there is greater discretion by the coroner on whether or not to hold an inquest and situations where inquests would normally be held in the Republic of Ireland may not result in an inquest in Northern Ireland.

Recommendation 4 - Coroner Returns - Annual Report
It is recommended that an annual report on the Coroner Service is prepared on the cases and activities of the coroner network. The report should be based on the calendar year 31 December and submitted to the Minister for Justice and Equality within an agreed timeframe.

7. Coroner Remuneration

7.1 Coroner Retainer Fee

Section 9(1) of the Coroners Act 1962 Act specifies that each coroner shall be paid by the local authority by whom he is appointed such salary as shall from time to time be fixed, with the approval of the Minister, by that local authority.

The rate paid is based on three grades, increasing for the number of deaths reported in the coroner district as highlighted below in Exhibit 13. It is determined by the Department of Justice and Equality with sanction from Department of Public Expenditure and Reform (previously Department of Finance). A review of the grading of coroners was carried out by the Department of Justice and Equality in 2003 based on the case workloads over a three year period 1999-2001.

Exhibit 13: Retainer Fee Grades

Grade	No. of Cases	Annual Retainer €
Grade 1	Over 115 cases per year	21,774
Grade 2	Between 51 and 114 cases	17,932
Grade 3	Less than 50 cases	12,807

A further review was due to be carried out again in 2009. However pending the enactment of any new coroner legislation, this review was never completed. The study found that while a review has not been completed by the Department of Justice and Equality, some coroners have negotiated a revised retainer rate, when coroner districts were amalgamated or following retirements. The amount is based on the office and administrative requirement within their coroner district and the revised amount has been paid by the local authority. With the exception of these districts, the above retainer fees continues to apply to all coroners in the years examined 2012- 2015.

The study also found that there were two coroners carrying out their role in more than one coroner district. From a review of the payments made in 2015, one of these coroners was paid a retainer fee for one of their coroner districts together with other fees, PRSI and arrears payments. However, following a retirement the districts have now been amalgamated and the current coroner is in receipt of only one retainer. The counties of Sligo and Leitrim are amalgamated. Here there is only one coroner district as one county was deemed too small to have a county district. The study found that the coroner appointed in the amalgamated counties of Sligo and Leitrim is paid two retainer fees, one from each local authority.

This is despite the fact that this appointment was in 2014 and the district should have been formally amalgamated under the 2011 legislation with only one retainer fee. The explanation provided was that it is required to cover the increased administrative functions in each county and that the retiring coroner had a similar arrangement prior to their retirement. When the retirement occurred in 2014 the deputy coroner carried out the function in an acting capacity and the arrangement continued as before.

The total retainer fee paid includes an element of PRSI for individual coroners in these years and is set out in Exhibit 14 below;

Exhibit 14: Retainer Fees paid 2012 – 2015

Province	No of Coroners June 2016	2015 €	2014 €	2013 €	2012 €
Connacht	8	155,645	155,645	156,115	156,266
Cork City	1	44,152	44,152	44,152	44,152
Dublin	1	27,595	27,595	27,595	27,595
Leinster	12	226,650	223,945	221,553	226,246
Munster	12	246,603	246,595	247,249	266,407
Ulster	4	94,210	100,664	102,554	99,899
Total	**38**	**794,855**	**798,596**	**799,218**	**820,565**

Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report.

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2016

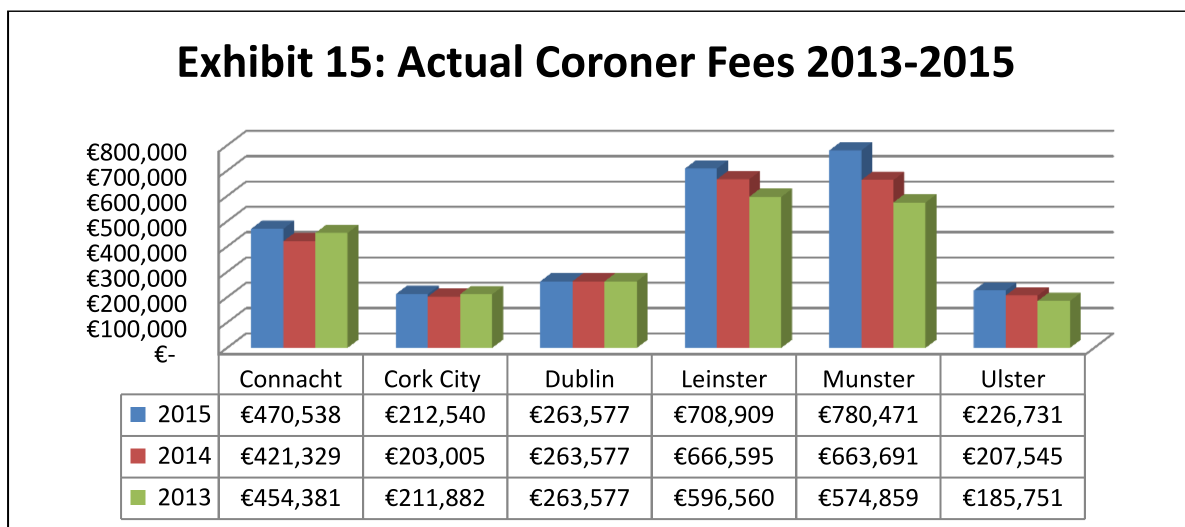
7.2 Coroner Fees per death reported

In addition to the retainer fee earned, each coroner is also paid a fee per death reported, each time a function is carried out under the Coroners Act 1962 (Fee and Expenses) Regulations 2009 (SI 155 of 2009) as follows:

Type of Certification	Rate per Regulation €
Reported death	129.68
Certifying death following a post mortem	188.54
Certifying death following post mortem and inquest	522.97

The rates are set by the Department of Justice and Equality. The coroner self certifies payments in respect of his/her services.

Based on all of the local authorities surveyed and a review of the transaction listing of the payments to coroners for each of the three years to 31 December 2015, the total of the actual fees paid to coroners was; **2015**:€2.663m, **2014**:€2.426m and **2013**:€2.287m. Exhibit 15 sets out a detailed analysis by province below.



Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report.

Source: Local Authorities survey questionnaire and transaction listing 2013-2015

However, based on the annual return of coroner death reports submitted to the Department of Justice and Equality, the calculated fee per death reports, based on the rates as set out in the 2009 Fee regulation, is estimated at; **2015**: €2.487m **2014**: €2.376m. See Exhibit 16 below;

Exhibit 16: Calculated Fee Income based on Annual Returns 2014-2015

		2015		2014	
	Rate per regulation €	No of Cases	Calculated Income €	No of Cases	Calculated Income €
Reported deaths	129.68	8,090	1,049,111	7,521	975,323
Certifying death following post mortem	188.54	2,261	426,289	2,185	411,960
Certifying death following post mortem and inquest	522.97	1,431	748,370	1,387	725,359
Total excluding Dublin		**11,782**	**2,223,770**	**11,093**	**2,112,642**
Dublin - Fee Income prior to 2016 was voluntarily fixed based on No. of inquests held in 2011.	Fee income post 2016 is based on no of inquests held	4,974	263,577	4,740	263,577
Grand Total		**16,756**	**2,487,347**	**15,833**	**2,376,219**

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2015

The above differences were further investigated and the study found that they could be explained as follows:

- **Annual Returns** - Under Section 55 of the 1962 Coroner's Act, there is a requirement that every coroner submit a written return to the Department of Justice and Equality of the number of death reports requiring an inquest and the number of death reports dealt with during the year ended 31 December.
- **Timing** - The submission of the invoice to the local authority by all coroners is not consistent, and means that the payment can accrue significant arrears. It varies from district to district, in some local authorities the coroner will submit an annual invoice, while in others the invoice is on a quarterly basis in arrears.

The study analysed the transaction listing for all local authorities and it was found that particularly since 2014, the vast majority of local authorities were paying both the coroner fees per death reported cases and the retainer fee through the payroll system.

The coroner fees per death reports should be treated as professional fees and are subject to professional services withholding tax. The payment of the fees though the payroll system would not have provided for this deduction. Therefore this treatment may not be in compliance with the Revenue Commissioners guidelines on the payment of professional fees.

The nature of the professional service provided by the coroner should also be considered as the coroner is not an employee of the local authority. They are employed in a judicial capacity on a 'part time basis' as the majority of the coroner network continue to practice as doctors and solicitors in a self- employed capacity. However as noted earlier, the coroners employed on a 'part time basis 'are available and on call every day of the year on a 24 hour basis.

The study sought an explanation on this finding and the response received from some local authorities sampled was that it was to simplify the payments process and reduce the administrative burden by having all coroner related remuneration processed through one section in the local authority.

Recommendation 5 - Coroner Remuneration - Retainer fee
It is recommended that the retainer fee is reviewed to ensure that it is consistent with the current number of death report certifications for each coroner district. The majority of the rates paid have not been updated since the last review in 2003 with the exception of individual coroners/local authorities that have negotiated updated amounts following amalgamation of districts.

Recommendation 6 - Coroner Remuneration - Fee per case
It is recommended that the rate for the fee per case is reviewed as the last review was in 2009. The appropriateness of paying the fee through the payroll system should be reviewed by local authorities, to ensure that nature of the professional service is reflected in the payment, and that the procedure used is in line with Revenue Commissioners' guidelines.

Recommendation 7 - Coroner Remuneration - Guidance
It is further recommended that guidance material should be drafted for local authorities with clear instruction to all local authorities on payments to coroners and the interpretation of the legislation and its application. This would ensure that there is a consistent and integrated approach for all coroner and related expenditure.

7.3 Review by Internal Audit

The study asked all local authorities whether the expenditure relating to the Coroner Service was ever reviewed or reported on by their Internal Audit Unit in the last three years.

The study found that for the majority of local authorities, coroner related expenditure was not subject to Internal Audit in the last three years. Three local authorities stated that this area had been reviewed by Internal Audit in specific years, two of which were outside the three year window. The reports were completed by the individual local authorities over a number of different periods - 2015, 2012 and 2011.

7.4 The Role of Deputy Coroner

Section 13(1) of the 1962 Act specifies that each coroner shall appoint a deputy coroner. All deputy coroner appointments must be approved by the relevant local authority and, following a statutory amendment in 2011, by the Minster for Justice and Equality. The local authority does not have any involvement in the selection process as the person is paid directly by the individual coroner.

The study found that the deputy coroner is appointed and paid by the coroner in every coroner district except for the Dublin district. Here there is a sanctioned provision that the deputy coroner is paid by Dublin City Council.

To ensure continuity of the coroner role there are provisions in the 1962 Act whereby;

- under Section 13(4) (a) of the Act, a person appointed as a deputy coroner may act for the coroner in the event that the coroner is unable to carry out the function e.g. during the illness or absence of the coroner or where, for example, the office of the coroner is vacant and
- under Section 13(4) (b) of the Act, a deputy coroner, acting as a coroner, has all the duties and powers of a coroner.

The study found that all of the coroners appointed in an acting capacity had previously held the position of deputy coroner in the district. The appointment was made on the recommendation of the retiring coroner pending a selection process within the local authority.

The survey asked all local authorities to provide details of the payments (if any) to deputy coroners and in the case of three local authorities, it was noted that the deputy coroner was paid in addition to the coroner by the local authority. When it was subsequently verified it was found that the deputy coroner had been appointed in an acting capacity as coroner for a recent retirement and was therefore entitled to be paid by the local authority and not the coroner in those cases.

The survey found that there was limited information and guidance on the appointment and role of the deputy coroner for local authorities. When vacancies arise and to ensure continuity of service there may be circumstances in which the deputy coroner could be deployed outside the coroner district with paid fee income for cases dealt with, e.g. to cover leave and unplanned absences. Guidance on the role and development of deputy coroner would assist local authorities and could include details on when local authorities are required to pay deputy coroner remuneration and when it would be more appropriate for the deputy coroner to be paid by the coroner.

7.5 Arrangements for Dublin and Cork City

In the Republic of Ireland, there are two full time coroners in Dublin and Cork city. The fee amount paid per deaths reported to these full time coroners is fixed based on the number of reported deaths requiring an inquest in the year in their districts. As there is a higher volume of reported deaths dealt with in these districts, this requires a higher fixed retainer fee (Dublin: €27,595, Cork city: €44,152). The amount is sanctioned and agreed with the Department of Justice and Equality.

1. Arrangements in the Dublin district

The Dublin coroner district deals with approximately 30% of the cases in the country per section 6 'Coroner Annual Returns' as many cases from outside the capital are dealt with in Dublin if the person is transferred to a Dublin hospital prior to his/her death.

In June 2016 the agreed retainer fee for the temporary assignment of the Dublin coroner was €25,000 with a further fee per deaths reported based on the number of inquests held in the year. The total number of inquests held in 2016 was 670 (**2015**:615, **2014**:666).

It should be noted that the Dublin coroner service has a staff compliment of 14 employed by Dublin City Council working on behalf of the Dublin coroner. This district also has a separate Coroner Court and county mortuary and all costs associated with these facilities are paid for by Dublin City Council.

2. Arrangements in the Cork City district

In Cork city coroner district the increased retainer fee of €44,152 is sanctioned as it is required to cover the increased administrative functions in this district. Unlike the Dublin district there is no additional facilities of Coroner Court available and paid for by the local authority, and therefore the retainer fee is higher as a result.

8. Payments to Other Service Providers and State Agencies

8.1 Funeral and Undertaker Services

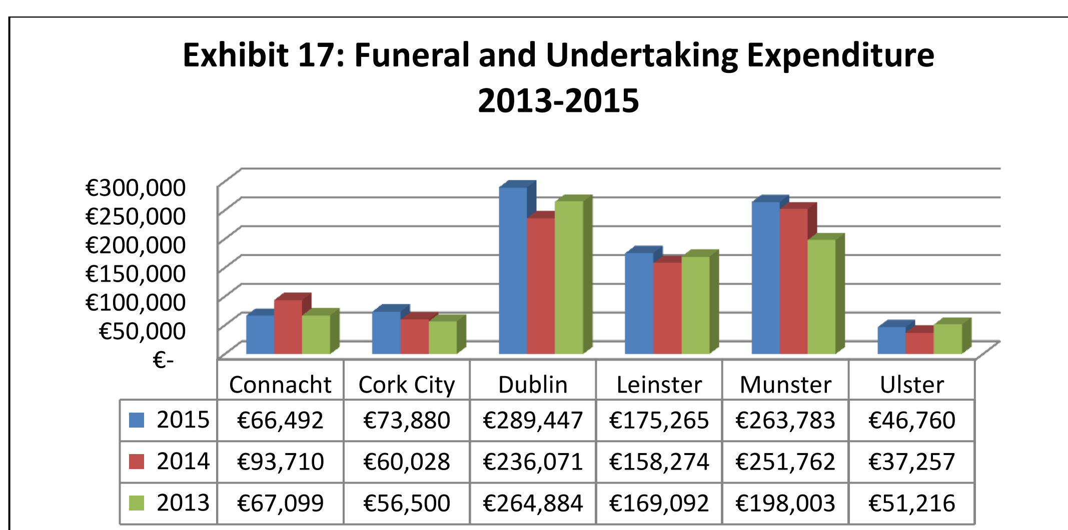
Coroners also engage funeral and undertaker service providers to transport the deceased to morgues and hospitals. As post mortem examinations are carried out on a regional hospital basis, not all coroners will have this facility in their district. In this instance, when a post mortem examination is required, coroners then make arrangements with funeral and undertaker service providers to ensure that the bodies are transferred to the nearest regional hospital for the examination. In some cases this can mean travelling outside the local authority area. This results in increased costs for funeral and undertaking services for the local authorities without a regional hospital.

Local authorities have discretion with regard to the fee/expenses paid for the removal /custody of a body, under the 2009 fee regulation. However the study found that there was a lack of consistency in the service provided to all local authorities with large variations in the amounts charged. When rates quoted were compared between each of the local authorities, they were not consistent with other undertakers throughout the country for similar work and shorter distances.

The Coroners Act 1962 (Fees and Expenses) Regulations 2009 (S.I. 155 of 2009) Part 2 Item 4 states that ;

'The expenses payable in connection with the removal or custody of a body shall be those which, in the opinion of the appropriate Local Authority are necessarily and reasonably incurred in such removal or custody in accordance with the direction of the Coroner'

The total expenditure relating to funeral and undertaking services for 2015 was €915,627 (**2014**: €837,102, **2013**: €806,794) and Exhibit 17 analyses this further by province as follows;



	Connacht	Cork City	Dublin	Leinster	Munster	Ulster
2015	€66,492	€73,880	€289,447	€175,265	€263,783	€46,760
2014	€93,710	€60,028	€236,071	€158,274	€251,762	€37,257
2013	€67,099	€56,500	€264,884	€169,092	€198,003	€51,216

Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report .

Source: Local Authorities survey questionnaire and transaction listing 2013-2015

8.2 Procurement of the Funeral and Undertaker Services

The study found that the total costs of providing funeral and undertaking services for the deaths reported to the coroner requiring postmortems were significant and increasing each year. With this escalation in costs, some local authorities sought the advice of the Department of Justice and Equality, Coroner Service Implementation Team (CSIT) on ways to achieve better value for money.

In January 2012, the CSIT issued a memorandum (Appendix 8) to all local authorities advising them to create a panel and, in which they recommended one of two options:

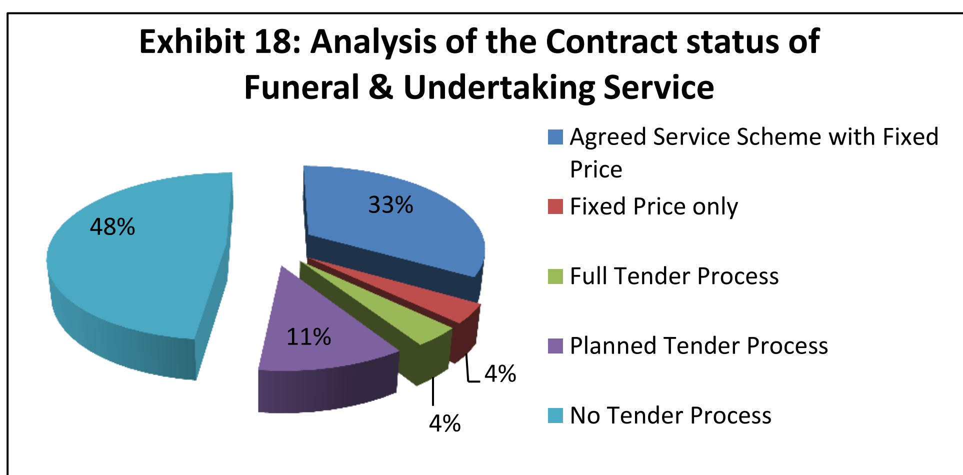
(i) **Agreed Service Providers** - Whereby local authorities write to all funeral undertakers in the county and inform them of the price that they are prepared to pay for the provision of the service. Invite the undertakers to indicate whether they are prepared to offer their service for this price and forward their names to An Garda Síochána for future use.

(ii) **Tender Competition** - Whereby local authorities hold a competitive process and tender for the provision of the service.

In order to comply with procurement and tendering rules[1], our study found that the memorandum should have stated that where the procurement threshold was exceeded then the local authority is required to tender for the service.

The survey asked all local authorities if this service was procured by them either in accordance with public procurement guidelines or based on the above memorandum. The vast majority of local authorities did not complete a full competitive tender, instead opting for an agreed service provider which is a non-competitive panel process, with a fixed price for some or all elements of the service.

Exhibit 18 sets out the current status of the funeral and undertaker contracts in the relevant local authorities for the years examined.



Source: Local Authorities survey questionnaire

[1] In accordance with National and EU Procurement rules and thresholds as regulated by the Office of Government Procurement (OGP) and outlined under Section B -04 of the Public Spending Code.

Over the three years examined, the aggregate of the total expenditure incurred exceeded the procurement threshold and there was a requirement to tender for the service. All local authorities, with the exception of one, were not in compliance with procurement and tendering rules for the level of expenditure incurred for the service.

There are only 27 local authorities with coroner districts and related funeral and undertaking expenditure. Exhibit 19 shows a breakdown of the responses on the contract status of the funeral and undertaking service from the relevant local authorities.

Exhibit 19: Contract status of the funeral and undertaking service

Provision of the service categories	No. of local authorities
Agreed service provided with fixed price for some elements of the service	9
Agreed service provided with fixed price for all of the service	1
Full tender process	1
Planned tender process	3
No tender process	13
Total	**27**

Source: Local Authorities survey questionnaire

The responses received from local authorities were examined further and there was a lack of consistency in the procurement and payments for the service in local authorities as follows:

a. Two local authorities were not charged for the funeral and undertaking service.
b. One local authority was not charged for the service in prior years but has only started to be invoiced since 2015.
c. Nine local authorities used a selection panel whereby the price is fixed for only part of the service and the part varied in each local authority.
d. The remaining local authorities have no tender process or fixed price selection panel for the provision of the service. However three local authorities stated that they plan to tender.

Good practice was identified in two local authorities as follows:

a. One local authority fixed the price and used a select panel and, as wait time was an issue, the local authority fixed the price based on an agreed mileage rate and not based on waiting time to reduce their costs further.
b. One local authority fully tendered for the service.

Recommendation 8 - Funeral and Undertaking Service
It is recommended that all local authorities comply with procurement and tendering rules for the provision of funeral and undertaking services in an open or restricted competition. (A restricted competitive process can be used where there is a particular specialist skill or expertise required to carry out the service).

8.3 Mortuary Facilities

Coroner post mortem examinations are completed on a regional hospital basis and receive referrals from a number of neighbouring coroner districts. The survey asked local authorities to provide information on the mortuary facilities and who provides the facility in their coroner district(s) and the cost of the service provided. All local authorities stated that the facilities were provided by local and specific hospitals.

In relation to the expenditure, it was found that the majority of local authorities did not incur any expenditure for mortuary facilities with the exception of Dublin and Cork city. In the case of Cork city, the study identified that there was an annual fixed payment paid to the HSE for the mortuary facilities in that district.

8.4 Pathologists

Healthcare facilities operated or funded by the HSE provide many of the core support services required by the Coroner Service. These can include mortuary and post mortem facilities, pathology, histology and hospital administration services and the provision of support to families. A coroner may direct a post mortem examination if the death is not immediately explicable, to help establish the cause of death. A post mortem examination directed by the coroner is a mandatory event and consent is not required by the family of the deceased. By contrast a post mortem requested by the next of kin at the hospital or by the hospital itself does require consent before it can be carried out.

The post mortem directed by the coroner is carried out by a pathologist who, although usually attached to a hospital, acts independently of the hospital as the 'coroner's agent' for the purposes of the post mortem. The pathologist is not contractually obliged to conduct coroner post mortems but does so on the basis of fees provided for under the Coroners Act 1962 (Fees and Expenses) Regulations 2009 (S.I. 155 of 2009).

The pathologist's invoices are approved by the coroner and then forwarded to the local authority for payment. The survey found that the majority of local authorities have a system whereby the coroner approves the invoices in advance, however this certification is only in relation to the post mortem carried out and not, that the amount charged is reasonable and correct. Our study found that there was no register of cases requiring post mortems or a reconciliation of the pathologists invoices submitted to the local authority.

This was due to the fact that there can be a considerable delay in the completion of a post mortem, which can mean that there is a delay in the receipt of the pathologists' invoice. In some instances the local authority are required to process invoices relating to cases over 3 to 6 months old and in some cases relating to the prior year. The study found that, in the area of pathology expenditure, many local authorities stated that they have no control over the amount charged nor have they any expertise in the area to query the amounts invoiced, particularly if there was a time delay, and a number of months' invoices are submitted together.

The study found that, given the time lapse between the payment to the coroner and the subsequent payment to the pathologist, there is a need for a register of the cases dealt with within each coroner district, which can be reconciled to the invoices received.

The survey asked all local authorities to provide information on the payments to the various pathologists. The responses received from local authorities were either not complete or left blank for total expenditure i.e. the rate per 2009 regulation was included but not the total amounts paid for the period or any analysis of the expenditure type.

In order to ascertain the actual expenditure for the years examined, the study reviewed the transaction listing provided for the majority of the local authorities surveyed. The study found that in relation to pathology services, there is a lack of consistency and standardisation of coding and classification in the financial system used in the majority of local authorities. It was difficult to identify the individual pathologists that were paid in each local authority for the periods. While a significant amount of local authorities use the same financial management system, Agresso, the classification and coding of the expenditure categories did not allow for the extraction of the pathologists costs. For this reason, the study found that it is difficult to identify with accuracy the total amount of expenditure incurred for pathology services.

The study also found that, in the majority of local authorities, it was usual for the invoice to be received from an individual pathologist working on behalf of the coroner to complete the post mortem. However in one local authority this was not the case, in this local authority the hospital billed for the pathology service.

Exhibit 20 below sets out the estimated expenditure paid to the various pathologists providing this service to coroners based on the annual returns report of the number of deaths requiring post mortem and inquests for each of the three years.

Exhibit 20: Estimated Pathologists Costs based on Annual Returns 2013 -2015

Category	Rate per Regulation €	2015		2014		2013	
		No of Cases	Total €	No of Cases	Total €	No of Cases	Total €
Certifying death following **post mortem**	321.40	2,261	726,685	2,185	702,259	2,154	692,296
Certifying death following **post mortem & inquest**	535.68	1,431	766,558	1,387	742,988	1,486	796,020
Sub Total Excluding Dublin			**1,493,243**		**1,445,247**		**1,488,316**
Dublin Coroner District							
Certifying death following **post mortem**	321.40	1,305	419,427	1,236	397,250	1,309	420,712
Certifying death following **post mortem & inquest**	535.68	615	329,443	666	356,763	601	321,944
Dublin Total			**748,870**		**754,013**		**742,656**
% of the Overall Total			**33%**		**34%**		**33%**
Overall Total Including Dublin			**2,242,113**		**2,199,260**		**2,230,972**

Source: Department of Justice and Equality - Coroner Annual returns 2014- 2015

In the case of pathologist's fees, the issue is the contractual status that pathologists have with the HSE while also billing the local authorities for the service. This practice should be reviewed to ascertain if the service has already been paid for through their employment contract status with the HSE.

Recommendation 9 - Pathology Services - Financial Management System
Based on the findings in this study in relation to pathology services, there is a lack of consistency and standardisation of coding and classification in the financial system used in the majority of local authorities. For this reason, the study found that it is difficult to identify with accuracy the total amount of expenditure incurred for pathology services. It is recommended that the coding of the expenditure is reviewed to provide improved analysis of the costs incurred for pathology and other services and to monitor the budget of coroner related expenditure to achieve greater value for money.

Recommendation 10 - Pathology Services - Standard Template Invoice
In line with recommendation 3, it is recommended that a standard template invoice, on which fee income is paid to pathologists, should be created. The invoice should contain details of the post mortem with the unique case number, created initially by the coroner on report of death and order of the post mortem. It should be verifiable to the annual returns submitted by each coroner to the Minister for Justice and Equality, as required under the 1962 legislation. This would ensure that the payments to the pathologist are for cases dealt with by the relevant coroner and are complete and accurate in accordance with the fees regulation currently in place. It would provide a tracking facility for the paying authority where there is a time lag between the reported death, post mortem and subsequent inquest.

Recommendation 11 - Pathology Services - Memorandum of Understanding
It is recommended that the Department of Justice and Equality, consult with coroners and the HSE to create a suitable memorandum of understanding for coroners in their districts for the provision of pathology services. This would ensure that all of the requirements for a quality service are included in the memorandum and better value for money achieved as a result.

8.5 The State Laboratory

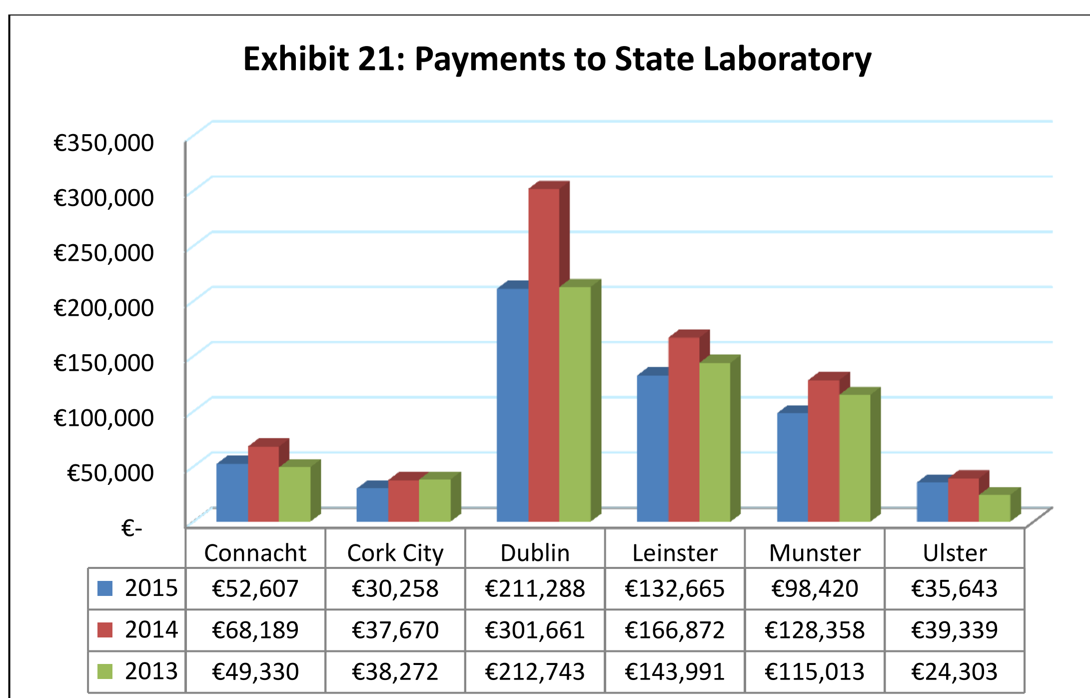
The State Laboratory provides a forensic toxicology service to assist coroners and the State Pathologist to investigate the causes of unexpected death. The agency undertakes chemical analyses for a variety of different purposes which include toxicology testing. This testing analyses samples for the presence of alcohol and drugs, assisting the coroners to determine the cause of death, e.g. in cases of alcohol / drug overdoses.

The Coroners Act 1962 (Fees and Expenses) Regulations 2009 (S.I. 155 of 2009) provides that the fee payable to a person assisting with a postmortem examination which applies to the State Laboratory is set out under Part 1 Section 3(d) as follows:

*"(d) for special laboratory examinations (including histological, micro bio-logical, toxicological, and biochemistry tests) in respect of each hour or part of an hour be €24"***.**

The survey asked all local authorities to provide the total amount of State Laboratory expenditure for the three years to 31 December 2015. Our study examined the payments in detail and compared the payments in each of the three years from the individual local authorities.

The total amount for 2015 is €560,881 (**2014**:€742,089, **2013**:€583,652) and Exhibit 21 below shows a breakdown by province for all of the local authorities.



	Connacht	Cork City	Dublin	Leinster	Munster	Ulster
2015	€52,607	€30,258	€211,288	€132,665	€98,420	€35,643
2014	€68,189	€37,670	€301,661	€166,872	€128,358	€39,339
2013	€49,330	€38,272	€212,743	€143,991	€115,013	€24,303

Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report .

Source: Local Authorities survey questionnaire and transaction listing 2013-2015

When the amounts are analysed further, the data showed that over the three years there is a large increase in 2014 and this was explained. It was due to a backlog following a change in the processing

of coroner samples, see extract from the State Laboratory Annual Report 2014 and Strategy Statement 2015-2017.

According to the State Laboratory Annual Report 2014 *"The Laboratory's other major clients are the Coroners and the Office of the State Pathologist. The new regime introduced in 2013, whereby all Coroners' samples are now submitted directly to the State Laboratory for both screening and confirmatory toxicology analysis, resulted in a large backlog of samples being carried into 2014. This backlog was cleared early in 2014 and agreed turn-around-times were met for all Coroners' samples submitted during the year. This new streamlined arrangement has resulted in a much improved and timelier service overall for the Coroners".*

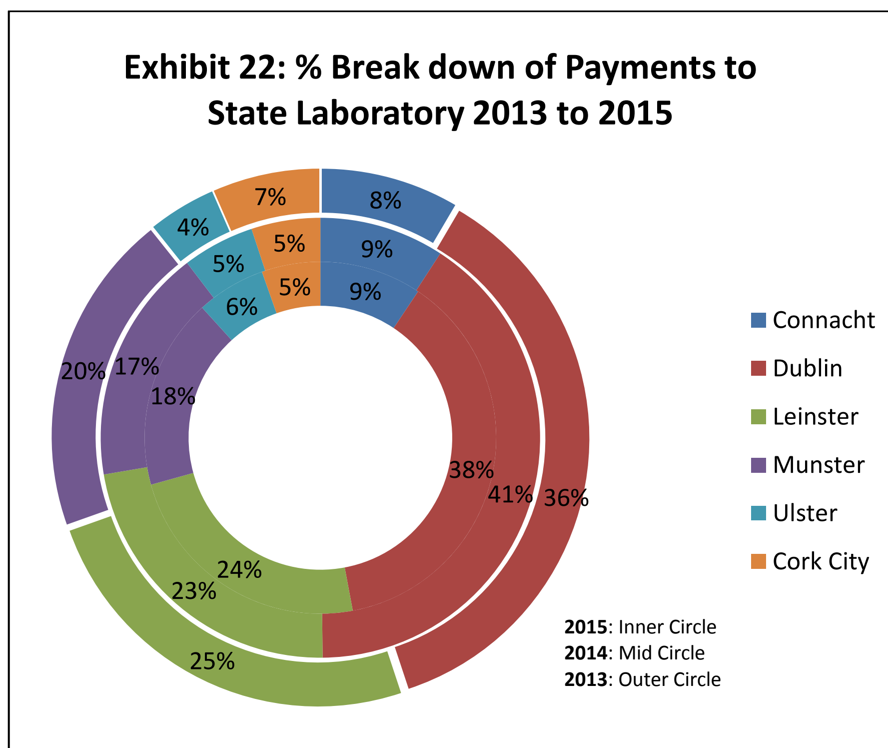
According to the State Laboratory Strategy Statement 2015 – 2017, the State Laboratory have stated that, "*regarding the quality and efficiency of the service provided to the Coroners and the Office of the State Pathologist, their main priority is to have the currently agreed turnaround times reduced.*

Following a greater than 40% increase in annual sample numbers since 2012 which have now stabilised, this will enable the Laboratory to focus on streamlining processes to

- *Reduce turnaround times to acceptable levels*
- *Provide a comprehensive forensic toxicology service to public sector clients*
- *Keep abreast of emerging illicit drug use trends and adapt testing protocols accordingly*
- *Reduce turnaround times to meet client requirements."*

When payments made to the State Laboratory were analysed further in Exhibit 22 below, it highlights that, while there was an increase in expenditure in 2014 for all districts, there was very little fluctuation in the overall percentage breakdown for each location over the three years.

Exhibit 22 below shows that the vast proportion of State Laboratory expenditure was incurred in the Dublin and Leinster regions with 62% of the costs in 2015 (**2014**:64%, **2013**:61%), while the remaining 38% (**2014**:36%, **2013:**39%) of costs are incurred for the rest of the country.



Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report .

Source: Local Authorities survey questionnaire and transaction listing 2013-2015

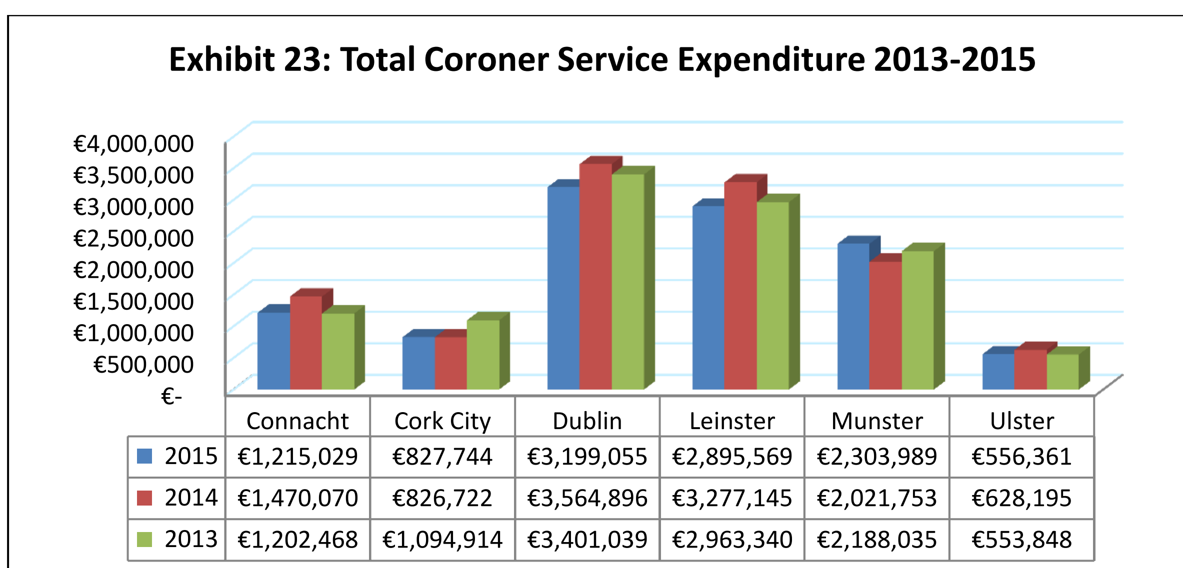
Recommendation 12 - State Laboratory Expenditure - Centralised Service
It is recommended that payment arrangements for this service should be centralised within a shared service to achieve better value for money, rather than through individual local authorities. Based on the findings in this study in relation to the payments to the State Laboratory there is a considerable amount of expenditure incurred for pathology and toxicology testing for local authorities. It is also recommended that in consultation with the service provider the relevant shared service should create a suitable service level agreement or memorandum of understanding for coroners in local authority districts. This would ensure that all of the requirements for a consistent quality service would be included as part of the agreement and better value for money should be achieved as a result.

9. Total Coroner Expenditure Incurred in Local Authorities

9.1 Annual Financial Statements

Total coroner and related expenditure is disclosed in the financial statements of local authorities under the 'Miscellaneous Services division H05', and the expenditure is recorded in a single line item.

The gross expenditure incurred by local authorities in 2015 was €11.00m (**2014**: €11.79m, **2013**: €11.40m). However income of €1.19m was recouped from four local authorities for their contribution to the Coroner Service and, when deducted, the net expenditure incurred by local authorities in 2015 was €9.81m (**2014**: €10.36m, **2013**: €10.32m). This amount includes administration costs of the local authorities, undertaker's fees and pathologist fees. Exhibit 23 below details out this expenditure by province as follows:



	Connacht	Cork City	Dublin	Leinster	Munster	Ulster
2015	€1,215,029	€827,744	€3,199,055	€2,895,569	€2,303,989	€556,361
2014	€1,470,070	€826,722	€3,564,896	€3,277,145	€2,021,753	€628,195
2013	€1,202,468	€1,094,914	€3,401,039	€2,963,340	€2,188,035	€553,848

Data is summarised on a provincial basis for display purposes only and are not based on regional coronial districts or jurisdictions - Full analysis by local authority is included in the Appendices of the report .

Source: Local Authorities survey questionnaire and transaction listing 2013-2015

The study examined the recoupment arrangement with four local authorities as highlighted above and sought to ascertain what the annual amount recouped was based on. The fixed annual payment was an estimated budget amount which was not reflective of actual coroner related expenditure or activity in the period.

As part of the survey questionnaire, all 31 local authorities were asked to provide the transaction listing for coroner related expenditure for each of the three years to 31 December 2015. The study found that the transactions were not coded or analysed in a standardised format to identify coroner related expenditure in the Coroner Service. It was difficult to extract out some of the data under each category of expenditure or identify certain suppliers for services provided, particularly in the case of individual pathologists, funeral directors and undertakers. With the assistance of the Local Government Auditor in each local authority, additional financial analysis for the individual categories of expenditure was obtained. This data was analysed and included in the Appendices of the report.

The study found that, apart from the CSIT in the Department of Justice and Equality, it was difficult to identify a contact person in the local authorities dealing with the Coroner Service to respond to our queries. This was noted when sending information requests on some of the transactions recorded. In each local authority, there were many different sections including HR/Payroll, Finance and Corporate Services dealing with various aspects of the Coroner Service and the administration of some of the payments was not consistently applied and varied between local authorities.

Local authorities perform functions across a wide range of divisions with numerous additional roles and activities and the Coroner Service is only a small percentage of the overall budget that local authorities manage. It is in this context that the study found that local authorities did not have a contact person with sole responsibility for the Coroner Service. Staff are assigned to core functions in priority areas and this means that the finance, payroll and HR functions are tasked with the role in additional to their other functions as needs arise.

As staff have been reallocated or reassigned to other priority areas in the local authority the knowledge base for the Coroner Service has been eroded, particularly in the interpretation of the current legislation and regulations in operation. This was evident in the questionnaire responses that some local authorities were not aware how their coroner was appointed or the specific appointment date of the coroner as they all were appointed a number of years earlier.

In order to build expertise and a stronger knowledge base the study recommends that the Coroner Service should be considered as a shared service. This will enable an assigned contact liaison person for the administrative support of the appointed coroners and ensure better coordination of the service and service providers with improved financial information on related expenditure. It would also provide greater liaison with the Department of Justice and Equality on specific legislative and fee regulation matters arising on the service.

Recommendation 13 - Overall Coroner Expenditure - Financial Management System
It is recommended that local authorities should review their financial IT systems to provide better analysis and coding of the expenditure relating to the overall cost of the Coroner Service and this will ensure that the local authorities will be in a position to monitor the coroner expenditure and budgets to achieve better value for money.

Recommendation 14 - Coroner Service - Shared Service
It is recommended that the Coroner Service should be considered as a shared service with a central lead local authority paying for all coroner related expenditure. This single point of contact would provide standardised practices for payments to coroner and other service providers with improved financial information on coroner related expenditure. The arrangements for some local authorities for the recoupment of coroner related expenditure could be updated with this improved financial information. This would provide additional administrative support to the coroner in the performance of their duties and ensure better coordination of the service and service providers and greater liaison with the Department of Justice and Equality on specific matters arising on the service.

10. Other Jurisdictions

It is outlined below for comparative purposes how other jurisdictions operate their Coroner Service. Historically, the Irish coronial system was based on the English system. The 2003 Luce Report was published following a review of coroner services in England, Wales and Northern Ireland. The report suggested radical reform with the following changes:

- a consistent professional service, based on full-time leadership is required
- consistency of service to families underpinned by a Family Charter
- a proper recognition of the work of coroner's officers.

10.1 Northern Ireland

In Northern Ireland, the Coroner Service is legislated under the Coroners Act 1959 and this Act has mostly remained unchanged since then despite the reforms envisaged under the Luce Review Report in 2003.

In April 2006, the Coroner Service in Northern Ireland was centralised and in the absence of the introduction of new legislation, following consultation with key stakeholders, the service implemented a number of changes to improve the system as follows:

- created a single coroner jurisdiction for Northern Ireland
- provided an improved service to the public with improved family liaison, enhanced administration and information technology, better public relations court hearings, training for coroners and liaison between the Coroner Service and other agencies
- established the role of the Coroner Liaison Officer
- established protocols with other agencies
- improved the availability of management information
- introduced the Coroner Service inspectorate
- planned future policy on the reform of the Coroner Service.

In 2015 a review of the Coroner Service for Northern Ireland was carried out and the report made a number of recommendations as follows:

- improving the timeliness and consistency on how cases proceed through the coronial system with better definitions on how deaths should be investigated
- addressing the areas of duplication and confusion between coroners and other investigating authorities
- ensuring effective information provision by strengthening the use of memoranda of understanding
- ensuring that a presiding judge has a clear oversight role.

Staffing

The Coroner Service in Northern Ireland was centralised in 2006 with a new staffing and judicial structure and the introduction of the role of Coroner Liaison Officer. There is no statutory maximum number of coroners. In 2015/16 there were 3,895 deaths reported (2014/15: 4,006 deaths).

Number of reported deaths

Exhibit 24 below sets out the number of cases reported to the coroner for each of the two years 2015 and 2014 with a comparison for each. This data was used to compare with the cases dealt with in the Republic of Ireland. See section 6 'Annual Returns' Exhibit 12. As noted earlier, the number of inquests held in Northern Ireland is much lower than in the Republic of Ireland as there is greater discretion by the coroner on whether or not to hold an inquest than in the Republic of Ireland.

Exhibit 24: Analysis of Northern Ireland Coroner Cases 2015/16 – 2014/15

Northern Ireland Coroner Cases	2015/16	2014/15	% Increase /decrease
No. of deaths reported to the coroner	3,895	4,006	-3%
No. of cases that did not require a post mortem	2,083	2,014	3%
No. of post mortems held	1,149	1,092	5%
% of post mortems per deaths reported	29.5%	27.3%	
No. of inquests held	85	115	-26%
% of inquests per deaths reported	2%	3%	
No. of other disposals	564	691	-18%

Source: Northern Ireland Courts and Tribunals Service Annual Report and Accounts 2015-16

Performance Measurement

According to the Northern Ireland Courts and Tribunals Service Annual Report and Accounts 2015-16 the following performance indicators are used to facilitate the efficient completion of Coroner Service business and these are set out in Exhibit 25.

Exhibit 25: Performance measurement indicators target versus achieved 2015/16

Northern Ireland Coroner Service Business	% Target	% Achieved 2015/16
All deaths investigated that do not require a post mortem examination will have the certificate of registration issued to the Registrar of Deaths **within three working days** of the death being reported to the Coroner	97	100
All deaths where a post mortem examination reveals a natural cause of death will have the certificate of registration issued to the Registrar of Deaths **within five working days** of receipt of the post mortem report	92	97
All inquests will have administrative listing arrangements completed **within 28 days** of the Coroner's direction to list	92	100

Source: Northern Ireland Courts and Tribunals Service Annual Report and Accounts 2015-16

10.2 England and Wales

The reforms envisaged under the Luce Review Report in 2003 were legislated for under the 2009 Coroners Act. However it has taken some time for these reforms to be implemented under this Act as the process was only completed in July 2013. The English and Welsh coroner service is still funded through local authorities however the system differs from the Republic of Ireland and Northern Ireland.

The English and Welsh coroner system provides for a Chief Coroner position to provide judicial oversight of the coroner system, leadership, guidance and support to coroners. The Chief Coroner also publishes an annual report which is laid before Parliament. As at July 2016 there have been three reports issued covering the periods 2013/2014 to 2015/2016.

There are currently 97 coroner areas, with 91 senior coroners and 380 assistant coroners (part-time). The English and Welsh coroner service dealt with 236,406 reported deaths in 2015 (**2014**: 223,841, **2013**: 227,984) compared to only 16,815 reported deaths in Ireland for 2016 (**2015:** 16,756, **2014**: 15,833, **2013**: 16,182).

Similar to the amalgamation of coroner districts in the Civil Law Reform (Miscellaneous Division) 2011 in Ireland, the 2014 Chief Coroner report stated that, "under the reform process in England and Wales, it will be necessary to reduce their coroner areas to about 75 from their current coroner areas of 97." This reduction is based on the principle that each coroner area should deal with approximately 3,000-5,000 deaths each year in order to continue to be considered a coroner area.

There are also 450 coroner officers in England and Wales. These coroner officers act as a representative of a coroner in the investigation of a death and will liaise with relatives. There are no coroners officers in Ireland but an informal reliance is placed by coroners on local Gardaí who perform limited functions on behalf of the coroner.

The Chief Coroner has proposed setting salaries for coroners in England and Wales after a survey revealed highly variable figures and diverse payment arrangements. Currently each coroner and each relevant local authority may agree any level of remuneration that they choose without reference to any national scale.

The Annual Report of the Chief Coroner for England and Wales provides a comprehensive schedule of all the cases of reported deaths in each of the English and Welsh regions. For each of the reports issued by the Chief Coroner, data is provided which includes a number of interesting statistics of reported deaths and the circumstances e.g. death in custody etc. It includes a number of comparable data and percentages. This information would be useful in local authorities for management and budgetary purposes; however it is not currently available in the Republic of Ireland.

This study analysed the data for each of the three years to 2015 and Exhibit 26 was compiled below for each of the UK coroner regions with data included for the Republic of Ireland as follows:

Exhibit 26: Total No. of Reported deaths in England and Wales

Coroner Regions	2015	2014	2013
ENGLAND			
EAST MIDLANDS	22,383	21,198	22,067
EAST OF ENGLAND	23,378	21,275	21,523
LONDON	21,119	21,123	22,129
NORTH EAST	13,789	12,102	12,055
NORTH WEST	34,915	33,319	33,544
SOUTH EAST	34,920	32,654	33,155
SOUTH WEST	25,173	24,190	24,181
WEST MIDLANDS	25,481	23,748	24,823
YORKSHIRE AND THE HUMBER	21,016	20,032	20,009
WALES	**14,232**	**14,200**	**14,498**
Total England & Wales	**236,406**	**223,841**	**227,984**
Republic of Ireland	**16,756**	**15,833**	**16,182**

Source: UK -Chief Coroner Third Annual Report England & Wales 2015/16
Source: IRL - Department of Justice and Equality

11. Implementation of Recommendations

The Value for Money Unit will carry out a follow up report within an agreed timeframe on the implementation, by local authorities, of recommendations and reforms relevant to them as set out in this report to ensure that findings have been successfully implemented.

12. Acknowledgement

The LGAS would like to thank the following for their cooperation and advice during the course of this VFM study on the Coroner Service in local authorities;

- The local authorities - Human Resources /Payroll/Corporate affairs /Accounts payable
- The local authorities visited and the personnel consulted
- The Department of Justice and Equality - Civil Law and Administration section personnel consulted
- Local Government Auditors in each local authority
- Department of Housing, Planning and Local Government, Local Government Finance Division and personnel consulted
- The VFM Advisory Committee established for this study.

References

Sources

Report of the Working Group (Dept. of Justice Equality and Law Reform).

www.coroners.ie

Local Authority Budgets 2014 -2016

Amalgamated AFS 2012 - 2015

www.coronersociety.org.uk

England and Wales Coroners 2014 Annual Report

Review of the Coroner Service for Northern Ireland

Luce Report

Enacted Legislation

Coroners Act 1962 http://www.irishstatutebook.ie/eli/1962/act/9/enacted/en/

Coroners Amendment Act 2005 http://www.irishstatutebook.ie/eli/2005/act/33/enacted/en

Coroners Act 1962 (Fee and Expenses) Regulations 2009 (SI 155 of 2009)
http://www.irishstatutebook.ie/eli/2009/si/155/made/en

Civil Law (Miscellaneous Provisions) Act 2011 (Part 9)
http://www.irishstatutebook.ie/eli/2011/act/23/enacted/en

Proposed Legislation

Coroners Bill 2007

Coroners Bill 2015

Coroners (Amendment) Bill 2017

Appendices

1. List of Coroner Districts
2. Annual Returns of Reported Deaths 2015-2016
3. Local Authority Adopted Budget 2014-2016
4. Local Authority Actual Expenditure 2013-2015
5. Coroner Retainer Fees paid 2012-2015
6. Coroner Fees paid for Death Reports 2013-2015
7. Funeral and Undertaking Expenditure 2013-2015
8. Extract from the Department of Justice and Equality memorandum re funeral and undertaking procurement
9. State Laboratory Expenditure 2013-2015

Appendix 1

List of Coroner Districts *

Local Authority	Coroner District	Local Authority	Coroner District
Carlow County Council	Carlow	Limerick City and County Council	Limerick SE Limerick
Cavan County Council	Cavan	Louth County Council	Louth
Clare County Council	Clare	Longford County Council	Longford
Cork County Council	Cork South Cork North Cork West	Mayo County Council	Mayo East Mayo North Mayo South
Cork City Council	Cork Co. Borough	Meath County Council	Meath
Donegal County Council	Donegal	Monaghan County Council	Monaghan South Monaghan North
Dublin City Council	Dublin	Offaly County Council	Offaly
Galway County Council	Galway East Galway North Galway West	Roscommon County Council	Roscommon
Kerry County Council	Kerry North Kerry SE Kerry West	Sligo County Council	Sligo/Leitrim
Kildare County Council	Kildare	Tipperary County Council	Tipperary North Tipperary South
Kilkenny County Council	Kilkenny	Waterford City & County Council	Waterford City Waterford East Waterford West
Laois County Council	Laois	Westmeath County Council	Westmeath
Leitrim County Council**	Sligo/Leitrim**	Wexford County Council	Wexford
		Wicklow County Council	Wicklow East Wicklow West
***Each Coroner district has one coroner and one deputy coroner** ****Combined with Sligo as deemed too small to have a county coroner district**			

Source: Department of Justice - www.coroners.ie

Appendix 2

Annual Returns of Reported Deaths 2015 -2016

Coroner Districts	Deaths Reported	Post Mortems	Inquests	Total	Deaths Reported	Post Mortems	Inquests	Total
	2016				2015			
Carlow	115	29	28	172	153	14	31	198
Cavan	143	44	35	222	154	43	29	226
Clare	386	49	43	478	360	57	46	463
Cork Co. Borough	637	208	253	1098	590	148	207	945
Cork North	262	38	16	316	206	36	40	282
Cork South	439	92	55	586	392	81	53	526
Cork West	173	24	24	221	132	25	24	181
Donegal	710	90	79	879				
Donegal NE					94	18	23	135
Donegal NW					203	34	23	260
Donegal SE					303	32	33	368
Donegal SW					72	9	5	86
Dublin	2,970	1,195	670	4,835	3,054	1,305	615	4,974
Galway East	233	83	14	330	236	74	36	346
Galway North	69	27	11	107	59	31	0	90
Galway West	458	145	86	689	495	150	110	755
Kerry North	58	20	6	84	74	14	6	94
Kerry South East	206	47	28	281	168	28	11	207
Kerry West	152	71	37	260	195	69	39	303
Kildare	388	99	52	539	380	94	67	541
Kilkenny	277	87	30	394	249	76	28	353
Laois	101	45	28	174	118	48	35	201
Leitrim	75	22	12	109	87	17	8	112

Appendix 2 (cont'd)

Coroner Districts	Deaths Reported	Post Mortems	Inquests	Total	Deaths Reported	Post Mortems	Inquests	Total
	2016				2015			
Limerick City & County	94	44	16	154	65	35	18	118
Limerick SE	313	69	31	413	302	83	37	422
Limerick West					125	6	24	155
Longford	83	19	9	111	76	30	11	117
Louth	207	104	61	372	241	120	44	405
Mayo East	71	16	4	91	28	10	3	41
Mayo North	64	18	27	109	80	23	16	119
Mayo South	150	71	65	286	187	115	50	352
Meath	248	55	46	349	44	243	37	324
Monaghan North	35	4	13	52	46	8	2	56
Monaghan South	54	16	6	76	43	6	12	61
Offaly	209	26	16	251	203	30	18	251
Roscommon	175	0	55	230	172	0	76	248
Sligo	194	89	26	309	193	68	23	284
Tipperary North	219	31	27	277	186	31	19	236
Tipperary South	209	52	30	291	220	60	46	326
Waterford City	216	85	29	330	162	95	20	277
Waterford East	134	15	16	165	118	14	19	151
Waterford West	18	8	7	33	27	12	5	44
Westmeath	230	30	35	295	246	47	25	318
Wexford	411	65	49	525	385	69	33	487
Wicklow East	184	43	28	255	179	47	27	253
Wicklow West	49	12	6	67	42	11	12	65
Total	**11,419**	**3,287**	**2,109**	**16,815**	**11,144**	**3,566**	**2,046**	**16,756**

Source: Department of Justice - www.coroners.ie

Appendix 3

Local Authority Adopted Budget 2014-2016

City & County Councils	Budget 2016		Budget 2015		Budget 2014	
	Expenditure €	Income €	Expenditure €	Income €	Expenditure €	Income €
Carlow County Council	90,076	0	88,013	0	88,226	0
Cavan County Council	155,299	860	154,115	922	119,029	900
Clare County Council	211,366	4,102	210,573	4,439	210,466	4,439
Cork City Council	847,700	2,700	871,300	2,800	864,800	2,800
Cork County Council	598,641	0	603,697	410	602,271	410
Donegal County Council	308,048	466	304,924	454	305,651	454
Dublin City Council	3,357,991	1,100,000	3,305,579	1,100,000	3,622,532	1,100,000
Dún Laoghaire-Rathdown County Council	350,568	0	392,609	0	331,346	0
Fingal County Council	420,662	0	440,631	0	441,000	0
Galway City Council	180,000	0	180,000	0	180,000	0
Galway County Council	496,000	180,000	496,000	180,000	496,000	180,000
Kerry County Council	337,725	419	334,511	434	384,393	434
Kildare County Council	315,202	935	310,861	834	307,493	834
Kilkenny County Council	141,600	0	151,200	0	73,900	0
Laois County Council	101,486	958	113,246	916	112,868	916
Leitrim County Council	74,801	337	59,124	326	52,060	326
Limerick City & County Council	423,880	4,325	403,586	8,936	425,633	8,936
Longford County Council	72,662	694	66,620	705	66,854	705
Louth County Council	217,262	1,297	234,712	2,252	217,611	2,252
Mayo County Council	234,096	170	234,164	167	238,167	167
Meath County Council	195,939	848	194,937	817	148,578	817
Monaghan County Council	91,245	0	93,403	0	123,349	0
Offaly County Council	148,442	0	151,737	0	152,191	0
Roscommon County Council	143,380	597	146,100	600	141,317	600
Sligo County Council	176,747	1,274	198,892	1,308	196,510	1,308
South Dublin County Council	350,100	0	305,300	0	450,200	0
Tipperary County Council	299,889	2,404	334,662	2,344	332,018	2,344
Waterford City & County Council	223,377	0	253,555	3,773	190,874	2,872
Westmeath County Council	224,248	1,424	228,286	1,672	220,001	1,672
Wexford County Council	221,842	980	214,001	767	206,375	875
Wicklow County Council	195,076	3,576	175,375	3,373	177,764	3,373
Total	**11,205,350**	**1,308,366**	**11,251,713**	**1,318,249**	**11,479,477**	**1,317,434**

Source: Local Authorities Annual Budgets

Appendix 4

Local Authority Actual Expenditure 2013-2015

City & County Councils	2015		2014		2013	
	Expenditure €	Recouped from other Local Authorities €	Expenditure €	Recouped from other Local Authorities €	Expenditure €	Recouped from other Local Authorities €
Carlow County Council	91,973		100,152		106,113	
Cavan County Council	121,910		136,644		116,264	
Clare County Council	224,204		195,071		208,464	
Cork City Council	827,744		826,722		1,094,914	
Cork County Council	604,182		594,349		531,640	
Donegal County Council	337,108		368,627		308,239	
Dublin City Council	3,199,055	1,007,537	3,564,896	1,248,154	3,401,039	916,711
Dún Laoghaire-Rathdown County Council	218,482		392,651		294,527	
Fingal County Council	404,921		405,342		368,232	
Galway City Council	180,000		183,966		170,000	
Galway County Council	409,012	180,000	445,288	183,966	403,676	170,000
Kerry County Council	346,842		374,814		468,938	
Kildare County Council	310,356		302,276		310,151	
Kilkenny County Council	169,097		161,301		229,913	
Laois County Council	112,544		111,630		119,004	
Leitrim County Council	73,342		62,413		62,087	
Limerick City & County Council	554,214		343,558		350,292	
Longford County Council	81,141		77,720		77,969	
Louth County Council	274,947		242,095		224,737	
Mayo County Council	252,541		258,024		248,268	
Meath County Council	175,374		245,393		196,706	
Monaghan County Council	97,343		122,924		129,345	
Offaly County Council	137,928		141,733		156,616	
Roscommon County Council	140,339		145,826		149,075	
Sligo County Council	159,795		374,553		169,362	
South Dublin County Council	384,134		450,161		253,952	
Tipperary County Council	275,117		236,978		327,192	
Waterford City & County Council	299,430		276,983		301,509	
Westmeath County Council	165,153		260,374		254,726	
Wexford County Council	192,931		216,450		197,248	
Wicklow County Council	176,588		169,867		173,446	
Total	**10,997,747**	**1,187,537**	**11,788,781**	**1,432,120**	**11,403,644**	**1,086,711**

Source: Local Authorities Annual Financial Statements

Appendix 5

Coroner Retainer Fees paid 2012- 2015

City and County Councils	No of Coroners June 2016	2015 €	2014 €	2013 €	2012 €
Carlow County Council	1	17,932	17,932	17,932	17,932
Cavan County Council	1	17,871	17,871	18,558	17,932
Clare County Council	1	21,774	21,774	21,774	21,774
Cork County Council	2	61,480	61,480	61,480	61,480
Cork City Council	1	44,152	44,152	44,152	44,152
Donegal County Council	1	50,725	57,179	58,382	56,353
Dublin City Council	1	27,595	27,595	27,595	27,595
Galway County Council	3	56,365	56,365	56,365	56,365
Kerry County Council	2	42,111	42,103	42,757	48,671
Kildare County Council	1	21,774	21,774	21,774	21,774
Kilkenny County Council	1	20,032	20,032	20,032	20,032
Laois County Council	1	17,870	17,870	17,870	17,870
Leitrim County Council	0.5	12,186	12,186	12,656	12,807
Limerick City & County Council	2	34,581	34,581	34,581	47,388
Longford County Council	1	12,871	12,871	12,871	12,871
Louth County Council	1	21,774	21,774	21,774	21,774
Mayo County Council	3	47,388	47,388	47,388	47,388
Meath County Council	1	21,774	21,774	21,774	21,774
Monaghan County Council	2	25,614	25,614	25,614	25,614
Offaly County Council	1	21,774	21,774	21,774	21,774
Roscommon County Council	1	17,932	17,932	17,932	17,932
Sligo County Council	0.5	21,774	21,774	21,774	21,774
Tipperary County Council	2	43,548	43,548	43,548	43,548
Waterford City & County Council	3	43,109	43,109	43,109	43,546
Westmeath County Council	1	17,932	17,932	17,932	17,932
Wexford County Council	1	22,178	19,473	17,081	21,774
Wicklow County Council	2	30,739	30,739	30,739	30,739
Total	**38**	**794,855**	**798,596**	**799,218**	**820,565**

Source: Local Authority Survey Questionnaire

Appendix 6

Coroner Fees Paid for Death Reports 2013- 2015

City and County Councils	2015 €	2014 €	2013 €
Carlow County Council	30,631	35,414	32,323
Cavan County Council	46,778	51,800	36,533
Clare County Council	82,212	71,976	69,472
Cork County Council	227,241	180,454	141,428
Cork City Council	212,540	203,005	211,882
Donegal County Council	153,880	128,906	122,941
Dublin City Council	263,577	263,577	263,577
Galway County Council	206,785	231,729	215,538
Kerry County Council	112,677	128,547	101,815
Kildare County Council	102,240	114,185	96,179
Kilkenny County Council	61,262	52,894	57,251
Laois County Council	35,152	32,494	32,200
Leitrim County Council	22,593	16,798	24,658
Limerick City & County Council	186,274	117,188	104,153
Longford County Council	17,128	21,911	16,374
Louth County Council	161,716	99,705	77,294
Mayo County Council	88,805	103,126	108,571
Meath County Council	64,388	73,077	58,164
Monaghan County Council	26,073	26,839	26,277
Offaly County Council	45,052	42,052	48,559
Roscommon County Council	62,051	36,666	42,533
Sligo County Council	90,304	33,010	63,081
Tipperary County Council	94,158	84,758	79,327
Waterford City & County Council	77,909	80,768	78,664
Westmeath County Council	54,591	57,061	56,796
Wexford County Council	86,537	94,331	64,605
Wicklow County Council	50,212	43,471	56,815
Total	**2,662,766**	**2,425,742**	**2,287,010**

Source: Local Authority Survey Questionnaire

Appendix 7

Funeral & Undertakers Expenditure 2013- 2015

City and County Councils	2015 €	2014 €	2013 €
Carlow County Council	17,640	23,314	17,463
Cavan County Council	10,295	8,310	12,192
Clare County Council	39,795	24,898	30,958
Cork County Council	99,690	85,440	91,100
Cork City Council	73,880	60,028	56,500
Donegal County Council	16,488	15,785	14,790
Dublin City Council	289,447	236,071	264,884
Galway County Council	11,821	12,981	8,439
Kerry County Council	33,720	28,980	34,385
Kildare County Council	31,611	23,317	21,394
Kilkenny County Council	14,440	15,005	11,407
Laois County Council	690	4,020	2,740
Leitrim County Council	11,060	13,850	9,355
Limerick City & County Council	35,695	28,980	29,575
Longford County Council	30,970	15,680	15,165
Louth County Council	22,406	17,815	10,125
Mayo County Council	3,495	0	0
Meath County Council	11,634	12,303	27,512
Monaghan County Council	19,977	13,162	24,234
Offaly County Council	0	620	1,160
Roscommon County Council	18,376	25,911	22,080
Sligo County Council	21,740	40,968	27,225
Tipperary County Council	41,938	64,869	0
Waterford City & County Council	12,945	18,595	11,985
Westmeath County Council	19,654	16,040	26,336
Wexford County Council	8,010	15,910	17,440
Wicklow County Council	18,210	14,250	18,350
Total	**915,627**	**837,102**	**806,794**

Source Local Authority Survey Questionnaire

Appendix 8

Extract from Department of Justice and Equality
Memorandum re Funeral & Undertaking Procurement

20 January 2012

To: Each Local Authority with responsibility for paying Coroners expenses

Dear Sir/Madam

The attention of the Coroner Service Implementation Team has been drawn to difficulties which have arisen in some local authority areas regarding the cost of providing undertaking facilities for coroners' cases. It seems that prices for the provision of these services can vary greatly from undertaker to undertaker causing concern for both the coroner and the local authorities.

In order to rectify this situation, it is recommended that your local authority should consider either of two options.

i. **Agreed Service Providers** - Whereby local authorities write to all funeral undertakers in the county and inform them of the price that they are prepared to pay for the provision of the service. Each local authority should have a good idea of what constitutes a fair price, as you have been paying for these services regularly. Invite the undertakers to indicate whether they are prepared to offer their service for this price and forward their names to the An Garda Síochána for future use.

ii. **Tender Competition** - Whereby local authorities hold a competitive process and tender for the provision of the service.

All of the attachments to this letter are for guidance only, and can be adapted or changed to suit each individual local authority's circumstances.

It is strongly recommended that you give consideration to employing either scheme in your area.

Yours Sincerely

Coroner Service Implementation Team

Appendix 9

State Laboratory Expenditure 2013- 2015

City and County Councils	2015 €	2014 €	2013 €
Carlow County Council	4,792	7,752	7,128
Cavan County Council	9,308	12,096	9,192
Clare County Council	10,173	7,489	10,920
Cork County Council	31,158	50,476	40,526
Cork City Council	30,258	37,670	38,272
Donegal County Council	19,724	19,879	8,367
Dublin City Council	211,288	301,661	212,743
Galway County Council	18,151	29,578	25,936
Kerry County Council	19,344	27,873	23,143
Kildare County Council	21,794	30,072	25,104
Kilkenny County Council	7,992	10,786	9,312
Laois County Council	12,823	10,344	8,981
Leitrim County Council	4,204	6,943	5,610
Limerick City & County Council	15,168	15,826	15,864
Longford County Council	7,800	7,392	7,680
Louth County Council	18,922	13,464	22,704
Mayo County Council	4,174	5,028	3,288
Meath County Council	11,760	22,752	15,192
Monaghan County Council	6,611	7,364	6,744
Offaly County Council	8,424	10,992	9,054
Roscommon County Council	5,976	6,384	6,984
Sligo County Council	20,102	20,256	7,512
Tipperary County Council	12,360	15,192	13,400
Waterford City & County Council	10,217	11,502	11,160
Westmeath County Council	9,529	19,272	14,788
Wexford County Council	12,221	14,467	11,568
Wicklow County Council	16,608	19,579	12,480
Total	**560,881**	**742,089**	**583,652**

Source: Local Authority Survey Questionnaire