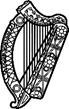
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**Call for inputs: Protection of dead persons and their human remains, including victims of potentially unlawful killings**

**Submission of Ireland**

**Policies:**

Every death that occurs in the State must be recorded and registered. The legal obligation to register a death rests with the key contacts of the deceased. The General Register Office (GRO) records all deaths registered. The legal requirement with respect to the registration of deaths is set out in Part 5 of the Civil Registration Act 2004, as amended.

The Coroner Service comprises of a network of coroners located in districts throughout the country. Coroners are independent quasi-judicial office holders whose function under the Coroners Act 1962, as amended is to investigate sudden and unexplained deaths which may involve a Post Mortem Examination and / or an Inquest. The conclusion of a death investigation by a coroner allows a death certificate to be issued. Approximately 70% of deaths occurring in Ireland are reported to the Coroner however not all of these deaths result in an investigation being initiated. Deaths reportable to the coroner under rules of law are outlined according to Second Schedule, Coroners (Amendment) Act 2019.

All deaths in custody are the subject to a police investigation and subsequently an inquest is held in a Coroner's Court. The cause of death is determined by a jury on the basis of the information presented to the Coroner’s Court. The Irish Prison Service also has a robust, internal review mechanism which assesses the circumstances of a death in custody, highlights accountability and actions taken in relation to the incident, and outlines lessons learned. This outcome review is reported to the Irish Prison Service National Suicide and Harm Prevention Steering Group, which is chaired by the Director General.

The circumstances of each death in custody are also examined by a suicide prevention group in each institution. The groups are chaired by the relevant Prison Governor, and include representatives from the various services including; Doctor, Psychiatry, Psychology, Chaplaincy, Probation, Education, and Prison staff. The Groups are required to meet quarterly, or more often if necessary. Their examinations fully cover the background and circumstances of each death. Their objective is to identify, where possible, measures which might be implemented to contribute to a reduction in the risk of deaths in the future.

In Ireland, the Office of the State Pathologist (OSP) provides a nationwide forensic pathology service where a forensic pathologist is on duty, twenty-four hours a day, every day of the year. The OSP is an independent, non-statutory body under the aegis of the Department of Justice, which provides independent expert advice on matters relating to forensic pathology and performs post mortems examinations (PME) in criminal, suspicious or unusual deaths. These are known colloquially as “State cases”. The Office deals with a significant range of cases, including homicides (victims of unlawful killing), road traffic collisions and drug-related deaths, among others. The OSP also deals with skeletonised remains, which may require the additional expertise of a forensic anthropologist or forensic archaeologist. The pathologists provide post mortem reports to the relevant Coroner and attend inquests or court proceedings, which may arise out of a police investigation.

In 2022, there were 417 cases dealt with by the OSP (335 in 2019, 345 in 2020, 327 in 2021). State forensic cases comprised 51% of the total caseload (213 cases). In approximately 12% of cases, this may also require a visit to the scene of death.

Ireland operates a coronial system of death investigation. A corner’s post mortem examination (PME) is carried out at the direction of the coroner for the district where death occurs. A coroner in Ireland is an independent office holder who is obliged by law (Coroner’s Acts 1962 to 2020) to investigate certain deaths, including sudden, unnatural, violent and unexplained deaths, to establish who died, when, where and how they died, and a medical cause of death.

Deaths are reportable to the coroner under the Coroner’s Act and amendments 1962 – 2020 and under rules of good practice as determined by the coroner for the district. As part of the coronial death investigation, a coroner may request that a PME is performed. The PME is performed by a histopathologist or forensic pathologist, depending on the circumstances of death. During the PME, the pathologist carries out a detailed examination of the body, working to international best practice and professional standards set by the Faculty of Pathology of the Royal College of Physicians of Ireland (RCPI) and the Royal College of Pathologists in the UK.

**Laws/regulations:**

The Institutional Burials Act 2022 seeks to ensure that the remains of those who died in residential institutions, and who were buried in a manifestly inappropriate manner, may be recovered and re-interred in a respectful and appropriate way. It also provides for the identification of remains and their return to family members, where possible.

According to the Coroners Act 1962, a PME must involve a full three-cavity examination of the body (head, chest and abdominal organs examination). It may also include the retention of organs, tissues and/or other body fluids for detailed diagnostic purposes, but only to establish the cause of death. Consent in not required for a coroner’s PME because it is a mandatory process under Irish law.

At present, in relation to PME and post mortem activities, Ireland works under the Anatomy Act 1832. A new Human Tissue Bill was published in December 2022. The bill sets out the modern legal framework for the donation and transplantation of organs, the use of bodies/body parts for anatomical examination and education and the public display of bodies/body parts. It aims to regulate of the retention, storage, use, disposal and return of organs and tissue from deceased person following all PMEs in Ireland. This will protect the rights and dignity of the deceased and their families in these situations.

**Practice:**

The HSE is currently working on National clinical guidelines for care of the deceased person. The purpose of this Guideline was to develop and provide a comprehensive evidence-based guidance on the care after death of adults in all settings such as home, hospital, hospice, nursing home or other residential care facilities.

The Medical Council regulates medical doctors in Ireland. The Council’s purpose is to protect the public by monitoring and ensuring high standards of professional conduct, education, training and competence among doctors practicing in Ireland. Any doctor who practices medicine in Ireland is required by law (under the Medical Practitioners Act 2007) to be registered with the Irish Medical Council (IMC).

Pathologists are bound by the principles that govern the standards set out by the IMC. The responsibilities of the pathologist are the same as those of every medically qualified doctor and include the eight domains of good professional practice.

The pathologists’ duties are towards the deceased and the family of the deceased by performing high quality autopsies and ensuring the respectful treatment and protection of the remains of the deceased. In addition, forensic pathologists have responsibilities to the criminal justice system. When providing expert and impartial evidence, the primary duty of the pathologist is to the Court, helping to ensure justice for victims of unlawful killings and their bereaved relatives.

It is important for forensic pathology as a specialty to have a set of best practice guidelines. This allows key stakeholders, such as An Garda Síochána (the national police service of Ireland), coroners and the court system, to have confidence in the practitioners’ skills and know that they are providing the highest quality autopsy service to the state. Forensic pathologists have a duty to the deceased, from the time of initial contact regarding a death, to attending the scene, performing the PME, collecting evidence and writing the autopsy report.

**HSE National Clinical Guidelines for PME Services**

During 2022, the Chief State Pathologist, Professor Mulligan, was nominated by the Faculty of Pathology, RCPI to chair a review group charged with updating the 2012 Health Service Executive (HSE) Standards and Recommended Practices for PME Services. The resulting HSE National Clinical Guidelines for PME Services and HSE National Toolkit of Templates for PME Services documents were published and launched by the HSE in 2023[[1]](#footnote-1). These documents outline recommended practices for PME services, based on current legal requirements, professional standards, clinical expertise and international best practice.

The guidelines provide a comprehensive framework to assist healthcare staff as they provide support and guidance to families around a PME, ensuring that there is open and clear communication during the process, which is considerate of the emotional impact on bereaved families. The document explains all steps of the process, from the person’s death to the issuing of the death certificate. They provide guidance on record management and the sensitive management of tissue samples, biological fluids and temporarily retained organs following a PME, with consideration of the cultural, religious and social needs of the family.

The Faculty of Pathology, RCPI have published guidelines for post mortem consent and retention of samples at PME[[2]](#footnote-2). The guidelines support pathologists and other healthcare professionals in the area of post mortem consent and the sensitive management of organ and tissue samples. The Faculty of Pathology strongly endorses high quality PME and the retention of samples (blood, tissue or organs) remains an integral part of such examinations. Their guidelines recommend that the relevant samples to be retained at PME is determined by the pathologist performing or supervising the examination.

The storage and management of blocks and slides from the PME follows the same laboratory procedures in place for dealing with samples from surgical procedures and is in line with best practice standards.

The International Organisation for Standardisation (ISO) develops and publishes international standards for quality management and quality assurance in laboratories. Storage and management of post mortem materials (tissue samples, tissue blocks, glass slides, and retained organs) should comply with the standards set out in ISO 15189:2012 (ISO, 2012). This includes identification, security, retention, storage and retrieval, and sensitive management (burial or cremation).

Local policies are in place at the Office of the State Patholgogist, at Dublin District Mortuary and in hospital mortuaries around the country to clearly delineate a role responsible for each step in the process with Standard Operating Procedures in place.  In addition, policies and procedures should be monitored by local managers/governance teams with documented periodic review for quality assurance and improvement.

**The Effect of the Sars-Cov-2 (COVID-19) Pandemic on PME in Ireland**

The importance of PME in medical practice to determine the natural course of a new/unknown disease was highlighted during the recent pandemic involving the SARS-CoV-2 virus (COVID-19). PME provided fundamental evidence on complications arising from this disease, including its effects on multiple organs and the assessment of co-morbidities and their impact on the disease outcome.

The role of PME in understanding COVID-19 led to increased awareness among healthcare professionals and hospitals around the importance of PME and its role in the education of junior doctors and healthcare staff.

In Ireland, in response to the COVID-19 pandemic, the Faculty of Pathology, RCPI published guidelines on PME Practice during the COVID-19 Pandemic.[[3]](#footnote-3) The recommendations were developed to ensure that during the pandemic, coroners, with the help of histopathologists and forensic pathologists could investigate all deaths fully, respectfully and with full empathy for the families of the deceased.

**Human Rights Unit, Department of Foreign Affairs**

**Coroners Service**

**The Office of the State Pathologist**

**January 2024**

1. HSE National Clinical Guidelines for Post Mortem Examination Services and HSE National Toolkit of Templates for PME Services. Available from: <https://www.lenus.ie/handle/10147/635255> [↑](#footnote-ref-1)
2. The Royal College of Physicians of Ireland, Faculty of Pathology. Guidelines for post mortem consent and retention of samples. 2000. Accessible from: <https://www.rcpi.ie/news/publication/guidelines-for-post-mortem-consent-and-retention-of-samples/> [↑](#footnote-ref-2)
3. Faculty of Pathology, 2021. Royal College of Physicians of Ireland. [Online] Available at: <https://www.rcpi.ie/news/releases/faculty-of-pathology-publishes-guidelines-on-autopsy-practise-during-the-covid-19-pandemic/> [↑](#footnote-ref-3)