JOINT SUBMISSION TO OIREACHTAS COMMITTEE ON CHILDREN, EQUALITY, DISABILITY AND INTEGRATION

RE: GENERAL SCHEME OF A CERTAIN INSTITUTIONAL BURIALS (AUTHORISED INTERVENTIONS) BILL

26 February 2021

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INTRODUCTION

If the Government wishes to act urgently to meet the needs and legal rights of the relatives of those who died and/or disappeared in institutional contexts, the Attorney General can – and must – order inquests immediately under the Coroners Act 1962 (as amended). Under this existing legislation, inquests are already required at institutional sites. The Coroner system already provides for exhumations, for the dignified treatment of remains, for special post-mortem examinations which can include DNA identification, and for relatives' right to participate in the investigation into their loved one's death.

The General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill proposes to breach families' rights under existing Irish, European and international law by disapplying the mandate and powers of the Coroner wherever an Agency is established under the Bill (Head 7). We recommend a range of amendments to the Bill, most importantly: (1) to retain and improve upon the Coroner's powers in respect of institutional sites, so as to enable the immediate commencement of inquests; and (2) in the alternative to create a Coroner Agency out of the proposed Agency, as a permanent structure that is fully compliant with Article 2 of the European Convention on Human rights.

The General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill[1] creates a legal framework whereby a Government Minister **may, if a 5-part test is met, establish a temporary, site-specific Agency for the purpose of exhuming, DNA testing and re-interring** the remains of individuals who died in institutional settings.

The overall effect of this 5-part test is to signal a strong resistance and reluctance on the part of the Bill's drafters to facilitate exhumations, examinations or identification. Bearing in mind what is known about the Mother and Baby Home sites from the Final Report of the Mother and Baby Homes Commission of Investigation ("MBHCOI") ("MBHCOI Final Report")[2] among other sources, the test set out in the Bill will likely have the effect of precluding the operation of the Agency in at least Tuam, Co. Galway; Bessborough, Co. Cork; and Sean Ross Abbey. This is contrary to the government's stated intention to permit the exhumation of remains at Tuam.

Furthermore, and of critical importance: the creation of an Agency under the Bill as currently drafted disapplies the Coroner's ordinary jurisdiction and powers. The Bill effectively creates an either/or situation: the remains of individuals who died in institutional settings will either fall within the scope of this Bill and not be subject to inquests *or* they will remain within the Coroner's jurisdiction but may never be subject to inquests if the State's neglect of its legal duties under the Coronters Acts to date continues. It is unacceptable to require families to sacrifice their right to an inquest in order to obtain exhumation, identification and

[1] Department of Children, Equality, Disability, Integration and Youth, General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill, https://www.gov.ie/en/publication/51a535-general-scheme-of-a-certain-institutional-burials-authorised-interve/

[2] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020).

dignified reburial under this Bill. It is also unacceptable for the Government to suggest, as this Bill does, that exhumations, identification and dignified reburial of remains and/or the return of individuals' remains to their relatives cannot be undertaken as part of the inquest process.

The relatives of children and adults who died in abusive State-supported institutional settings, many of whose fate and whereabouts remain unexplained, must be provided with the full range of legal and practical responses that each of their situations merits. There can be no question of creating a scenario where the wishes of one family, for example, who have requested an inquest into the apparently unnatural or unexplained death of their relative in institutional custody or care must be subordinated or ignored in order for another family's wish, for their relative's remains lying in the same site to be retrieved swiftly, to be met. Those affected have already expressed a range of wishes, including for treatment of sites as crime scenes, for excavation and identification, for marking and memorialisation,[3] and for inquests with campaigner Catherine Corless stating, for example: "we need to know what happened as regards all the deaths - how did the burials take place, in regards Tuam, who was responsible for discarding the babies and little toddlers in a sewage area. We need answers to that."[4]

Coroners have had jurisdiction over the investigation of unexplained or unnatural deaths in Ireland since before independence. The Coroner is under a mandatory duty to hold an inquest in respect of a person who died within his or her district "if he is of opinion that the death may have occurred in a violent or unnatural manner, or suddenly and from unknown causes or in a place or in circumstances which, under provisions in that behalf contained in any other enactment, require that an inquest should be held."[5] Dr Brian Farrell, Dublin City Coroner for 20 years, stated that the reference to place or circumstance "applies not only to hospitals but to nursing homes, residential centres or any situation where the deceased was in a dependent position."[6] As of 2019 the coroner is explicitly obliged to hold an inquest in every instance where a person has died while in State custody or detention.[7] Furthermore, under section 6 of the Children Act 1908 the death of an infant in care under the Act was required to be reported to the Coroner. This is an obligation not merely to register the deaths, which was done in some contexts, but to report the death to the coroner. There is little evidence that this reporting obligation was discharged by all relevant institutions. The

[3] Sheron Boyle, 'Scandal of the cesspit babies: Liam Neeson joins fight for Pope to confront truth about 800 children dumped in a mass grave by Irish nuns as star makes film about tragic home for unmarried mothers' *Mail on Sunday* (25 August 2018). <https://www.dailymail.co.uk/news/article-6098137/Tuam-scandal-cesspit-babies-Liam-Neeson-joins-fight-Pope-face-truth.html> accessed on 16 February 2021. Sylvia Pownall, 'Survivor pleads for halt to plan to build over babies' graves' *Irish Sunday Mirror* (17 January 2021) <https://www.pressreader.com/ireland/irish-sunday-mirror/20210117/281741272068586> accessed 17 February 2021. Shane Phelan, 'Mystery persists around the final resting places of 5,000 discarded children' *Irish Independent* (16 January 2021) <https://www.independent.ie/irish-news/mystery-persists-around-the-final-resting-places-of-5000-discarded-children-39974528.html> accessed 16 February 2021.

[4] Craig Hughes, 'Our Homes of Shame' *Irish Daily Mail* (13 January 2021) <https://www.pressreader.com/ireland/irish-daily-mail/20210113/281500753891800> accessed on 17 February 2021.

[5] Coroners Act 1962, Section 17, https://revisedacts.lawreform.ie/eli/1962/act/9/section/17/revised/en/html

[6] Farrell, B Coroners, (2000) Practice and Procedure, p. 127.

[7] Coroners Act 1962 (as revised), Section 17, https://revisedacts.lawreform.ie/eli/1962/act/9/section/17/revised/en/html

extraordinarily high mortality rates evidenced in the MBHCOI Final Report[8] and discussed at Section 4 below indicate that deaths may have been unnatural, in addition to occurring in a context of State care where an inquest was required as a matter of course. Therefore we submit that inquests are, and have been, required under Irish law.

There is an ongoing obligation on the State under Article 2 of the European Convention on Human Rights to hold prompt and comprehensive investigations into deaths which occurred within the jurisdiction. This obligation also extends to providing families with the remains of their deceased loved ones to the extent possible and to ensuring that family members have an effective right to their genetic identity. Inquests are a primary mechanism through which Ireland satisfies its Article 2 ECHR obligations, and so inquests are required to realise human rights, in addition to the domestic obligation. The European Court of Human Rights has concluded that persons trying to establish their ancestry--i.e. the identity of their relatives--have a vital interest, protected by the European Convention, in obtaining the information they need in order to discover the truth about an important aspect of their personal identity. This submission argues that in the exceptional circumstances of Ireland's institutional burials, this European human rights law requirement involves an effective investigation, the return of human remains to family members, access to all relevant records, and DNA identification of remains to ascertain the truth about one's family history and identity. We urge the Committee to consult further the Principal Submissions of the 'Clann Project' to the MBHCOI, which contend (at Section 4) that the State's ongoing failure to provide families with all possible information about the fate and whereabouts of their loved ones who died while in State custody or 'care' constitutes a situation of 'enforced disappearance' as the concept is understood in European and international law.[9]

It is imperative that the Committee on Children, Equality, Disability and Integration invites oral evidence from survivors of institutions (who are frequently relatives of those who died in institutional custody or 'care') and family members of the deceased **before** hearing evidence from other experts. This is not only a matter of rebuilding trust; it is also necessary for other experts to understand the key concerns of those who have the most knowledge of the facts and issues at hand and who are personally affected by the proposed legislation, in order to be able to provide effective evidence to the Committee afterwards. Survivors and family members are a diverse group, and all concerned should be given time and space to provide their views.

While the Government has directed significant attention—in its public statements, at least—to the Tuam Children's Home/Mother and Baby Home, it is imperative that other institutional sites are included within the scope of the proposed Agency. All survivors, sites and burials are worthy of equal treatment and all relatives have equal rights.

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[8] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020).

[9] Maeve O'Rourke, Claire McGettrick, Rod Baker, Raymond Hill *et al*., *CLANN: Ireland's Unmarried Mothers and their Children: Gathering the Data: Principal Submission to the Commission of Investigation into Mother and Baby Homes*. Dublin: Justice For Magdalenes Research, Adoption Rights Alliance, Hogan Lovells, 15 October 2018, pp109-110, http://clannproject.org/wp-content/uploads/Clann-Submissions_Redacted-Public-Version-October-2018.pdf.

1. THE ROLE OF THE CORONER

In this part we outline what the role of the Coroner is. We note their legal and demoractic function, their contribution to transitional justice, and the nature of the Coroner's jurisdiction and purpose of inquests under Irish law.

Legal and democratic function

Coroners investigate sudden or unexplained deaths. They do so to ensure that the details of deaths in complex or contested circumstances are thoroughly examined, to ensure as far as possible that bereaved families and those close to the deceased are informed of the context in which their loved one died, to inform public understanding and accountability for those deaths, and to inform policy and practice regarding death prevention, particularly those involving State or private institutions. They also have an important role in allaying wider public rumour and suspicion.[10] For these reasons, inquests increasingly have become important forums to ensure in which State institutions and practices are held to account for their operational policies and practices. Clearly, they must play an important role pursuant to the Irish State's obligations in addressing the history of the Mother and Baby Homes scandal.

Coronial investigation, from pathology and exploration of the circumstances of death through to the conduct of inquests, adopts an inquisitorial rather than accusatorial approach. When it functions well, it provides much needed answers to the bereaved about how loved ones died. Establishing 'how' is the crucial element for the bereaved and often this is recognised by coroners in their opening address. Increasingly in England and Wales at the opening of inquests bereaved families are invited to provide a pen picture of their loved one to humanise and to recognise the loss of the person. Beyond this priority, there is a wider objective: in establishing the circumstances, to consider whether deaths indicate systemic institutional failures in the 'duty of care' noting 'patterns' of death (eg. the Cambridge Coroner's recent statement of concern regarding adequacy of hospital care following the deaths of five women from anorexia) and to make recommendations to prevent future deaths. The role of the coronial investigation and the conduct of the inquests, not least the calling of expert witnesses, are critical in revealing circumstances where there is reason or suspicion that State institutions, in their policies and practices, their employees acts or omissions, were involved or responsible for contributing to the death.[11]

In 2000 the Working Group of the Review of the Coroner Service in Ireland published a comprehensive Report presenting detailed evidence and multiple findings recommending a phased overhaul of the coronial system. It commented:

> "…the coroner system is a service for the living. It serves and reassures society as a whole by public investigation of sudden or unexplained death. It informs and supports the bereaved by establishing the cause of death – a service often critical to the process of mourning and adaptation especially where the circumstances of the death may have been unusual or tragic."[12]

[10] Dr Brian Farrell, Dublin City Coroner v The Attorney General [1998] 1 IR 203 § 224

[11] Scraton, Phil, and Kathryn Chadwick. "Speaking ill of the dead: Institutionalised responses to deaths in custody." *Journal of Law and Society* 13.1 (1986): 93-115.

[12] Report of the Working Group (2000) Review of Coroner's Service in Ireland, preamble.

As explained further in Section 5 of this submission, Ireland is required under the European Convention on Human Rights (ECHR) to hold prompt and comprehensive investigations into deaths which occur within the State's jurisdiction.[13] The right to life not only imposes obligations on member states of the ECHR to protect life, but it also imposes positive, procedural obligations to conduct effective investigations where an individual's life has been taken.[14] To be effective, the investigation must be independent, prompt, public and must lead to the identification and punishment of the persons responsible.[15]

It has long been established by the European Court of Human Rights that an inquest can and will form a crucial part of the package of measures utilised by a member state to discharge its Article 2 ECHR procedural duties. In Ireland, the inquest is one means by which the state fulfils the requirements which arise under Article 2 and the right to life. Often, it is one arm of that investigation, while in some cases it may be the sole investigation. Invariably, it will be the only arm that satisfies the need for transparent and public dimensions of Article 2 investigations. Consequently, inquests are essential to the state's satisfaction Article 2 obligations. By way of an informed comparison, the inquest process and coronial investigations have played a fundamental part in addressing and investigating human rights abuses during the Conflict in Northern Ireland. They have constituted a crucial mechanism for discharging the Article 2 procedural duty many years after the events. Similarly, the 2013-2016 second inquests into the deaths of 95 people in the 1989 Hillsborough Stadium disaster were central to delivering a full and thorough examination of the context and circumstances of the deaths, replacing an accidental death verdict with unlawful killing and adding multiple informed riders regarding institutional liability. The use of an inquest in these circumstances has been approved by the United Kingdom Supreme Court.[16] It is submitted that in analogous circumstances, the inquest is a crucial and essential component of Ireland's infrastructure in addressing its human rights obligations, even when deaths occurred sometime in the past.

Inquests and Transitional Justice

In April 2017 the Department of Children and Youth Affairs committed to a transitional justice approach to the issue of Mother and Baby Homes and in the intervening period has taken a number of specific initiatives to facilitate this. The holding of an inquest into historical institutional abuse sites could form a key pillar in this transitional justice strategy and reflect the humanitarian forensic action approach that centres families of the deceased. In *Farrell v Attorney General* [1998] 1 IR 203, at 223, Keane J, approved of Lane L.C.J. in *R. v. South London Coroner, ex parte Thompson (1982) 126 S.J. 625*:

> ". . . it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no

[13] Article 2, European Convention on Human Rights. See Korff, Douwe. "The right to life: a guide to the implementation of Article 2 of the European Convention on Human Rights." *Council of Europe-Human Rights Handbook* 8 (2006).

[14] McCann, judgment of 27 Sept. 1995, 17/1994/ 464/545, at 202–214, available at: www.echr. coe.int/ECHR/EN/Header/Case-Law/Hudoc/ Hudoc+database/.

[15] Kelly and Others v. the United Kingdom, ECtHR, judgment of 4 May 2001

[16] Re McCaughey [2011] UKSC 20.

indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use."

By its nature an inquest is non adversarial. This offers an appropriate and sensitive vehicle to engage relatives and other affected parties in a legal process that can serve the purposes shared by the Gardai, families and Government to have certainty and clarity regarding the circumstances regarding the deaths of children in Tuam but does not engage questions of legal liability.

The Coroner has already been notified regarding Tuam and Sean Ross Abbey, and unidentified and possibly unnatural deaths are also known to have occurred at other institutional sites

The MBHCOI's public statement of 3 March 2017,[17] confirming the presence of 'significant quantities of human remains…in at least 17 of the 20 underground chambers which were examined' at Tuam, noted that 'the Coroner has been informed'. The Coroner's jurisdiction is thus engaged regarding the site at Tuam and remains the necessary and exclusive legal basis for addressing the issues that arise.

Additionally, according to the forensic archaeologists' report of the text excavation in Sean Ross Abbey in 2019: 'An Garda Siochana were in attendance for the duration of the excavation, specifically when human remains were exposed…The Coroner for Tipperary, Mr J Kelly, had been notified of the potential to find modern human remains … The protocol agreed with AGS and the Coroner was that once human remains were located N McCullagh would inform the local Gardai, who would in turn inform the Coroner. A Garda 'Scenes of Crime' photographer, on behalf of the Coroner, would be deployed to photograph the remains and the context in which they were found. The Coroner provided permission for remains to leave his jurisdiction for radiocarbon dating at the Scottish Universities Environmental Research Centre (SUERC) laboratory.'[18]

In relation to other sites, Gardaí will be in breach of section 18 of the 1962 Act if they failed to make the coroner aware of a death "in whose case a medical certificate of the cause of death is not procurable".

Legal Jurisdiction of Coroners in Ireland

Coroners have played a role in death investigation in Ireland since the twelfth century. For the period relevant to this submission, the following are Acts which apply the coroners jurisdiction:

1846 – 1962 Coroners (Ireland) Act 1846
1962 – 2019 Coroners Act 1962
2019 - present Coroners (Amendment) Act 2019

[17] MBHCOI, Latest News, 'Notice-3rd March 2017', http://www.mbhcoi.ie/mbh.nsf/page/Latest%20News-en
[18] N McCullough, LG Lynch, A Harte, *Report of Forensic Archaeological Investigations at Sean Ross Abbey Mother and Baby Home Children's Burial Ground, Roscrea, Co Tipperary*, on behalf of The Mother and Baby Homes Commission of Investigation, submitted to Judge Y Murphy, 5 September 2019, p.3.

Under the existing legislation the Coroner is under a general duty to hold an inquest of a person who died within her/ his district:

> "if he is of opinion that the death may have occurred in a violent or unnatural manner, or suddenly and from unknown causes or in a place or in circumstances which, under provisions in that behalf contained in any other enactment, require that an inquest should be held."[19]

Furthermore, since 2019 inquests are mandatory for deaths in state custody or in detention at the time of death or immediately before, and also when the death of the person is a maternal or late maternal death.[20] The key provision of Section 17, for current purposes, is 'in a place or in circumstances which…' Dr Brian Farrell, former coroner for Dublin, has stated in his exhaustive text of Coroner Practice and Procedure that this "provision applies not only to hospitals but to nursing homes, residential centres or any situation where the deceased was in a dependent position. Indeed the provision could be invoked in relation to almost any circumstance where concerns arise." Other legislation had mandated inquests for deaths in prison.[21]

Further, section 18(4) of the 1962 Act stated:

> "every person in charge of any institution or premises, in which a deceased person was residing at the time of his death, who has reason to believe that the deceased person died, either directly or indirectly, as a result of violence or misadventure or by unfair means, or as a result of negligence or misconduct or malpractice on the part of others, or from any cause other than natural illness or disease for which he had been seen and treated by a registered medical practitioner within one month before his death, or in such circumstances as may require investigation (including death as the result of the administration of an anaesthetic), shall immediately notify the coroner within whose district the body of the deceased person is lying of the facts and circumstances relating to the death."

Thus those who were in charge of institutions were under a legal obligation, dating back to 1962 to report such deaths. Failure to comply with this requirement is a criminal offence. This section was not altered by the most recent reforms to the Act.

Moreover, Regulation 108 of the Regulations for the Discharge of the Duties of Registrars of Births, Deaths and Marriages in Ireland pursuant to the Births and Deaths Registration Acts, Ireland, 1863–1880 provided:

> "In any case in which it appears to the Registrar that a Death has been caused by Violence or has been attended by suspicious circumstances and no Inquest has been held, he must not immediately register the Death, but must take such means as may be necessary, either through the police or otherwise, to bring the case under the notice of the Coroner having jurisdiction in the place in which the Death occurred, and before registering such Death, must ascertain that an Inquest is considered by the Coroner to be unnecessary".

[19] Coroners Act 1962, Section 17.
[20] Ibid, as amended.
[21] The General Prisons (Ireland) Act 1877, and the Rule 140 of the Rules for the Government of Prisons 1947.

Purpose of the Inquest

Under section 18 of the 1962 Act (as amended), the purpose of the inquest is to establish:

> "(a) the identity of the person in relation to whose death the inquest is being held,
> (b) how, when and where the death occurred, and
> (c) to the extent that the coroner holding the inquest considers it necessary, the circumstances in which the death occurred,
> and to make findings in respect of those matters … and return a verdict."

Inquests become contentious when evidence over 'how' the deceased came by their death is disputed by witnesses, some of whom understand that the questions they address have implications for personal or collective liability or reveal institutional failures, for example, in the duty of care.

In *Eastern Health Board v Farrell* [2001] 4 IR 627, the Supreme Court confirmed that the verdict of a coroner or a jury is not confined to the medical cause of death:

> *"It is clear that the inquest may properly investigate and consider the surrounding circumstances of the death, whether or not the facts explored may, in another forum, ultimately be relevant to issues of civil or criminal liability. The intention of the Oireachtas that the inquest should not simply take the form of a formal endorsement by the coroner or a jury of the pathologist's report on the post-mortem is also made clear by s 31…" §30.*

The Supreme Court has also set out the public interests which an inquest should serve, in *Dr Brian Farrell, Dublin City Coroner v The Attorney General* [1998]; these include:

> "1. To determine the medical cause of death;
> 2. To allay rumours or suspicions;
> 3. To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;…"[22]

This reflects the approach in England and Wales.[23]

The duties to ascertain and to state findings on how the death occurred must be read with those important public interests in mind. Thus, the inquest verdict may need to make findings additional to the medical cause of death, if that is necessary to satisfy the second and third public interests, namely allaying rumour and suspicion, and the prevention of future deaths.

Addition benefits which the coronial process brings, in terms of realising the Article 2 ECHR rights of families, are that the bereaved are entitled to (i) make representations to the Coroner before any decision is

[22] 1 IR 203 at 224.
[23] R (Amin) v Secretary of State for the Home Department [2004] 1 AC 653, §31, per Lord Bingham; and Assistant Deputy Coroner for Inner West London v Channel 4 Television Corp [2008] 1 WLR 945, at §7.)

taken, (ii) request that representations are heard in public, and (iii) tchallenge any decision by a Coroner via judicial review in the event that there was an error of law.

The Requirement to Hold Inquests Now

At the time that they occurred, these deaths should have been reported to the Coroner, should have been investigated, and should have been thoroughly investigated by way of public inquests. Those with reporting duties (managers of institutions, medical practitioners who attended, and Gardaí aware of the deaths) and coroners who were aware of institutional deaths, acted illegally in failing to fulfil their duties. That multiple State bodies breached their respective legal obligations and, in turn, acquiesced in a policy of cover-up and collusion should not be grounds for not pursuing their legal obligations.

We fully acknowledge the demands of this task. Yet, the unprecedented scale and societal impact of the deaths demand that the State's failure to its citizens be corrected.

The passage of time does not negate the duty to hold inquests. We note that the 2007 Coroners Bill – i.e. draft legislation – contained a provision time-limiting inquests to 70 years from death. The fact that this provision was not carried into the Coroners (Amendment) Act 2019 must be read as a decision not to include such a limitation. Put simply, there is no time limitation on the holding of an inquest. We are aware from examples from within the neighbouring jurisdictions (eg. Hillsborough and Ballymurphy Inquests) of the utility of an inquest into historic events. More importantly, such utility is ever-present in this jurisdiction as we await the hearing of the fresh inquest opened into the Stardust fire atrocity in 2021.

Inquests are required now for all deaths in the Mother and Baby institutions and County Homes, among other institutions which must be considered in greater depth (such as Magdalene Laundries, Industrial and Reformatory Schools, adoption agencies and other 'care'-related institutions) for the following reasons:

- These were reportable deaths under the relevant legislation;
    - Because these were unnatural deaths;
    - Because they occurred in places of State care or custody;
- To provide clear and accurate information to loved ones regarding the context and circumstances of the death;
- To inform Government and State institutions of the context and circumstances of the death;
- To allay suspicion and rumour in relation to these deaths;
- To prevent such deaths in the future;
- To address and investigate in circumstances in which the fate of the missing remains continues to be unresolved;
- To satisfy European and international human rights requirements;
- To satisfy government commitments concerning transitional justice;
- To hold the State accountable for addressing the wrongs identified by inquests, reflected in their verdicts, particularly focusing on reform in policy and practice.

The next section will consider how these legally mandated inquests should be performed.

2. RECOMMENDED AMENDMENTS TO THE BILL

2.1 Inquests must occur in relation to the deaths at Mother and Baby Homes and other institutions.

2.2 The Coroner should retain full jurisdiction over Mother and Baby Homes and other institutional deaths and should be provided with enhanced functions (to ensure compliance with Article 2 ECHR) and a relationship with the proposed Agency under a revised Bill. Inquests should commence urgently.

It is clear from the above that the inquest has a crucial role in contextualising and examining how a person or persons died. Therefore, it is extremely concerning that in its current form the Bill appears to absolve the Coroner of responsibility regarding exhumation and investigation (see Head 7, further discussed below in Section 3). Instead, the Bill proposes to transfer responsibility to the proposed Agency. This is, with respect, an inversion of responsibility. It is our submission that the Coroner should retain responsibility for all investigations and remain the adjudicator of the decision-making process throughout, with assistance and support from the Agency where required.

Head 7 read in conjunction with Heads 29 and 31 excludes the Coroner from having any role in the exhumation process save for circumstances in which it appears that 'the remains concerned do not appear to be in the scope of the exhumation being carried out under this General Scheme'. We propose that the alternative and correct approach is to invest all powers and responsibility with the Coroner who can and will be assisted by the Agency where required.

Under the current draft of the Bill, the proposed Agency would perform a large number of the Coroner's functions, including establishing who died, when and where. In effect, we request that consideration be given to enhancing the powers of the Agency to assist the Coroner's investigation. Further, in circumstances in which the remains of a person or victim are *missing*, the procedural obligation of a Coroner's investigation under Article 2 ECHR will persist while the fate of the person is unaccounted for continues.[24]

We propose that the correct and proper amendments are those which seek to redistribute the decision-making to the Coroner, and those which, in turn, will provide the Coroner and the Agency with necessary additional powers.

It is clear that the current legal framework provides for the holding of inquests in these circumstances (albeit we propose some reforms – see the next section). In terms of what would be needed to hold such inquests, we note provisions in the current Coroners Acts 1962 – 2019:

- The Coroner's jurisdiction enables the appointment of a Multi-Disciplinary Body as envisaged by the Expert Technical Report.[25] The Expert Technical Group report suggested that were more involved options for the treatment of remains at Tuam to be pursued, a multi-disciplinary body of experts would be an appropriate mechanism to shepherd the task involved. Such an approach can

[24] Varnava and Others v Turkey, ECtHR, Judgment of the Grand Chamber on 18 September 2009

[25] Report of the Expert Technical Group, December 2017, available at https://www.gov.ie/en/press-release/a3f353-minister-zappone-publishes-expert-technical-group-report-on-the-site/

be consistent with the exercise of the coroner's jurisdiction. Section 33 of the Coroners Act 1962 (as amended) provides that a coroner may request the Minister for Justice to arrange post-mortem examination of the body by any person appointed by the Minister; special examination by way of analysis, test or otherwise.

- The coroner has an obligation to request such a process if a member of the Garda Siochana not below the rank of inspector applies and provides reasons to do so. We urge relevant members of the Garda Siochana to exercise this power and offer the opportunity to enable a team of appropriate experts to address the situation. There is considerable international expertise including the International Commission on Missing Persons, the International Committee of the Red Cross and Argentine Forensic Anthropology Team (EAAF), which could be used if the ETG team felt the task would be too complex or challenging.

- The power of exhumation rests with the Minister for Justice. It should be exercised to grant an exhumation in the interests of the Commission of Investigation into Mother and Baby Homes, affected families and relatives, former residents of the Home, the local community and the national interest. Section 47 provides that where informed by a member of the Garda Siochana not below the rank of inspector, that there is a death of a person in a violent or unnatural manner, the coroner may request the Minister to order the exhumation of the body by the Garda Síochána. The Minister "may, as he thinks proper, either make or refuse the order."

- Under section 22 of the Coroners Act 1962 (as amended), where the body of any person, upon which it is necessary to hold an inquest, has been buried and it is known to the coroner that no good purpose will be affected by exhuming the body for the purposes of an inquest she/ he may proceed to hold an inquest without exhumation. Section 23 takes this further, stating that where a body may be irrecoverable and the coroner considers it appropriate to hold an inquest, the Minister may order the coroner accordingly. Further, under Section 24(1), the Attorney General can direct the holding of an inquest where he deems same to be 'advisable'.

2.3 Reforms are required to the Coroners system in order for it to be able to conduct human rights compliant inquests

The wider issues regarding coronial reform have been on the agenda since publication of the 2000 Review. In order to be able to perform human rights compliant investigations, the instant Bill will need to take the opportunity to amend existing legislation in the short term to bring the Irish Coronial system into line with wider European and International Law standards.

Existing problems which will impede timely and effective inquests as required for these institutions include that:

- Most Coroners are part-time post-holders, and work from their business premises without appropriate and necessary administrative support;
- There is no appropriate oversight of the coronial service;

- There is no consistent induction, nor training for coroners and no in-service review;
- The service lacks clear procedural clarity including, but not limited to, selection process for jurors, inconsistent and discretionary access to information, absence of clear regulation of procedures, absence of a formalised process for implementing recommendations, and lack of an accessible appeals mechanism.
- There is no centralised funding, with a discretionary allocation which often amounts to the 'bare minimum'. The consequences of this are limited investigation by the Gardaí, and a lack of necessary services to support families.
- Coroners are not sufficiently independent, being overly reliant, for instance, on gardaí. An Garda Siochána: select jurors, conduct investigations, and present evidence (outside Dublin). The service operates contrary to basic principles under the rule of law such as the separation of powers, the need for practical and hierarchical independence, and the need for clear and transparent oversight. This does not satisfy the requirements of Article 2 ECHR.
- Delay is a pre-eminent and unacceptable feature of the inquest system. Inquests regularly take many years to hold yet only short periods to complete leaving grieving families frustrated and pained. Article 2 ECHR mandates expedition.

In order for the Irish coronial system to undertake public, human rights compliant inquests for Mother and Baby Homes and other institutions the following amendments to the Bill are necessary:

(1) Heads 7, 27 and 31 should be amended to allocate responsibility to the Coroner, with the Agency providing support and assistance in the execution of such functions.

(2) Head 28(9) should be amended to ensure that the threshold for leave for judicial review of the decisions by the Coroner is in accordance with normal practice, namely that of 'arguable', and not 'substantial' as per the proposed term.

(3) Head 32 should be amended to bestow the power of adjourning any investigations or exhumations to the Coroner and not An Gardai Síochána. In the usual manner, if a parallel criminal investigation is ongoing, the Coroner should be provided with discretion to adjourn the inquest or exhumation until the conclusion of same, if required. This discretion should not be the decision of An Garda Síochána.

(4) The Bill should be amended to provide the Coroner with additional safeguards necessary to ensure that inquest related to the institutions comply with Article 2 ECHR. Such amendments would be necessary for Coroners to conduct the current inquests and should include:

    a. Establishing national infrastructure, governance, and consistent practices and policies;
    b. Provision of funding for full-time Coroners;
    c. Implementing independent investigations within the Coronial system;
    d. Establishing procedural rules which include and cater for full disclosure of information to victims and families;
    e. Mandatory publication of reports on findings; and
    f. Extension of powers to follow-up responses to verdicts;

2.4 An alternative option would be to create a permanent Agency for institutional deaths, with full independence from Government and full Article 2 ECHR-compliant coronial mandate and powers

2.4.1 A single Agency should be created

The Bill proposes the establishment of a new Agency for each different site of institutional burials. This approach is restrictive and cumbersome in light of the range of institutions in which unidentified and unexplained deaths, and inappropriate burials have occurred as detailed in Section 4 of this submission. A single Agency would avoid confusion, eliminate replication of administrative work, ensure consistency, and aid in smoother conduct of the work.

2.4.2 That Agency should be empowered and given jurisdiction to hold human rights complaint inquests

The need for reform should not overly delay the holding of human rights compliant inquests. Given the pressing need to hold these inquests post-haste, to ensure the greatest opportunity to achieve the functions of an inquest this submission proposes that Government select the most effective way to satisfy that need. If reform of the Coroner system cannot be realised in a speedy fashion, then consideration should be given to enhancing the functions, independence and resources of the Agency to enable it to take primary jurisdiction over the holding of inquests.

As it is proposed in this Bill, the Agency is set to perform the 'who', 'when' and 'where' functions of the Coroner, only. We propose that the Agency Coroner could – and, if the Government is determined to oust the Coroner's jurisdiction with the creation of an Agency, must – be mandated, resourced and empowered to conduct the additional coronial function of 'how', via Article 2 ECHR-compliant public inquests (as outlined above). It will be essential that that the victims or next of kin are entitled to (i) make representations to the Agency Coroner before any decision is taken, (ii) to request that the hearing of any such representations are in public, and (iii) to challenge any decision by an Agency Coroner by way of judicial review in the event that there was an error of law. The Coroner Agency must be:

- Appropriately staffed with persons qualified to conduct inquests;
- Resourced sufficiently to conduct the investigations and other work necessary;
- Independent from government to satisfy article 2 requirements;
- Adequately empowered to conduct human rights complaint inquests.

3. THE GOVERNMENT'S PROPOSAL: WHAT DOES THE BILL SAY?

Part 2 -- Making an Order is the critical part of the Bill, as it concerns the circumstances in which the Government may make an order establishing an Agency with the powers to excavate and exhume any particular site, manage an identification programme, and organise the re-interment of remains.

Head 3 creates a 5 stage test, allowing for the establishment of an Agency only where:

1. "a Minister is satisfied, on reasonable grounds, that *manifestly inappropriate burials* have taken place at a site, associated with an institution, of persons who died while ordinarily resident at that institution"[26] (Head 3(1)), and
2. "Government forms the view that it is necessary for the purposes of safeguarding important objectives of general public interest" (Head 3(3)), and
3. Government has considered "the proportionality of any intervention with regard to factors including the following -
   (a) public health,
   (b) respect for the deceased,
   (c) respect for the views of the relatives of the deceased,
   (d) the potential impacts on the site and the surrounding area, including any potential impact on –
      (i) residents whose dwelling adjoins the site, and
      (ii) archaeological features of the site,
   (e) the social interest to be served by carrying out an intervention,
   (f) the economic impact of an intervention,
   (g) avoidance of obstructions to any official or legal inquiry, investigation or process, proceedings pending or due before court, tribunal of inquiry or commission of investigation,
   (h) possible alternative options available to accord dignity to persons buried there, and
4. the circumstances outlined in Head 5 (Criteria for intervention) apply, and
5. the circumstances outlined in Head 6 (Restrictions) do not apply.

The existence of a **5 stage test** creates an unduly high barrier for the establishment and operation of the Agency. The factors listed in Head 3(8) for a proportionality assessment do not prioritise the rights of family members to know the whereabouts of their loved ones, and whether those children are in fact alive or dead, or the manner and cause of their death. A requirement of a "general public interest" precludes the interests of survivors and families affected by Mother and Baby Homes burials being a sufficient interest to establish the Agency and engage the processes of exhumation, examination and identification of remains. Factor (e) in Head 3(8) also re-introduces a further requirement of a social interest, when this has already been considered in Head 3(3) above and is unnecessary.

The decision procedure for a government intervention is unnecessarily complicated and is not in compliance with the State's obligations to investigate under ECHR law. Head 3(8) provides that Government shall consider the proportionality of any intervention with regard to factors including the following "(c) respect for the views of the relatives of the deceased". There is no weighing or proportionality among this long list

[26] "Institution" and "ordinarily resident" are not defined under the General Scheme. The purpose of the Scheme mentions interventions regarding burials "associated with institutions operated by or on behalf of the State or in respect of which the State had clear regulatory or supervisory responsibilities."

of factors. As a result, it cannot be said to reflect a survivor centred approach to decision making. Among the factors mentioned is "(f) the economic impact of an intervention". Where the State is under a legal duty to engage in an effective investigation of the deaths of children in the site and the view is taken that this warrants exhumation and examination of the remains, the perceived high cost of the intervention is not a basis for the State to decline to do so that is compliant with the ECHR.

Head 5 sets out the Criteria for Intervention. According to Head 5(1), an Agency cannot be created unless 'the criteria set out in subheads (2) - (4) apply". Subheads (2) - (4) read as follows:
(2) …in determining whether certain burials are manifestly inappropriate, Government shall consider the presence of **two or more** of the following factors as particularly significant:

(a) the human remains are uncoffined;
(b) the burials would not reasonably be considered to provide a dignified interment;
(c) the human remains were not buried at the appropriate depth specified in the Rules and Regulations for the Regulation of Burial Grounds 1888 and amendments to those regulations;
(d) the human remains are buried collectively and in a manner or in a location that is repugnant to common decency and would reasonably have been so considered at the time the burials took place.

(3) The burial site shall be associated with a current or former institutional setting.

(4) The land on which the burial site is located is --

(a) in the ownership of a public authority, or
(b) available to access because consent has been provided by the owner, or
(c) is not available to access because consent has been withheld by the owner but, in the opinion of Government, consent has been unreasonably withheld on the basis that either --
(i) they were also the owner of the land at the time that the manifestly inappropriate burials were carried out, or
(ii) they acquired the site in question on or after [date of publication of this General Scheme].

Head 6 lists Restrictions, prohibiting the Government from making an order establishing an Agency under Head 3 where *any* of the circumstances in Subheads 6(2) – (10) apply. This approach seems to militate against any intervention at all, without apparent justification. Of particular concern is that:

6(2) provides that the Government may not make an order where "There is evidence that human remains at the site were buried there following death in violent or unnatural circumstances." This is the language of section 17 of the Coroners Act 1962 (requiring an inquest in such circumstances). It is also clear from existing evidence discussed in Section 4 of this submission below, that several of the deaths in multiple Mother and Baby Home sites occurred in unnatural circumstances. Under this head, it would seem the operation of the Agency is precluded. On this basis it remains unclear what basis exists for the proposed Agency to proceed.

6(3) provides the Government may not make an order where "There is an ongoing Garda investigation into the circumstances surrounding the burials or the way the deaths took place." The authors of this submission are aware of at least one Mother and Baby home site where family members of the deceased have written to the Gardai seeking an investigation. It seems perverse for survivors and families' attempts to access information, truth and the recovery of remains would provide a basis for excluding the application of a specialist Agency.

6(4) provides that the Government may not make an order where "The burial site-

(a) is not associated with a current or former institutional setting,

(b) is not known to include burials that are manifestly inappropriate in comparison to the practices and traditions of the time that the burials took place,

(c) could not be excavated without disturbing appropriately buried human remains that are not to be exhumed, or

(d) is a burial ground within the meaning of the Public Health (Ireland) Act 1878 (Part III), the Rules and Regulations for the Regulation of Burial Grounds 1888, the Local Government (Sanitary Services) Act 1948, the Local Government Act 1994 or is a private burial ground delineated or recognised as such."

Regarding these:

6(4)(a) is already provided for in Head 5 and is unnecessary.

6(4)(b) sets a historical standard to compare a specific burial with the context of the practices and traditions of the time. However, this does not account for the State and other institutional actors' historical obligations to report the death to the coroner in circumstances provided for in existing legislation. A burial could have been conducted in compliance with contemporary burial practices and traditions, but have failed to discharge the legal obligations on the institution regarding the death.

6(4)(c) does not address the possibility of "exposing" remains, which is contemplated in the Mother and Baby Home Commission's Report of Forensic Archaeological Investigations at Sean Ross Abbey Mother and Baby Home Children's Burial Ground, Roscrea, Co. Tipperary. That report states at page 1: "The term 'exposed' will be used throughout this report to describe graves encountered during excavation. Human remains were not disturbed for the purpose of this investigation." That report seems to contemplate the exposure of remains as a term used to facilitate the examination of some remains in a site without the disturbance of other remains. IT may be possible for the Agency to conduct interventions and exhumations that expose other buried human remains but does not disturb them. As a result this exemption is overly broad.

6(4)(d) does not contemplate the possibility that remains may be buried in an manifestly inappropriate fashion within a burial site.

6(5) provides that the Government may not make an order where "Exhumation would be unreasonably difficult or unsafe." It is important note regarding Tuam, that according to the report of the Expert Technical

Group, the infants' remains are recoverable. Their report provides several options for the treatment and removal of these remains and the extent of removal. Questions of cost and technical challenges are considered at length in the report that indicate varying levels of complexity to the process - but regardless of the options proposed excavation exhumation are possible.

6(6) provides that the Government may not make an order where "Evidence is available that-

(a) informed family consent was given for burials arranged by the institution, or

(b) the lapse of time since the last known burial exceeds 70 years in relation to the date on which the circumstances of the burials concerned became widely known.

There is no definition of 'informed family consent' and it is not clear if this is a question to be determined in the aggregate or on an individualised basis. Furthermore, and crucially, no reason for 70-year time limitation is provided, which could potentially exclude any burial sites prior to 1950[27]. Notably, the MBHCOI examined the period of 1922 to 1998.

6(7) provides that the Government may not make an order where "Evidence is insufficient to determine-

(a) the existence of manifestly inappropriate burials, as referred to in Head 5(2), or

(b) the location of the alleged burials."

The MBHCOI Final Report concluded that the MBHCOI was unable to establish where the remains of children are buried at Bessborough.[28]

6(8) provides Government may not make an order where: "The land on which the burial site is located contains one or more dwellings." This may exclude an intervention on the full former site in Tuam.

6(9) provides Government may not make an order where: "The owner of the land on which the burial site is located-

(a) is not a public authority,

(b) has not consented to an intervention taking place, and

(c) has not unreasonably refused an intervention taking place."

6(10) provides that the Government may not make an order where "Government has formed the view that memorialisation of the site without further intervention is more appropriate." Memorialisation in the absence of excavation, exhumation and identification of remains maladapts transitional justice ideas. It is impossible to memorialise something if we do not know or agree on what we are acknowledging.[29] The report of the Expert Technical Group itself states: "In order to memorialise, it is essential to know what and

[27] For example, the old burial ground at Stranorlar, which was not used after 1949 as it was so overcrowded with burials of infants; see below Appendix 1, Infant / child deaths in individual institutions (Stranorlar).

[28] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) 29.

[29] Memorialisation processes in the content of serious violations of human rights and humanitarian law: the fifth pillar of transitional justice. Report of the Special Rapporteur on the promotion of truth justice reparation and guarantees of non-recurrence A/HRC/45/45 (2020)

whom are being acknowledged. Further investigation on behalf of Government would be required in order to memorialise effectively."[30]

Head 7 disapplies the Coroners Acts 1962 to 2019 to the bodies exhumed by an Agency under the Bill for the period of the Agency's existence. The only exception to this is, according to Head 31, where evidence emerges concerning remains that: "do not appear to be in the scope of the exhumation being carried out under this General Scheme, then the Agency shall immediately inform the coroner within whose district the remains were exhumed and An Garda Síochána."

It is unclear how these provisions interact with Head 6(2), which precludes the establishment of an Agency in the first place where "There is evidence that human remains at the site were buried there following death in violent or unnatural circumstances." If the intention of Head 7 is to exclude deaths unrelated to the institutions from the disapplication of the coroner's legislation (i.e. to say deaths unrelated to the institutions still fall under the coroners jurisdiction), then this is undermined and contradicted by Head 6(2). Many of the deaths within the institutions may well have been following unnatural circumstances. Thus Head 6(2) in effect makes Head 7 futile.

As discussed below, it is not permissible under European human rights law (and arguably the Irish Constitutional right to life) to derogate from the State's obligations to protect life by ensuring independent investigations into deaths in state custody or where deaths are unexplained or lives appear to have been taken unlawfully.

Part 3 of the Bill provides that works associated with this Bill shall be considered exempted development within the meaning of Section 4 of the Planning and Development Act 2000.

Part 4 - The Agency and its Functions provides for the establishment of the Agency as a legal entity.

Head 11 provides for the financing of the Agency via the Department of Public Expenditure. Provision should also be made in this section for contributions from relevant religious orders. The Bons Secours Sisters have already made a financial commitment regarding the intervention at Tuam.[31]

Head 16 provides for the secondment of staff from existing public bodies. While there is considerable expertise within the State, it would be inappropriate and could lead to the perception of bias were this provision to facilitate the secondment of staff from public bodies that may bear historical political or legal responsibility for a failure to investigate the deaths and burials involved.

Head 18 provides that the Agency may engage such consultants, advisers or contractors as it considers necessary for the performance of its functions. The 2017 report of the Expert Technical Group suggested that a multi-disciplinary body of experts would be an appropriate mechanism to shepherd the task involved. Such an approach can be consistent with the exercise of the coroner's jurisdiction. Section 33 of the Coroners Act 1962 provides that a coroner may request the Minister for Justice to arrange post-mortem

[30] Report of the Expert Technical Group, December 2017, 38.
[31] Patsy McGarry, 'Bon Secours sisters agree to contribute €2.5 million to costs Tuam excavation' *Irish Times* (23 October 2018).

examination of the body by any person appointed by the Minister; special examination by way of analysis, test or otherwise.

Head 25 provides for the disclosure of information from public bodies to the Agency to assist in its functions. This provision should be expanded in two respects. First survivors and family members of the deceased should be entitled to any relevant information under this Head. Second, the Agency should be entitled to receive information from non-state institutions, particularly religious orders, that may have information relating to burials and deaths in institutional contexts. Furthermore, it should have power to compel production of any documents or files and powers of seizure. The legislative language for drafting these provisions is in the Adoption (Information and Tracing) Bill 2016.

Heads 31 and 32 provide for the suspension of the Agency and the reengagement of Gardai investigative and coronial jurisdiction. It is our view that the establishment of an Agency in the first place should not be allowed to disapply any coronial or Garda jurisdiction or powers. These heads of Bill indicate that it is possible to create an interoperable relationship between the coroner, gardai and specialist agency. As a result, it remains unclear why the coronial jurisdiction is not the primary basis for addressing the burials related to Mother and Baby Homes given their primary functions of establishing who died, where, when and how.

Head 33 provides for the Agency to make "final arrangements for the remains as it deems most appropriate, including but not limited to arranging re-interment at a place and in a manner chosen by the Agency or, where it is feasible to do so, releasing remains to family members of the deceased." Head 33(2) states that arrangement to reintern or return human remains shall occur no later than 5 years from the date that exhumation works were carried out.

This provision arguably breaches the European Convention on human Rights obligations regarding a prompt and effective investigation and regarding the right of families to obtain the remains of loved ones, as set out in part 4 below. Instead this Bill should place a statutory duty on the State to return, on request and without delay, the identified human remains and personal artefacts to families once the intervention and identification has been completed.

Part 5 - Dissolution of Agency and Transitional Provisions.

Heads 44 and 45 provide for the records of the dissolved Agency to become Departmental records within the meaning of the National Archive Act 1986. In 2020 the government committed to the establishment of a national and central museum/repository of records and archives related to institutional abuse contexts. The records of this Agency should form part of that repository in due course.

4. THE RELEVANT FACTS

We summarise here information that is available to examine in more detail in the tables at **Appendix 1**, created from the contents of the MBHCOI Final Report.[32] Following our discussion of the deaths, burials and disappearances in the institutions investigated by the MBHCOI, we highlight that there are many other institutions in respect of which deaths, burials and disappearances occurred that require attention and warrant Coroner's inquests and inclusion within the remit of any future Agency Coroner.

4.1 Findings of the MBHCOI

Numbers and rates of infant/child deaths

The MBHCOI Final Report finds in relation to those institutions of its assigned 18 for which records were available that approximately 9,000 children died (amounting to 15% of the children who were in the institutions)[33] and 200 women died (including four women institutionalised in Bessborough Mother and Baby Home for between three and six decades each).[34]

Chapter 33A of the MBHCOI Final Report, observes that '[m]ortality rates in each of the institutions were very high in the period compared to the overall national rate of infant mortality'.[35] This higher-than-average rate of mortality continued into the 1980s, as demonstrated in relation to Pelletstown for example in Chapter 33A.[36] Chapter 33A notes that infant deaths occurred up to the 1980s in Pelletstown and Bessborough.[37] Chapter 33 of the MBHCOI Final Report explains that 'Maternal mortality in the homes was higher than the national rate until the 1970s.'[38] In addition to deaths connected to childbirth, the Final Report contends: 'The 16 deaths of women from infectious diseases reflects major shortcomings in these institutions that were also responsible for many infant deaths.'[39]

Identities of the deceased

The MBHCOI's terms of reference precluded the MBHCOI from assisting any family or individual to trace their relative,[40] and the MBHCOI declined throughout its work to provide any person affected by the matters under investigation with access to any of the personal or familial records that it held in relation to them.[41] The MBHCOI Final Report alludes to the experiences of mothers and other immediate and extended family

[32] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020)
[33] ibid Executive Summary, para 229.
[34] ibid Executive Summary, para 243.
[35] ibid ch 33A, 6.
[36] ibid ch 33A, 11.
[37] ibid
[38] ibid ch 33, para 33.25.
[39] ibid ch 33, para 33.26.
[40] Commission of Investigation (Mother and Baby Homes and Certain Related Matters) Order 2015, SI No 57 of 2015, http://www.mbhcoi.ie/mbh.nsf/page/Terms%20of%20reference-en
[41] Clann Project, Press Release, 15 October 2018, http://clannproject.org/2018/10/15/clann-publishes-findings-of-three-year-project-on-adoption-and-mother-and-baby-homes/

members who have been denied information about the fate and/or whereabouts of those who died in institutions; the MBHCOI states that it 'understands the wishes of family members to know more'.[42] Regarding the right of family members to know their relative's fate and whereabouts, however, the MBHCOI opines that 'that there would be enormous practical difficulties in establishing and implementing such rights. The costs involved would probably be prohibitive.'[43] This argument fails to engage not only with existing domestic legal obligations under the Coroners Acts 1962 to 2019 or human rights law standards but also with existing feasibility studies and international comparators for DNA testing.[44]

The MBHCOI Final Report's information on child deaths comes from the institutional records and the General Register Office (GRO).[45] It is not entirely clear what type of records the Commission is referring to, and the information is incomplete. As noted in the first table in **Appendix 1** (which contains citations to the MBHCOI Final Report) there is very little information for St Gerard's, there are no GRO records for the Regina Coeli Hostel, and other institutions have GRO records but not for all deaths: this is the case for Dublin Union (104 deaths), Tuam (6 deaths), Bessborough (11 deaths), Sean Ross (2 deaths), Castlepollard (17 deaths), Dunboyne (5 deaths), Bethany (6 deaths), Denny (8 deaths), Cork County Hospital (33), Stranorlar (4 deaths), and Thomastown (8 deaths).

Section 10 of the *Births and Deaths Registration (Ireland) Act 1880* required that the Registrar General be notified of deaths occurring in a *"house"*, defined under section 37 to include a *"public institution"* that was *"a prison, lock-up, workhouse, barracks, lunatic asylum, hospital, and any prescribed public, religious, or charitable institution"*. Where a death took place in a setting other than a house, section 11 of the 1880 Act imposed notification obligations on relatives having knowledge of the death, every person present at the death, any person taking charge of the body and the person causing the body to be buried. According to section 17 of the 1880 Act, there was an obligation on any person who buried or performed any funeral or religious service for the burial of a dead body to notify the Registrar if they had not received a certificate of death.

Section 10 of the *Registration of Maternity Homes Act 1934* made it an offence to fail to keep proper records of every reception into and discharge from the institution as well as every confinement, miscarriage, birth

[42] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 36, para 36.80.
[43] ibid, ch 36, para 36.81.
[44] In April 2018, a University College Dublin (UCD) and Trinity College Dublin (TCD) team challenged the findings of the Expert Technical Group which suggested that it would be difficult to exhume and identify remains at Tuam because the remains are "commingled". The UCD/TCD team maintain that new technologies would address the difficulties outlined in the Expert Technical Group report: Irish Times, 13th April 2018, Tuam mother-and-baby home remains 'can be identified'. Furthermore, for comparison, in the International Commission on Missing Persons (ICMP)'s 2020 budget the specific figures for its contracted professional services regarding exhumation, excavation and identification range from USD 54,200 to USD 341,900. While the budgets have figures between USD 515,300 (Mexico) to USD 3.4 million (Iraq) for its work overall, it is easily anticipated that figures for any proposed action in Ireland would be at the lower end of this scale, due to (i) the targeted nature of the sites under consideration and (ii) the lack of security concerns for ICMP staff in Ireland which are present in several of its other national contexts.
[45] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 33, para 33.1.

and death of every child therein and every removal of a child therefrom and the name of the person removing said child and the address to which the child has been removed.

Section 11 of the Act required that every death of a registered person at a maternity home be notified to the Local Authority. Section 11 made specific provision for the recording of the cause of death:

> "11.—(1) Whenever on or after the appointed day a death occurs in a maternity home in respect of which a person is registered in the register kept by a local authority, such person shall give in writing to the chief executive officer of such local authority notice of such death and the cause thereof by delivering or by despatching by registered post, within twelve hours after such death, to such chief executive officer such notice.
>
> (2) If any person fails or neglects to comply with the provisions of this section, such person shall be guilty of an offence under this section and shall be liable on summary conviction thereof to a fine not exceeding ten pounds".

Whereabouts of the deceased

The table in **Appendix 1** demonstrates that many of the burial locations of individuals who died in the institutions under the MBHCOI's investigative remit are not accounted for. Generally in relation to burial locations, the MBHCOI Final Report states: 'The Commission remains convinced that there are people who have further information, but they have not come forward.'[46]

According to the MBHCOI (and while we recognise that the MBHCOI's Final Report is not complete and that there may indeed be contradictory information elsewhere):

- In the Dublin Union/St Patrick's/Pelletstown institution, 513 burial whereabouts appear to be unaccounted for. The MBHCOI identified 3,615 deaths but only established the burial place of 3,102 children (85.8%).[47]
- In Tuam,[48] according to the MBHCOI, no register of burials was kept. The only burial records located relate to burials in external cemeteries in Dublin and Galway following hospital deaths[49] (51 of 978 deaths). The MBHCOI found it 'likely that most of the children who died in Tuam are buried inappropriately in the grounds of the institution'.[50] Human remains were found in a 'structure with 20 chambers...built within the decommissioned large sewage tank'; it was not established that all children who died are buried here; there is some evidence of possible burials in other parts of what were the grounds.[51] A memorial garden on the former Tuam institution site

[46] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 38, para 38.1.
[47] See Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Dublin Union/St Patrick's Navan Road/ Pelletstown/Eglinton House).
[48] See Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Tuam).
[49] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 15A, 34.
[50] ibid Executive Summary, paras 83-85.
[51] *Fifth Interim Report of the Commission of Investigation into Mother and Baby Homes* (2019), para 9.

contains human remains and the MBHCOI considered it likely that a large number of burials took place here.[52]

- Bessborough:[53] According to the MBHCOI the religious order that operated Bessborough failed to keep a register of infant burials and the majority of burial locations are unknown. The MBHCOI Final Report states that the MBHCOI remains perplexed and concerned at the inability of any member of the Congregation who ran the institution to identify the burial place of the children who died in Bessborough;[54] that the MBHCOI recognises that it is highly likely that burials did take place in the grounds of Bessborough; that the only way that this can be established is by an excavation of the entire property including those areas that are now built on;[55] and that former staff members believe that babies were buried in the congregational cemetery and occasionally elsewhere.
- Sean Ross:[56] According to the MBHCOI, no register of burials was maintained at Sean Ross Abbey. The MBHCOI Final Report confirmed that buried infant human remains were located at Sean Ross Abbey during a test excavation on the site in February and March 2019.[57] There is a designated burial ground and the MBHCOI had 'little doubt that they are the remains of children who died in Sean Ross. Without complete excavation it is not possible to say conclusively that all of the children who died in Sean Ross are buried in the designated burial ground.'....'[t]he Commission does not consider that further investigation is warranted'.[58]
- Castlepollard:[59] According to the MBHCOI, no register of burials was maintained and 'it seems likely that most children who died are buried in the designated burial ground.'[60] The MBHCOI Final Report cites, as evidence, correspondence with the Midland Health Board in 1994 regarding the nuns' wish to place a memorial stone on what they stated were the children's burial plots in 'marked burial ground'.[61] 17 (of 247) deaths were not registered in GRO.
- Kilrush:[62] There is no information in the MBHCOI Final Report on burials or deaths.
- Regina Coeli: The MBHCOI Final Report noted that the MBHCOI did not investigate the burial arrangements at Regina Coeli as the children died in many different locations.[63] There is no

[52] ibid.
[53] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Bessborough).
[54] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020), ch 38, para 38.12.
[55] ibid, ch 38, para 38.17.
[56] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Sean Ross).
[57] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 38, para 38.1.
[58] ibid ch 38, para 38.9.
[59] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Castlepollard).
[60] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020), Executive Summary, para 111.
[61] ibid, ch 38, para 38.26.
[62] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Kilrush).
[63] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020), Executive Summary, para 119.

information on burial whereabouts of the deaths of children associated with this institution other than a former employee who believed that some infants were buried in a graveyard in Dunboyne.

- Dunboyne: A Sister employed at the institution gave evidence that "There was no burial plot in the grounds of Dunboyne. The Good Shepherd Sisters bought a plot in the local authority graveyard in Dunboyne where some infants were buried."[64] There is no further information in the dedicated section of the MBHCOI Final Report (chapter 24) which deals with this institution, about burial arrangements.
- Bethany: 262 child deaths were identified; according to the MBHCOI, burial records for 235 children were located for Mount Jerome Cemetery, Harold's Cross (231) Glasnevin Cemetery (4).[65]
- Denny House: the MBHCOI states that burial records were located for 34 children interred in Mount Jerome cemetery."[66]"The burial place of the others is not known; they may have been buried by their family or in a plot owned by the hospital where they died."[67]
- Cork County Home:[68] No burial registers were located despite extensive efforts. The MBHCOI Final Report notes that of the 449 confirmed deaths of 'illegitimate' infants and children in Cork County Home in the period 1922-60, burial records for just two were found. Many other concerns were raised regarding the burial practices at this institution.
- Stranorlar:[69] According to the MBHCOI: There is no official information about the burial whereabouts of the children who died in Stranorlar. A burial register for a new burial ground (opened 1950) is held at St Conal's Hospital, Letterkenny for a period between 1950 –1973; however, no recorded burials relate to infants or children, despite around 30 children (discriminatorily termed) 'illegitimate' children dying in Stranorlar County Home during that time; evidence suggests they were buried in the old workhouse cemetery. The MBHCOI Final Report contains maps outlining the sites. Both burial grounds are now part of Stranorlar and Ballybofey Golf Club fairways. Evidence in the MBHCOI Final Report shows that a carpenter was employed on a regular basis to make 'small coffins', and regular complaints are recorded from the institution's storekeeper, matron and the clergy between 1927 and 1948 as to the need for an extension to the old burial ground, including because of its overcrowdedness. Institutional records clearly state that graves were shallow and that bodies were buried in an ad-hoc manner.[70]
- Thomastown: the MBHCOI Final Report notes there was no information relating to just under 5% of child deaths. As regards burials, evidence of incineration of institution records, including burial registers, being ordered by the matron was given to the MBHCOI by a groundsman. Seven of 169 recorded child deaths occurred outside Thomastown County Home, including at Bessborough and

[64] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 24, para 24.188.
[65] ibid ch 22A, 25.
[66] ibid ch 23A, 16.
[67] ibid ch 23, para 23.94.
[68] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Cork County Home).
[69] See below, Appendix 1: Infant/child deaths in individual institutions, column on Burial / whereabouts / identities of the buried (Stranorlar).
[70] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 29, paras 29.35 - 29.39.

in Cork District Hospital. Burial records exist for the deaths at these two locations, recording burials in St Joseph's Cemetery, Cork.[71]

- There is no information on burial whereabouts or records for Miss Carr's Flatlets, The Castle, or St. Gerards in the MBHCOI Final Report.

Causes of child/infant deaths

The MBHCOI Final Report notes in relation to child / infant deaths that 'A relatively high percentage of deaths (18%) [in the largest institutions] were classified as "non-specific" as they did not have adequately specific information to ascertain a primary cause'.[72]

Furthermore, the Final Report acknowledges that concerns have arisen in the public domain regarding the frequency with which 'marasmus' was cited as the cause of death on an infant / child death certificate. The Final Report dismisses this concern[73]; however, it is not clear from the Final Report whether 'marasmus' was in fact more frequently cited as a cause of death in the institutions under investigation than in the population at large. Nor does the MBHCOI appear to consider whether 'marasmus' could occur as a result of neglect or harmful conditions that might not constitute 'wilful neglect' as the MBHCOI understands the term (without defining it).

The Final Report states that: 'Medical certification of the cause of death was not an absolute requirement...If there was no medical certificate from an attending medical practitioner, unless the death was, in the opinion of the Registrar, sudden, violent or suspicious, the Registrar could fill in the cause of death on the basis of the "best information" obtained from the informant, rather than a certificate.'[74] The MBHCOI dismisses, however, the contention that a person named Bina Rabbitte who lived and worked in the Tuam institution 'effectively "certified" the deaths' of the many children on whose certificates she is named as the informant. The MBHCOI states that '[t]here is no evidence'[75] that Rabbitte provided the cause of death. It is not clear on what grounds the MBHCOI finds there to be no evidence of this or what the evidence to the contrary may be.

The findings of the MBHCOI Final Report in relation to the causes of infant/child deaths for each of the institutions, along with indications of the conditions in each of the institutions can be found in the MBHCOI

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[71] ibid ch 30A, 10.

[72] See below, Appendix 1: Maternal Deaths; and Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 33, 5 and ch 18A, 11.

[73] ibid ch 33, para 33.5: 'Some commentators have concluded that infant deaths which occurred in mother and baby homes due to marasmus indicates that infants were neglected, not appropriately cared for, and/or wilfully starved to death in these institutions. However, marasmus was a frequently cited cause of infant deaths in institutional, hospital and community settings in early twentieth-century Ireland. The Commission considers it unlikely that deaths in hospitals and family homes were due to wilful neglect and so cannot conclude that the term marasmus denotes wilful neglect in mother and baby homes. The more likely explanation is that marasmus as a cause of death was cited when an infant failed to thrive due to malabsorption of essential nutrients due to an underlying, undiagnosed medical condition.'

[74] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 33, paras 33.12 - 33.13.

[75] ibid, para 33.15.

Final Report chapters relating to the individual institutions. These causes of death and conditions—which suggest extensive neglect—are summarised in **Appendix 1** below.[76]

Maternal Deaths

Chapter 33 of the MBHCOI Final Report examined the records of 11 institutions in order to establish the number and causes of maternal deaths.[77] Only maternal deaths of unmarried women in County Homes were analysed by the MBHCOI. Married women also gave birth in County Homes; their maternal mortality rates were not examined. 200 women were identified as having died while registered in one of the institutions.[78] The MBHCOI located GRO death records for 193 deaths. There was no GRO death record for 7 of the deaths. The MBHCOI findings in relation to the deaths and burial whereabouts of women in the individual institutions is summarised in a table below (see Appendix 1: Maternal Deaths). Maternal mortality in the institutions was found to be higher than the national rate until the 1970s.[79]

The MBHCOI Final Report classified maternal deaths into three categories: Direct obstetric deaths, indirect obstetric deaths, and coincidental maternal deaths.[80] It notes that "mortality from causes that were not associated with pregnancy, either directly or indirectly is a greater cause of concern than the national death rates associated for pregnancy."[81]

The findings of the MBHCOI Final Report in relation to the causes of deaths of women in the institutions are summarised in a table below (see **Appendix 1**). In the Dublin Union/St Patrick's/Pelletstown institution, there were 30 deaths not associated with pregnancy or childbirth which were recorded as being due to tuberculosis, dysentery, pneumonia, and cardiac failure[82]. In the Tuam home, 6 deaths not associated with pregnancy were caused by tuberculosis, measles, pneumonia, and cardiac failure. Typhoid, and/or tuberculosis were common causes of deaths not related to childbirth or pregnancy in many of the institutions, including Bessborough, Sean Ross Abbey, Regina Coeli, Cork County Home, Stranorlar and Thomastown.

Conditions in the institutions from the contemporaneous reports are also described in the table. They show that the facilities were poor in all of the homes where the maternal death rates were high. In many of the homes, there were no adequate measures to prevent or control disease. An overview of the conditions in several of the homes is described below (and this information is provided with citations in **Appendix 1**).

The MBHCOI Final Report does not contain information on the whereabouts of the women who died in Dublin Union/St Patrick's/Pelletstown, Tuam, Sean Ross Abbey, Castlepollard, Kilrush, Regina Coeli, Bethany (other than one report of a funeral of a woman who died in hospital), Denny House, Cork County

[76] See below, Appendix 1: Infant/child deaths, "Causes of death" column (categorised by individual home).
[77] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 33, para 33.18, footnote.
[78] ibid, ch 33. Deaths per home are stated in the sections of chapter 33 on the individual homes; see also Appendix 1: Maternal Deaths below.
[79] Ibid ch 33, para 33.25.
[80] ibid para 33.19.
[81] Ibid para 33.26.
[82] See below, Appendix 1: Maternal Deaths: Dublin Union/St Patrick's Navan Road/Pelletstown/Eglinton House.

Home, Stranorlar, or Thomastown. The MBHCOI found burial records for 12 of the 31 women whose deaths are associated with the Bessborough home, who were buried in St Joseph's Cemetery, Cork[83].

4.2 There are many more institutions to consider, in addition to 14 Mother and Baby Homes & 4 County Homes.

The MBHCOI investigated only a fraction of the institutions through which unmarried families were separated and in which infants, children and women died. Numerous institutional abuse survivors are actively campaigning for all institutions to be included in the Government's measures to investigate and identify the whereabouts and fate of those who died while in state and other, institutional, custody or 'care'.[84]

Journalist Conall Ó Fátharta wrote in the *Irish Examiner* in February 2018,[85] for example, about the following unmarked graves at St Finbarr's Cemetery in Cork City relating to St Anne's Adoption Society:

(1) One plot without any markings whatsoever to demonstrate that it is a grave or the identities of those interred in it, according to Ó Fátharta, is recorded as containing the remains of children who died in 1979, 1983, 1988 and 1990. Only one of these children has both a corresponding birth certificate and death certificate. Death certificates could not be located for two of the children.

(2) Another plot which is marked as a grave has 16 recorded burials of children who died between 1957 and 1978; however no names are recorded for 15 of those children.

(3) A third plot discovered - a non-perpetuity plot - contains the remains of at least one child. The death certificate for this child, who died in 1989, states that the death occurred in St Finbarr's Hospital but that the child was in the care of "c/o Sacred Heart Hospital, Blackrock, Cork" — the address of the Bessborough Mother and Baby Home.

All but one of the children discussed above are interred in plots owned by a formerly State-accredited adoption agency—St Anne's Adoption Society, which closed in 2003—and by the St Patrick's Orphanage, which operated as a nursery for St Anne's Adoption Society. Neither institution was named in the terms of reference of the MBHCOI. However, five of the children were linked to an institution that *did* fall under the MBHCOI's remit: the Bessborough Mother and Baby Home. This exemplifies the unnecessary and unprincipled exclusions and distinctions which have been a hallmark of State inquiries into so-called 'historical' abuses in recent decades.

As noted by Justice for Magdalenes Research (JFMR) to the United Nations Committee Against Torture in 2017,[86] the Report of the Inter-Departmental Committee to establish the facts of State involvement with

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[83] See below, Appendix 1: Maternal Deaths; and Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 18A, 11.

[84] Sinéad Kelleher, 'Map, preserve and respect the graves' *The Kerryman* (3 February 2021) https://www.independent.ie/regionals/kerryman/news/map-preserve-and-respect-the-graves-40044022.html> accessed 22 February 2021.

[85] Conall Ó Fátharta, 'Children in two unmarked graves: Shame of what lies beneath' *Irish Examiner* (19 February 2018), https://www.irishexaminer.com/news/arid-20467336.html

[86] Maeve O'Rourke, Justice for Magdalenes Research, NGO Submission to the UN Committee Against Torture (2017), pp.13-15, http://jfmresearch.com/wp-content/uploads/2017/07/JFMR-report-to-CAT-for-the-session-2017-Main-Report.pdf citing Claire McGettrick and others, *Death, Institutionalisation and Duration of Stay: A critique of*

Magdalen Laundries (the IDC Report) relied heavily on the religious congregations' evidence and records which are not available in the public domain and did not identify individual women or their burial places, nor did it address the issue of unmarked graves. Claire McGettrick, of JFMR, has been directing the 'Magdalene Names Project' (MNP)[87] for many years; this project aims to record the names and whereabouts of all women who died in Magdalene Laundries so that they can be honoured and remembered, including by family members who may be searching for them. The MNP database is drawn from gravestones, digitised census records, electoral registers, exhumation orders, cemetery records and newspaper archives.

Following the publication of the IDC Report, and despite the intensive efforts of the MNP to ascertain the identities and whereabouts of all women who died from publicly available sources, many questions and gaps in information remain. They include (and are not limited to) the following:

- The IDC Report states that according to the available records, from 1922 onwards 57 women died in the Galway Magdalene Laundry and 21 in the Dun Laoghaire Magdalene Laundry.[88] JFMR has identified 98 women who died in the Galway Magdalene and 12 women who died in Dun Laoghaire, as no locations were supplied in the IDC Report. This means that 47 women in Galway have been omitted from the Report, while the burial places of at least 9 women who died in Dun Laoghaire remain unknown.
- The question of the identification of all women who died in the former High Park Magdalene Laundry is still unresolved. The IDC accepted the religious congregation's explanation regarding the 1993 exhumations and cremations that '[t]he paper-work and historic records of the Congregation were, at the time, uncatalogued' but that, following cataloguing work between 2003 and 2005, 'all 155 women whose remains were exhumed from the consecrates graveyard at High Park were identified and matched to their names and dates of death.'[89] However, MNP research on the gravestones and graveyard records relating to the High Park Magdalene Laundry at Glasnevin Cemetery in Dublin, contradicts this finding.[90]
- Research into the Sean McDermott Street Magdalene Laundry records at Glasnevin Cemetery reveals that 51 women whose names are inscribed on three headstones at a particular location in Glasnevin are not buried at that location, but are interred elsewhere in the cemetery. The vast majority of these women died within the time period covered by the IDC Report.
- The IDC Report lists the various public and private burial grounds where there are plots maintained by the religious orders, but it does not offer a breakdown of how many sites exist in each location

Chapter 16 of the Report of the Inter-Departmental Committee to establish the facts of State involvement with the Magdalen Laundries and related issues (Justice for Magdalenes Research, 19 February 2015), http://jfmresearch.com/wp-content/uploads/2017/03/JFMR_Critique_190215.pdf. Some details have been updated to reflect new research findings.

[87] For more information, see www.jfmresearch.com and Claire McGettrick and others, *Death, Institutionalisation and Duration of Stay: A critique of Chapter 16 of the Report of the Inter-Departmental Committee to establish the facts of State involvement with the Magdalen Laundries and related issues* (19 February 2013) http://jfmresearch.com/wp-content/uploads/2017/03/JFMR_Critique_190215.pdf

[88] *IDC Report*, Chapter 16, para 55.

[89] *IDC Report,* Chapter 16, paras 105 – 108.

[90] The High Park exhumations will be covered extensively in an upcoming JFMR publication. See also: Claire McGettrick and others, *Death, Institutionalisation and Duration of Stay: A critique of Chapter 16 of the Report of the Inter-Departmental Committee to establish the facts of State involvement with the Magdalen Laundries and related issues* (19 February 2013) http://jfmresearch.com/wp-content/uploads/2017/03/JFMR_Critique_190215.pdf

and how many women are in each plot. The Report also omits public cemeteries that have been used by the religious congregations after the closure of the laundries, for example, Kilcully Cemetery in Cork, which has been used by both the Good Shepherd Sisters and the Sisters of Charity.

A June 2017 submission to the United Nations Committee Against Torture by Reclaiming Self[91] highlighted that the Commission to Inquire into Child Abuse (Ryan Commission) reported a number of instances in which children died while in the care of the institutions. Of the 222 deaths noted on the religious orders' Main Fatalities File, death certificates existed for only 80%.[92] There is one inquest that gets prominent attention in the Ryan Report, that being the case of Stephen Cavanagh in Artane in the 1950s, but otherwise there is a notable absence of discussion, particularly given that the *1933 Rules and Regulations for the Certified Industrial Schools in Saorstát Éireann* state in regard to inquests that 'In the case of violent death, or of sudden death, not arising in the course of an illness while the child is under treatment by the M.O., a report of the circumstances shall be at once made to the local Gardaí for the information of the Coroner, a similar report being at the same time sent to the Inspector'.

[91] Reclaiming Self, "Ryan Report Follow - up Submission to the United Nationals Committee Against Torture" (2017), https://tbinternet.ohchr.org/Treaties/CAT/Shared%20Documents/IRL/INT_CAT_CSS_IRL_27959_E.pdf

[92] Staines, A., Boilson, A., Craven, F., & Wyse, E. (2008) Assessment of Health Status of Children Detained at Irish Industrial Schools 1940-1983, p.3 as cited in Commission to Inquire into Child Abuse (2009), Vol 5, Staines Submissions

5. IRELAND'S EUROPEAN AND INTERNATIONAL HUMAN RIGHTS OBLIGATIONS CONCERNING THE WHEREABOUTS OF FAMILY MEMBERS

The European and international legal position offers clear guidance that (i) Ireland has an obligation to return human remains to family members affected by the sites of historical institutional abuse and (ii) those family members have a right to pursue their genetic identity and ascertain the whereabouts of their loved ones. The European Court of Human Rights has concluded that persons trying to establish their ancestry had a vital interest, protected by the European Convention, in obtaining the information they needed in order to discover the truth about an important aspect of their personal identity. This submission argues in the exceptional circumstances of institutional burials, this involves an effective investigation, the return of human remains to family members, and access to relevant records and DNA identification of remains to ascertain the truth about their ancestry.

5.1 Obligation to Investigate in ECHR Compliant Manner[93]

The right to life includes a procedural obligation to investigate deaths and disappearances and to identify and punish those responsible.[94] For the avoidance of doubt the jurisdiction of the Convention applies historically, due to the ongoing procedural duty on Ireland to conduct an effective investigation into these deaths. Government statements acknowledging the presence of human remains in Tuam and the examination of deaths and burials in the MBHCOI report create a "critical date" for activating Convention jurisdiction.[95]

An effective investigation must also consider 'all the surrounding circumstances including such matters as the planning and control of the actions under examination'[96] and have four elements: independence, promptness, transparency, and effectiveness. In *McKerr v United Kingdom,* the Court stated that to ensure effectiveness, 'the persons responsible for and carrying out' the investigation should be independent from those implicated in the events'.[97] Secondly, the investigations must be prompt to maintain public confidence in adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts. Thirdly, the Court found that transparency is necessary, to practically secure accountability and that this should include allowing the victims' next-of-kin to be involved in the procedure 'to the extent necessary to safeguard his or her legitimate interests'.[98] Finally, the Court has held that to be effective an investigation must be "capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances … and to the identification and punishment of those responsible. This is not an obligation of result, but of means."[99] As a result, where an investigation does not result in a prosecution, this does not necessarily violate the state's obligation to investigate provided that the investigation was

[93] This section draws on James Gallen, "The European Court of Human Rights, Transitional Justice and Historical Abuse in Consolidated Democracies" Human Rights Law Review, Volume 19, Issue 4, December 2019, Pages 675–704

[94] *McCann v United Kingdom App No 18984/911*, Merits and Just Satisfaction, 27 September 1995, [Grand Chamber], at para 161.

[95] *Janowiec v Russia*, Application No 39630/09, Merits and Just Satisfaction (ECtHR, 13 December 2012).

[96] Ibid at para 150.

[97] *McKerr v United Kingdom* Application No 28883/95*,* Merits and Just Satisfaction, 4 May 2001 at para 112.

[98] ibid at para 115.

[99] ibid at para 113.

conducted in an effective manner.[100] This approach has been subsequently affirmed repeatedly and extended to the lethal use of force by both State and private actors.[101]

In *El-Masri*, the Grand Chamber stated that an adequate response and investigation is 'essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts'.[102] In *Janowiec v Russia*, the ECtHR recognised both the public interest in a transparent investigation into the crimes of the previous totalitarian regime and the private interest of the victims' relatives in uncovering the circumstances of their death, but this can be contrasted against the significant cost that may attach to investigations of historical deaths. The ECtHR has drawn a distinction between a duty to investigate a death on the one hand, which concerns acts capable of leading to the identification and punishment of those responsible or to an award of compensation to the injured party, and other types of inquiries that may be carried out for other purposes, such as establishing a historical truth, on the other.[103] In addition, the right to truth and investigations of historical abuse is multi-layered and generates obligations under other Articles of the Convention. The Court has held that 'it is an integral part of freedom of expression to seek historical truth.'[104] The emerging right to access to information of public interest by members of the general public supports the existence of a collective dimension to the right to truth and is evidenced by the Court's case law regarding Article 10 concerning NGOs seeking information of public interest.[105]

5.2 ECHR on Burials and Treatment of Human Remains

International legal obligations require Ireland to address this issue in a fashion that maximises the possibility of exhumation and identification of remains and a dignified burial of remains for affected families and for all remains.

The ECHR has specifically addressed questions of burials and treatment of human remains. In *Dödsbo v Sweden,* the applicant, the widow of the deceased, sought to move her husband's urn from a burial plot in Fagersta to a family burial plot in Stockholm the city to which she had moved.[106] All her children agreed to the removal but the authorities denied the request under the UK Funeral Act 1990, which adopted a presumption in favour of 'a peaceful rest'. Domestic appeals were rejected and the applicant herself died and was buried at Stockholm. The five children as sole heirs of the applicant pursued the application to the European Court of Human Rights invoking Article 8 (right to privacy and family life). The Court held that

[100] ibid.
[101] *Aliyeva and Aliyev v Azerbaijan* Application No 35587/08, Merits and Just Satisfaction, 31 July 2014 at para 69; *Kaya v Turkey* Application Nos (158/1996/777/978), Merits and Just Satisfaction, 19 February 1998.
[102] *El-Masri v Macedonia*, Application No 39630/09, Merits and Just Satisfaction, 13 December 2012 at para 192, restated in the Joint Concurring Opinion of Judges Tulkens et al, para 6. See also *Jelic v Croatia* Application No 57856/11, Merits and Just Satisfaction, 12 June 2014, at para 94.
[103] *Janowiec and Others v Russia, Application No 55508/07, Merits and Just Satisfaction, 21 October 2013* at paras 133; 214.
[104] *Monnat v Switzerland* Application No 73604/01, Merits and Just Satisfaction, 21 September 2006.
[105] *Youth Initiative for Human Rights v Serbia* Application No 48135/06, Merits and Just Satisfaction, 25 June 2013; *Magyar Helsinki Bizottság v Hungary* Application No 18030/11 Merits and Just Satisfaction, 8 November 2016 [Grand Chamber].
[106] *Dödsbo v Sweden,* (Application no. 61564/00) 17 January 2006

there had been no violation of Article 8 of the ECHR. The Court found that the Swedish authorities took all relevant circumstances into consideration and weighed them carefully against each other; the reasons given by them for refusing the transfer of the urn were relevant and sufficient; and the national authorities acted within the wide margin of appreciation afforded to them in such matters.[107] The starting point for consideration of ECHR rights and responsibilities regarding the burial of human remains is thus a discretion to member states such as Ireland, subject to effective consideration "all relevant circumstances" in the context of individual burials.

In several subsequent cases the Court has found violations of Article 8 in circumstances where the state delayed in the return of human remains to family members who sought to bury their loved one in accordance with their own wishes and traditions. In *Hadri-Vionnet v Switzerland*, the applicant gave birth to a stillborn baby while in a center for asylum seekers.[108] When she and the child's father were asked by the midwife, they said that they did not wish to see the baby's body. After an autopsy had been performed, the body was taken to the cemetery for burial in a communal grave for stillborn babies. The burial took place without a ceremony and without the parents being present. The applicant complained that the body of her stillborn baby was taken away from her and buried without her knowledge in a communal grave. The Court found that Article 8 was applicable to the question of whether the applicant had been entitled to attend her child's burial.[109] The ECHR found that the absence of intent or bad faith on the part of the municipal officials responsible in no sense absolves Switzerland from its own international responsibilities under the Convention. The Court was also not convinced by the Government's argument that the exhumation of the child's body and its transfer to the cemetery near the applicant's new home in Geneva, where it was buried in a Catholic ceremony, constitutes, together with this finding of a violation, adequate and sufficient reparation. The Court observed that having occurred more than a year after the birth and initial burial of the child, these measures were not likely to fully eradicate the suffering endured by the applicant over that period of time and therefore the pain and suffering caused by the inappropriate transport of the child's body remained intact.[110]

In *Girard v France*, the Court recognized a new right under Article 8 – the right to bury one's relatives. The parents argued that a delay in returning of samples taken of their deceased daughter's body during exhumation interfered with their Article 8 rights.[111] The Court accepted that taking of samples from the applicants' daughter did not constitute an interference with their Article 8 rights, but stated that a delay of over four months that elapsed between the decision of the authority to return the samples to the applicants and the actual return. The Court also noted that the parents held a final burial ceremony two days after they received the samples (the body itself had been buried already before). This combination of facts led the Court to establish that an interference with the applicant's private and family life had taken place as the right to bury one's relatives a daughter in this case was protected by Article 8.[112]

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[107] ibid, para. 28

[108] *Hadri-Vionnet v Switzerland,* Application No. 55525/20 14th February 2008

[109] Ibid para 69

[110] Ibid para 69.

[111] *Girard v France* Application no. 22590/04, 30th June 2011

[112] Ibid, para 101.

In *Pannullo and Forte v France,* the Court recognised a violation of Article 8 caused by a delay in returning the remains of a child to her family, "regardless of whether the delay was caused, as the Government submitted, by the experts' inertia or by the judge's "poor understanding of the medical aspects of the case", the Court finds that, regard being had to the circumstances of the case and the tragedy for the parents of losing their child, the French authorities failed to strike a fair balance between the applicants' right to respect for their private and family life and the legitimate aim pursued."[113] In *Zorica Jovanović v. Serbia*, a new-born baby allegedly died in hospital shortly after birth, but his body was never transferred to the parents. The mother complained that the state had failed to provide her with any information about the fate of her son, including the cause of his alleged death or time and place of his burial. The ECtHR held that a state's "continuing failure to provide [the mother] with credible information as to the fate of her son" amounted to a violation of her right to respect for family life.[114]

These decisions indicate the consistent approach of the Strasbourg court is for the return of the remains of the deceased to family members to enable effective respect and protection of the right to family and private life. This approach extends beyond paternal contexts and covers situations of delay or error and significantly develops the broad margin of appreciation understood in *Dodsbo*. However it is also important in the context of Mother and Baby homes to understand the right of families to have access to remains in conjunction with the right to genetic identity.

5.3 International standards regarding mass graves

There are resources including International standards in regard to the treatment of mass graves. The treatment of mass graves was considered in the Minnesota Protocol, which aims to protect the right to life and advance justice, accountability and the right to a remedy by promoting the effective investigation of potentially unlawful death or suspected enforced disappearance, *s*tates that "upon completion of the necessary investigative procedures, human remains should be returned to family members".[115] The Minnesota Protocol sets out that in cases of unlawful death, families of victims have a right "to information about the circumstances, location and condition of the remains and , insofar as it has been determined, the cause and manner of death. [116] It further states that states must enable participation of families in investigations into unlawful death and ensure they obtain available information on the circumstances, events and causes of death, and the location and condition of the remains insofar as these have been determined. In relation to mass graves there is also the Bournemouth Protocol on Mass Grave Protection and Investigation (2020) (the 'Bournemouth Protocol')[117]. The Bournemouth Protocol states that all stages of the investigation, exhumation, identification and return of the human remains process should be as transparent as possible for all parties involved in the protection and investigation effort, the family of the missing and the public. Also the UN Special Rapporteur on extrajudicial, summary or arbitrary execution published a report on mass graves (2020), which presents some of the complex normative and practical

[113] *Pannullo and Forte v France Application no. 37794/97*
[114] *Zorica Jovanović v. Serbia*, No. 21794/08, 26 March 2013.
[115] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016) Office of the United Nations High Commissioner for Human Rights, New York/Geneva, 2017.
[116] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), p 4.
[117] *Bournemouth University Bournemouth Protocol on mass grave protection and investigation, 2020.*

issues raised by the existence of mass graves and provides a set of human rights standards and possible steps towards the respectful and lawful handling of mass graves.

The Minnesota Protocol aims to apply to the investigation of all "potentially unlawful death" and, if, suspected enforced disappearance. For the purpose of the Protocol, this primarily includes psychiatric hospitals, institutions for children and the elderly.[118] The States duty to investigate is triggered where it knows or should have known of any potentially unlawful death.

5.4 Right to Genetic Identity

The European Court of Human Rights (ECtHR) has interpreted Article 8 to include a right to personal identity, including a right of access to information about parental and genetic identity. In *Gaskin v. U.K.,* for example, the Court held that the refusal to allow the applicant access to his paternity records involved a breach of his rights under Article 8, because there was no independent mechanism for determining whether or not access should be permitted where the consent of third party contributors could not be obtained. The Court emphasised the need for specific justification for preventing individuals from having access to information which forms part of their private and family life.[119] Relationships between children and foster parents or carers fall within the definition of 'family' within the meaning of Article 8.

Strasbourg case law has firmly established that the right to know one's genetic origins is an essential component of the right to identity protected under Article 8 (respect for private life). In *Mikulić v. Croatia* the Court concluded that Article 8 provided that the notion of private life which encompassed the right to determine the legal relationship between a child born outside wedlock and her natural parents. It observed in particular that, in determining an application to have paternity established, the courts were required to have regard to the basic principle of the child's interests. In the present case, it found that the procedure available did not strike a fair balance between the right of the applicant to have her uncertainty as to her personal identity eliminated without unnecessary delay and that of her supposed father not to undergo DNA tests. Accordingly, the inefficiency of the courts had left the applicant in a state of prolonged uncertainty as to her personal identity. The Court further held that there had been a violation of Articles 6 § 1 (right to a fair hearing within a reasonable time) and a violation of Article 13 (right to an effective remedy) of the Convention.[120] The limited State discretion in this regard was confirmed in *AMM v Romania*, which confirms that States still retain discretion as to the exact means of facilitating the right to know in the face of a putative father's refusal to cooperate; however, the complete unavailability of measures capable of inducing compliance with a court order directing a paternity test will breach Article 8.[121]

In *Odièvre v. France* the Court considered whether it was compatible with a woman's Article 8 rights that she be denied the right to trace her birth mother who had placed her for adoption under a procedure designed to preserve the mother's anonymity.[122] The Grand Chamber rejected the applicant's complaint, holding that there had been no violation of Article 8 (right to respect for private life), observing in particular that

[118] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016) p 1)
[119] *Gaskin v. U.K.*, [1989] 12 E.H.R.R. 36.
[120] *Mikulić v. Croatia* Application no. 53176/99
[121] *AMM v Romania*, App No 2151/10, ECtHR judgment of 14 February 2012.
[122] *Odièvre v. France* (2004) 38 E.H.R.R. 43

the applicant had been given access to non-identifying information about her mother and natural family that enabled her to trace some of her roots, while ensuring the protection of third-party interests. In addition, recent legislation enacted in 2002 enabled confidentiality to be waived and set up a special body to facilitate searches for information about biological origins. The French legislation thus sought to strike a balance and to ensure sufficient proportion between the competing interests. The ECtHR's decision in *Odièvre* was heavily criticised and it has been suggested by some that it would not be decided along the same lines today.[123]

In *Godelli v. Italy,* which concerned the system of anonymous adoptions in place in Italy, the Court found that Article 8 had been violated as the applicant did not have access to any information about her biological mother and birth family which would allow her to trace her roots.[124] Of particular concern to the ECtHR was the fact that the applicant had not been permitted to access non-identifying information about her birth mother and that disclosure of the birth mother's identity, even with the latter's consent, was not permitted under the Italian legislative framework. According to the Court, a fair balance had to be struck between the child's right to learn about their origins and the mother's right not to have her identity disclosed; the blanket and inappellable refusal of access to non-identifying information, which could have afforded sufficient protection to the mother's interest in preserving her anonymity, was thus found to overstep the State's margin of appreciation in balancing competing interests. Wildhauer et al state: " 'Odièvre found in a rather cursory way that there was no consensus (and no right of a child to learn the identity of the mother), whereas Godelli v Italy … which in effect overruled Odièvre , failed to discuss consensus"[125]

The case law further shows that, in principle, the right to know one's origins goes beyond the parent–child relationship. The *Menéndez García v Spain* decision thus indicates that grandpaternity is also covered, but that a lesser degree of protection is available under the Convention, insofar as States retain a wider margin of appreciation.[126] According to the Court, the interest in knowing one's identity varies depending on the degree of kinship in the ascending line, with parents being of the highest importance, whereas the weight of such interest in relation to grandparents diminishes. The task of weighing up the various interests at play is for each State, within its margin of appreciation.

The trend in Strasbourg jurisprudence is thus towards a restriction on the margin of discretion for member states, and an emphasis on the development of an effective right to genetic identity.

5.5 Obligation on States to enable DNA identification of the deceased to ensure respect for private and family life

The European Court of Human Rights has held that a failure by a State to enable an individual to perform DNA tests on the body of a deceased individual believed to be a family member breached Article 8 of the

[123] T. Callus, "Tempered Hope? A Qualified Right to Know One's Genetic Origin: Odièvre v France" (2004) 67(4) M.L.R. 658; N. Lefaucher, "The French 'Tradition' of Anonymous Birth: The Lines of Argument" (2004) 18 Int'l. J. Law, Pol'y. & Fam. 319.
[124] *Godelli v. Italy*, App. no. 33783/09 (ECt.H.R., 25 September 2012)
[125] L Wildhaber, A Hjartarson and S Donnelly, 'No Consensus on Consensus? The Practice of the European Court of Human Rights' (2013) 33 Human Rights Law Journal 248, 257
[126] *Menéndez García v Spain*, App No 21046/07, ECtHR decision of 5 May 2009.

Convention regarding respect for private and family life.[127] In *Jäggi v. Switzerland*, the applicant applied for a DNA test on the mortal remains of his alleged father. His application was refused by the trial courts and dismissed on appeal to the Federal Court, which concluded that at the age of 60 he had been able to develop his personality even in the absence of certainty as to the identity of his biological father. The Court considered that persons trying to establish their ancestry had a vital interest, protected by the Convention, in obtaining the information they needed in order to discover the truth about an important aspect of their personal identity. However, the need to protect third parties might exclude the possibility of compelling them to submit to any kind of medical analysis, particularly DNA tests.[128] The Court therefore intended to gauge the relative weight of the conflicting interests, namely the applicant's right to discover his parentage against the right of third parties to the inviolability of the deceased's body, the right to respect for the dead and the public interest in the protection of legal certainty.[129] In the first place, the Court considered that an individual's interest in discovering his parentage did not disappear with age, on the contrary. Moreover, the applicant had always shown a real interest in discovering his father's identity, since he had tried throughout his life to obtain reliable information on the point. Such conduct implied moral and mental suffering, even though this had not been medically attested.[130] Secondly, the Court noted that in opposing the DNA test, which was a relatively unintrusive measure, A.H.'s family had not cited any religious or philosophical reasons. Moreover, if the applicant had not renewed the lease on A.H.'s tomb, the peace of the deceased and the inviolability of his mortal remains would already have been impaired in 1997. In any event, his body was due to be exhumed in 2016, when the current lease expired. The right to rest in peace therefore enjoyed only temporary protection. In addition, the Court observed that the private life of the deceased person from whom it was proposed to take a DNA sample could not be impaired by such a request since it was made after his death. Lastly, the Court noted that the protection of legal certainty alone could not suffice as grounds to deprive the applicant of the right to discover his parentage.

The Court relied on their decision in *Estate of Kresten Filtenborg Mortensen v. Denmark*, where it found that the private life of a deceased person from whom a DNA sample was to be taken could not be adversely affected by a request to that effect made after his death.[131] The Court notes that the preservation of legal certainty cannot suffice in itself as a ground for depriving the applicant of the right to ascertain his parentage.[132] As a result the Court considered that Switzerland had not secured to Mr Jäggi the right to respect for his private life and held that there had been a violation of Article 8.

[127] *Jäggi v. Switzerland* (Application no. 58757/00) 13th October 2006.
[128] ibid, para 38.
[129] ibid, para. 39.
[130] ibid, para. 40.
[131] *Estate of Kresten Filtenborg Mortensen v. Denmark* ((dec.), no. 1338/03, ECHR 2006-V.
[132] ibid, para. 43.

APPENDIX 1: TABLES RELATING TO INSTITUTIONS INVESTIGATED BY MBHCOI

Infant / child deaths

Institution	Deaths	Causes of death	Burial / whereabouts / identities of the buried
Dublin Union/St Patrick's Navan Road/ Pelletstown/ Eglinton House	3,615 deaths identified;[133] 3,511 (97.12%) recorded in General Register Office (GRO).[134]	Information available for 3,511 deaths (97.12%)[135]: ● non-specific (19.2%); ● respiratory infections (18.4%); ● gastroenteritis (15.6%); <10%: each of: ● tuberculosis; ● malabsorption; ● other causes; <5%: each of: ● meningitis/encephalitis; ● spina bifida; ● congenital syphilis; ● congenital heart disease; ● measles; ● generalised infections; ● haemorrhage; ● diphtheria; ● influenza. ● Deaths higher amongst children who did not have their mother present[136]; ● a doctor "believed that the children died because of neglect"[137]; ● death from diphtheria preventable by inoculation[138]. <u>Conditions</u> Concerns were raised	Burial place of 3,102 children (85.8%) established[143]: ● Glasnevin cemetery (3,097). ● Mount Jerome cemetery (5).

[133] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) Executive Summary, paras 76-77.
[134] ibid ch 13A, 31.
[135] ibid ch 13A, 35.
[136] ibid ch 13, para 13.85; ch 13A, 35.
[137] ibid ch 13, para 13.171.
[138] ibid.
[143] ibid ch 13A, 34.

		throughout 1940s-1960s[139]. Descriptions include: ● acute overcrowding, ● facilities hopelessly inadequate, ● failure to isolate infectious children, ● inadequate heating[140]; ● lack of medical staff[141]; ● inadequate facilities to deal with disease, ● failure to immunise children against diphtheria[142].	
Tuam	978 identified (between 1921 - 1961)[144]. 972 (99.4%) registered in GRO.[145] The MBHCOI concluded that there were some problems with registrations of death.[146]	Causes of death[147]: ● non-specific causes (18.2%) ● respiratory infections (18.1%). ● Convulsions (>11%); ● other causes (10.8%); <10%: each of: ● tuberculosis; ● influenza; ● gastroenteritis/gastritis; <5%: each of: ● meningitis; ● measles; ● congenital heart disease; ● haemorrhage; ● diphtheria; ● malabsorptions; ● congenital syphilis; ● spina bifida; ● generalised infections.	No register of burials was kept; likely that most children are buried inappropriately in the grounds[156]. Human remains were found in a 'structure with 20 chambers...built within the decommissioned large sewage tank'; ● not established that all children who died are buried in this. ● some evidence of possible burials in other parts of what were the grounds.[157] Burial records were found for 51 children who died in hospitals: ● Bohermore Cemetery, Galway (50) ● Glasnevin Cemetery, Dublin (1).[158] Memorial garden on former Tuam home site contains human remains which date from the period of the home's operation. It is considered likely that a large number

[139] ibid ch 13, paras 13.202; 13.212.
[140] ibid para 13.173.
[141] ibid para 13.170.
[142] ibid para 13.160.
[144] ibid, Executive Summary, para 85.
[145] ibid ch 13A, 31.
[146] ibid ch 15, para 15.70.
[147] ibid ch 15A, 38.
[156] ibid, Executive Summary, paras 83-85.
[157] Department of Children, Equality, Disability, Integration and Youth, *Fifth Interim Report of the Commission of Investigation into Mother and Baby Homes* (2019), para 9.
[158] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 15A, 34.

		● Local authority records have virtually no information about deaths or illnesses in the home.[148] ● A 1946 report noting causes of high death-rate was not seen by MBHCOI[149]. ● There were calls for an enquiry into possible causes of death in 1946[150]; ● "regrettable" that MBHCOI saw no further detailed reports on the children in the home after 1947"[151]. <u>Conditions</u> ● Galway county council failed to properly maintain conditions. ● physical conditions were dire and unusually, much worse than a county home.[152] Inspections showed: ● calls for: an investigation, noting a lack of "prenatal care"; improvements; heating[153]; infants to be properly dressed;[154] ● cots in the nursery "did not have the usual bed clothes" ● poorly maintained, uncomfortable, badly heated and totally unsuitable building[155].	of the children who died in the Tuam home are buried there[159].

[148]Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020) ch 15, para 15.90.
[149] ibid ch 15, para 15.65.
[150] ibid ch 15, para 15.38.
[151] ibid ch 15, para 15.98.
[152] ibid Executive Summary, para 83.
[153] ibid ch 15, para 15.63.
[154] ibid ch 15, para 15.64.
[155] ibid ch 15, para 15.38.
[159] Department of Children, Equality, Disability, Integration and Youth, *Fifth Interim Report of the Commission of Investigation into Mother and Baby Homes* (2019).

Bessborough 1922-1998	923 identified[160].	Information was available for 912 children:[161] ● Non-Specific Causes (184). ● Malabsorption (169). ● Respiratory Infections (167). ● Gastroenteritis (153) ● Tuberculosis (40). ● Haemorrhage (38). ● Other Causes (36). ● Congenital Heart Disease (30). Inspections/reports (1943 and 1945) showed: ● unsatisfactory milk supply to the home and failure to breastfeed as main causes of the high death rate and unhealthy condition of children[162]. ● as 60% of infants under one year old die, it seemed that very little steps were taken to keep them alive; ● indications that absolutely no trouble is taken to induce the mothers to breast-feed[163]. ● most deaths "preventable"[164]. **Conditions**	Bessborough failed to keep a register of infant burials; unknown burial location for majority of children.[168] MBHCOI "perplexed and concerned" at inability of any member of the Congregation of the Sacred Hearts of Jesus and Mary to identify the burial place of the children[169]. A number of people and organisations have made suggestions about possible grave locations both in the current Bessborough estate (roughly 60 acres) and in areas sold (total area was once about 200 acres). During 2019, MBHCOI followed up on some of these suggestions.[170] MBHCOI recognises that it is highly likely that burials did take place in the grounds of Bessborough. The only way that this can be established is by an excavation of the entire property including those areas that are now built on[171]. A former Bessborough staff member (1948 - 1998) stated her belief that infants were buried in the same onsite cemetery as the nuns[172]. Another reported a burial in a family plot in St Michael's Cemetery[173] and burials in the Bessborough congregational burial ground onsite[174]. A third former staff member stated that infants were buried in the congregational cemetery at Bessborough[175], but she did not know where children who died in

[160] ibid Executive Summary, para 95.
[161] ibid ch 18A, 41.
[162] ibid ch 18, 26-27.
[163] ibid ch 18, 28.
[164] ibid ch 18, para 18.129.
[168] ibid Executive Summary, para 97.
[169] ibid para 38.12.
[170] ibid para 38.13.
[171] ibid para 38.17.
[172] ibid ch 18, para 18.227.
[173] ibid ch 18, para 18.242.
[174] ibid ch 18, para 18.250.
[175] ibid ch 18, para 18.280.

		Bessborough at times accepted the high infant mortality as "inevitable"[165]. Inspection in 1941 showed: ● overcrowding, ● understaffing, ● lack of up to date information about miscarriages and deaths in maternity hospital[166], ● tendency to discourage breastfeeding. Following interventions by the Department of Local Government and Public Health in 1945 and revised operational structures in Bessborough, child mortality fell[167].	Bessborough from the 1920s to the 1970s were buried[176]. Evidence was given by a mother who was told that her child was buried in the small cemetery at Bessborough[177] but the MBHCOI found that this was not the case[178].
Sean Ross Abbey 1931-1969	1,090 babies died[179]. Institutional records show when infant and child deaths occurred[180]: 1932-1947: 79% 1930s: 42.5%. 1940s: >39.5% 1950s: 12% 1960s: 6%.	Information was available for 1,088 deaths (99.8%)[181] : ● respiratory infections (15.5%); ● nonspecific causes (13.3%); ● generalised infections (13%); ● gastroenteritis, gastritis and epidemic enteritis /diarrhoea (12%); <10%: each of: ● malabsorption; ● influenza; ● asphyxia pallida, pyloric stenosis and a range of mostly one off causes;	Registers of burials were not maintained. There is a designated burial ground; MBHCOI established that the coffined remains of some children under the age of one are buried there[185]. Without complete excavation it is not possible to say conclusively that all of the children who died in Sean Ross are buried in the designated burial ground. MBHCOI does not consider that further investigation is warranted[186]. An archaeological report[187], appended to the MBHCOI Final Report notes: (i) Their geophysical survey conducted over four weeks represented just less than 10% of the total available area within the site boundary (page 107);

[165] ibid ch 18, 18.
[166] ibid ch 18, 22.
[167] ibid ch 18, 35.
[176] ibid ch 18, para 18.281.
[177] ibid ch 18, para 18.305.
[178] ibid ch 18, para 18.310.
[179] ibid Executive Summary, para 103.
[180] ibid ch 19A, 26.
[181] ibid ch 19A, 30.
[185] ibid Executive Summary, para 104.
[186] ibid ch 38, para 38.9.
[187] N McCullough, LG Lynch, A Harte, *Report of Forensic Archaeological Investigations at Sean Ross Abbey Mother and Baby Home Children's Burial Ground, Roscrea, Co Tipperary* (2019).

		• Diphtheria; <5%: each of: • congenital heart disease; • convulsions; • haemorrhage; • spina bifida; • tuberculosis; • congenital syphilis • meningitis. • Overcrowding and unsuitable accommodation were the chief causes of the high infant mortality[182]. <u>Conditions</u> • Overcrowding is repeatedly reported;[183] • additional accommodation and improvements to existing accommodation was necessary and 'a matter of extreme urgency' as infant mortality in the home was 'exceptionally high'.[184] (1933-34)	(ii) Only 42 infants' remains were found in the test excavation: Within the test trenches the skeletal remains of 21 infants were found, the majority of whom seemed to be in coffins. A further 11 coffins were also recorded and undisturbed by excavation. Finally, 'Archaeological evidence and evidence from disarticulated skeletal remains indicates a further 10 possible individuals represented in the results of this excavation' (page 108); (iii) There were no coffin- or name-plates in evidence and 'an absence of grave markers or headstones' (page 108) (iv) Thirteen samples of bones were submitted for radiocarbon dating...The range of estimated years-of-death for these samples are in the 1930s, 1940s and 1950s. This clearly falls within the period of the operation of the Sean Ross Abbey Mother and Baby Home (page 108); (v) 'The total number of infant deaths which are recorded as having occurred here are 1078. Without complete excavation it is not possible to say conclusively that all of these individuals are buried within the present site of the Children's Burial Ground. There may have been dense concentrations of burials in other areas of the site that were not excavated. This excavation recorded evidence of a minimum number of 32 individuals and a further four possible graves and six disarticulated individuals across 10% of the ground surface. It was not possible to determine if other tiers or layers exist beneath these burials. No young adult or adult remains were exposed during this excavation; however, there are two memorials to older individuals. These individuals are recorded in the maternal death register, indicating that the burial ground was not exclusively designated for infants and young children

[182] ibid ch 19, para 19.31.
[183] ibid ch 19, paras 19.11, 19.105, 19.30.
[184] ibid para 19.30.

			who died while in the care of the Home' (page 109).
Castlepollard 1935-1971	247 children died[188]. date of death was available for 246 children. 230 deaths are recorded in the GRO.[189] 1935-1947: 67.5% of deaths;[190] Mortality was high in 1940 and in 1944-47.[191]	Cause of death was available for 230 children (93.1%)[192]: ● congenital debility and prematurity (26.1%); ● respiratory infections (22.2%); ● gastroenteritis and gastritis (13%); <10%:each of: ● whooping cough and one off causes; ● congenital heart disease; ● haemorrhage; ● malabsorption; <5%: each of: ● influenza; ● convulsions; ● meningitis or encephalitis; ● spina bifida; ● generalised infections; ● tuberculosis ● congenital syphilis. <u>Conditions</u> 1927 report: ● sanitary and bathing conditions in the home insufficient, ● bad and wanting in comfort, poor (no heat or ventilation, milk supply suspect, ● no proper lavatory accommodation, ● unsatisfactory sanitary conditions, ● defective drainage and	'No register of burials was maintained but it seems likely that most of the children who died are buried in the designated burial ground.'[197] The MBHCOI Fifth Interim Report states: 'However, there is no documentary evidence to confirm this.'[198] However, the MBHCOI Final Report cites correspondence between the nuns and the Midland Health Board in 1994 regarding the nuns' wish to place a memorial stone on what they stated were the children's burial plots as evidence that children are buried in the 'marked burial ground'[199]. It is not clear how many children are in this burial plot.

[188] ibid Executive Summary, para 110.
[189] ibid.
[190] ibid ch 20A, 27.
[191] ibid.
[192] ibid ch 20A, 31.
[197] ibid Executive Summary, para 111.
[198] Department of Children, Equality, Disability, Integration and Youth, *Fifth Interim Report of the Commission of Investigation into Mother and Baby Homes* (2019), para 4.
[199] ibid, ch 38A, para 38.26.

		• no disinfecting apparatus).[193] By 1937: • grossly overcrowded • overcrowding worsened subsequently. By 1941, women and their older children were sleeping in unheated lofts above the stables some distance from the main house. There was one toilet for 44 women and no space to store clothing or personal belongings. Women had no space for recreation and there was no space in the nurseries for children to play. Castlepollard continued to exceed the specified accommodation limits until the early 1950s. Although central heating was installed in the new hospital unit it was not used for some years because the home, which had its own generator, was supplying electricity to the town of Castlepollard.[194] 1941 inspection report: "conditions here are very bad and admissions should be stopped until such time as the overcrowding is reduced. There is a serious menace to health in the present conditions."[195] 1945: conditions reported to be uncivilised.[196]	

[193] ibid ch 20A para 20.12.
[194] ibid, Executive Summary para 107.
[195] ibid ch 20, para 20.34.
[196] ibid ch 20, para 20.41.

Kilrush 1922-1932	Numbers are unknown; medical officer described death rate in 1927 as 'appalling.'[200] Central Statistics Office figures show 168 deaths of "illegitimate" infants in Co. Clare institutions between 1923 and 1932.[201] MBHCOI consider it probable that at least the majority died in Kilrush nursery, as it was the only Co Clare institution for 'illegitimate' children.[202] Death rate in Co Clare institutions is very high when compared with the numbers in the baptismal record.[203]	No formal cause of death information. Available records refer to childrens' deaths and to conditions which contributed to the deaths.[204] February 1927 report: at one time, the death rate in the nursery was so high that special precautions had to be taken to protect them.[205] An indicator of the high mortality rate was the continuous requisitions for coffins which are recorded in the minutes. This record also points to children of different ages dying in the nursery as the coffins were of different sizes.[206] <u>Conditions</u> It was a former workhouse and was even worse than Tuam. It had no running water, baths or indoor toilets.[207] Evidence from an inspection in 1922 found that the physical condition of the Kilrush nursery was always very poor and so bad that its closure was considered less than a year after it opened and " that it was a 'perfect scandal to have anyone in the place'. The inspector was concerned that the prevailing conditions, 'would give rise some time or other to an outbreak of fever for which the County Board of Health would be responsible'.[208] When the home closed, there were records on ongoing serious concerns from a doctor, the matron and others about conditions in the nursery and the risk they posed to the residents.[209] In 1924 a doctor sent a report asking the board to approve a	No information on burial whereabouts.

		revised ‘dietary scale’ as ‘the mothers were unable to nurse their children satisfactorily’. He also wanted the diet of the school children revised.[210]	

Regina Coeli 1930-1998	734 children died.[211] Date of death information was available for 718 children (97.8%)[212] Worst period: 1941 to 1946 (54.2%).[213]	No available records. "An attempt to locate GRO death records …proved difficult; the [MBHCOI] considered that efforts to establish cause of death through engagement with GRO death records was not feasible."[214] <u>Conditions</u> 1948 report[215]: ● infant mortality was three times the rate in Pelletstown; ● Regina Coeli hostel lacked 'almost every proper facility in regard to both nursing and structure'.	Burial arrangements were not investigated by the MBHCOI 'as the children died in many different locations'.[216]
Dunboyne 1955-1991	37 children died; (two-thirds in a maternity hospital; others mainly in children's hospitals)[217]. GRO death records: 32 of 37 children.	Cause of death[218] was available for 32 of 37 deaths (86.5%): ● one off incidents (37.5%). ● respiratory infections (28.1%); ● spina bifida (15.6%) ● non-specific causes (12.5%) ● congenital heart disease (6.3%). <u>Conditions</u> ● facilities were very good. ● adequate sanitary arrangements and central heating.[219]	A Sister employed at the home gave evidence that "There was no burial plot in the grounds of Dunboyne. The Good Shepherd Sisters bought a plot in the local authority graveyard in Dunboyne where some infants were buried."[220] There is no further information in the dedicated section of the MBHCOI Final Report (chapter 24) which deals with this home, about burial arrangements.

[211] Ibid Executive Summary, para 118.
[212] ibid ch 21A, 8.
[213] ibid.
[214] ibid.
[215] ibid Executive Summary, para 118.
[216] ibid Executive Summary, para 119.
[217] ibid ch 24A, 25.
[218] ibid ch 24A, 27.
[219] ibid Executive Summary para 122.
[220] ibid ch 24, para 24.188.

Bethany 1922-1971	262 children died.[221] 195 deaths (almost 75%) occurred in the Bethany home; 17.4% died in hospitals; seven children died in Emmanuel House.[222]	Information relating to cause of death[223] was available for 256 children (97.7%): ● malabsorption (32%); ● gastroenteritis (15.2%); ● respiratory infections (13.7%); <10%: each of: ● non-specific causes; ● congenital heart disease; ● a range of other mostly one off causes; <5%:each of:: ● generalised infections; ● convulsions; ● tuberculosis; ● meningitis/encephalitis; ● haemorrhage; ● congenital syphilis; ● spina bifida; ● influenza; ● measles.[224] Deaths were recorded in the Bethany Baby Book Register (1922 -1970). Two columns headed 'where gone' and 'later news', were used to record the death, date and place of death. <u>Conditions</u> Reasons[225] for high infant mortality: ● Overcrowding (especially 1930s); ● inadequate facilities for treating illnesses; ● under-qualified staff; ● frequently dire financial pressures; ● inadequate heating and sanitary conditions; ● lack of heating and facilities for drying clothes;	Burial records for 235 children were located[226]: ● Mount Jerome Cemetery, Harold's Cross (231) ● Glasnevin Cemetery (4).

[221] ibid, Executive Summary, para 131.
[222] Ibid ch 22A, 23.
[223] ibid ch 22A, 25.
[224] ibid ch 22A, 23.
[225] ibid ch 22, para 22.81.
[226] ibid ch 22A, 23.

		● the number of children without their mother may have been a factor.	
Denny House 1765-1994	55 children died[227]. 47 GRO death records were located.[228] Deaths[229]: 1920s: 13. 1930s: 24. 1940s: 16. 1950s: 2.	Information on cause of death[230] was available for 48 deaths (85.7%): ● non-specific (35.4%); ● gastroenteritis (16.6%); ● respiratory infections (12.5%); ● a range of other, mainly one off causes (12.5%); ● malabsorption (8.3%); ● congenital heart disease (6.2%); ● tuberculosis (4.1%); ● Influenza; ● Meningitis. "The infant mortality rate was substantially lower than in other mother and baby homes."[231] <u>Conditions</u> No indication of overcrowding[232]. Possible reasons for lower infant mortality in this home than others include[233]: ● small size; ● less exposure to infection than in larger homes; ● no evidence of overcrowding; pre-admission screening of mothers for infectious diseases; ● non-admission of older children who might transmit infectious diseases	"Burial records were located for 34 children - all are interred in Mount Jerome cemetery."[234] "The burial place of the others is not known; they may have been buried by their family or in a plot owned by the hospital where they died."[235]

[227] ibid Executive Summary, para 139.
[228] ibid ch 23A, 16.
[229] ibid ch 23, para 23.94.
[230] ibid ch 23A, 16.
[231] ibid ch 23, para 23.95.
[232] ibid Executive Summary, para 136.
[233] ibid ch 23, para 23.96.
[234] ibid ch 23A, 16.
[235] ibid ch 23, para 23.94.

		to infants; ● apparently high rate of breastfeeding; ● detailed records from the 1940s suggest that doctors were regularly called into this home and were involved in its governance.	
Miss Carr's Flatlets 1972-present	Three deaths recorded[236].	Causes: ● Cot deaths (2); ● Viral pneumonia (1).[237] <u>Conditions</u> ● Nine flatlets in a large house. ● Residents were expected to be self-supporting.[238]	No information.
The Castle 1982-2006	Five babies died[239].	"All died soon after birth in the hospitals in which they were born."[240] <u>Conditions</u> The women had individual bedrooms with sufficient space for a child.[241]	No information about burials. Diaries record that the staff were upset by the deaths and they helped with funeral arrangements if the mothers were not getting family assistance.[242]
St Gerards 1919-1939	No information.	Very little is known about St. Gerard's because the MBHCOI was unable to access its institutional records.[243]	No information.
Cork County Home 1921-1960	545 children died.[244] (according to institutional records. Some of these children	Information was available[246] for 512 deaths (93.9%): ● gastroenteritis (26.37%) malabsorption (17.19%); ● non-specific cause(16.8%);	The MBHCOI understands that unclaimed remains of those who died in Cork county home were buried at Cork District Cemetery at Carr's Hill.

[236] ibid ch 25, paras 25.74 – 25.77.
[237] ibid ch 25, para 25.75.
[238] ibid Executive Summary, para 142.
[239] ibid Executive Summary, para 145.
[240] ibid ch 26, para 26.21.
[241] ibid Executive Summary para 147.
[242] ibid ch 26, para 26.21.
[243] ibid Executive Summary, para 148; ch 27, para 27.2 – 27.3. It has not been possible to extract St. Gerard's files from St. Patrick's Guild files, of which they are a part. These were provided to the Child and Family Agency (TUSLA) in 2017 but have not yet been fully processed.
[244] ibid Executive Summary, para 156.
[246] ibid ch 28, 13.

	may in fact have been boarded out by the local authority or had been placed at nurse by their mother. Cross reference with GRO records confirmed the deaths of 512 'illegitimate' children.)[245]	• respiratory infections (13.28%); • tuberculosis (10.35%); • a range of other, mostly one off, causes (5.08%); <5% :each of: • infantile convulsions; • congenital syphilis; • generalised infections; • congenital heart disease; • haemorrhage; • meningitis/encephalitis; • spina bifida; • measles; • diphtheria. <u>Conditions</u> • Living conditions in this and all county homes were appalling (1920s). • Women ate their meals squatting on the floor (1921). • Most heating was by open fire. • Food was often adulterated or unfit for consumption. • Milk was watered and meat was of poor quality. • No major improvements were carried out until the 1950s.[247]	No burial registers were located despite extensive efforts. Limited mortuary records containing burial records were found. Anecdotal evidence suggests that burials from Cork county home/St Finbarr's Hospital continued at Carr's Hill until 1962.[248] Of 449 confirmed deaths of 'illegitimate' children in Cork county home (1922-60), burial records for just two were found in Cork city and hinterland, both in St Finbarr's Cemetery 'poor ground' section.[249] A 'Record of Deaths in Cork County Home and Hospital' (1931-1940) shows that a board of assistance allotted shrouds to 50 'illegitimate' children and coffins to those over one year old, but not burial plots (as was the case for many adults).[250] Mortuary records (1968-85) show that 'illegitimate' infants who died in St Finbarr's Hospital were all interred in St Michael's Cemetery, but no burial records for them were found there. Some infants were buried in the coffin of a deceased adult patient or in coffins containing amputated limbs.[251] The MBHCOI has not been able to establish if burying infants in coffins of deceased adults was done from 1948 (burials plots for deceased adults from Cork County Home were purchased from 1948 by health authorities).[252]
Stranorlar 1922-1964	343 children died.[253] GRO death records for 339 children	Information available for 339 children (98.8%)[255]: • respiratory infections (60.47%); • nonspecific causes (11.8%);	<u>Burial whereabouts</u> The burial ground was the original workhouse burial ground, north of the main building. It later doubled in size to encompass the plot to the east.[258] The MBHCOI Final Report contains maps outlining the sites. Both burial grounds are

[245] ibid ch 28, para 28.64.
[247] ibid Executive Summary, para 154.
[248] ibid ch 28, para 28.75.
[249] ibid, ch 28, para 28.76.
[250] ibid ch 28, para 28.77.
[251] HSE, Cork University Maternity Hospital, Burial index card box/folder of burial records 1968-85.
[252] ibid ch 28, para 28.78.
[253] ibid, Executive Summary, para 161.
[255] ibid ch 29A.
[258] ibid ch 29, para 29.36.

	(98.8%)."[254]	• icterus neonatorum and a range of other, mainly one off causes (10.62%); <5%: each of: • congenital syphilis malabsorption • tuberculosis convulsions • haemorrhage • congenital heart disease; • influenza; • spina bifida; • measles; • diphtheria; • meningitis/encephalitis • gastroenteritis. • "extremely poor living conditions …may..explain excessively high infant mortality rates recorded..during 1930. (Of 37 infants born or admitted during 1930, 23 died there)."[256] <u>Conditions</u>[257] • very poor. • Overcrowded (early 1920s). • Inadequate water and sanitary services - only two flush toilets; • outdoor toilets 'bad and rather revolting'; • no hot water in the operating theatre; • Several outbreaks of typhoid; • diet was dominated by bread and tea.	now part of Stranorlar and Ballybofey Golf Club fairways.[259] <u>Burials</u> A carpenter was employed on a regular basis to make coffins, and notably 'small coffins', which suggests that the deceased were buried in lined red deal caskets; burial ceremonies were conducted by one of the three chaplains. Regular complaints are recorded from the institution's storekeeper, matron and from the clergy between 1927 and 1948 as to the need for an extension to the burial ground, its "wretched" and "deplorable" condition, its overcrowdedness and its unsuitability as a burial ground due to being shallow, rocky and full of springs. For example, in April 1948, the curate complained that it was 'overcrowded and graves were overlapping'. As a result, the gravedigger had split another coffin while digging a grave.[260] The rocky terrain of the old burial ground could not facilitate deep graves; institutional records clearly state that graves were shallow and that bodies were buried in an ad-hoc manner.[261] Following an inspection by the county engineer, a new burial ground was created in 1949 and the first burial occurred in February 1950. <u>Burial Records</u> A burial register for the new burial ground is held at St Conal's Hospital, Letterkenny for a period between 1950 –1973. However, no recorded burials relate to infants or children, despite around 30 'illegitimate' children dying in Stranorlar county home during that time. Evidence suggests they were buried with other deceased 'inmates' in the old workhouse cemetery.

[254] ibid ch 29.
[256] ibid ch 29, para 29.58.
[257] ibid Executive Summary, para 158.
[259] ibid ch 29, para 29.38.
[260] ibid ch 29, paras 29.35 - 25.39.
[261] ibid ch 29, para 29.39.

Thomastown 1922-1960	177 children died[262]. GRO death records found for 169 children (95.5%).[263]	Information[264] was available for 169 children (95.5%): ● non-specific (57.99%); ● tuberculosis (11.83%); ● respiratory infections (10.65%); ● gastroenteritis (5.92%); <5%: each of: ● malabsorption; ● convulsions; ● haemorrhage; ● congenital heart disease; meningitis/encephalitis; ● spina bifida; ● generalized infection; ● measles. <u>Conditions</u>[265] ● very poor; ● nursery was the worst part; ● 58 infants sleeping in 32 cots (1925); ● no significant improvements for several decades; ● eight baths, 16 WC and 16 wash-hand basins for 250 men, women and children; baths seldom had hot water (1946). ● laundry done by hand; ● no disinfecting facilities; ● no electric sockets, heating or sanitary equipment in the labour ward. ● Department of Health deferred installing central heating, prioritising county hospitals and sanatoria (1949).	<u>Burial records</u>[266] A groundsman told the MBHCOI that around 1990, he was asked by the matron to incinerate institutional records, which he believed would have included burial registers from the time of operation of Thomastown county home. <u>Likely whereabouts</u> Shortly after this, groundsmen were put to work renovating the institutional graveyard located in an adjacent field. The groundsman identified the graveyard location on a map - to the east of St Columba's Hospital (previously identified as a potential institutional graveyard by MBHCOI). He said that the graveyard, known locally as the 'Shankyard graveyard' had been neglected for some years and was in a state of disrepair. He stated that 'several loads of topsoil' were put down on the graves and that the site was levelled and grassed. The MBHCOI visited the graveyard in 2019 and found the site to be well maintained. A single cross with the inscription 'Remembering those who died' marks the site as a former graveyard. The graveyard was in operation from 1854 to 1978. The MBHCOI considers it likely that children who died in Thomastown county home were buried there. A small number of the 169 recorded child deaths occurred outside Thomastown county home: in Bessborough (4); Cork District Hospital (1); another hospital (1); another county home and in a private residence(1). Burial records for the children who died in Bessborough and in Cork District Hospital show they were buried in St Joseph's Cemetery, Cork.[267]

[262] ibid, Executive Summary, para 165.
[263] ibid ch30A, 10.
[264] ibid ch 30A, 12.
[265] ibid Executive Summary, para 163.
[266] ibid ch 30, para 30.51.
[267] Department of Children, Equality, Disability, Integration and Youth, *Final Report of the Commission of Investigation into Mother and Baby Homes* (2020), ch 30A, 10.

Maternal deaths:

Institution	**Deaths**	**Causes of death**	**Burial / whereabouts / identities of the buried**
Dublin Union/St Patrick's Navan Road/Pelletstown/Eglinton House	43 deaths (mortality rate of 0.29%). Majority of deaths occurred in Pelletstown/Dublin Union/St Kevin's Hospital."[268] Adhering to WHO guidelines, the maternal mortality rate was 0.08%.[269]	Thirty deaths: not associated with pregnancy or childbirth (in the main, due to tuberculosis, dysentery, pneumonia and cardiac failure). Five deaths: indirect obstetric deaths (developed during pregnancy, were aggravated by the physiological effects of pregnancy and generally resulted in cardiac failure). Eight deaths: directly associated with pregnancy and childbirth (mainly due to nephritis, pulmonary embolism, postpartum haemorrhage, septicaemia and peritonitis).[270]	No information.
Tuam	12 deaths (mortality rate of 0.54%). Seven deaths occurred in Tuam and five in the Central Hospital, Galway.[271] Adhering to WHO guidelines the maternal mortality rate in Tuam was 0.27%.[272]	Six deaths were not associated with pregnancy or childbirth (in the main, due to tuberculosis, measles, pneumonia and cardiac failure). One death due to coronary thrombosis was an indirect obstetric death (condition developed during pregnancy and was aggravated by the physiological effects of pregnancy). Five deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were mainly due to puerperal sepsis and albuminuria and postoperative shock (caesarean).[273]	No information.
Bessborough 1922-1998	31 deaths (mortality rate 0.32%).	Twenty deaths were not associated with pregnancy or childbirth - half of these relate to women who were long term residents in Bessborough, one was an	Burial records for 12 women in St Joseph's

[268] ibid ch 13A, 17.
[269] ibid.
[270] ibid.
[271] ibid, ch 15A, 17.
[272] ibid.
[273] ibid.

	Thirteen deaths occurred in external hospitals - mainly in Cork District Hospital".[274] The MBHCOI found GRO records for 29 of the 31 maternal deaths.[275] Adhering to WHO guidelines the maternal mortality rate was 0.11%. [276]	accidental death due to electric shock and the others were mainly due to diseases such as tuberculosis, pneumonia, meningitis and leukaemia. Three deaths were indirect obstetric deaths in the sense that they were conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy and generally resulted in cardiac failure. Eight deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were due to nephritis, haemorrhage, septicaemia, eclampsia and toxaemia. [277]	Cemetery, Cork.[278]
Sean Ross Abbey 1931-1969	37 deaths (mortality rate of 0.58%).[279] Sixteen deaths occurred in external hospitals."[280] Adhering to WHO guidelines the maternal mortality rate 0.35%.[281]	Fourteen deaths were not associated with pregnancy or childbirth - half of these were due to typhoid and the remainder were, in the main, due to tuberculosis. Eight deaths were indirect obstetric deaths in the sense that they were conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy and generally resulted in cardiac failure. Fifteen deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were due to eclampsia, puerperal sepsis, toxaemia, nephritis and coronary embolism and thrombosis.[282]	No information.
Castlepollard 1935-1971	Nine deaths (mortality rate of 0.18%). All bar one death occurred in Castlepollard.[283]	One death was not associated with pregnancy or childbirth (tubercular meningitis). Three deaths were indirect obstetric deaths (conditions that developed during pregnancy, were aggravated by the	No information.

[274] ibid, ch 18A 11.
[275] ibid, ch 18A 12.
[276] ibid, ch 18A 11.
[277] ibid.
[278] ibid.
[279] ibid, ch 19A, 16.
[280] ibid, ch 19A, 16.
[281] ibid, ch 19A, 16.
[282] ibid, ch 19A, 16.
[283] ibid, Ch 20A, 15.

	Adhering to WHO guidelines the maternal mortality rate was 0.16%.[284]	physiological effects of pregnancy) - all three were notified as syncope. Five deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were mainly due to puerperal septicaemia/sepsis, eclampsia and atrophy of the liver.[285]	
Kilrush 1922-1932	No information.	No information.	No information.
Regina Coeli 1930-1998	13 deaths. All 13 women died in external hospitals; the majority occurred before 1950.[286]	Three deaths were associated either directly or indirectly with pregnancy and childbirth. Most deaths were due to infectious disease such as tuberculosis (eight deaths) and bronchitis."[287]	No information.
Dunboyne 1955-1991	No information	No information	No information
Bethany 1922-1971	Five deaths (mortality rate of 0.32%). Three occurred in Bethany; two in external hospitals."[288]	Two deaths were indirect obstetric deaths (conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy) - both cases resulted in cardiac failure. Three deaths were directly associated with pregnancy and childbirth - all three deaths were due to puerperal sepsis."[289]	There is a report of a funeral for one woman (September 1957) who died in Adelaide Hospital following an operation.[290]
Denny House 1765-1994	Four deaths.[291] All occurred in external hospitals in the 1930s (2) and 1940s (2).[292]	Cause of death was available for two women[293]: ● Bronchopneumonia ● puerperal sepsis.	No information.
Miss Carr's Flatlets 1972-present	No maternal deaths recorded[294]	N/a	N/a

[284] ibid, ch 20A, 15.
[285] ibid, ch 20A, 15.
[286] ibid, ch 21, 4.
[287] ibid, ch 21, 4.
[288] ibid, ch 22A, 14.
[289] ibid, ch 22A, 14.
[290] Ibid, ch 22, para 22.72.
[291] ibid, ch 23A, 12
[292] ibid, ch 23A, 12
[293] ibid, ch 23A, 12.
[294] ibid, ch 25, para 25.67.

The Castle 1982-2006	No information.	No information.	No information.
St Gerards 1919-1939	No information.	No information.	No information.
Cork County Home 1921-1960	35 deaths (mortality rate of 1.5%).[295] Majority of deaths occurred in Cork district hospital - two occurred in Bessborough following transfer there.[296] Adhering to WHO guidelines the maternal mortality rate was 1.12%.	Eighteen deaths were not associated with pregnancy or childbirth - they were, in the main, due to tuberculosis, kidney disease, cancer, pneumonia and meningitis. Nine deaths were indirect obstetric deaths (conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy and generally resulted in cardiac failure). Sixteen deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were mainly due to puerperal septicaemia/sepsis, toxaemia eclampsia and obstruction of labour. [297]	No information.
Stranorlar 1922-1964	20 deaths between 1922 and 1946 (mortality rate of 1.2%). Majority of deaths occurred in Stranorlar - five occurred in external hospitals."[298] Adhering to WHO guidelines the maternal mortality rate was 0.48%[299] All but one death occurred in the institution: one occurred in Letterkenny fever hospital. One woman died on the day she was	Twelve deaths were not associated with pregnancy or childbirth - they were, in the main, due to tuberculosis and typhoid. Two deaths were indirect obstetric deaths (conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy) - both resulted in cardiac failure. Six deaths were directly associated with pregnancy and childbirth. Direct obstetric deaths were due to puerperal sepsis, eclampsia, phlebitis and peritonitis.[301] (Other causes of death included influenza and tabes mesenterica).[302]	No information.

[295] ibid, ch 28A, 6.
[296] ibid, ch 28A, 6.
[297] ibid, ch 28A, 6.
[298] ibid, ch29A, 7.
[299] ibid, ch 29A, 7.
[301] ibid, ch 29A, 7.
[302] ibid, ch 29, para 29.21

	admitted to the institution; others died having spent between three and five years living here. Women were aged between 17 and 45 years at the time of death.[300]		
Thomastown 1922-1960	Three deaths (mortality rate of 0.31%).[303] All three deaths occurred in the institution during 1922. The women were aged 15, 25 and 40 years respectively at the time of death.[304] Adhering to WHO guidelines the maternal mortality rate was 0.2%.	One death was due to heart disease and was not associated with pregnancy and childbirth. Two deaths were indirect obstetric deaths in the sense that they were conditions that developed during pregnancy, were aggravated by the physiological effects of pregnancy - they were confinement related influenza and tuberculosis. No deaths were directly associated with pregnancy and childbirth.[305]	No information.

[300] ibid, ch 29, para 29.21.
[303] ibid, ch 30A, 6.
[304] ibid, ch 30, para 30.11.
[305] ibid, ch 30A, 6.

APPENDIX 2: Suggested expert witnesses (AFTER hearing from survivor experts)

Bioarchaeology / forensic archaeology expertise (re. what is practically feasible; comparative international practice)

- UCD/Trinity genomics experts, authors of a submission to Galway County Council re. Tuam burials: Professor David MacHugh, Dr Jens Carlsson, Dr Stephen Donoghue (University College Dublin) and Professor Dan Bradley (Trinity College Dublin). See https://www.irishtimes.com/news/social-affairs/tuam-mother-and-baby-home-remains-can-be-identified-1.3460016
- Rebecca Gowland, Durham University: https://www.dur.ac.uk/research/directory/staff/?mode=staff&id=4567
- Argentine Forensic Archaeology Team (EEAF) https://eaaf.org/

Irish legal experts (re. families' rights and State obligations incl. under existing Irish legislation)

- Michael Lynn SC: https://www.lawlibrary.ie/members/Michael--Lynn/1343.aspx
- Colin Smith BL: https://www.lawlibrary.ie/members/Colin-Smith/4685.aspx
- Dr James Gallen, Dublin City University: https://www.dcu.ie/lawandgovernment/people/james-gallen
- Dr Vicky Conway, Dublin City University: https://www.dcu.ie/lawandgovernment/people/vicky-conway
- Mairead Enright, Birmingham Law School: https://www.birmingham.ac.uk/staff/profiles/law/enright-mairead.aspx
- Dr Maeve O'Rourke, NUI Galway & Co-Director of the 'Clann Project' https://www.nuigalway.ie/business-public-policy-law/school-of-law/staff/maeveorourke/

Coroner / Inquest expertise

- Prof Emeritus Phil Scraton, Queen's University Belfast (currently completing a report, funded by the Irish Human Rights and Equality Commission in collaboration with the Irish Council for Civil Liberties, on the coronial system in Ireland): https://pure.qub.ac.uk/en/persons/phil-scraton
- Darragh Mackin, Solicitor, Phoenix Law (extensive expertise in inquest law and proceedings both in Northern Ireland and the Republic of Ireland; currently representing bereaved families in the Stardust Inquest): https://www.phoenix-law.org/team/darragh-mackin/
- Caoilfhionn Gallagher QC (enormous expertise in inquests and also has expertise on issues arising from Ireland's Mother and Baby Homes):
- https://www.doughtystreet.co.uk/barristers/caoilfhionn-gallagher-qc
- Leslie Thomas QC (expert on all aspects of inquests)
- https://www.gardencourtchambers.co.uk/barristers/leslie-thomas-qc/sao
- Deborah Coles, Executive Director, INQUEST: https://www.inquest.org.uk/faqs/deborah-coles-director
- Dr Mary O'Rawe, Ulster University: https://pure.ulster.ac.uk/en/persons/mary-orawe

Records (Archival) Issues

- Catriona Crowe, Archivist
- Dr Fred Logue, Principal, FP Logue, https://www.fplogue.com
- Dr Sarah Anne Buckley, NUI Galway, https://www.nuigalway.ie/our-research/people/history-and-philosophy/sarah-annebuckley/

Northern Ireland expertise re. Exhumations and the Disappeared

- Dr Lauren Dempster, Queen's University Belfast: https://pure.qub.ac.uk/en/persons/lauren-dempster
- Geoff Knupfer, Investigative Scientist, lead investigator for the Independent Commission for the Location of Victims' Remains in Ireland/NI

Other jurisdictions' experience and international best practice re. exhumations of mass graves

- Dr Melanie Klinkner, University of Bournemouth (recently completed a UKRI project to develop guidelines on the protection of mass graves): https://staffprofiles.bournemouth.ac.uk/display/mklinkner
- Dr Heather Conway, Queen's University Belfast: https://pure.qub.ac.uk/en/persons/heather-conway
- Professor Cath Collins, Ulster University: https://www.ulster.ac.uk/staff/c-collins
- Professor Fionnuala Ní Aoláin, Queen's University Belfast and University of Minnesota Law School: https://www.law.umn.edu/profiles/fionnuala-ni-aolain