AN COIMISIÚN PLEAN LA
LDG- 087080-26
ACP-
20 MAR 2026
Fee: € 220 Type: cw
Time: 11:30 By:

An Coimisiún Pleanála

Planning Appeal Form

Your details

1. Appellant's details (person making the appeal)

Your full details:

(a)	Name	Bessborbo Mother and Baby Home Support Group
(b)	Address	c/o Carmel Cantwell. 6 Meadowlands, Upper Rochestown, Cork.

Agent's details

2. Agent's details (if applicable)

If an agent is acting for you, please **also** provide their details below. If you are not using an agent, please write "Not applicable" below.

(a)	Agent's name	FP Logue LLP
(b)	Agent's address	Lenin House, Rear 25 Strand Street Great, Dublin 1

Postal address for letters

3. During the appeal we will post information and items to you **or** to your agent. For this appeal, who should we write to? (Please tick ✓ one box only.)

You (the appellant) at the address in Part 1	☐	**The agent at the address in Part 2**	✓

Details about the proposed development

4. Please provide details about the planning authority decision you wish to appeal. If you want, you can include a copy of the planning authority's decision as the appeal details.

(a) Planning authority

(for example: Ballytown City Council)

Cork City Council

(b) Planning authority register reference number

(for example: 18/0123)

25/44442

(c) Location of proposed development

(for example: 1 Main Street, Baile Fearainn, Co Ballytown)

Bessborough, Ballinure, Blackrock, Co. Cork

Appeal details

5. Please describe the grounds of your appeal (planning reasons and arguments). You can type or write them in the space below or you can attach them separately.

Please see enclosures.

Supporting material

6. If you wish you can include supporting materials with your appeal. Supporting materials include:

   - photographs,
   - plans,
   - surveys,
   - drawings,
   - digital videos or DVDs,
   - technical guidance, or
   - other supporting materials.

Acknowledgement from planning authority (third party appeals)

7. If you are making a third party appeal, you **must** include the acknowledgment document that the planning authority gave to you to confirm you made a submission to it.

Fee

8. You **must** make sure that the correct fee is included with your appeal. You can find out the correct fee to include in our Fees and Charges Guide on our website.

Oral hearing request

9. If you wish to request the Commission to hold an oral hearing onyour appeal, please tick the "yes, I wish to request an oral hearing" box below.

Please note you will have to pay an **additional non-refundable fee** of €50. You can find information on how to make this request on our website or by contacting us.

If you do not wish to request an oral hearing, please tick the "No, I do not wish to request an oral hearing" box.

Yes, I wish to request an oral hearing ☐

No, I do not wish to request an oral hearing ✓

NALA has awarded this document its Plain English Mark

Last updated: April 2019 .

Plain English Approved by NALA

FPLOGUE SOLICITORS

Our Reference: FPL/
Your Reference:

20 March 2026

By Hand

An Coimisiún Pleanála
64 Marlborough Street,
Dublin 1
D01 V902

AN COIMISIÚN PLEANÁLA
LDG- _____
ACP- _____
20 MAR 2026
Fee: € _____ Type: _____
Time: _____ By: _____

Re Third Party Appeal of Decision by Cork City Council (Ref. 25/44442)

Applicant Estuary View Enterprises 2020 Limited

Proposed Development Large-Scale Residential Development (LRD) at a site located at Bessborough, Ballinure, Blackrock, Cork. The development will consist of: The demolition of 10 no. existing agricultural buildings /sheds and log cabin residential structure and the construction of a residential development of 140 no. residential apartment units over 2 no. retained and repurposed farmyard buildings (A & B) with single storey extension and 3 no. new blocks of 3-5 storeys in height, with supporting resident amenity facilities, crèche, and all ancillary site development works. The proposed development includes 140 no. apartments to be provided as follows: Block C (9 no. 1-bedroom & 25 no. 2-bedroom over 3 storeys), Block D (34 no. 1-bedroom & 24 no. 2-bedroom over 3-4 storeys), Block E (27 no. 1-bedroom, 20 no. 2-bedroom & 1 no. 3-bedroom over 4-5 storeys). It is proposed to use retained Block A and Block B for resident amenities which include home workspace, library, lounge and function space. The proposal includes a new pedestrian/cycle bridge over the adjoining Passage West Greenway to the east, connecting into the existing down ramp from Mahon providing direct access to the greenway and wider areas, as well as new pedestrian access to Bessborough Estate to the north including upgrades to an existing pedestrian crossing on Bessboro Road. The proposed development provides for outdoor amenity areas including publicly accessible parkland, landscaping, surface car parking, bicycle parking, bin stores, substation, public lighting, roof mounted solar panels, wastewater infrastructure including new inlet sewer to the Bessborough Wastewater Pumping Station to the west, surface water attenuation, water utility services and all ancillary site development works. Vehicular access to the proposed development will be provided via the existing access road off the Bessboro Road. Part of the proposed development is situated within the curtilage of Bessborough House which is a Protected Structure (Reference: RPS 490). An Environmental Impact Assessment Report and a Natura Impact Statement has

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	been prepared in respect of the proposed development. The planning application together with the Environmental Impact Assessment Report and Natura Impact Statement may be inspected or purchased at a fee not exceeding the reasonable cost of making a copy at the offices of the Planning Authority, City Hall, Cork, during its public opening hours. The LRD application may also be inspected online at the following website set up by the applicant: www.thefarmlrd.ie.
Development address	Bessborough, Ballinure, Blackrock, Co. Cork.
Date of decision	24 February 2026
Appellant	Bessboro Mother and Baby Home Support Group
Appellant Address	c/o Carmel Cantwell. 6 Meadowlands, Upper Rochestown, Cork
Agent	FP Logue LLP
Agent Address	Lenin House, Rear 25 Strand Street Great, Dublin 1

A Chara,

Introduction and Background

1. We wish to lodge an appeal against the above decision on behalf of Bessboro Mother and Baby Home Support Group, c/o Carmel Cantwell, 7 Meadowlands, Upper Rochestown, Cork. The proof of submission to the Planning Authority is included in **Annex 1**. The appeal fee of €220 is paid by credit card in the office. The Appellant's submission to the Planning Authority is at **Annex 2**. A full list of members of The Bessboro Mother and Baby Home Support Group that wish to forego their anonymity to add their names to this appeal are included at **Annex 3**.

2. This Large Scale Residential Development ("LRD") proposal, "The Farm" (Cork City Council Planning Ref. 25/44442), at Bessborough, Ballinure, Blackrock, Cork seeks to demolish 10 existing farmyard structures and construct 140 apartments, a crèche and ancillary works, together with a new pedestrian/cycle bridge to the Passage West Greenway to the east. Part of the project sits within the curtilage of Bessborough House (RPS 490) and across lands historically associated with the Bessborough Mother and Baby Home (1922–1998), where 9,768 mothers and 8,938 children were admitted.

3. The current development application, "The Farm" is Phase 1 of an envisioned multiphase development around the site of Bessborough, which is followed by Phase 2, "The Meadows" immediately to the east of the current development, and Phase 3, "The North Fields", to the west of the current development as outlined in the developer's masterplan for Bessborough lands, commissioned in 2021.[1]

4. Bessborough is a site of profound national significance, associated with the former Mother and Baby Home institution, where 923 infant deaths are documented and burial records remain incomplete. Expert commentary and investigations have long indicated the credible possibility

[1] Extract from ShipseyBarry Masterplan (2021) showing Phases 1 – 3 (enclosed) (**Annex 4**)

of unrecorded burials beyond the cemetery within the wider estate[2]. Infant mortality at Bessborough was very high, particularly throughout the 1940s (including 82% infant mortality in the year ending 31 March 1944).[3] The Mother and Baby Home Commission of Investigation (**MBHCOI**) recorded multiple accounts of direct testimony about on-site infant burials including staff and mothers referring to burials at the convent cemetery and within the grounds generally. The MBHCOI was not in a position to forensically excavate the 60 acre estate, and therefore explicitly stated that only a thorough, site-wide excavation could establish burial locations:

> *"The Commission recognised then [at the time of the MBHCOI's 5th interim report] and still 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.[4]"*

5. Therefore, this is not a routine greenfield development given that the State's own Commission of Investigation says that burials are likely, their locations are largely unknown, and any certainty requires intrusive investigation. Any groundworks that take place here risk disturbing human remains.

Planning History: The Risk of Potential Burials as a Determinative Factor

6. An Coimisiún Pleanála ("ACP") has twice refused major schemes within the Bessborough curtilage citing the direct, unresolved risk of finding on-site burials while refusing others for materially contravening Cork City Development Plan zoning objectives.

7. **ABP-308790-20 (25 May 2021)** dealt with an application on a site to the southeast of the current LRD application and within the curtilage of Bessborough House. The Board refused permission for 179 apartments and held that it would be premature to grant permission prior to establishing if there is a children's burial ground located within the site and the extent of any such burial ground. The Board Order explicitly stated that:

> *"The Board is not satisfied that the site was not previously used as, and does not contain, a children's burial ground, associated with the former use of the lands as a Mother and Baby Home over the period 1922 – 1998… it would be premature to grant permission for the proposed development prior to establishing whether there is a children's burial ground located within the site and the extent of any such burial ground.."*[5]

8. The Cork Survivors and Supporters Alliance (CSSA) submitted a 1949/1950 OSI "trace map" which marks a "Children's Burial Ground" to the north west of the Bessborough folly. This demonstrates the existence of a documented burial area on the estate.[6]

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[2] https://www.rte.ie/news/2021/0112/1189184-bessborough-house-mother-and-baby-homes/

[3] Mother and Baby Homes Commission of Investigation Final Report, 30th October 2020, Executive Summary and Chapter 18: Bessborough, pp.33-34. (**Annex 5 and Annex 6**)

[4] Mother and Baby Homes Commission of Investigation Final Report, 30th October 2020, Chapter 38 Addendum to Burials Report, pp. 3-4. (**Annex 7**)

[5] Board Order ABP-308790-20

[6] A copy of this map and further evidence is included in a CSSA Oireactas submission dated 14 March 2021 (**Annex 8**)

9. **ABP 309560-21 (15 June 2021)** saw the Board uphold a decision by Cork City Council refusing planning permission for a development of 67 apartments adjacent to ABP 308790-20 as it would be a material contravention of the zoning objectives of the CDP[7].

10. **ABP-315820-23 (September 2024)** saw the refusal in September 2024 of an application for 92 apartments in the southeastern corner of the wider Bessborough lands. The first reason for refusal restated prematurity prior to establishing the extent of human remains and/or burials remains having regard to Board Order for ABP 308790-20. The second reason for refusal cited adverse impact on the protected historic landscape.[8] The Board Direction indicated:

> *"The Board considers it would therefore be premature to grant permission for this proposed development prior to establishing the extent of human remains and/or burials, if any, and that such matter* ***extends beyond the scope of normal planning conditions*** *particularly having regard to the impacts this may have on the development as proposed."*[9] [emphasis added]

11. **ABP 313216-22**: **(23 July 2025)** concerns "The Meadows SHD", a concurrent application for Phase 2 of the overall masterplan located adjacent and to the east of the current Phase 1 site. This was rejected by ACP on 23rd July 2025 for materially contravening the CDP on unit mix.[10]

12. **The current LRD development** ("The Farm"), Cork City Council Ref. **25/44442** and the subject of this appeal, is a direct iteration of the Strategic Housing Development application, **ABP-313206-22** which was submitted directly to, and refused, by An Coimisiún Pleanála in July 2025. In the SHD inspector's report, the Inspector stressed that burial legacy issues remain relevant on these lands, highlighted that no new evidence of material significance was provided since ABP 308790-20 to remove the "significant uncertainty" regarding the location and extent of unrecorded burials within the site as recorded in the Fifth Interim Report and the Final Report of the MBHCOI, and concluded that granting permission would be premature given the possibility of unrecorded burials and the impracticality of addressing that by planning condition.[11]

13. Ultimately both the Council and the Commission in its previous decision accepted the possibility of unrecorded burials but decided to address this by way of condition. In the appellant's view this is an incorrect approach and given the extremely sensitive nature of the location it is not appropriate and the Commission should not have rejected this ground for refusal in case 313206.

14. A screenshot of the ACP map search function is enclosed with this appeal which illustrates the proximity of the aforementioned planning applications across the Bessborough lands.[12]

Evidence for On-Site Burials at Bessborough

<u>MBHCOI (Chapter 18: Bessborough)</u>

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[7] ABP Order 309560-21
[8] ABP Order 315820-23
[9] ABP Direction 315820-23
[10] ACP Order 313216-22
[11] ACP Inspector's Report 313206-22 at pp. 132-133
[12] https://www.pleanala.ie/en-ie/map-search (**Annex 9**)

15. The findings recorded by the MBHCOI at Chapter 18 of the final report, which deals specifically with Bessborough, document multiple testimonies from former residents as well as the Sisters and staff of the institution which acknowledge that burial locations throughout the greater site are largely unknown.

16. Two of the Sisters that worked at Bessborough testified to the Commission that infants who died in the home were buried in the congregational burial ground onsite at Bessborough. This is located near the historic folly (NIAH 20872007) in the south east of the site, not part of the current development but within the curtilage of Bessborough house. Another of the Sisters, did not know where children who died in Bessborough from the 1920s to the 1970s were buried. She said that she had visited cemeteries in Cork in a bid to ascertain where the children had been buried but could not settle the matter.[13]

17. A landscaper who worked at Bessborough between 1983 – 2003, did some excavation work around the folly where he found what he believed to be animal bones. Although in his testimony, he records an archaeologist telling him that the area surrounding the Sisters' graveyard and folly was suspected to be a children's graveyard, he did not believe that anything he came across at the time would amount to a children's burial ground.[14]

18. One of the mothers' whose baby died at Bessborough was told by the nuns that her child was in the "small cemetery at Bessborough"[15]. The Commission was neither able to confirm or deny this account, which underscores the conflict and uncertainty with regard to records and living memory.

19. The prevailing theme through the report is one of uncertainty which can only be resolved by way of a full and independent archaeological assessment of the grounds as a whole to establish exactly the extent of any burials on site.

Developer's EIAR and Archaeological Impact Assessment

20. Chapter 10 on Cultural Heritage of the Environmental Impact Assessment Report (**EIAR**) submitted by the developer in respect of this application fails to demonstrate that significant adverse effects have been understood and mitigated prior to the grant of planning permission.

21. The report notes that no burials were encountered during the digging of test trenches in 2019, but this testing was carried out on a different area of the wider site and therefore says nothing about the current application. Nonetheless the EIAR accepts that there is a residual risk of the same, and proposes forensic archaeological monitoring of all groundworks with preservation *in situ* where necessary[16]. In other words, the developer's own documents concede that uncertainty remains, and propose to discover and decide during construction, a process that ACP has already held against in many of the previous decisions described above.

22. The Archaeological Impact Assessment submitted by the developer crucially does not deal with the site of the current Phase 1 application, but rather that of Phase 2 ("The Meadows"). At page 3, the outline subject site of test trenches dug in 2019 shown in red describe lands to the east of the current site, not the current application site.

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[13] Chapter 18, at 18.281
[14] *Ibid* at 18.287
[15] *Ibid* at 18.305
[16] EIAR Chapter 10

23. Notwithstanding this, the archaeologists themselves in their report state the following:

> *"Given the large number of children who died while resident in the Bessborough Mother and Baby Home and the fact that no records of burial arrangement and/or burial places of the children survive, the potential exists for unrecorded burials to have taken place within the wider Bessborough landholding, this includes both undeveloped and previously developed areas of the Bessborough landholding.*[17]"

24. The EIAR states that "in the unlikely event of previously unrecorded burials being encountered during site development works, such works will be monitored in accordance with the methodology outlined in Appendix 10.5 by Aidan Harte, Forensic Archaeologist. It goes on to cite a four-stage "Method Statement: Forensic Control" that would observe excavations and react if remains are found. It does not deliver a comprehensive, pre-permission site characterisation of potential burial areas across the estate, nor the exhumation and / or identification process that a coroner or a Director of Authorised Intervention would lead.

25. The developer has not demonstrated through any site-specific archaeological assessment of the Phase 1 lands that potential burial grounds are absent. Instead, it relies on an Archaeological Assessment carried out for different lands (Phase 2), which the archaeologists themselves acknowledge was inconclusive given the potential for unrecorded burials across the wider Bessborough estate. In those circumstances, the developer's proposal to defer investigation to construction-stage forensic monitoring amounts to the very "discover-and-decide" approach already rejected by the ACP, and fails to provide the pre-permission site characterisation required to understand and mitigate significant effects in advance.

26. The problem with the EIAR is that it that information is not complete since it does not resolve the uncertainty in relation to burials while accepting such a possibility. Given the uncertainty and the sensitivity this is a significant factor for which certainty is required before planning permission is granted and the environmental assessment is completed. It is further impossible to specify mitigation without knowing precisely the nature, size and location of the likely significant effects on the environment to be mitigated.

27. For example, the EIAR proposes monitoring during excavations but there is no information as to how this would actually ensure that all potential burial sites would be identified when the excavation programme is aimed at construction of the project, not investigating the site for burials. This methodology cannot therefore guarantee that all unrecorded burials would be identified since there is no specifically designed systematic process for investigating unrecorded burials proposed. The proposal of the developer to carry this out at the same time as construction is not an adequate mitigation since it is not specifically designed, there appears not to be anything built in suspend works and/or redesign the project if remains are found etc.

28. The mitigation proposes recording and/or avoidance of any potential sub-surface archaeological features without specifying which or how avoidance can be used if this would mean that the project would have to be redesigned.

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[17] Archaeological Impact Assessment, John Cronin and Associates, at p. 5

29. In light of this a lawful EIA cannot be carried out because the EIAR does not comply with the requirements of Article 5 of the Directive.

Human Rights

30. As set out in detail in the attached letter[18] from Dr Maeve O'Rourke, associate professor, Irish Centre for Human Rights and others the decision of the Planning Authority is incompatible with and constitutes an unwarranted interference with fundamental rights under the European Convention of Human Rights and indeed the equivalent rights under the Charter of Fundamental Rights such as the right to life and the right to a private and family life. Similar rights are also guaranteed by the Constitution.

31. The Commission required to give effect to these rights in relation to this application since it comes within the sphere of EU law and additionally by virtue of Section 3(1) of the European Convention on Human Rights Act 2003.

32. The Commission is precluded from unlawfully interfering with the fundamental rights identified in the letter, and where it does so it must show that the interference is provided for by law, respects the essence of the right, meets an objective of general interest and necessary and proportionate.

Legal and Procedural Consequences if Remains are Found

33. The issue with the Planning Authority Conditions 9 and 10, which envisage intervention from other authorities upon discovery of human remains or other evidence of burial, is that if construction proceeds without prior site characterisation and human remains are uncovered, two statutory regimes may be triggered:

    i) Coroners Act 1962 (as amended) and
    ii) Institutional Burials Act 2022.

    Each imposes immediate legal obligations that require suspension of works and the transfer of control of the site to State authorities, and this possibility has not been taken into account.

Coroner's Act 1962 (As Amended)

34. Section 17 of the Coroners Act 1962 (as amended) states that an inquest must be held where a death may have occurred in a violent or unnatural manner, or unexpectedly and from unknown causes. It follows that any discovery of unidentified human remains therefore engages the coroner's jurisdiction. The death becomes a 'reportable death' under Section 16A of the same act. Once notified, the coroner would assume control of the site. Gardaí may also become involved, and the area may be designated a crime scene, requiring all works to stop until investigations and any required post-mortem or inquest steps are complete.

[18] **Annex 10**

35. For the avoidance of doubt, No. 25 of Schedule II to the Coroner's Act 1962 (as amended) lists "any death of a child in care" as a death reportable to a coroner which would bring the lands at Bessborough squarely under its remit.[19]

Institutional Burials Act 2022

36. Separately, if remains are discovered that meet the higher threshold criteria outlined in Section 8 of the Institutional Burials Act 2022 to the extent that they were buried in a "manifestly inappropriate" manner, i.e. uncoffined burials, collective burials, or burials lacking dignified interment, the Government may then issue an order under Section 7 to establish an Office of Director of Authorised Intervention. This would involve a full forensic excavation, analysis, potential DNA identification and the respectful reinterment of any remains[20]. Such intervention, as occurred in Tuam, Co. Galway would require the control of the land by the Director, supported by forensic specialists, and cannot operate alongside construction. Works would cease until the recovery and identification process concludes.

37. Both of the above statutory regimes would require cessation of works and immediate notification to An Garda Síochána where circumstances of death are unknown, unnatural, or potentially criminal. A Garda direction designating the land a crime scene would require the immediate suspension of works until the conclusion of any investigation. Ultimately, these legal obligations mean that construction-stage 'monitoring', rather than pre-permission archaeological assessment, reverses the correct order of operations and creates an actual risk of serious interruption if and once remains are found.

38. The triggering of either statutory regime which would require an inquiry or forensic investigation calls into account the viability of any development on this site. There is a material risk that the development will be indefinitely delayed or rendered incapable of progressing to construction at all. This is inherent to the nature of these lands, as outlined above, and should have been taken into consideration by Cork City Council prior to its decision to grant permission.

Likelihood of Implementation

39. Pursuant to section 34(3)(c) of the Planning and Development Act 2000, as amended (the "**2000 Act**"), the Planning Authority was required to have regard to:

> *"(c) where an application for permission relates to a residential development comprising 10 or more houses—*
>
> *(i) any information available to the planning authority, or furnished to it by the applicant, concerning implementation by the applicant of any housing development in the previous 5 years, and*
>
> *(ii) an assessment by the planning authority of the likelihood of the proposed development being implemented within the appropriate period sought, being the appropriate period within the meaning provided for by section 40(3)."*

(Emphasis added.)

[19] Coroner's Act 1962 (as amended) Sections 16A, 17 and Schedule II
[20] Institutional Burials Act 2022 Sections 7-8

40. In light of the accepted likelihood of unrecorded burials on site and the fact that works cannot proceed where these are found, there is a low likelihood of the permission being implemented within the appropriate period (i.e. 5 years) or at all in circumstances.

41. This provision also applies to the Commission on Appeal under Section 37(1)(b) of the 2000 Act.

Reliance on Apartment Guidelines 2025 in Granting Permission

42. The previous version of the proposed development was a Strategic Housing Development application. Permission was refused for the following reason:

> *"Objective 11.2 Dwelling Size Mix and Table 11.8 of the Cork City Development Plan 2022-2028 set out* ***clear unit mix requirements*** *to be adhered to except in exceptional circumstances where justification is provided. The unit mix proposed does not meet the target levels set out under Table 11.8 for any of the proposed unit types and does not conform to the unit mix ranges that would be acceptable subject to adequate justification on the basis of market based evidence. No Statement of Housing Mix in accordance with Objective PO1 of the Housing Strategy and Housing Need Demand Assessment of the Supporting Studies accompanying of the Cork City Development Plan 2022-2028 has been submitted and, therefore,* ***no justification has been provided in relation to the unit mix proposed****. The Commission is therefore not satisfied that the proposed development meets the requirements of these objectives. The Commission considers that the proposed development materially contravenes the Development Plan in relation to the provision of unit mix requirements".*[21] [emphasis added]

43. The Planning Statement with the current application addresses this ground of refusal at 1.3, saying the sole reason for refusal (non-compliance with Objective 11.2 / Table 11.8 (unit mix) in the CDP) is now "no longer applicable" because the *Planning Design Standards for New Apartments (2025)* introduce SPPR 1 that precludes statutory plan restrictions on apartment mix, save for limited exceptions.

44. The document relies on SPPR 1(B) to argue the Development Plan's unit mix tables cannot be applied to this single apartment scheme. The proposed mix in the current LRD application therefore remains unchanged at 70 x 1-bed, 69 x 2-bed, 1 x 3-bed.

45. It is important to note that the *Design Standards for Apartments, Guidelines for Planning Authorities 2025*, including SPPR 1 on apartment mix, are currently the subject of ongoing judicial review on the basis that a strategic environmental assessment ("SEA") should have been, but was not, carried out. In *McDonald & Ors v Minister for Housing* [2025] IEHC 728[22], the High Court referred key questions to the Court of Justice of the European Union to determine whether the Guidelines amount to a "plan or programme" requiring SEA under Directive 2001/42/EC. As of February 2026, the process for transmitting the reference to the CJEU was still ongoing and once the CJEU is in receipt of the same, it could take up to 18 months to make a determination, after which a final judgment of the High Court will issue. The

[21] ACP Order 313216-22

[22] McDonald & Ors. V Minister for housing, Local Government and Heritage [2025] IEHC 728

legal effect of the guidelines therefore remains uncertain pending the CJEU's judgment which also casts doubt on the legal status of any grant of planning permission which relies on them because it is impermissible as a matter of EU law to grant planning permission on the basis of a plan which was made unlawfully in breach of the SEA Directive.

46. During and related to these proceedings, the Court was informed that the State, while continuing to defend the 2025 Guidelines, intends to replace them with a draft National Planning Statement and to carry out an environmental assessment. Although the State maintains that the Guidelines remain "operational" in the interim, the status of the July 2025 Guidelines is unsettled. The combination of an active judicial review and a live reference to the CJEU creates an obvious litigation risk.

47. If it is concluded in the *McDonald* proceedings that SEA of the Apartment Guidelines was not required, this would not assist the applicant in this instance. This is because a plan that was itself subject to SEA (the Cork City Development Plan) cannot be derogated from by a plan that was not subject to SEA (the Apartment Guidelines). This is set out in the judgment of the CJEU in *Site of St Teresa's Gardens Case C-09/22* where it was explained that the objective of the SEA Directive would be "undermined if it were possible to derogate from the framework defined by a plan or programme [...] without such a derogation being subject, at the very least, to the obligation, arising from Article 3(3) of that directive, to establish whether that derogation is likely to have significant effects on the environment.[23]"

48. Therefore, either the Apartment Guidelines should have been subject to SEA, in which case the assessment will need to take place before they can be applied and consequently permission should not be granted pursuant to them, or they should not have been subject to SEA, in which case they cannot be relied upon to derogate from the Cork City Development Plan which was itself subject to SEA.

49. In these circumstances, it would be premature for the Commission to uphold the grant of permission on the basis that SPPR 1 displaces the Development Plan's unit mix requirements, given that the lawfulness of that very proposition is presently awaiting determination.

Conclusion

50. For the reasons set out in this appeal, the application is invalid and/or should be refused.



Yours faithfully

FP LOGUE LLP

[23] C-09/22, Site of St. Teresa's Gardens, At para. 43

AN COIMISIÚN PLEANÁLA
LDG-
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20 MAR 2026
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Comhairle Cathrach Chorcaí
Cork City Council

Halla na Cathrach, Corcaigh – City Hall, Cork – T12 T997

11-Feb-2026

Bessboro Mother & Baby Home Support Group
c.o Carmel Cantwell
6 Meadowlands
Upper Rochestown
Cork

Re: 25/44442

Permission for a Large-Scale Residential Development (LRD) at a site located at Bessborough, Ballinure, Blackrock, Cork. The development will consist of: The demolition of 10 no. existing agricultural buildings /sheds and log cabin residential structure and the construction of a residential development of 140 no. residential apartment units over 2 no. retained and repurposed farmyard buildings (A & B) with single storey extension and 3 no. new blocks of 3-5 storeys in height, with supporting resident amenity facilities, crèche, and all ancillary site development works. The proposed development includes 140 no. apartments to be provided as follows: Block C (9 no. 1-bedroom & 25 no. 2-bedroom over 3 storeys), Block D (34 no. 1-bedroom & 24 no. 2-bedroom over 3-4 storeys), Block E (27 no. 1-bedroom, 20 no. 2-bedroom & 1 no. 3-bedroom over 4-5 storeys). It is proposed to use retained Block A and Block B for resident amenities which include home workspace, library, lounge and function space. The proposal includes a new pedestrian/cycle bridge over the adjoining Passage West Greenway to the east, connecting into the existing down ramp from Mahon providing direct access to the greenway and wider areas, as well as new pedestrian access to Bessborough Estate to the north including upgrades to an existing pedestrian crossing on Bessboro Road. The proposed development provides for outdoor amenity areas including publicly accessible parkland, landscaping, surface car parking, bicycle parking, bin stores, substation, public lighting, roof mounted solar panels, wastewater infrastructure including new inlet sewer to the Bessborough Wastewater Pumping Station to the west, surface water attenuation, water utility services and all ancillary site development works. Vehicular access to the proposed development will be provided via the existing access road off the Bessboro Road. Part of the proposed development is situated within the curtilage of Bessborough House which is a Protected Structure (Reference: RPS 490). An Environmental Impact Assessment Report and a Natura Impact Statement has been prepared in respect of the proposed development. The planning application together with the Environmental Impact Assessment Report and Natura Impact Statement may be inspected

or purchased at a fee not exceeding the reasonable cost of making a copy at the offices of the Planning Authority, City Hall, Cork, during its publ icopening hours. The LRDapplication may also be inspected online at the following website set up by the applicant: www.thefarmlrd.ie.

At: Bessborough, Ballinure ,Blackrock, Cork

A Chara,

I wish to acknowledge receipt of your submission, received on 30 January 2026, regarding the above planning application.

This submission in accordance with the provisions of the Planning & Development Regulations 2001 (as amended) forms part of the file, which is available for inspections by the public at the Planning Department, City Hall, Cork. Opening hours are Monday-Friday from 10.00a.m.– 4.00p.m.

You will be notified when a decision is made on the application.

This letter should be retained. If you wish to appeal such decision, a copy of this acknowledgement letter must accompany your appea lto An Coimisiún Pleanála.

A copy of the Council's decision will issue to you in due course.

Is mise, le meas,

Aisling Ring

Assistant Staff Officer
Planning and Integrated Development

Acknowledgement of Receipt of Submissi on or Observation on a Planning Appli cation

THIS IS AN IMPORTANT DOCUMENT

Keep this document safely. You will be required to produce this acknowledgement to An Coimisiún Pleanála if you wish to appeal the decision of the Planning Authority. It is

Planning Submissions or Observations

—

Carmel Cantwell

Email: [redacted]

Application ID : A239CC213768
Custom Ref.:

Application Start Date: 2026-01-14 15:37:40
Application Completed Date: 2026-01-30 01:35:44

Personal Details

1 Full Name:

Carmel Cantwell on behalf of Bessboro Mother & Baby Home Support Group

2 Address Line 1:

6 Meadowlands

3 Address Line 2:

Upper Rochestown

4 Address Line 3:

Cork

5 County:

Cork

6 Eircode:

Cork, Co. Cork, T12 RW9F, Ireland
Latitude : 51.8695512
Longitude : -8.365903099999999

7 Contact telephone number:

[redacted]

Submission Details

8 Please provide the relevant **Planning Reference Number.**
For Example: 22/12345

25/44442

9 Address pertaining to the planning application:

Bessborough, Ballinure, Blackrock, Cork

10 Please provide details of your submission/observation:
Please note that this submission will be available to view on Cork City Council's website.

-

Please ensure that you are making the submission within the **5-week period** from the date of receipt of the application by the planning authority. You can find the submission deadline using the planning search facility on the city council website.

Attached PDF document outlining our objection to the proposed development.

11 Upload any other relevant documents here.

1 Document Uploaded

12 Please choose the option which applies to you:

You are making a submission for the first time on this application within the first 5 weeks of receipt of the application. A payment of €20 applies.

12.1 A payment of €20 per submission is required:

paid

Declaration and Signature

13 I Carmel Cantwell, declare that the information given in this form is correct and that I have read and agreed to the guidelines in relation to making a planning submission/observation. -
Type your full name in the space provided.

Carmel Cantwell on behalf of the Bessboro Mother & Baby Home Support Group.

Powered by Submit.com

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Powered by Submit.com

Planning Objection to Proposed Development at Bessborough, Cork. Ref 25/44442

From:
Carmel Cantwell
On behalf of the **Bessboro Mother & Baby Home Support Group**
6 Meadowlands
Upper Rochestown
Cork
T12 RW9F

Date: 30th January 2026

To:
Planning Department
Cork City Council

CORK CITY COUNCIL
PLANNING & DEVELOPMENT
30 JAN 2026
DEVELOPMENT MANAGEMENT

Re: Planning Application 25/44442
Applicant: Estuary View Enterprises 2020 Ltd
Site: Bessborough, Blackrock, Cork

1. Introduction

I am submitting this objection on behalf of the Bessboro Mother & Baby Home Support Group, representing survivors and families connected to the Bessboro Mother and Baby Institution. This site is one of profound national significance, containing a landscape of trauma, loss, and unmarked burial locations. Any proposed development must be approached with the highest level of sensitivity, transparency, and compliance with planning law. The current proposal fails to meet these standards and should be refused.

2. Heritage, Trauma, and Cultural Sensitivity

Bessborough is not an ordinary development site. It is a location where thousands of women and children lived under coercive conditions, and where hundreds of children died. The full extent of burial locations on the grounds remains unknown. Key concerns include: no comprehensive, independent archaeological investigation has been completed; survivors and families have repeatedly expressed fear that unmarked burial sites may be disturbed; the proposal fails to demonstrate that development can proceed without risking irreversible harm to a landscape of national memory. The State has acknowledged the need for truth, dignity, and respect for survivors. Allowing development without full clarity on burial locations would contradict these commitments. The Farmyard area and surroundings hold particular memories for some of our members who recall working there with their mothers, in one case a man visits Bessboro regularly from the USA to walk around the farmyard and grounds, the place he last saw his mother. Witnesses have reported burials in the area just outside of the walled in area of the farmyard and in one particular case up against a wall nearby.

3. MaterialContr aventbn – Section 37(2)(b)

An Coimisiún Pleanála has already refused a previous ap plicatbn on this site on the explicit basis that the proposed development failed to provide an appropriate and pol icy-compliart housing mix. This refusal is a significant material planning consideration that Cork City Council is required to take into account. The current application does not demonstrate any material change in relation to this fundamental deficiency. The same D evelopment Plan policies, national guidance, and regional objectives on housing mix remain in force, and the applicant has not provided evidence of compliance with these mandatory requirements. In the absence of any substantive alteration to address the Board's findings, Cork City Council is bound to reach the same conclusion: the proposed development remains contrary to established housing mix policy and the application does no tmeet the requirements of section 8(1)(a)(iv)(II) of the Planning and Development (Housing) and Residential Tenancies Act 2016, as amended. Therefore the council cannot invoke section 37(2)(b) of the Planning and Development Act 2000 and must therefore be refused.

4. Zoni ngContext

The Bessborough lands are subject to zoning objectives primarily guided by the Cork City Development Plan 2022–2028 that emphasizes protection of heritage assets, preservation of open space, and respect for existing landscape character. The proposed development conflicts with these zoning intentions by introducing large-scale residential construction on lands that have not been fully assessed for burial locations or heritage sensitivity.

5 National Policy / N ational Planning Framework / Heritage I reland203 0

The proposed development is fundamentally inconsistent with national and regional planning policy as set out in the National Planning Framework (NPF), its National Policy Objectives and the Southern Regional Spatial and Economic Strategy. The NPF requires the protection of cultural heritage and sensitive historic landscapes, the safeguarding and appropriate treatment of sites associated with national trauma. The Bessborough lands clearly fall within these categories. A large-scale residential scheme on a site of such documented historical sensitivity, with unresolved concerns regarding potential unrecorded burials, directly conflicts with these policy objectives.

6. Environmental and Landscape Impact

The cumulative effect of this development would significantly alter the character of the Bessborough landscape, including loss of green space and mature planting, visual intrusion on a historically sensitive site, and insufficient ecological assessment of potential impacts. The environmental documentation does not justify such a transformation.

7. The Strategic Environmental Assessment (SEA) Directive

Under the SEA Directive a decision to materially contravene the development plan, i.e. to derogate from it, is impermissible without a new SEA procedure.

9. Conclusion

For the reasons outlined above — including the inappropriate reliance on Section 37(2)(b), the failure to respect the heritage and cultural significance of Bessborough, the conflicts with the Cork City Development Plan, the zoning context, the national and regional policy conflicts— I respectfully request that this application be refused in full. On behalf of the Bessboro Mother & Baby Home Support Group, I emphasise that Bessborough is a place of memory and national and international importance. Any development must begin with truth, respect, and full clarity regarding the children who died there. This proposal does not meet that standard.

Signed,



Carmel Cantwell
On behalf of the Bessboro Mother & Baby Home Support Group



Members of The Bessboro Mother and Baby 'Home' Support Group that wish to forego their anonymity to add their names to this appeal.

Carmel Cantwell
Pam Meehan
Treassa Lonergan
Geraldine Fitzgerald
Martin Parfrey
Ruth O'Mahony
Margaret Clifford
Moira Gleeson
Mary Theresa Smith Ni Vaughan
Mark O'Mahony
Maureen Dundon
Carmel Hayes,
Kathy Finn
Deirdre Crowley
Sheila Mary O'Shea
Brendan Mclaughlin
Ann Dolores Hayes
Brendan Lanigan
Noreen Condon
Mary Theresea Fitzgerald
Maeve Joyce
Andrew Kerley
Joy O'Regan
Will kerley
Edel Byrne,
Eoin Byrne
Aoife Byrne
Sean Cantwell

Madeleine Walsh Marvier
Jo Kelso Au
Michael Owens
Lorraine Lyons
Nichola Kennedy
Rose Kissane
Brian Cantwell
Brian Cullen
Sally Mulvihill
Anne Hennon
Anna Marie Flanagan
Jackie Lyons
Cormac O'Sullivan
Noelle Brown
Mary Donovan
Aoife Byrne
Katie Byrne
Liam Byrne
Christopher Feehan
Sean Feehan
Emma Collins
Joy Gannon.
Grace Kerley
Veronica Galavan
Elliot Cantwell
Jo Quinn
Matty Montgomery

Marie Therese Ryan
Vivienne Downey
Lelia Foley
Geraldine Ratcliffe
Rita Collins
Lisa Clancy
Sheila Johnson
Lynda Young
Phil Cullen
Ena Ronayne
Thomas Walsh
Ann Crowe
Christy Kirwan
Miriam Hayes Delaney
Mary Teresa Leahy
Matty Montgomery
Jude McCracken
Anne Feehan
Sarah Collins
Richie Collins
Eimear Kerley
Bernadette Bradley
Ruth Kerley
Therese Fennessy
Sean Byrne
Ryan Cantwell
Katie Byrne


CONVENT
MATER
PRIVATE
' FARM GIRLS'
Memorial Area
PUBLIC PARK LAND
'THE FARM'
(in SHD Process)
'THE MEADOWS'
(in SHD Process)
'NORTH FIELDS'
(proposed future
housing area)
SURVIVOR
MEMORIAL AREA
PUBLIC PARK LAND
BESSBOROUGH HOUSE
NEW PUBLIC REMEMERANCE PARK
N 40
MASTERPLAN
LOUGH MAHON


'THE FARM'
(in SHD Process)
'THE MEADOWS'
(in SHD Process)
GREEN WAY
CROSSING & LINK
'NORTH FIELDS'
(proposed future
housing area)
MEMORIAL AREA
(HIGH SENSITIVITY)
BESSBOROUGH HOUSE
FOLLY
ICE HOUSE
PUBLIC
REMEMERANCE
PARK
GREEN WAY LINK
Community & Public linkages

Executive Summary

The story of mother and baby homes in Ireland is complex and its nuances cannot easily be captured in a summary. The Commission's Terms of Reference cover the period 1922 - 1998, a span of 76 years. There was great change in that period: massive improvements in living conditions and changes in attitudes to religion and morals. The experience of women and children in the 1920s was vastly different from the experience in the 1990s regardless of where they lived. The institutions under investigation changed considerably over the period: the two largest institutions were in operation for the entire period but they were very different institutions in 1998 than they were in 1922.

Ireland was a cold harsh environment for many, probably the majority, of its residents during the earlier half of the period under remit. It was especially cold and harsh for women. All women suffered serious discrimination. Women who gave birth outside marriage were subject to particularly harsh treatment. Responsibility for that harsh treatment rests mainly with the fathers of their children and their own immediate families. It was supported by, contributed to, and condoned by, the institutions of the State and the Churches. However, it must be acknowledged that the institutions under investigation provided a refuge - a harsh refuge in some cases - when the families provided no refuge at all.

Improvements in society generally and in the institutions came gradually. Significant changes included the introduction of free post-primary education in the 1960s and the changes consequent on membership of the then EEC from 1973. 1973 also saw the introduction of the Unmarried Mother's Allowance; this was the first time a direct State payment was available to assist an unmarried woman to rear her child in the community.

A: The people

1. There were about 56,000 unmarried mothers and about 57,000 children in the mother and baby homes and county homes investigated by the Commission. The greatest number of admissions was in the 1960s and early 1970s. It is likely that there were a further 25,000 unmarried mothers and a larger number of children in the county homes which were not investigated; admissions to county homes were largely pre-1960. While mother and baby homes were not a peculiarly Irish phenomenon, the proportion of Irish unmarried mothers who were admitted to mother and baby homes or county homes in the twentieth century was probably the highest in the world.

The women

2. The women who were admitted to mother and baby homes ranged in age from 12 years old to women in their forties. However, 80% were aged between 18 and 29 years and this was remarkably consistent across the larger mother and baby homes. 5,616 women, 11.4% of the total for whom information about their age is available, were under 18 years of age. The Commission has not seen evidence that the Gardaí were routinely notified about pregnancies in under-age women.

3. The number of admissions among women under 18 rose sharply in the early 1960s and it remained at a high level for the next two decades. While Pelletstown, followed by Bessborough accounted for the largest number of admissions of women under 18 years of age, Dunboyne was the mother and baby home with the highest proportion of women under 18 years - 23.4% of total admissions.

4. Some pregnancies were the result of rape; some women had mental health problems, some had an intellectual disability. However, the majority were indistinguishable from most Irish women of their time. The only difference between the women in mother and baby homes and their sisters, class-mates and work companions was that they became pregnant while unmarried. Their lives were blighted by pregnancy outside marriage, and the responses of the father of their child, their immediate families and the wider community.

5. Women were admitted to mother and baby homes and county homes because they failed to secure the support of their family and the father of their child. They were forced to leave home, and seek a place where they could stay without having

to pay. Many were destitute. Women who feared the consequences of their pregnancy becoming known to their family and neighbours entered mother and baby homes to protect their privacy. Some travelled to Britain, for the same reason.

6. Ireland appears to be the only country where large numbers of unmarried pregnant women left their native country. However, it must be acknowledged that many of their fellow citizens also emigrated.

7. The profiles of the women in mother and baby homes changed over the decades, mirroring changes in Irish women's lives. In the early decades most women who were admitted were domestic servants or farm workers or they were carrying out unpaid domestic work in their family home. In later years, however, many of the women were clerical workers, civil servants, professional women and schoolgirls or third-level students.

8. There is no evidence that women were forced to enter mother and baby homes by the church or State authorities. Most women had no alternative. Many pregnant single women contacted the Department of Local Government and Public Health (DLGPH), later the Department of Health, their local health authority, or a Catholic charity seeking assistance because they had nowhere to go and no money. Women were brought to mother and baby homes by their parents or other family members without being consulted as to their destination.

9. The overwhelming majority of women and children were maintained in the institutions by their local health authority but there were some who were 'private patients' and were paid for by themselves or family members. In many cases, they were cut off from the world and some were assigned a 'house name'. The mother and baby homes gave women some assurance that their secret would be protected.

The children

10. The vast majority of children in the institutions were 'illegitimate' and, because of this, suffered discrimination for most of their lives. (This was true of all 'illegitimate' children). The vast majority of children born in the institutions have no memory of their time there but some stayed in the institutions after their mothers left and a small number were in institutions until the age of seven.

11. Before the availability of legal adoption (from 1953), children who left the institutions usually ended up in other institutions such as industrial schools or were boarded out or nursed out. After legal adoption became available, it gradually became the most likely outcome. There can be no doubt that legal adoption was a vastly better outcome than the alternatives previously available.

12. The very high rate of infant mortality (first year of life) in Irish mother and baby homes is probably the most disquieting feature of these institutions. The death rate among 'illegitimate' children was always considerably higher than that among 'legitimate' children but it was higher still in mother and baby homes: in the years 1945-46, the death rate among infants in mother and baby homes was almost twice that of the national average for 'illegitimate' children. A total of about 9,000 children died in the institutions under investigation - about 15% of all the children who were in the institutions. In the years before 1960 mother and baby homes did not save the lives of 'illegitimate' children; in fact, they appear to have significantly reduced their prospects of survival. The very high mortality rates were known to local and national authorities at the time and were recorded in official publications.

B. The institutions

13. There were different types of institutions with different governance, financial arrangements and practices. Some were owned and run by the local health authorities - the county homes, Pelletstown, Tuam and Kilrush. Others were owned and run by religious orders, for example, the three homes run by the Congregation of the Sacred Hearts of Jesus and Mary - Bessborough, Sean Ross, Castlepollard (the Sacred Heart homes). They are often described as 'extern' homes or 'special' homes. Regina Coeli hostel was run by the Legion of Mary and it differed from the other large homes in that it aimed to keep mothers and children together. The Bethany Home was founded by a Protestant evangelical group.

14. Some of the institutions were in very poor physical condition. Living conditions in Irish homes were generally poor before the 1960s; however, poor sanitary conditions in congregated settings have much more serious consequences than in individual homes. County homes, Kilrush and Tuam had appalling physical conditions. Conditions in the other mother and baby homes were considerably better and improved over time; in particular, conditions in Dunboyne were very

good. The Commission has not seen any evidence of major shortcomings in any of the homes or flatlets that were operating in the 1970s-1990s.

Treatment in the institutions

15. The women and children should not have been in the institutions. The conditions were regimented and institutional especially in the larger institutions and particularly before the 1970s but there is no evidence of the sort of gross abuse that occurred in industrial schools. There are a small number of complaints of physical abuse. The women worked but they were generally doing the sort of work that they would have done at home; women in the county homes did arduous work for which they should have been paid and there are a few other examples where this is also the case.

16. Many of the women did suffer emotional abuse and were often subject to denigration and derogatory remarks. It appears that there was little kindness shown to them and this was particularly the case when they were giving birth. The large institutions were regimented and they were inadequately staffed until the later decades. The atmosphere appears to have been cold and seemingly uncaring. They offered little sympathy or counselling to women who may have been rejected by their family and by the father of their child. There were no qualified social workers, or counsellors attached to these homes until at least the 1970s, and until that time, there is no evidence that women were given opportunities to discuss the circumstances of their pregnancy or future options for their child. Women were dissuaded from sharing their stories with their fellow residents, because of concerns to protect their privacy though such conversations might have offered some comfort at a traumatic time. Conditions improved in all respects in the later decades.

17. Many of the women found childbirth to be a traumatic experience. The overwhelming majority were first-time mothers and they were probably uninformed about childbirth. First-time childbirth can be frightening for any woman; it was undoubtedly worse for women whose pregnancy had devastated their normal life and resulted in their removal from home, family and friends. The trauma of childbirth must have been especially difficult for the many women who had no prospect of keeping their child. However, the hostile comments were not restricted to mother and baby homes. Letters written in the 1970s to Cherish describe hostile comments made by neighbours to women and their families. Women who

were transferred from a mother and baby home to maternity hospitals to give birth, for medical reasons, were subjected to unfriendly comments by fellow-patients and their visitors.

18. Mother and baby homes were greatly superior to the county homes where, until the 1960s, many unmarried mothers and their children were resident. Conditions in the county homes were generally very poor; this, of course, was also true for the other residents who were mainly older people and people with disabilities. The women in county homes have been largely forgotten. They included women on a second or subsequent pregnancy and women from the poorest families. County homes admitted women with special needs, mental health problems, venereal disease or a criminal conviction, who would be rejected by a number of mother and baby homes. They also accommodated children who had special needs, including the children of married families. The accommodation and care given to these children in county homes was grossly inadequate; some of the descriptions are extremely distressing.

19. Until 1973 when the Unmarried Mother's Allowance was introduced, most women had no realistic prospect of keeping their child unless they were assisted by their family. Regina Coeli hostel was the only institution that supported women who wished to raise their child. There is evidence that women who became pregnant after 1973 were not always aware of this State support and they continued to face pressure from family and perhaps from the staff in a mother and baby home to place their children for adoption.

Regulation of mother and baby homes

20. The county homes, successors to the pre-independence workhouses, were owned and controlled by local authorities. They were responsible for running costs, maintenance, and major improvements. Money came from the local rates - a tax on property. The staff in county homes were local authority employees, though most of the domestic work was done by residents who were unpaid: the majority were unmarried mothers. The DLGPH, later the Department of Health regulated many aspects of the county homes including diets, and county homes were subject to regular inspections by the department.

21. As noted earlier there were two distinct types of mother and baby homes: Pelletstown, Kilrush and Tuam were established by local authorities, and they were

owned and under the control of local authorities. Dunboyne, which opened in 1955, was established and equipped by a group of local authorities. It was leased to the Good Shepherd Sisters who were responsible for its day-to-day running. The three Sacred Heart homes and Bethany and Denny were privately owned and controlled. Most women and children in the Sacred Heart homes were maintained by local authorities. Denny received public funding, as did Bethany from the 1940s. The Regina Coeli hostel, run by the Legion of Mary did not receive regular public funding.

22. Overall responsibility for the homes owned by a local authority rested with the local authority. They were responsible for the upkeep, improvements and oversight. The Dublin Union and its successor organisations visited Pelletstown regularly, and there is evidence that they exercised oversight. The Daughters of Charity, who ran Pelletstown were salaried local authority employees, as were the lay nurses and other staff. Food and supplies were bought and paid for by the local authority. When the Sisters of Mercy ran Kilrush, most of the Sisters were local authority employees, who received a salary; the lay staff was paid by the local authority.

23. When the Children's Home was in Glenamaddy the Bon Secours Sisters who ran the home were salaried local authority employees; the Sisters had previously run the Glenamaddy workhouse on a similar basis. When the Children's Home relocated to Tuam the Sisters were no longer treated as local authority employees and they did not receive a salary. Staff in Tuam were recruited and paid by the Sisters, from the capitation payment that they received from the Galway and Mayo local authorities, though much of the work was carried out unpaid by the mothers. The Galway local authority held regular meetings in the Children's Home; however, it is unclear whether these were used to conduct inspections. The Superior in Tuam kept the county manager informed about the women and children in the home, and he was involved in making decisions about their future, including specifying that some women should be sent to a Magdalen laundry. There is evidence that the Department of Health was confused as to the status and ownership of Tuam.

24. The remaining mother and baby homes were private institutions, so governance was a matter for the religious congregation or the charity that owned the institution. In the 1920s there was regular communication between the South Cork health

authority and the Superior in Bessborough. There does not appear to have been any legal basis for this, other than the recognition that the Cork authority was maintaining most of the women and children in Bessborough. There is no evidence of comparable communication between the other private mother and baby homes and a local authority.

The respective roles of local and national government

25. Bessborough opened without any apparent involvement by the DLGPH. An application to the Hospitals Commission for funding to construct a maternity hospital in Bessborough led to inspections and more frequent contact with the department and the Hospitals Commission in relation to the building tender and the requirements of this mother and baby home. Sean Ross, Castlepollard, and Pelletstown also secured major funding from the Hospitals Commission, which though technically independent, worked closely with the DLGPH. The Hospitals Commission inspected the homes, commenting on facilities and matters that required improvement. They acted in a similar manner in the case of all institutions that they funded.

26. Some oversight was exercised by national and local government but there was no clear policy on oversight and no clear demarcation between the roles of national and local government. The women inspectors in the Department of Local Government and Public Health/Department of Health tried valiantly to have conditions improved. This is especially true of Miss Alice Litster[1] who was an inspector from 1922 to 1957. While the department inspectors were thorough in carrying out inspections and were constantly seeking improvements, the responsibility to actually do anything rested mainly with the local authorities.

27. The *Registration of Maternity Homes Act 1934* gave the DLGPH/Department of Health the authority to inspect all places where women gave birth, or received nursing care following a birth. All maternity homes were required to register, and registration was the responsibility of the local authority. The inspections conducted under the 1934 Act enabled the DLGPH/Department of Health to visit the private mother and baby homes and to recommend improvements. However, there was a lack of clarity in the legislation. Did the powers of inspection extend to the entire mother and baby home, including the nurseries that accommodated babies, who

[1] Her name is very frequently misspelled, even by her colleagues, as Lister.

were older than one month and the mothers' dormitories and living space, or was it confined to the maternity unit? In practice, the departmental inspectors inspected all aspects of the homes.

28. The power to initiate prosecutions for infringements of the 1934 Act rested with the local authority and the penalties were generally light. (No mother and baby home was ever prosecuted). In the early 1940s when successive inspections carried out by the DLGPH revealed major shortcomings in Bessborough, the only power open to the department was to withdraw ministerial approval for local authorities to maintain women and children in Bessborough. They could not order the closure of the home, which continued to admit private patients, many of whose children died. The county Cork health authority had the power to close Bessborough but there is no indication that it considered doing so.

29. Registration certificates issued by local authorities under the 1934 Act stipulated the maximum number of beds, but this was often exceeded, and the numbers specified on the certificates were greater than numbers determined by a DLGPH buildings inspector. However, the department did not set maximum occupancy figures for mother and baby homes until the 1940s, some years after the Act came into force. These were not statutorily binding and were not enforced in either the local authority homes or the private mother and baby homes because they would have resulted in a massive reduction in capacity.

30. Although the DLGPH/Department of Health received regular inspection reports on mother and baby homes, which were often critical of conditions, the evidence suggests that the department preferred to use persuasion, not compulsion to implement improvements. The department's main interest appears to have been the occupancy figures, and the rising cost of maintaining women and children in these homes.

Influence of religion and religious organisations

31. Local authorities often deferred to the views of the religious orders that ran mother and baby homes or to the views of the diocesan bishop. Galway county council acceded to the demands of the Sisters of Bon Secours that children should remain in the Children's Home until the ages of five (boys) and seven (girls), despite the fact that this contravened the wishes of the DLGPH/ Department of Health. When

Mayo county council decided to remove children from Tuam at an earlier age, the Sisters threatened not to admit Mayo children in future and the local authority conceded their demands. Clare county council consulted the bishop of Killaloe about future arrangements for unmarried mothers when they decided to close Kilrush; he advised that women should be sent to Sean Ross.

32. There is no evidence that the Catholic hierarchy played a role in the day-to-day running of mother and baby homes. A religious congregation who wished to open any establishment in a diocese - such as a school, novitiate, or a mother and baby home - required the permission of the diocesan bishop. The Congregation of the Sacred Hearts of Jesus and Mary made several attempts to open a mother and baby home in Dublin, but the archbishop of Dublin did not grant approval. In the 1940s, the bishop of Cork, Dr Cohalan, claimed that he had had regular dealings with the DLGPH when Bessborough was being established but the Commission has seen no evidence to support this claim. In 1924 he asked the Congregation of the Sacred Hearts to admit pregnant women to Bessborough but they were reluctant to do so. In 1928 he 'almost insisted' that Bessborough should provide maternity services. A small maternity unit was opened in 1930; whether this was in response to Bishop Cohalan's request is unclear. By the early 1940s the inspectors of boarded out children in the DLGPH were becoming concerned about the well-being of children born to private patients in Bessborough and they sought information about their whereabouts when they left Bessborough. Dr Coholan declared that providing such information would be a breach of canon law. When the DLGPH sought a change of Superior in Bessborough because of the appallingly-high death rate, he denounced this request. The replacement of the Bessborough Superior was delayed for four years after the department requested it, and many infants died during that time. It seems probable that the bishop's intervention was elicited by the congregation.

33. The Galway county manager kept the archbishop of Tuam and the bishop of Galway informed about plans to move the Children's Home from Tuam, to the outskirts of Galway in the late 1950s. The archbishop described the proposal as 'undesirable in every way'; he claimed that the proposed new location was close to a busy road. 'Anyone who has experience of the workings of a Home for unmarried mothers will tell you that such a Home must be in a place that is quiet, remote and surrounded by high boundary walls ... In many cases they are on the look-out to get in touch with men, and some of them cannot repress their

excitement even when a man comes to the Home to deliver a message ... Many of these unmarried mothers are anxious to get off without delay. The only thing that prevents their leaving is the strict supervision and boundary walls ... in some cases it has been known that attempts were made from outside to get at the inmates'. Although the archbishop objected to Tuam being closed, he was overruled by the Minister for Health. When the Department of Health proposed to transform Sean Ross into a home for children with special needs in the 1960s, the bishop of Killaloe rejected the proposal. His intervention resulted in a number of visits to the bishop, by senior civil servants, and deferential letters from ministers. The closure of Sean Ross was delayed for several years, until the bishop had died, and his successor gave his approval.

34. In 1928 the DLGPH refused to sanction the appointment of a Sister of Mercy as matron in Kilrush - a local authority mother and baby home - because she was not a qualified nurse, and the congregation left Kilrush as a consequence. The *Registration of Maternity Homes Act 1934* did not give the department or the local authority the power to refuse to sanction the appointment of a matron in Bessborough because she lacked the appropriate qualifications, though all maternity homes were required to employ one or more qualified midwives. Staffing by religious sisters in Bessborough and other private homes was determined by the congregation.

Finances

35. The capitation payments for women and children in the mother and baby homes were financed from the rates paid to the local authorities. In 1947, the health services generally started to be partially financed from national taxation. It seems to be at this stage that the mother and baby homes started to be required to provide audited accounts to the Department of Health. These accounts were then used to determine whether an increase in the capitation payments was merited.

36. The Commission has not seen any evidence that the religious orders who ran the mother and baby homes made a profit from so doing. At various times, it is clear that they struggled to make ends meet and their members were not always paid for their work. This was a particular problem when occupancy levels fell and women stayed for shorter periods. Payments by local authorities were not always on time.

37. The capitation rates, while they were not overly generous, and often failed to keep pace with inflation, were considerably more generous that the social welfare payments available to an adult and a child living in the community.

38. Under the institutional assistance regulations, the women in the homes (or, if they were under 16, their parents) could have been charged for their stay in the homes but this does not appear to have happened in most of the larger institutions. Residents in county homes were charged if they had an income.

C: What was different about Ireland

39. The Commission is not aware of any comprehensive international study that is comparable to this report. However, it is probable that the proportion of Irish unmarried mothers who were in mother and baby homes was the highest in the world. In 1967 the number of babies who were adopted in Ireland was equal to 97% of the 'illegitimate' births; this was the highest in the world. Large numbers of Irish women continued to give birth in mother and baby homes in the 1970s, though by that time most mother and baby homes in other countries had closed.

Concept of illegitimacy

40. 'Illegitimacy' was widely regretted and disowned in most countries in the early and mid-twentieth century so in that respect Ireland was not unique. Few single women had the financial resources to raise a child without the support of their family or the father of their child. The proportion of Irish men who acknowledged paternity was low. In the German state of Westphalia one-third of the fathers of 'illegitimate' children born in 1929 voluntarily acknowledged their paternity. Few Irish men contributed to the maintenance of their 'illegitimate' child or acknowledged their existence. For the first half of the century many would have been unable to do so because they were farm labourers or unpaid workers on family farms or in family businesses. While mothers had the right to apply for maintenance under the *Illegitimate Children (Affiliation) Orders Act 1930,* it generally proved impossible to secure the necessary evidence.

Responsibility of fathers

41. In the past when a single woman was known to be pregnant the most common response in all countries was to try and arrange a marriage between the woman and the father of her child. In the early and mid-twentieth century the Irish

marriage rate was the lowest in the western world and there is an extensive literature in fiction and non-fiction about the reluctance of Irish bachelors to marry. Chapter 8 relates the stories of women who became pregnant by a long-term boyfriend who refused to marry and often disappeared on hearing of the woman's pregnancy. In other cases the man or the woman's parents opposed their marrying because of difference in social background or religion. In the light of Ireland's low marriage rate and late age of marriage, it seems possible the proportion of men who married their pregnant girlfriend may have been lower than elsewhere.

Woman's parents

42. In the past, if a single woman gave birth and there was no prospect of marriage, a common outcome was that the mother's family provided a home for her child who was raised either by grandparent(s) or by her/his mother with the support of her family. This child might remain with grandparents when the mother married, or might live with the mother and her husband, who might not be the father. There are many contemporary accounts throughout this report of Irish parents who were willing to welcome their daughter back into the family home following the birth but were not prepared to accept her child. There are various reasons why Irish parents may have been less willing to welcome an 'illegitimate' grandchild into their home than elsewhere. Irish families were large; in 1960 Irish marital fertility, that is, the number of children born in a marriage, was the highest in the developed world despite the fact that couples married at a late age. Many families were poor and living in overcrowded homes so an additional child would have put them under pressure. Such a child would have been especially unwelcome in a farm house where the marriage of the inheriting son depended on clearing the home of non-inheriting siblings.

43. There is also the question of a family's standing in the community. Many Irish marriages until the 1960s involved an element of match-making and a dowry and these processes were reliant on a family's respectability. An 'illegitimate' birth could destroy the marriage prospects, not just for the woman who had given birth, but for her siblings, hence the pressures to keep it a secret by sending her to a mother and baby home. Many women who concealed their pregnancy from parents or family members were conscious of such attitudes. Pressure to keep their pregnancy a secret added to a woman's trauma.

44. The dominance of the family farm and family business and the slow pace of economic development meant that Irish men and women in their late teens and early twenties were more likely to be dependent on their parents than their counterparts elsewhere. Land inheritance was important with farms passing from father to son. Agricultural concerns with breeding and lineage appear to have applied to marriage partners and children. When legal adoption was introduced in 1953, the take-up was slowest among the farming community. The rural values of respectability and family standing also existed in cities and towns, though to a lesser extent.

Fleeing to Britain

45. Many pregnant women fled to Britain, to protect this secrecy, only to face the prospect of being returned to Ireland against their wishes. There is no other known instance where substantial numbers of pregnant single women fled their country, though it was common elsewhere for women to move from their home place, generally to a city, in search of anonymity. British Catholic charities put considerable pressure on the Irish Hierarchy and on the government to repatriate the women. Some of the treatment meted out to these women, who were commonly described as PFIs, pregnant from Ireland, was inhumane and occasionally it placed them at medical risk. British authorities also returned children born there to Irish women, sometimes approaching the woman's family who might be unaware of the child's existence, asking them to take the child. The Department of Health and local authorities appear to have co-operated with these practices. The bishop of Cork, Dr Lucey, established an adoption society to place children born to Irish women in Britain with Irish adoptive parents.

Church and State attitudes

46. The Catholic church did not invent Irish attitudes to prudent marriages or family respectability; however, it reinforced them through church teachings that emphasised the importance of pre-marital purity and the sexual dangers associated with dance halls, immodest dress, mixed bathing and other sources of 'temptation'. In the 1920s, the Irish Free State was a newly-independent nation which was determined to show the world that it was different; part of that difference related to the capacity to withstand the undesirable aspects of modernity, including sexual licence and alien cultures. There was a strong alignment of views between church and State, resulting in legislation against contraception, divorce, censorship of cinema and publications that was bolstered by church sermons denouncing

sexual immorality and the evils of modern society. Priests who denounced a man or woman who was responsible for an extra-marital pregnancy were reinforcing wider social concerns with family lineage and the respectability of a community. It should be noted that, while there is evidence of such denunciations, they were not as common as is sometimes suggested.

Infant mortality

47. Although the first report of the registrar general of the Irish Free State highlighted the appalling excess mortality of children born to unmarried mothers and subsequent DLGPH reports noted the fact, there is little evidence that politicians or the public were concerned about these children. No publicity was given to the fact that in some years during the 1930s and 1940s, over 40% of 'illegitimate' children were dying before their first birthday in mother and baby homes. The high level of infant mortality in the Tuam Children's Home did not feature at meetings of Galway county council, though Tuam was under the control of the local authority and it held meetings in the Children's Home. The Bethany management board could describe health in the home as 'excellent', despite the minutes of the same meeting recording the deaths of a number of children. In wartime Birmingham the local authority introduced targeted measures to reduce infant mortality among 'illegitimate' infants and the death rate fell below the average for all infants in the municipality. But such action required public acknowledgement that these children existed and a commitment to promoting their well-being. There is little evidence of similar concerns within Irish society; the children of Irish unmarried mothers were hidden from the public gaze. Infant mortality in general remained high in Ireland until the late 1940s, especially in the inner cities, yet there was no national outcry about this, except among a small number of medical professionals.

Distinctive features of Irish institutions

48. Mother and baby homes were not unique to Ireland; in fact, Ireland was a latecomer but they did remain in existence for longer than other countries. Some features were distinctive. Irish homes were much larger. Scottish mother and baby homes ranged in size from 18 to 30 beds; in 1969 the modal size of the 22 mother and baby homes in the Netherlands was between ten and 19 places for mother and baby. British homes in the late 1960s accommodated an average of 13 women. The average number of women in Sean Ross and Castlepollard in the early 1950s was 140 or higher and the large size inevitably meant that Irish mother and baby homes were impersonal and highly regimented. It was common practice

for mother and baby homes in other countries to require that women remain for a designated period following the birth of their child - because it was believed that women who parted with their child very shortly after birth were at danger of a second pregnancy. But only in Ireland was it widely stated that women should remain for two years (in practice, as is set out below, relatively few stayed for two years).

Religious involvement

49. Most mother and baby homes in other countries were run by religious organisations and the religious salvation of mothers and children was central to their mission. In nineteenth-century Ireland there was intense competition between religious denominations to save the souls of orphaned, abandoned and destitute children including the children of unmarried mothers and this continued into the twentieth century. There were a number of charities whose mission was to 'rescue' Catholic children and bring them up as Protestants. Many Catholic charities such as St Patrick's Guild, the Catholic Protection and Rescue Society of Ireland, the Rotunda Girls' Aid Society and the Catholic Women's Aid Society (based in Cork) were established to counteract this. Such denominational rivalry was not unique to Ireland but it appears to have persisted for a longer time than elsewhere; it impacted on Irish mother and baby homes until the 1940s. The main motivation behind the British and Irish Catholic charities who were involved in repatriating Irish women from Britain, either pregnant or with their new-born infant, was to prevent these children being 'lost' to Catholicism through adoption into Protestant families. Concerns, however-far-fetched, that state-regulated adoption would result in Catholic children being adopted by parents of a different religion were a factor in delaying the introduction of legal adoption in Ireland until 1952. Ireland was the second-last country in western Europe to legislate for adoption. The Netherlands, where religious divisions were deeply entrenched, introduced legal adoption in 1956.

D: A brief chronological narrative

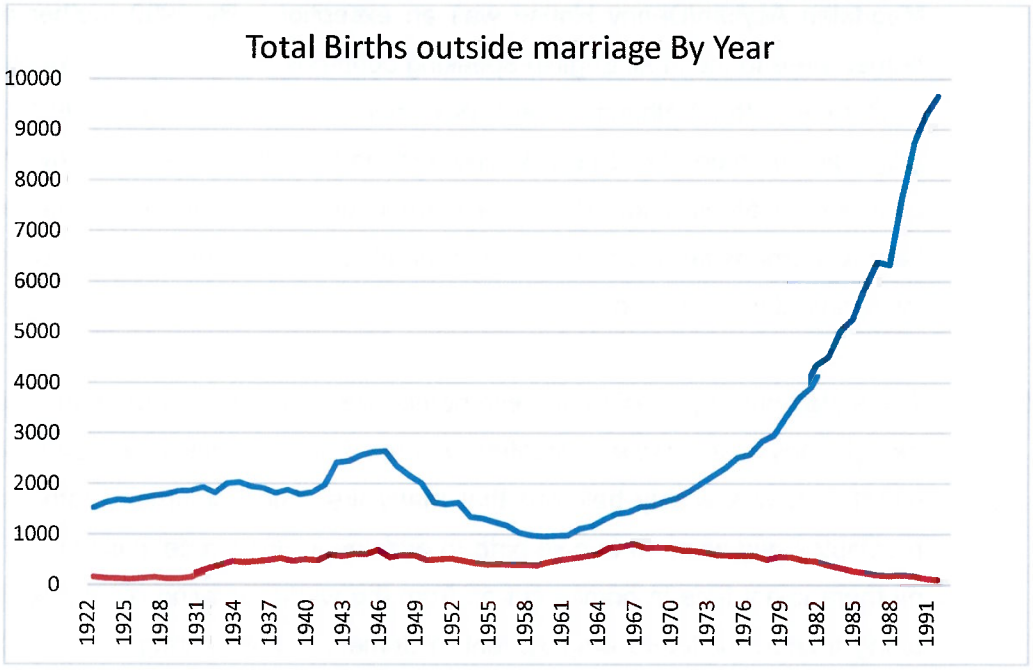
50. As already stated, mother and baby homes were not unique to Ireland; they were established later in Ireland than in other places. There were many Magdalen institutions and 'rescue' homes in nineteenth-century Ireland but they did not admit pregnant women or unmarried mothers who were accompanied by a child. The

Magdalen Asylum/Denny House was an exception. By 1900 mother and baby homes were found in all English-speaking countries, and similar institutions existed in Germany, the Netherlands and elsewhere. They were generally founded by religious communities/ charities and the early homes were run by Protestant charities. Catholics appear to have been slow to establish mother and baby homes, perhaps because members of female religious orders were precluded from involvement with childbirth.

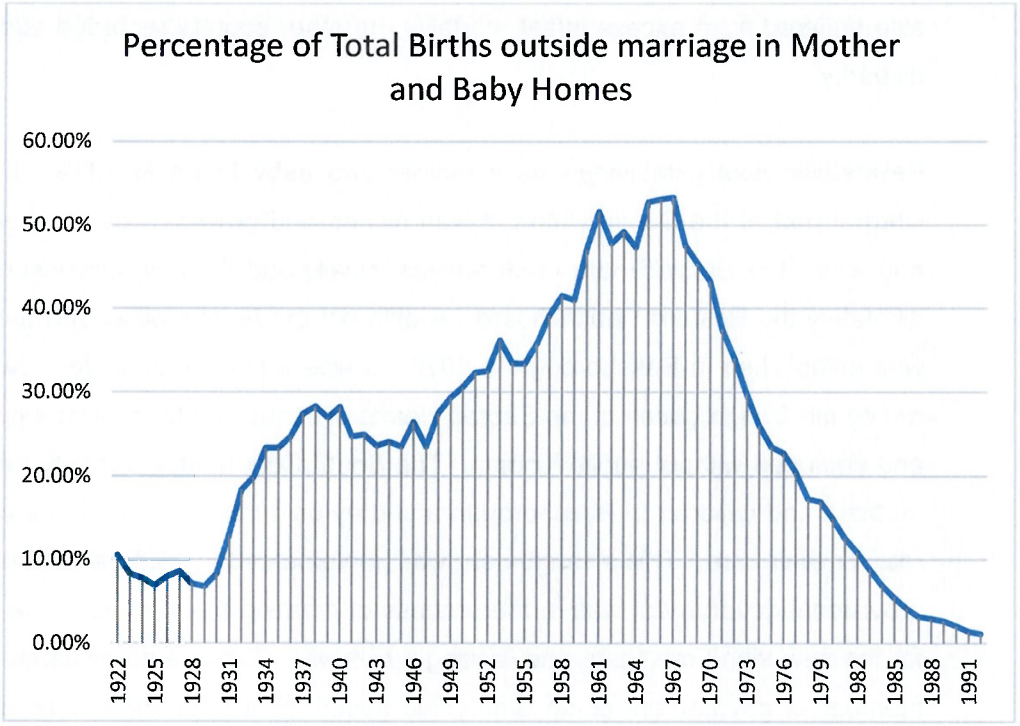
51. The stated primary mission of these homes was to promote reform and repentance though they also rescued destitute women from homelessness and life on the streets. It was widely believed that many first-time unmarried mothers became prostitutes and went on to give birth to additional 'illegitimate' children. If first-time mothers spent time in homes cut off from the world, carrying out domestic duties, being trained for future employment in domestic work, caring for their child, and spending time in prayer and other religious experiences, it was believed that they would avoid that danger.

52. The first proposal for mother and baby homes in Ireland came in the 1907 Vice-Regal Commission on the Irish Poor Law. At the time the workhouses were the only institutions providing for unmarried mothers. The Vice-Regal Commission suggested that unmarried mothers and their children should no longer be accommodated in workhouses but in dedicated mother and baby homes. These homes should be owned and run by religious organisations; alternatively they should be established by local authorities, who would place them under the control of a religious community. This became the template that was implemented by the Irish Free State.

53. The years of World War I and the immediate aftermath were marked by a rise in the rate of 'illegitimate' births in Ireland and elsewhere, though the rate of 'illegitimate' births in Ireland was among the lowest in Europe. The number of 'illegitimate' births rose slightly during the 1920s and 1930s and it increased more sharply during the years 1940-46 when it reached a peak. It fell quite sharply in the late 1940s and this decline continued until 1960 when the rate was 37% of the 1946 figure. The number of 'illegitimate' births began to rise after 1961 and continued to rise for the remainder of the century.



54. The chart shows the total number of 'illegitimate' births by year as recorded by the General Register Office (in blue) and the total number associated with mother and baby homes (in red). In the 1920s, 1930s and 1940s, less than one-third of 'illegitimate' births were associated with mother and baby homes. The proportion rose steadily during the 1950s even though the number of 'illegitimate' births fell sharply in this decade. In 1961, and in 1965, a majority of 'illegitimate' births were to women in mother and baby homes. Admissions remained high throughout the 1970s, though they accounted for a steadily declining proportion of 'illegitimate' births.



55. Mother and baby homes were established as part of the reforms to the poor law that were instituted after independence. The stated policy of the government was that unmarried mothers and their children should not remain in county homes (which were the successors to the workhouse), yet there were 450 unmarried mothers in county homes in March 1950. The number fell sharply over the next decade.

56. The motivation behind the creation of mother and baby homes was not clearly articulated, other than the fact that it removed the mothers and children from the county homes. It was believed that dedicated mother and baby homes could 'reform' first-time mothers, and prevent subsequent pregnancies. There was a strong opinion that first-time mothers should not come into contact with the mothers of more than one child who might be found in a county home. A DLGPH inspector suggested that mother and baby homes would reduce the incidence of infanticide and the number of women who were forced to resort to private nursing homes where they were financially exploited and their children placed, for a fee, in unsuitable foster homes. The first report of the registrar general of the Irish Free State had highlighted the fact that infant mortality among 'illegitimate' children was five times the national average, and while 'illegitimate' children in other countries

also suffered from excess infant mortality, no other country recorded such a high disparity.

57. Pelletstown was established as a mother and baby home in 1919. It was an integral part of the Dublin Union. It was owned and governed by the local health authority - the Dublin Board of Guardians initially and then its successors in title, ultimately the Eastern Health Board. A different model of mother and baby home was established in Bessborough in 1922. It was a private institution, owned and run by the Congregation of the Sacred Hearts of Jesus and Mary; it was purchased and equipped without public funding. The South Cork health authority transferred mothers and children to Bessborough and they paid the congregation a capitation rate for their care. This arrangement was implemented in 1922, at a time when a provisional government was in the process of creating the administrative systems for the new Irish Free State and fighting a civil war. There is no evidence that any member of government or an embryonic government department was consulted about this arrangement. But given that health and welfare services were the responsibility of local authorities, there is nothing untoward in that. The Bessborough model, where a local authority paid a capitation rate to a private mother and baby home, became the funding model which remained in place until the end of the twentieth century. The Bethany Home was founded in 1922 by a Protestant evangelical group. However, it did not seek public funding at that time.

58. During the 1920s two further local authority owned mother and baby homes opened - Kilrush and Tuam (which was initially based in Glenamaddy). Neither of these was exclusively a mother and baby home; they also housed unaccompanied children and Tuam housed homeless families. The three local authority homes were staffed by religious sisters. This was consistent with the practice in Irish workhouses before independence where many of the matrons and nursing staff were religious sisters.

59. A number of developments in the early 1930s ensured that the expansion of mother and baby homes took place in institutions that were privately-owned. The Department of Local Government and Public Health (DLGPH) asked the Congregation of the Sacred Hearts of Jesus and Mary to establish a second home. The senior inspector, Mrs Crofts, assisted the congregation in identifying a suitable location. In the early weeks of 1932, the Minister for Local Government and Public Health allocated money to Bessborough for capital improvements from the

Hospitals Trust Fund that was at his discretionary disposal. The *Public Hospitals Act 1933* listed mother and baby homes among the institutions that were eligible to apply for hospitals sweepstake money in future. When Pelletstown, Bessborough and Glenamaddy opened women were not admitted until after the birth of their child; Kilrush was the exception. By the mid-1930s however, most women entered a mother and baby home in the final stages of pregnancy and gave birth there. Capital funding from the Hospitals Trust Fund made it possible to construct and equip the maternity units and carry out other improvements to mother and baby homes.

60. The number of women entering mother and baby homes rose steadily in the 1930s. In the 1920s women who were maintained by a local authority had first to enter a county home before being transferred to Bessborough. By the end of the decade women were admitted directly removing the association with poor law institutions. The introduction of maternity services resulted in increased admissions and Bessborough began to admit private patients. Despite the opening of Sean Ross in 1931 and Castlepollard in 1935, both run by the Congregation of the Sacred Hearts, mother and baby homes were overcrowded by the mid-1930s.

61. Maternity units were added to mother and baby homes because unmarried mothers were not welcome in county hospitals. Galway county council determined that unmarried mothers should be excluded from the Central Hospital in Galway because their presence deterred 'respectable' married women from giving birth in the hospital. Unmarried mothers in Kilkenny were excluded from the county hospital and sent, regardless of distance, to give birth in the county home in Thomastown. However the Dublin maternity hospitals admitted unmarried women and appear to have given them similar care to married mothers.

62. The introduction of maternity units in mother and baby homes increased their medical/nursing responsibilities. The *Registration of Maternity Homes Act 1934* gave local authorities authority to license, inspect and regulate all hospitals and nursing homes where women gave birth or were cared for with their child following the birth. It also gave the DLGPH the right to inspect these institutions. This was the first time that a government department secured a role in overseeing privately-owned mother and baby homes. By 1939 a department inspector was expressing concern about the high rate of infant mortality in these homes. Infant mortality

rates peaked in most homes during the early and mid-1940s, coinciding with a national peak in infant mortality. 75% of the children born in Bessborough in 1943 died within the first year of life; 62% of children born that year in the Bethany Home died. The high rate of infant mortality raised serious questions about mother and baby homes: the large size, unqualified staff and inadequate staffing, poor management, and the limitations on the local and national authorities' willingness and capacity to implement reforms.

63. There is no evidence that unmarried mothers were ever discussed at Cabinet during the first 50 years after independence. Responsibility for unmarried mothers and their children was seen as resting with the local authorities. As described above, the relative roles and powers of the DLGPH and the local health authorities were never sufficiently clarified. In the late 1930s and the 1940s, DLGPH ministers and staff were aware of the major shortcomings in the mother and baby homes most especially the high rate of infant mortality. By the mid-1940s, ministers and senior department officials were involved in planning major reforms to health and welfare services; these reforms resulted in the establishment of separate Departments of Health and Social Welfare, and the drafting of a mother and child scheme. Yet with the exception of memoranda written by Miss Litster and submissions by the Joint Committee of Women's Societies and Social Workers, proposing alternative arrangements for supporting unmarried mothers and their children, there is no indication that consideration was given to effecting major changes to the existing provisions. Infant mortality fell sharply in the late 1940s in the mother and baby homes and nationally. This may have removed the motivation for major reforms, which would have involved fraught negotiations with religious congregations and members of the Catholic Hierarchy. There is no evidence of public concern being expressed about conditions in mother and baby homes or about the appalling mortality among the children born in these homes even though many of the facts were in the public domain.

64. The introduction of legal adoption from 1953 removed one of the underlying problems facing Irish mother and baby homes - the long-term future of the children. By the 1960s most women placed their child for adoption and left a mother and baby home within a few months of giving birth. In 1967 the number of babies adopted was 97% of the number of 'illegitimate' births. These statistics dispel any myth that the 1960s brought major changes in family or societal attitudes or practices towards 'illegitimacy'.

65. There was little public discussion about unmarried mothers or mother and baby homes before the 1960s. Stories began to appear in newspapers and magazines in the 1960s. In the late 1960s, Ally began to provide family placements for pregnant single women, as an alternative to mother and baby homes. The 1970 Kilkenny Conference on the Unmarried Parent indicated that change was underway. Cherish was founded in 1972 as a support organisation for unmarried mothers which was run by the mothers. It provided both practical and psychological supports for women especially those who wished to raise their child. A growing number of single women no longer concealed their pregnancy and were determined to raise their child, though the difficulties that unmarried mothers continued to face in the 1970s and 1980s cannot be understated. By the 1970s however the Catholic church was more sympathetic towards unmarried mothers than in earlier times, because a growing number of single Irish pregnant women were opting to have abortions in Britain.

66. The introduction of Unmarried Mother's Allowance in 1973 passed without comment by any TD in Dáil Éireann, other than the Parliamentary Secretary to the Minister for Health and Social Welfare, Frank Cluskey who was introducing the legislation, and it attracted no attention in local or national newspapers. This silence suggests public uncertainty about the appropriate response - an unwillingness to either praise or criticise this new welfare payment. It was not until the tragic death of Ann Lovett in 1984 that there is evidence of extensive public commentary on unmarried motherhood, and serious questioning of Irish attitudes. Ireland was not unique in the 1970s or 1980s in its ambivalence towards single parents and the merits of providing them with state benefits; public criticism in Ireland was probably less vehement than among right-wing groups elsewhere. The enactment of the 8th Amendment to the Constitution in 1983, which guaranteed the right to life of the unborn, and the widespread attention given to the large numbers of single Irish women travelling to England for abortions, may have resulted in more tolerant attitudes.

67. The number of births to unmarried mothers doubled between 1971 and 1980. In 1980 a total of 552 babies were born to women who were in mother and baby homes. This figure was higher than the 498 born in these homes in 1950 or the 456 babies born in 1960. The numbers only began to fall in the 1980s. Mother and baby homes closed, down-sized, or were replaced by flatlets and hostels. In 1971, the number of adoption orders was 71% of the number of 'illegitimate' births;

by 1980 this had fallen to 37%, and to less than 9% by 1990. By the late 1990s most adoption orders in Ireland were family adoptions, or adoptions of foreign-born children.

68. By the 1970s unmarried mothers and their children in other western European countries were viewed as part of a wider cohort of one-parent families. The continuing compartmentalisation of unmarried mothers in Ireland - which lasted until the end of the century - reflected the constitutional prohibition on divorce and a failure to recognise broader categories of single parenthood, such as extra-marital births to married or deserted women, and births to married women who were divorced or separated. The status of 'illegitimacy' was not abolished until 1987. A married woman, who gave birth to an extra-marital child, faced particularly difficult circumstances. The *Adoption Act 1952* applied only to 'illegitimate' children and orphans; unless a woman's husband testified that he was not the father, extra-marital children could not be adopted. Some were transferred to Nazareth Home in Fahan, Donegal from where they were sent to Northern Ireland where such adoptions were legal.

69. The women in mother and baby homes in the closing decades of the century remained for a much shorter time; they were generally free to come and go as they pleased, to meet friends or family, including boyfriends or spend weekends away, and visitors were encouraged. Almost all the work was carried out by paid staff. There was a transition from institutional care to supported accommodation in flatlets where women were encouraged to be independent. The first of these developments, Miss Carr's Flatlets opened in 1972. Women in Dunboyne were tutored for State examinations; this enabled them to continue with their education at a time when most schools either excluded pregnant students and new mothers or certainly did not encourage them to attend. Women in Bessborough attended state-funded training courses. Denny House assisted women in learning to care for their child; it supported women with mental illness or addiction problems and women with difficult personal or family circumstances. The Commission believes that the flatlets and homes that survived in the 1980s and 1990s provided important supports for single mothers, who had specific medical or social needs that could not be met within the community, because of continuing prejudice or hostility on the part of families and the wider society.

E: The distinctive features of the institutions

70. As already stated, even though there was a lot in common between the institutions under investigation, there were also distinct differences. The following provides a very brief summary of the distinctive elements of each institution:

Dublin Union/St Patrick's Navan Road/Pelletstown/Eglinton House 1919 - 1998

71. ***The people***: 15,382 women and 18,829 children; it was not exclusively a mother and baby home as it also housed unaccompanied children; 5,888 children entered unaccompanied and many others stayed after their mother left. Initially, the unaccompanied children were foundlings and children who were abandoned, neglected or homeless. Later, it also admitted children with serious physical or intellectual disabilities and children who discharged from hospital with untreatable conditions. Many of the unaccompanied children were the children of married couples.

72. Before 1935, women were admitted to the Dublin Union and gave birth there before being transferred to Pelletstown. A maternity hospital opened in Pelletstown in 1935 and women entered directly. It was not restricted to first-time mothers; almost 30% of the women for whom this information is available were pregnant for a second or subsequent time.

73. ***Length of stay***: The length of stay for mothers changed considerably over time but, apart from a few years in the 1940s, the average was always less than a year and less than six months from the early 1960s onwards.

74. ***Premises/Living conditions***: Pelletstown itself was an institutional building with large dormitories and large children's nurseries. Although improvements were gradually carried out, facilities were inadequate. In 1950 there were only four lavatories for 140 resident women. In 1966, women were sleeping in dormitories with 52 and 30 beds respectively that offered no privacy although plans were underway to divide them into cubicles. It closed in 1985. Eglinton House was a large house which catered for about 15 mothers and children and had good facilities.

75. ***Governance***: It was owned and financed by the Dublin Board of Guardians and its successors - ultimately the Eastern Health Board. It was run by the Daughters of Charity who were salaried local authority employees as were the lay nurses and other staff.

76. ***Infant Deaths***: 3,615 children died; 78% of deaths occurred between 1920 and 1942. Pelletstown is unique in not recording a peak in mortality during the 1940s despite the record infant mortality in Dublin city during these years. In the years 1943-45 infant mortality in Pelletstown was 14.8%, which was substantially lower than other mother and baby homes. Some of the children who were in Pelletstown were there because they were seriously ill and there nothing further could be done for them in the children's hospitals.

77. ***Burials***: The burials of the children who died are properly recorded in Glasnevin Cemetery.

Belmont Flatlets 1980- 2001

78. This was not a traditional mother and baby home but rather hostel type short-term accommodation for a small number of women and children, about nine or ten at any one time. It was opened by the Daughters of Charity who ran Pelletstown and was financially supported by the Eastern Health Board. The women lived independently but did get support from social workers and public health nurses.

Children's Home Tuam (originally Glenamaddy) 1921- 1961

79. ***The People***: 2,219 women and 3,251 children; it was not exclusively a mother and baby home as it also accommodated unaccompanied children of married couples and widow(ers) whose parent was unable to care for them and married women or widows with children who were homeless or destitute. There were always large numbers of unaccompanied children; in 1943 there was an average of 258 resident children and 53 mothers. Almost all the women and children were from Galway and Mayo.

80. Before 1935, when a maternity unit was opened in Tuam, women gave birth in the Central Hospital in Galway. Medical care was provided by a local dispensary doctor, who was in his late 80s when he retired in 1951, and a dispensary midwife. This was similar to the care available to a woman having a home birth.

81. ***Length of stay***: Women remained in Tuam on average for less than a year. Some children remained up to the age of six or seven years.

82. ***Premises***: Both Glenamaddy and Tuam were former workhouses and the physical conditions were dire. Galway county council failed to properly maintain, much less improve, the conditions. In 1959, Tuam's physical condition was much worse than that of the county home in Loughrea even though conditions in county homes were generally much worse than in mother and baby homes.

83. ***Governance***: it was owned and controlled by Galway county council, which made all the major decisions, and run on a day-to-day basis by the Sisters of Bon Secours who were not salaried employees. The local authority paid a capitation rate for mothers and children, and a salary to the chaplain, the attending medical officer and an external midwife; other staff costs were paid by the Sisters. The local authority was responsible for maintenance and improvements.

84. ***Child deaths***: 978 children who were in Tuam or Glenamaddy died; 80% were under a year, and 67% were aged between one and six months. Three-quarters of the deaths happened in the 1930s and 1940s; the worst years were 1943-1947.

85. ***Burials***: No register of burials was kept and it is likely that most of the children who died in Tuam are buried inappropriately in the grounds of the institution.

Kilrush 1922 - 1932

86. ***The people***: The exact numbers are not known but the Commission estimates that there were between 300 and 400 unmarried mothers and a much larger number of children in the Clare County Nursery in Kilrush. It accommodated a number of unaccompanied children including children of school-going age.

87. ***The premises***: It was a former workhouse and was even worse than Tuam. It had no running water, baths or indoor toilets.

88. ***Governance***: It was owned and governed by Clare county council. From 1922 to 1928 it was run by the Congregation of the Sisters of Mercy, who had been employed in the former workhouse. They left when the Department of Local Government and Public Health refused to approve the appointment of a Mercy sister as matron because she lacked a nursing qualification. From 1928 until 1932

it was run by lay staff. All the lay staff were local authority employees as were three of the four religious sisters who were in the home in 1928.

89. ***Child Deaths***: The numbers are not known but the medical officer described the death rate in 1927 as appalling.

Bessborough 1922 - 1998

90. ***The people***: 9,768 women and 8,938 children; between 1933 and 1944, 30% of the women were private patients who were not financed by a local authority. The number of women admitted increased by 25% in the 1940s, when there was a sharp rise in 'illegitimate' births.

91. In 1930 Bessborough opened a small maternity unit. This was replaced in 1933 by a 26 bed maternity hospital which was funded by the Hospitals Trust. Admissions rose sharply following the opening of the maternity hospital. It was overcrowded in the 1940s; it failed to isolate infected cases and screen incoming patients.

92. ***Length of stay***: The average length of stay varied very widely over time. The average is somewhat distorted by the fact that women whose children died left immediately after the death and private patients did not stay as long as public patients. The very lengthy stays were generally before the 1960s. Those admitted in 1950 stayed on average for about a year; this had decreased to nine months for those admitted in 1960 and to about three months for those admitted from 1970 onwards.

93. ***Premises/Living conditions***: It was a large Georgian house initially on over 200 acres of land. Until the 1970s living conditions were basic and institutional but much better than county homes. Dormitories and nurseries were large and there was no privacy but it did have running water, bathrooms and central heating. The large dormitories were replaced by cubicles and bedrooms in the 1970s.

94. ***Governance***: It was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. It was financed by capitation payments from the local health authorities and received capital funding from the Hospitals Trust Fund. Some residents were private patients. In the 1940s in particular, there was a shortage of qualified nurses and midwives and the religious sister who was in charge was incompetent. Although it was closed to women and children who were supported

by local authorities in 1944, it continued to admit private patients and many of their children died. The evidence suggests that the Cork local health authorities did not properly monitor Bessborough and did not take appropriate action when it became aware of the very high rate of infant mortality. The bishop and the congregation resisted implementing the changes demanded by the DLGPH for some years.

95. ***Child deaths***: 923 children who were associated with Bessborough died. In 1934, it had the highest recorded infant mortality rate among mother and baby homes. Infant mortality reached even higher levels in the early 1940s. In 1943 three out of every four children born in Bessborough died. Although only 9% of the babies were the children of private patients, they accounted for 21% of deaths. Private patients were leaving Bessborough without their child, shortly after giving birth, and it is evident that these children received inadequate care.

96. Infant mortality improved significantly from 1945. Private patients were no longer permitted to leave without their child; a visiting medical officer, a new matron and additional nursing staff were appointed; penicillin became available. More bathrooms and washrooms were provided. Overcrowding eased with the falling number of 'illegitimate' births in the late 1940s, and this continued into the 1950s.

97. ***Burials***: Bessborough failed to keep a register of infant burials and the burial location of the majority of children who died there is still unknown.

Sean Ross 1931 - 1969

98. ***The people***: 6,414 women and 6,079 children.

99. ***Length of stay***: The length of stay varied considerably over time. It remained high (but generally less than two years on average) until the 1950s and shortened dramatically from 1961.

100. ***Living conditions***: It was located in a large country house. The Hospitals Trust Fund provided capital funding for a dedicated maternity hospital and increased accommodation including a nursery block. However the buildings were not connected; access to the maternity hospital was through the farm yard. It became overcrowded shortly after it opened. The maternity unit lacked basic equipment. Other parts of the home were renovated in the early 1950s; they included a new recreation hall for mothers.

101. Sean Ross experienced several outbreaks of diphtheria during the 1930s and 1940s (this did not happen in other homes). Diphtheria was the leading cause of death in 1936 and 1937. Mothers and children were treated in the local authority fever hospital in Roscrea, which relied on Sean Ross mothers to carry out some of the nursing duties without payment. Many children who died became ill shortly after their mother returned from nursing duties in the fever hospital and it is probable that mothers transmitted the infection to their children. This pattern can be identified until 1945. In 1944 Sean Ross experienced a major epidemic of typhoid; on this occasion a fever unit was created within the home. The cause of the outbreak was not identified. Four women died of typhoid in Sean Ross, and three women who had been transferred to other hospitals also died. The appointment of a new medical officer appears to have resulted in improvements in health and mortality from 1945.

102. ***Governance***: Like Bessborough, it was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary and it followed a similar model.

103. ***Infant deaths***: A total of 1,090 of the 6,079 babies, who were born or admitted died; 79% of the deaths occurred between the years 1932 and 1947. The worst years were 1936 and 1942. Within two years of Sean Ross opening the congregation acknowledged that there was a 'problem' with the high rate of infant mortality, and they sent a Sister from Liverpool to investigate the cause.

104. ***Burials***: Registers of burials were not maintained. There is a designated burial ground and the Commission has established that the coffined remains of some children under the age of one are buried there.

Castlepollard 1935 - 1971

105. ***The people***: 4,972 women and 4,559 children.

106. ***Length of stay***: The length of stay varied considerably over time. In the period 1947 to 1959 it was 304 days on average and decreased dramatically during the 1960s.

107. ***Premises/living conditions***: It was located in a large period house at Castlepollard. A maternity hospital which was financed by the Hospitals Trust Fund was opened in 1942; it included accommodation for mothers and children.

By 1937 it was grossly overcrowded and the 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.

108. 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. The town generating station was destroyed in 1941; this continued until 1948.

109. ***Governance***: Like Bessborough, it was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary and it followed a similar model.

110. ***Infant deaths***: A total of 247 children died in Castlepollard; 60% of deaths were in the 1940s. The peak year was 1940 when the home was grossly overcrowded; mortality was also high in the years 1944-47 but it fell sharply thereafter. In the worst year, 1940, infant mortality in Castlepollard was 26%; this was approximately half the peak figure in Sean Ross, 50%, and one-third the peak mortality in Bessborough at 75%. Approximately 10% of Castlepollard mothers were private patients, but in contrast to Bessborough, the mortality of the infants of private patients were well below the average for the home, probably because the mothers were not permitted to leave without their child. The peaks in infant mortality occurred when the home was most overcrowded.

111. ***Burials:*** No register of burials was maintained but it seems likely that most of the children who died are buried in the designated burial ground.

Regina Coeli 1930 - 1998

112. ***The people***: 5,631 mothers and 5,434 children; other women who are not within the Commission's Terms of reference were also there. It was designed to provide accommodation for destitute and homeless women. It was not designed as a mother and baby home, but pregnant single women, and unmarried mothers with their children began to seek admission. Until the 1970s it was the only place that supported unmarried mothers who wished to raise their child. Women were

referred by social workers in Dublin maternity hospitals. The DLGPH used it as short-term emergency accommodation for pregnant women who had arrived from the country or from England pending their transfer to a mother and baby home. It did not distinguish between first-time mothers and women on a second or subsequent pregnancy. It accommodated women with mental illness, and women who had been involved with crime who might not have been accepted in the private mother and baby homes. Women who had the means to pay for a private nursing home were not admitted.

113. Women and children in Regina Coeli did not receive state support. Mothers were encouraged to work as servants in private homes and in nearby hospitals and other institutions. Most of the work in the hostel was carried out by volunteer members of the Legion, assisted by women who were not working externally. One of the core principles was that no services should be provided free of charge: women paid a modest sum for their meals and 1s a week for their children.

114. ***Length of stay***: Some women stayed for only one or two nights. Many remained for several years, and others entered and left on several occasions. A woman who arrived in 1953 stayed for ten years with her two children. A woman who was admitted in 1955 gave birth to six children during the course of a 15-year stay.

115. ***Governance***: It was run by the Legion of Mary which is a voluntary organisation. It got no regular State funding.

116. ***Premises/Living conditions***: It was located in North Great Brunswick Street, in part of the former North Dublin Union workhouse. Most women gave birth in the nearby Rotunda hospital. It was never registered under the *Registration of Maternity Homes Act 1934*, even though it should have been. There were regular outbreaks of infectious disease among mothers and children. This was not surprising, given that Regina Coeli admitted destitute, often homeless women and children, and sanitary facilities were primitive. No efforts were made to isolate new arrivals until the mid-1940s. Public health doctors and nurses, visited the hostel, and temporary nurses were appointed to cope with outbreaks of infectious disease. It operated on the principle that all staff should be volunteers, so medical care was provided by the local dispensary doctor, which the Dublin medical officer of health regarded as unsatisfactory.

117. ***Funding***: In 1950, the Hospitals Trust Fund provided funding to improve the accommodation for unmarried mothers and children. Most of the money was spent providing 'family units' for mothers with older children. These consisted of six cubicle bedrooms, each for a mother and her child(ren), plus a common room and an open fire place for 'cooking' and nearby sanitary facilities. The plan was that five women would go out to work, and one mother would mind the children. However, this former workhouse required much greater investment; in 1956 a staircase collapsed injuring a Legion volunteer. In 1963 the hostel was condemned by Dublin Corporation as structurally unsafe. They recommended that it should close, with residents moving to a former sanatorium in county Dublin. Regina Coeli survived thanks to the support of Minister for Health Seán MacEntee; part of the building was demolished, residents were accommodated in chalets. A major reconstruction was eventually completed in the late 1970s, funded by the Eastern Health Board.

118. ***Deaths***: A total of 734 children died; the peak in infant and child morality was in the early 1940s, coinciding with a peak in infant mortality in Dublin city; 68% of the children's deaths were in the 1940s; over 91% of deaths took place before 1950. A 1948 report claimed that infant mortality was three times the rate in Pelletstown and the hostel lacked 'almost every proper facility in regard to both nursing and structure'.

119. ***Burials***: The Commission has not investigated the burial arrangements as the children died in many different locations.

Dunboyne 1955 - 1991

120. ***The people***: 3,156 mothers and 1,148 children; the children were almost all born in Holles Street hospital. It was initially designed for women on second or subsequent pregnancies but the vast majority were first-time mothers. By the late 1980s, 58% of the women were teenagers; roughly one-quarter were students. In 1980 it was designated as a centre for intermediate and leaving certificate exams. Classes were provided by a team of part-time teachers, who were paid by the local vocational education committee.

121. ***Length of stay***: Like the other institutions, the length of stay varied over time. Women admitted to Dunboyne in the 1950s spent 383 day on average there; women admitted in the 1970s were there for 85 days on average. In later years,

some women did not return to Dunboyne after giving birth. At this time, children generally were placed with adoption societies or foster parents direct from the hospital and spent no time in Dunboyne.

122. ***Premises/Living conditions***: It was located in Dunboyne Castle. The facilities were very good. It had adequate sanitary arrangements and central heating. It had better facilities than the average Irish home when it opened. An extension financed by the Sisters was opened in 1963. Women slept in shared bedrooms; there were ample bathrooms and wash-basins, all laundry other than personal clothing was sent to a commercial laundry. It had reception rooms for visitors, a television room, a smoking room, and a room with a record player. Although capitation payments were higher than in other homes, spending generally exceeded income.

123. ***Governance***: It was bought and fitted out by a number of county councils of which Meath was the lead. It was leased to and run by the Sisters of the Good Shepherd. It was financed by capitation payments from the local authorities; these were always at a higher rate than was paid to the Sacred Heart homes.

124. ***Child deaths***: A total of 37 children born to Dunboyne mothers died; two-thirds of the deaths were in a maternity hospital and the others were mainly in children's hospitals.

Bethany 1922 - 1971

125. ***The people***: 1,584 women and 1,376 children. Bethany was an amalgam of two charities, one providing for female ex-prisoners and a rescue home for women. Both charities were associated with the Church of Ireland but they admitted women of all religions. Bethany's main mission was as a mother and baby home but it continued to admit a number of women who were 'rescued' on the streets, and it was a place of custody for Protestant women, including women who had committed infanticide; 113 of the 1,584 women in Bethany were neither pregnant nor recent mothers. A total of 419 women, 27% of total admissions were Catholics. In the 1920s and 1930s they constituted over 45% of mothers. Bethany accepted women who were pregnant for a second time, provided that they had not been admitted on a previous pregnancy; 20% of the women were pregnant for a second or subsequent time, which may be an under-estimate because the data are incomplete. It ceased to take in Catholic women in 1940.

126. ***Length of stay***: The average length of stay was 154 days; this fluctuated between 300 days on average for women admitted in 1953 to 62 days on average for women admitted in 1969.

127. ***Premises/Living conditions***: Initially it was located in Blackhall Place in the north-inner city. It moved to Orwell Road, Rathgar in 1933. The accommodation in Blackhall Place appears to have been inadequate. The Orwell Road premises was a 6,000 square feet detached house on an acre of grounds in Rathgar. Improvements were carried out including converting the adjoining stables. Initially this was used as a separate institution that accommodated older children; in the late 1930s it became the women's dormitory. In 1935 Bethany had four wards, with a total of 25 beds, but one four-bed ward constituted the maternity unit. There appear to have been ample baths and toilets.

128. It was consistently short-staffed, and very reliant on voluntary workers. Throughout its existence Bethany found it difficult to recruit and retain qualified midwives and nurses. Medical care was supplied on a voluntary basis by a visiting doctor who was voted an annual honorarium of £10. It is unclear how often he visited. In 1936, it was described as overcrowded and there was inadequate medical and nursing staff. The decision to no longer admit Catholic women meant that it was less over-crowded than the other mother and baby homes in the 1940s. Throughout most of the 1950s there were fewer than ten women resident at any time, and that trend continued in the 1960s. There was a high incidence of infectious disease, including gastro-enteritis.

129. ***Governance***: It was run by a board of trustees, and governance was overseen by monthly meetings of the management board. Meetings opened with a 'season of prayer' and closed with a prayer. The Plymouth Brethren, an evangelical Protestant church founded in the nineteenth century, and the Irish Church Missions to the Roman Catholics, which sought to convert Roman Catholics to Protestantism, were prominent in the running of Bethany. Despite frequent protests to the contrary, those in charge often sought to convert the mothers to their beliefs.

130. Bethany did not seek or receive public funding in the 1920s or 1930s. The income came from investments, legacies, donations and proceeds of sales of work. Bethany sought financial support from the parents and local clergyman of the

women who were admitted, but it is unclear how much they were able or willing to pay. The home was in financial difficulties for most of its existence, though it often received short-term relief from a legacy or sales of stocks and shares. In 1944 Bethany applied to the DLGPH for financial assistance. In 1943 Monaghan county council secured permission from the DLGPH to maintain women and children in Bethany on a similar basis to women in the Sacred Heart homes but only a minority of Bethany women appear to have applied to their local authorities for maintenance. In 1949, the Department of Health informed Bethany that it was eligible for reimbursement under the expanded Maternity and Child Welfare scheme, which covered 50% of approved expenditure on maintaining mothers and children.

131. ***Infant deaths***: A total of 262 children associated with Bethany died; 61% of child deaths occurred between 1937 and 1947.

132. ***Burials*:** The burials of Bethany children are properly recorded in Mount Jerome cemetery.

Denny House (formerly the Magdalen Asylum) 1765 - 1994

133. ***The people***: 1,416 mothers and 1,134 children between 1922 and 1994. The largest number was in the 1980s. Before 1980, it admitted single Protestant women who were pregnant for the first time. In 1980, it started to admit women of all religions and separated, deserted, or recently widowed women and their children. The name was changed from the Magdalen Asylum to Denny House.

134. ***Length of stay***: In the early years the average length of stay was less than one year; women admitted in 1959 spent 86 days on average there; this had decreased to 41 days for women admitted in 1983.

135. ***Premises/living conditions***: It was originally in Leeson Street and moved to Eglinton Road in 1959. Religion had a prominent place - the matron conducted daily prayers; mothers were 'churched'; there were bible classes, hymn-singing sessions and a chaplain paid regular visits. In the 1960s a chapel was erected beside the new residence in Donnybrook.

136. There is no indication that Denny House was overcrowded at any time, in contrast to other mother and baby homes. The small numbers meant that Denny House

was less regimented than other homes; in the 1950s women went shopping, to the cinema, the Gaiety pantomime, and religious services. Denny House was also much better staffed than other homes, though women were expected to carry out some domestic chores.

137. From 1980 Denny accommodated women who needed support in parenting their child; mothers and babies awaiting longer-term accommodation; women who were sorting out their relationship with their parents or the father of their child, and women with addiction or mental health issues. A voluntary social worker and Eastern Health Board social workers supported the women.

138. ***Governance***: The Magdalen Asylum was overseen by guardians and governesses. The guardians and associate guardians/governesses included the Church of Ireland archbishop of Dublin and on occasion his wife, plus prominent Dublin doctors, including leading paediatricians and gynaecologists. It received funding under the Maternity and Child Welfare scheme which covered 50% of the cost of maintaining mothers and children. It was also funded by endowments, proceeds of charity sermons and fund-raising by members of the Mothers' Union and Church of Ireland parishes. Women appear to have made a contribution towards their maintenance, or their local parish made a contribution. In the 1950s a number of women were maintained by their local authority, and from the 1970s it secured funding from the Eastern Health Board.

139. ***Infant Deaths***: A total of 55 children died. Infant mortality was consistently lower than other mother and baby homes; mortality peaked in the years 1930-36. The small numbers resident was a factor in the low mortality; women were screened before admission and breast-feeding was almost universal.

Miss Carr's Flatlets 1972 - present

140. ***The people***: Approximately 180 mothers and 200 children in the period 1972-1998; it is still in operation. It was not a traditional mother and baby home. It provided hostel-type supported accommodation that aimed to enable unmarried mothers and deserted wives to raise their children. The goal was to encourage families to move to long-term independent housing.

141. ***Length of stay***: The average stay was approximately one year.

142. ***Premises/Living conditions***: There were nine flatlets in a large house. The residents were expected to be self-supporting; many of the mothers would have qualified for Unmarried Mother's Allowance. Residents could avail of the nursery in Miss Carr's Children's Home at a cost of £3 a week.

143. ***Governance***: It was established by Miss Carr's Children's Home, a long-established Protestant children's home. Miss Carr's purchased a nearby house, having borrowed the necessary money, and they sought financial assistance from the Eastern Health Board. The Department of Health eventually approved this application on condition that the flatlets would be non-denominational. It was a private institution, run by a general committee.

The Castle 1982 - 2006

144. ***The people***: 329 women and 64 accompanying children between 1982 and 1998. It was not a traditional mother and baby home but rather a supported hostel for women and children, designed to give women an opportunity to decide on their future and that of their babies.

145. Most women were referred by health boards or by CURA. They were from every part of Ireland, including Northern Ireland. Some had professional qualifications, some were students/schoolgirls; some had intellectual disabilities or mental health problems, and a number had deficient parenting skills. The babies were born in maternity hospitals - the majority in Letterkenny and Altnagelvin in Derry. Sometimes the babies came to the Caste with their mothers but more frequently, they went to St Mura's or to foster parents while their mothers made decisions about their future. Five babies died in the hospitals shortly after birth.

146. ***Governance***: It was established, funded and governed by the North Western Health Board (NWHB) and the Catholic dioceses of Raphoe and Derry. The staff were employed by the NWHB.

147. ***Premises/Living conditions***: The women had individual bedrooms with sufficient space for a child. Eating and living areas were communal, though women could cook if they wished. The women were visited regularly by social workers from the health board and CURA. People came and went as they pleased. Families and boyfriends visited and women frequently went away for weekends.

St Gerard's 1919 - 1939

148. ***The people***: The Commission knows very little about St Gerard's because it was unable to access its institutional records. It is likely that there were about 200 mothers and the same number of children there.

149. ***Governance***: It was run by St Patrick's Guild, a charity founded in 1911 to assist unmarried Catholic mothers by placing their children with Catholic families in order to prevent them being converted to Protestantism. St Patrick's Guild was also associated with Temple Hill Children's Hospital.

The County Homes

150. The county homes that were investigated by the Commission had many common features. They were located in former workhouses and they were under the control of the local authority. The day-to-day running of the county homes was largely carried out by religious orders. Unmarried mothers and their children constituted a minority of residents - the majority of residents were older or infirm people, or suffering from physical or mental disability or a mental illness. The physical conditions were generally very poor. The unmarried mothers often carried out the difficult work of looking after some of the other residents and, in general, they were not paid for this.

Cork County Home 1921 - 1960

151. ***The people***: 2,318 unmarried mothers and 2,408 children between 1921 and 1960. A number of the children were unaccompanied. Many had transferred from Bessborough prior to being boarded out by the local authority, others were sent to the county home by foster parents when the money paid by the child's mother had been exhausted, or when a foster family was no longer able or willing to keep a child. The nursery in the county home was overcrowded for most of the time; many children were of school-going age.

152. During the 1920s some women gave birth in the county home and were transferred to Bessborough with their child. Admissions of unmarried mothers peaked in 1926, and fell sharply from 1934, following the opening of a modern maternity unit in Bessborough. Admissions rose again from 1939 and remained high until 1948; 'illegitimate' births rose significantly in 1945 when Bessborough was closed to public patients.

153. In a number of cases where the children of women who had given birth in the county home were boarded out, their mothers remained in the home working as wardsmaids or kitchen staff, however in contrast to many other county homes they were paid.

154. ***The conditions***: In the 1920s the living conditions in this and all county homes were appalling. In 1921 the women ate their meals squatting on the floor. Most heating was by open fire. The 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.

155. There are several reports of unmarried mothers being assaulted by 'inmates' who were drunk or suffering from mental illness. One woman, who had given birth to two babies, became pregnant apparently by a male 'inmate'; she was sent to a Magdalen laundry. A number of women 'absconded' leaving their baby behind; although the Gardaí were contacted, they do not appear to have returned the mothers.

156. ***Child deaths***: 545 children died, 93% were under one year. The death rate was high during the early and mid-1940s, but fell sharply from 1948. The most common cause of death was gastro-enteritis. Infection control would have been extremely difficult in an overcrowded institution, with poor sanitary facilities, that admitted children of various ages.

Stranorlar 1922 - 1964

157. ***The people***: 1,646 unmarried mothers and 1,777 children. One-quarter of women were admitted between 1942 and 1948, a time when the number of 'illegitimate' births increased and mother and baby homes were overcrowded. The number of women admitted fell throughout the 1950s. 98% of the women were Catholics, the remainder were almost equally divided between Church of Ireland and Presbyterians.

158. ***The conditions***: The conditions were very poor. In the early 1920s it was overcrowded and consideration was given to removing unmarried mothers and their infants to a disused workhouse in Ballyshannon. Water and sanitary services were inadequate with only two flush toilets. Most residents had to use outdoor

toilets that were described as 'bad and rather revolting'. There was no hot water in the operating theatre. Given these conditions it is not surprising that there were several outbreaks of typhoid. The diet was dominated by bread and tea, but the Minister for Local Government determined that it was too generous and the county home was informed that residents should receive three meals a day not four.

159. In 1935 the local medical officer discontinued admissions to the labour ward because it lacked a bathroom and running water. An inspection in the 1940s reported that there were no facilities to bathe children and arrangements for washing and drying clothing were poor. During the day children spent much of their time in a 'hut'. The first major improvements commenced in 1949. They included installing washing and sanitary facilities in the children's ward and a wash-hand basin in the labour ward. In 1952 the former fever hospital was renovated to accommodate unmarried mothers and their children.

160. Most of the work was carried out by the unmarried mothers, who were unpaid. The mothers of older children lived and slept in the main section of the county home and they could only see their children on Sundays; the administration believed that more frequent visits disrupted the routine and upset the children. In 1954 when plans were being drawn up to remove unmarried mothers and children from the county home, the matron objected that she would be unable to find replacement workers.

161. ***Child deaths***: 343 'illegitimate' children who were in Stranorlar died in infancy or early childhood. The death rate peaked in 1930 with an infant mortality rate of 42%; deaths were also high in the 1940s. Over 60% of deaths were attributed to pneumonia or bronchitis.

Thomastown 1922 - 1960

162. ***The people***: 970 pregnant women and 1,241 children. A number of the children were unaccompanied. In March 1960 there were 14 children in Thomastown, eight were 'illegitimate'. In 1963 there were two unmarried mothers and three children in the county home and there was an unmarried woman and her child in the home in 1966.

163. ***The conditions***: Living conditions were very poor. The nursery section was described as the worst part of the institution. In 1925, 58 infants were sleeping in

32 cots. There were no significant improvements for several decades. In 1946 there were only eight baths, 16 WC and 16 wash-hand basins for 250 men, women and children and the baths seldom had hot water. All the laundry was done by hand; there were no disinfecting facilities and there were no electric sockets, no heating and no sanitary equipment in the labour ward. In 1949 the Department of Health decided to defer installing central heating, in order to give priority to county hospitals and sanatoria.

164. Most of the domestic work was carried out by the unmarried mothers, without payment, and some women were not sent to Sean Ross or Bessborough because they were needed in the county home.

165. ***Child deaths***: 177 'illegitimate' children who were in Thomastown died in infancy or early childhood; 54% of the mothers who were in Thomastown experienced the death of at least one child; more than a quarter of these deaths happened outside the county home. Most of the older children had been placed at nurse by their mothers and were sent to the county home when payments ceased or the lump sum was exhausted; some of the nurse children who were admitted had broken bones. A DLGPH inspector described others as 'dying from neglect'.

F: Terms of Reference

The Terms of Reference require the Commission to address specific issues . Because of different availability of information and different practices in the institutions, it is difficult to provide summarised assessments. The following is an attempt to do so.

Entry Pathways

166. The information on the entry paths of mothers is incomplete. There is no information about 99% of the mothers admitted to Sean Ross, over 98% of the mothers admitted to Castlepollard and over 97% of the mothers who were admitted to Bethany. Women who were admitted to the county homes would have either approached a local assistance officer or arrived at the county home without advance notice.

167. The overwhelming majority of women in mother and baby homes were maintained by their local authority and they had to secure prior approval from the local

authority before they were admitted. In the 1920s, women who were admitted to Bessborough or to Pelletstown had first to enter the county home, or in the case of Pelletstown, the Dublin Union. Women were also transferred to Bessborough from other county homes following similar procedures. By the end of that decade women from the South Cork Health district were being admitted to Bessborough without entering the county home, if their admission was approved by a dispensary doctor, local official/councillor, or a priest, and though information is limited, this probably applied to women from other health areas.

168. Securing the sanction of a local authority to pay for her upkeep required that a woman or somebody acting on her behalf would contact local officials. Given the secrecy that surrounded the pregnancies of single women, and the low levels of mass education in Ireland at the time, many women or their families may not have known how to do this. There were no advice centres at this time. It was only at the end of the 1960s that the Department of Health approved a short leaflet informing pregnant single women where they could seek assistance.

169. In the 1940s and 1950s, if a woman had fled to England and had been repatriated, or had been working in Dublin, she might face difficulties in securing financial support from the local authority where she had formerly lived. County managers often disputed whether a particular woman should be maintained; local authorities disputed her address, how long she had been absent from the country. One of the most intrusive queries asked whether the infant had been conceived in county Kilkenny or in Laois. There was an element of discretion in a county manager's decision. Some local authorities carried out intrusive investigations into a woman's circumstances - or more specifically whether her family could afford to contribute to the cost of her maintenance in a mother and baby home. These investigations could seriously jeopardise her privacy, perhaps making her pregnancy known, not just to her immediate family but more widely.

170. Many distressed pregnant women travelled to Dublin seeking assistance and organisations such as the CPRSI often directed women to a mother and baby home, and they assisted her in securing financial support from her local authority, but at times it proved difficult to find a place in overcrowded mother and baby homes. Between the 1940s and the early 1960s more than 3,000 unmarried mothers contacted the Custom House - headquarters of the DLGPH, and later the Department of Health - seeking assistance, and the women inspectors had to

make several phone calls on their behalf - determining whether there was space in a particular home, which the woman was willing to enter, and securing the support of a local authority to maintain her. The woman had some choice as to which home provided that this was a first pregnancy and she was not a native of Galway or Mayo. Most women preferred to enter a home that was distant from her county of origin. Women who were natives of Galway or Mayo would be maintained only in Tuam. Some county managers insisted on admitting first-time mothers to the county home in order to ensure there was sufficient unpaid labour. There are several reports of women, who were given short-term accommodation in Regina Coeli and wished to remain there, rather than enter a mother and baby home, because they could smoke, make tea and come and go from the hostel.

171. In 1961 the CPRSI (the first port of call for many pregnant single women) reached an agreement with the City and County Managers' Association that they could make arrangements for women to be admitted to mother and baby homes without first having to contact the local authority to agree liability. The CPRSI was rightly enraged when officials in County Louth reneged on this arrangement and contacted the families of two pregnant women to check whether they could contribute to their maintenance. By the end of the decade mother and baby homes and some local authorities had agreed that a woman's name would not be recorded by the local authority; she would be given a number, and her identity would only be known to one person - commonly a social worker. This practice continued in later decades.

172. Women who were admitted as private patients could bypass these arrangements, though little information is available about their referral pathways. It is probable that doctors and clergy were involved.

173. The Commission has information about the referral pathway for 71% of the women who were in Denny House. The most common route was 'religious', presumably a clergyman. In the years 1920-59, two thirds of the women for whom information is available were referred by a clergyman. In the 1980s and 1990s 52% of referrals were by social workers with the balance coming from hospitals, voluntary organisations and the health boards.

174. The available statistics suggest that in the years 1920-60, clergy played a less important role in referring women to Bessborough than they did in Denny House.

In Bessborough, for the years 1922-60, the information that survives shows that one-third of the women were referred by a board of assistance. A further 19% were referred by a scheduled institution - this refers to institutions that are within the Commission's terms of reference; most of these women came from the Cork County Home or the Thomastown County Home; 15% were referred, and probably transferred from another county home, 13% were referred by their family, only 6% were referred by a priest or religious sister.

175. Referral pathways changed somewhat, following the introduction of legal adoption and the expansion in the number of social workers. From 1960 to 1998, information is available for almost 75% of the women admitted to Bessborough. The local authority/health boards accounted for almost 40% of referrals; 27% were referred by an adoption society, 13% by a social worker who was not attached to an adoption society, and 7% were referred by a voluntary organisation - the majority of these were referred by CURA, which was established in 1977 by the Catholic hierarchy to support women in crisis pregnancies. A total of 199 women are recorded as having self-referred, a sign of changing times.

176. Dunboyne is the only other mother and baby home for which substantial information about referrals is available. Dunboyne opened after the introduction of legal adoption and the most common referral pathway was an adoption society - 37% of the women. Over two-thirds of these referrals were from the CPRSI, with St Anne's Adoption Society in Cork accounting for 14%. However, one-third of the Dunboyne women were referred by a local authority/health authority and 13% by a voluntary organisation, which was usually CURA; 62 Dunboyne women self-referred. In the 1980s, over 40% of the referrals were by an adoption society, 20% from voluntary organisations, mainly CURA, and 25% by public assistance authorities.

Mothers' exit pathways

177. The surviving information relating to the mothers' exit pathways is also incomplete. Information is available for 59% of Bessborough women, 45% of the mothers who were in Castlepollard and almost 92% of the mothers who were in Sean Ross. A majority of the women in these three institutions are recorded as discharged to their home or to a private address. A total of 203 mothers from these three homes were recorded as going to a Sacred Heart placement, that is, work arranged by the

congregation. Given that the three homes accommodated over 21,000 women, the proportion is tiny; a further 1,984 women are recorded as being discharged to a situation or employment, that is, to a specific address or occupation, probably some form of domestic or institutional service; 1,280 of these women were in Sean Ross. These 'situations' may also have been arranged by the mother and baby home.

178. There is information on the exit pathways for 62% of the women who were in Bethany. The majority are recorded as going home or to a private address; 28% of those recorded went to a 'situation or employment', which may have been arranged by the Bethany authorities, though that is not stated. The destinations for Pelletstown women were not dissimilar with 26% going to a 'situation or employment'. The Pelletstown records show that the Sister in charge was frequently approached by people who were seeking domestic staff. Information about their geographical destination - whether they remained in Ireland or emigrated - is extremely limited and therefore does not bear analysis.

Magdalen laundries, Good Shepherd Convents

179. It has been suggested that many of the women in mother and baby homes were sent to Magdalen laundries when they were discharged. The McAleese report records that 313 women were sent to Magdalen laundries by mother and baby homes and adoption societies. An additional 349 women were sent from county and city homes though many of these were women who had not given birth. The institutional records analysed by the Commission record that 206 women who were in the three Sacred Heart homes were discharged to a Magdalen laundry or a Good Shepherd Convent. All except one of the 88 women from Bessborough, who were sent to a Magdalen laundry, were admitted before 1960. The number of women recorded as having been admitted to Magdalen laundries when they left the three Sacred Heart homes amounts to less than 1% of total admissions. For Pelletstown the figure is also less than 1%. A total of 20 women are recorded as transferring from Stranorlar to the Good Shepherd Convent in Derry; most of these women had multiple pregnancies. Given that there are only records relating to the exit pathways of 16% of Stranorlar mothers, this is probably an underestimate.

180. Information is available on the exit pathways for approximately 20% of the Tuam mothers. Fourteen women were discharged from Tuam directly to a Magdalen laundry. Institutional records relating to children who were in Tuam without their

mother show that a further 84 women were admitted to a Magdalen laundry at a later date. It is most likely that these women were on their second or subsequent pregnancy and, in line with Galway County Council policy, they were directed to enter a Magdalen laundry when they sought public assistance. In 13 other cases, children were admitted to Tuam unaccompanied while their mothers were admitted to a Magdalen laundry; these women had never been in the Tuam home. A further 22 women, all admitted to the Tuam home on second or subsequent pregnancies, were directed by Galway County Manager to seek admission to a Magdalen laundry; if they refused they were told to remove their child from the Tuam home. The Commission could not establish whether or not these women actually entered a Magdalen laundry. Four children born in or admitted to the Tuam home were subsequently admitted to a Magdalen laundry in their teens or in early adulthood.

181. Galway county council had a clear policy that women who gave birth to a second or subsequent child should be sent to a Magdalen laundry. The Commission has not seen evidence of a similar policy articulated by other local authorities. The more extensive evidence relating to Tuam (which exists because the children remained in Tuam for several years), suggests that many former residents of mother and baby homes were admitted to Magdalen laundries not directly from the mother and baby homes but at a later period in their lives, perhaps following the birth of a second child.

Length of Stay

182. It is commonly believed and has been widely stated on numerous occasions that women were required to remain in a mother and baby home for two years after the birth of their child. This was never a legal requirement although many women appear to have believed that it was. The motivation behind the two-year stay was both moral and pragmatic: a belief, that two years was sufficient time to 'reform' or 'rehabilitate' a woman. Many mother and baby homes in other countries required mothers to remain for a specified period but that was commonly for six or 12 months. In 1940 the length of stay in St Pelagia's Home in London, which was run by the Congregation of the Sacred Hearts of Jesus and Mary was reduced to six months. The fear of being required to remain in a home for two years was cited as a factor prompting women to go to England or to approach Protestant charities. Statements to this effect were made by Department of Health inspectors and by the CPRSI; both had extensive contact with pregnant women, so these statements should be treated seriously.

183. The length of time that women stayed in Irish mother and baby homes was linked to the provision of a long-term placement for the children, and the fact that legal adoption was not introduced until 1953. Unmarried mothers were legally responsible for their children. A mother could not leave a mother and baby home or a county home without taking her child or until long-term arrangements had been made for the child. Local authorities were unwilling to take responsibility for the children of unmarried mothers until they were at least two years old, and often older. During the Emergency years there was a shortage of foster homes (possibly because the payments to foster parents were not adequate) so children and mothers had to remain. Some women were required to remain in a county home, working without pay, in return for their child being boarded out by the local authority. There is evidence that in counties Wexford and Meath (and perhaps other counties), women who sought to leave the county home were presented with their child, who had been removed from a foster home, and told that they were responsible for the child's upkeep. Women in Tuam and Pelletstown were expected to stay for 12 months and there is evidence that a woman who wished to leave Tuam before that time was expected to pay for her child's upkeep. The average stay for women in Stranorlar and in the Cork county home was under one year for all decades, though a small proportion of women remained for several years.

184. The expectation of a two-year stay was associated with the three Sacred Heart homes. The statistics on a mother's length of stay are almost complete for the large mother and baby homes. They show that the two-year stay, which is widely cited as the norm, applied to only a minority of women. Less than 20% of the mothers in the three Sacred Heart homes remained for more than 700 days or approximately two years after giving birth. Overall, of the 46,671 women for whom the Commission has this information, less than 6% stayed for more than two years while 70% stayed for six months or less.

185. The small number of women who were admitted to Bessborough in the 1920s remained for an average of three years. Between 1929 and 1941, women on average remained for between 12 and 18 months. However this average conceals widespread variations in length of stay. A majority of women admitted in the 1930s left within six months of giving birth but almost a quarter (23%) remained for two years or longer. Bessborough had a substantial number of private patients who generally left without their baby within a couple of weeks of giving birth. Women

whose babies died left shortly afterwards and the appalling mortality in Bessborough in the early 1940s impacted significantly on the average length of stay. In the early 1940s, because of the number of private patients, and the high rate of infant mortality, the average length of stay for Bessborough mothers fell to six months. The contrast in length of stay between private and public patients continued in the 1950s, despite the ban on private patients leaving without their child. Private patients remained for an average of six weeks (before and after the birth); for public patients the figure was eleven months. With an increasing number of babies being adopted in the 1960s the length of stay for public patients fell sharply; by 1970 women remained for an average of one month after the birth.

186. There was also a wide variation in length of stay in Sean Ross. In the 1930s and 1940s, one-third of women left within 50 days of giving birth; by the 1950s over 40% left within 50 days. In the 1940s the average length of stay fluctuated between 300 and 400 days, and this continued into the 1950s; in 1955 the average stay for mothers was 369 days. It fell sharply in the late 1950s and throughout the 1960s. Private patients in Sean Ross also remained for a much shorter time than public patients; in the 1950s the figures were 65 days and 298 days respectively. Data for Castlepollard also show a major contrast between private and public patients; in the 1940s, they stayed for an average of 40 and 310 days respectively, and 31 and 297 in the 1950s. By the 1960s public patients were spending an average of four months in Castlepollard.

187. Between 1921 and 1950 women who were in Tuam/Glenamaddy remained for an average of 237 days; that increased in the 1950s to over 300 days. The increase probably reflects the fall in infant deaths; most women left almost immediately following the death of their child. Pelletstown, like Tuam did not retain women for two years. Between 1920 and 1942 the average length of stay fluctuated between 188 and 311 days. In 1943 and again in 1946 the average length of stay increased to 368 and 429 days respectively, for reasons that remain unclear. Between 1949 and 1958 women stayed for an average of 307 days. In the 1960s, as in other homes the average length of stay fell sharply.

188. Women who were admitted to Bethany remained for a shorter time; an average of 137 days in the 1920s, 155 in the 1930s and 164 days in the 1940s. The highest average length of stay, 212 days, was in the 1950s. The shorter stay for Bethany mothers compared with public patients in the Sacred Heart homes reflects the fact

that Bethany made arrangements for the placement of children; this was not the norm in the homes run by the Sacred Hearts congregation. Similar arrangements existed for the women who were in Denny House; however, their average length of stay was longer, except in the 1950s: 252 days on average in the 1920s, 194 in the 1930s, 231 in the 1940s and 144 in the 1950s. In the 1980s and 1990s when Denny House was caring for a very different cohort of mothers, the average stay was approximately two months.

189. Statistics on length of stay suggest that, despite frequent references to the two-year rule in the homes run by the Sacred Hearts congregation, and one year in Tuam and Pelletstown, there was no great difference in the average length of stay between the two types of mother and baby home. The average length of stay was much shorter in Bethany. Until the 1950s women remained in Denny for less time than in the Catholic mother and baby homes but longer than in Bethany.

190. The delay in introducing legal adoption explains why many Irish women spent such a long time in mother and baby homes. When adoption became widespread in the 1960s the average length of stay fell significantly and continued to fall in the 1970s. By the 1970s, mother and baby homes were conscious that a growing number of women were travelling to Britain for abortions, so they were under pressure to make life in a mother and baby home less onerous, including a shorter stay.

191. The statistics reveal a significant discrepancy between private and public patients. Private patients, or more probably their families, could afford to pay for a child to be placed at nurse, or as frequently happened in the 1940s, for the child to remain in Bessborough without their mother, under the auspices of the Catholic Women's Aid Society. However a majority of public patients left mother and baby homes within a year of the birth of their child. This suggests that the women or their family made financial arrangements for the long-term care of their child. A number of witnesses spoke of the Sisters being paid a sum of money to buy a mother's 'release'; this money was used to place her child 'at nurse', generally through an intermediary charitable society.

192. The longest stays were among women who lacked financial and personal support from their family that would enable them to make arrangements for their child. A number of women who were admitted to Bessborough in the 1920s remained there

for the rest of their lives. A Good Shepherd Sister, who worked in Dunboyne in the early 1960s and gave evidence to the Commission, stated that the small number of women who remained for two years were women who had been raised in institutions, such as industrial schools, and lacked family support. A number of contemporary references suggest that women whose child was being adopted in the USA had to remain for a longer period because children were not sent to the USA for adoption until they were over one year old. By the 1960s mothers of children with special needs were also at risk of having to remain for a longer period, because it proved more difficult to place their child.

Children length of stay and exit pathways

193. There were a number of distinct categories of unaccompanied children in the mother and baby homes within the Commission's remit. Pelletstown and Tuam admitted homeless and abandoned children and children whose parent(s) were unable to care for them - perhaps because of an illness or imprisonment; 71% of unaccompanied children in Tuam, where there is evidence of the child's status, were 'legitimate'. From the late 1950s, Pelletstown admitted substantial numbers of unaccompanied children who were suffering from serious illnesses. These children will be discussed below in the section on infant and child mortality and they will feature again in the section on discrimination.

194. A majority of children who were born in county homes left with their mother. However, county homes admitted children who were transferred from a mother and baby home preparatory to being boarded out. They also admitted children who had formerly been placed 'at nurse', that is, placed with a foster parent, either privately or by a charitable organisation, and had been brought to the county home when the money paid to the foster parent ceased, or the foster parent was no longer willing or able to care for the child. County homes also housed children who had been boarded out by a local authority, whose foster parents were no longer willing to keep the child or unable to do so - because of illness or death, and they also accommodated children with severe physical or intellectual disabilities, who were awaiting transfer to specialist institutions, and who might be children of married parents. Children who were found to have been neglected in either category of foster home also ended up in the county home. Such children were also admitted to Pelletstown and to Tuam. Some of these children were sent to industrial schools.

195. Almost half (47%) of the children in Bessborough were discharged on the same day as their mother; a further 27% were discharged before their mother; 21% remained in the home after their mother had left (many of these were the children of private patients); and 5% of children were admitted unaccompanied. Statistics for Sean Ross are similar, and again the distinction between the children of public and private patients is substantial. Over two thirds of the Sean Ross children were discharged on the same day as their mother; 28% left before their mother and only 6% remained in the home after their mother had left. In Castlepollard 59% of the children left on the same day as their mother, 32% were discharged before their mother had left, and 9% remained after their mother had left.

196. Although the children born to private patients were more likely to remain in Bessborough without their mother, they stayed for a much shorter time than the children of public patients. From the 1920s to the 1960s, publicly maintained children spent around three times longer in Bessborough than their private counterparts. The introduction of legal adoption reduced the distinction in length of stay between the children of public and private patients.

197. Children remained in Pelletstown and Tuam for longer periods than in the other homes, and they were more likely to remain without their mother. In the years 1943-56 children remained in Pelletstown for an average of 737 days. In the 1940s the average was 669 days; for the 1950s it had fallen to 530 - still substantially longer than the Sacred Heart homes. Just over half, 50.4% of Pelletstown children were discharged after their mother had left; 36% left on the same day.

198. Tuam children remained in the home for even longer periods than the children in Pelletstown, reflecting the deliberate delay in boarding them out, which was requested by the Sisters of Bon Secours, and facilitated by the Mayo and Galway local authorities. The average is potentially misleading; 20% of Tuam children remained for less than 50 days; they tended to be children who were admitted because of family circumstances, not children who were born in Tuam; 16.6% of children remained in Tuam for between five and ten years, and seven children were in Tuam for between ten and 15 years. The information is incomplete, but where it exists, it shows that 73% of children remained in Tuam after their mother had left. In 1950, Tuam mothers stayed for an average of 272 days; the average for a child born in or admitted to the home with their mother was 1,383 days.

Children whose mothers left Tuam in 1950 could expect to remain in the home unaccompanied for 1,111 days on average. Tuam was seriously out of line with the other homes.

199. The pattern was different again in Bethany, where 49% of children remained after their mother had left; 29% left on the same day as their mother, 22% left before their mother and 10% were unaccompanied children - often children who had been returned from a foster home; no information is available for the remaining children. The average length of stay for Bethany children was consistently under a year; the longest stay was in the 1940s, an average of 303 days. Children and mothers left Bethany earlier than they left the Sacred Heart homes. In Denny House the longest stay for children was in the 1920s when they spent an average of 200 days; in later decades the length of stay was six months or less. 67% of Denny children left on the same day as their mother but these statistics are skewed by the large number of admissions in the 1980s, when mothers and children generally left together and most mothers were planning to raise their child. A total of 204 children, 19% of the children who were in Denny House, were discharged before their mother and over 13% remained in the home for a period after their mothers' discharge.

200. The Commission has information about the outcomes for 7,401, or 79% of the children who were in Bessborough. Almost 60% of the children who survived were legally adopted; 27% are recorded as having left with their mother or a member of her family; 7% were transferred to another institution such as a county home, specialist hospital or long-stay institution, or an industrial school and 6% were boarded out or placed at nurse directly from Bessborough; the remaining 1% were informally adopted, before 1953.

201. Before the availability of legal adoption, children leaving the institutions were often boarded out by the local authority. There is evidence that local authorities commonly selected foster families for boarded out children to meet the needs/wishes of the foster parent rather than those of the child. Children were boarded out in impoverished households, where the monthly fee was regarded as a source of household income, rather than money to provide for the child. Farmers and other self-employed people often treated a foster child as a source of unpaid labour and for that reason they preferred older children. Children were placed with older unmarried women, or in households consisting of an elderly brother and

sister, where there was little understanding of a child's needs. Elderly women living alone regarded a foster child as a companion and an unpaid servant or carer. Some children were sent to remote parishes where the numbers on the national school roll were low, in the hope of preventing the loss of a teacher. Charities that placed children 'at nurse' also appear to have done so with the interests of the foster parent in mind, rather than those of the child.

202. The picture of foster care is not uniform; the files record stories of children who were placed with caring families where their needs were paramount; former foster children, now adult and working, who returned for holidays to their foster home. Many children who were placed at nurse or boarded out by local authorities were adopted by their foster parents when legal adoption was introduced. But others were grossly exploited, badly fed, kept from school, subjected to physical punishment, and hired out in their teens for less than the statutory rate, often unaware that they were free to leave their employer. By the 1950s many foster children continued at school beyond the statutory school leaving age of 14; they were maintained while in education, with school books, bicycles and other requirements, at a time when children living with their parents received no such assistance. Although the regulations preventing children being boarded out in towns and cities was removed in 1953, many children continued to be placed in remote rural homes, which reduced their chances of attending a vocational or secondary school.

203. Regulations relating to children who were boarded out by a local authority were determined by the DLGPH. Responsibility for inspections of boarded-out children and their homes was a matter for the assistance officers, who were predominantly men, and had no training for this role. Inspections were often perfunctory, and were unlikely to have included sleeping arrangements, bed clothes and children's clothing. The DLGPH inspectors - all women - carried out thorough inspections of boarded-out children and children at nurse, at approximately two-year intervals. Their reports describe squalid living and sleeping conditions; children dressed in rags. Foster families were given regular clothing allowances, which was often spent on clothing for the foster mother or her children. They described children who were required to carry out heavy unpaid work in their foster home; children suffering from medical ailments and children who experienced discrimination at school because they were foster children.

204. The department inspectors were often critical of the governance and inspections carried out by the local authorities. They repeatedly demanded that greater care be taken in choosing foster homes, and they were equally critical of local authorities who defied the minister by sending children in their care to industrial schools. Their efforts were not without success, however other officials in the department appear to have been conscious of the tensions that existed between central and local authorities and they were reluctant to force these issues. The female inspectors campaigned for the appointment of dedicated children's officers, whose sole role would be to oversee boarded-out children and children at nurse, with perhaps two adjoining counties sharing a children's officer. But many local authorities continued to leave responsibility for inspecting foster children with assistance officers; others determined that inspections should be carried out by public health nurses, whose heavy workload left little time for inspecting foster children. In 1970 only seven of the 17 designated local authority children's officers were qualified social workers.

205. As the number of children being placed for adoption increased from the mid-1950s, the number of children placed at nurse or boarded out by local authorities declined. By the end of the 1960s a majority of children being placed in foster homes were no longer the children of unmarried mothers, but children whose family circumstances meant that they could not be raised by their parent(s) and who needed either short-term or long-term care in a foster home.

206. The outcomes for children in mother and baby homes changed significantly from the late 1950s when legal adoption became common. For children who were in the Sacred Heart homes before 1960, the most common recorded outcome was that they left with their mother or a member of her family. This creates an impression that the child was brought to their mother's family home and may have been raised in the family. However, the overwhelming majority of these children were placed 'at nurse', in foster homes, either privately by the woman or by her family, or through a charity such as the Catholic Women's Aid Society. By the 1960s, however, 74% of children leaving Sean Ross were adopted, and the number who were recorded as having left with their mother had fallen to 19%, compared with almost 66% in the 1940s. Dunboyne opened in 1957, by which time adoption was becoming more common, and two-thirds of the children born to women who returned to Dunboyne following the birth of their child, are recorded as being placed for adoption.

207. Data on the outcomes for Pelletstown children are complicated by the number of children with special needs and the children of married couples. Nevertheless, legal adoption was the most common outcome; 41.7% of children left the institution via this route, almost 27% left with their mother or returned to the family home; 24.2% transferred to another institution; 5% were boarded out; 1.6% were nursed out and 0.5% were informally adopted (pre 1953). A higher proportion of Pelletstown children went to other institutions than happened in the Sacred Heart homes. This is partly due to the number of children with special needs, but regardless of this, it appears that in the years before adoption became widespread, more Pelletstown children went to institutions. From the mid-1930s older children who had not been boarded out were often sent to St Philomena', a children's home that was also run by the Daughters of Charity; other children were transferred to industrial schools. Children in Pelletstown were placed directly with foster families; in the 1940s the department inspector recorded complaints that would-be foster parents were not given a choice of children when they visited the home.

208. The data available for Tuam show that 38% of the children were boarded out; 37% left with their mother or a family member (this included most of the 'legitimate' children), and over 20% transferred to other institutions. Tuam closed in 1961 when adoption was becoming the most common outcome; less than 4% of the children were legally adopted. These patterns did not change significantly over the lifetime of the Children's Home.

209. There are clear distinctions between the outcomes for children in Protestant homes in the years before adoption became common. Denny and Bethany had close relationships with a number of children's homes and with charities that placed children at nurse, which accounts for the fact that children and mothers spent less time in Bethany and Denny than children did in the Sacred Heart homes. The most common outcome for Bethany children was to be sent to another institution - generally a children's home. This was the outcome for 28% of the children for whom this information is available; 22% left with their mother or a family member; 20% were placed for adoption; 19% were placed at nurse and 10% were informally adopted. In the 1950s and 1960s a majority of Bethany children were placed for adoption; the number who left with their mother or her family fell, as did the number of children placed at nurse. Nevertheless, in the 1950s, 20% of Bethany children went to another institution, as did almost one-third of the children born in the 1960s. It is probable that many of those children were later adopted. In Denny

House the most common outcome before 1950 was that the children were nursed out; this was the outcome for a majority of the children for whom information is available. In the 1950s and 1960s a majority of the children were adopted; in the 1980s and 1990s a majority left with their mother or a family member.

210. Protestant children were less likely to be boarded out by a local authority although there are records of Protestant boarded-out children in counties with a substantial Protestant population such as Donegal. Protestant children were more likely to be sent to institutions than Catholic children but these statistics only relate to their immediate destination and many were boarded out or informally 'adopted' from these children's homes. Many Catholic children, who were placed at nurse, left with their mother or were boarded out, and many of these children were sent to industrial schools at a later date.

211. In the years after 1970, adoption was the most common outcome for the children who were in Pelletstown, Dunboyne or Bessborough. This is consistent with the information on the women's admission pathways; most were referred to these homes by an adoption society which suggests that there was an expectation of adoption before the baby was born. By the 1970s, alternatives were emerging to mother and baby homes; some women were remaining at home or at work during pregnancy, before giving birth in a maternity hospital. Some pregnant women were placed with a family through Ally and later CURA. Entering a mother and baby home often meant that the women, or perhaps their family was thinking seriously about adoption, and although the women had access to external social workers, the prevailing climate in these homes favoured adoption.

Living conditions

212. The living conditions in the institutions must be seen in the context of the living conditions in private homes. Conditions in private homes changed dramatically over the period covered by this report (1922-1998) with the introduction of electricity, running water, indoor flush toilets, bathrooms, washing machines, electric or gas cookers, refrigerators, central heating, and radio and television. Many rural homes were without electricity until the 1950s and even the 1960s. In 1961 only 12% of rural households had water on tap, which meant that 88% had no indoor toilets, fixed baths, hot water on tap or washing machines. Thousands of working-class families in Dublin, Cork and Limerick lived in grossly over-crowded tenements with a toilet in the backyard which might be shared by several families.

Families were large so many beds were shared by two or more children; bedrooms were not heated, and old coats were often substituted for blankets. Many unmarried mothers came from such homes, and the conditions in mother and baby homes should be evaluated with this in mind.

213. It is important also to distinguish between mother and baby homes and the county homes. The most accurate information about living conditions comes from the inspections carried out by the Department of Health inspectors, but these only begin in the late 1930s, and not all survive. The available evidence suggests that, while living conditions in the mother and baby homes were basic, there is no indication that they were inadequate by the standards of the time, except in Kilrush and Tuam. In the years up to and including the 1960s, women slept in dormitories that might not be heated. These dormitories were large with no curtains between beds; women had no privacy and often had to store their belongings in a suitcase under their bed. While the number of baths, toilets and access to hot water may appear inadequate by modern standards, many private homes lacked these facilities. The standard of heating was equal to, and perhaps superior to most Irish homes at this time, though heating appears to have been deficient during the years of World War II, (as it was in private homes), and it would have been extremely difficult to heat the large dormitories, babies' nurseries and dining rooms.

214. When Bethany was located in Blackhall Place the facilities were poor. Conditions were much better when it moved to Rathgar. The home was well-provided with bathrooms, though as elsewhere, heating and clothes drying facilities were inadequate; the dormitories were overcrowded and from the late 1930s until the 1950s the mothers slept in an annexe to the main house, which apparently lacked sanitary facilities. In Sean Ross and Castlepollard some mothers slept in former stables and had to go outdoors to reach the dining room and other facilities.

215. Most institutions were located in large detached houses that underwent some improvements before being used as mother and baby homes. In the 1930s the three Sacred Heart homes and Pelletstown received substantial capital funding from the Hospitals Trust Fund for improvements. All the homes had running water and modern sanitary facilities including baths although the number would seem very inadequate by modern standards. The modern hospital at Castlepollard which opened in 1942, and accommodated mothers and children in addition to a maternity unit, had central heating (though it was not turned on much during the

war years) and modern sanitary facilities. Pelletstown, which opened in a former workhouse, underwent some improvements in the 1930s, though facilities were probably more spartan than in the Sacred Heart homes. Four toilets for 140 women, as reported in 1950, was seriously inadequate.

216. Comments about living conditions must take account of the fact that all the homes (with the exception of Denny House) were overcrowded from the mid-1930s until the 1950s. Extra beds and cots were squeezed into crowded dormitories and nurseries; women had cramped space in dining rooms, and overcrowding may have deprived women and children of sitting rooms and playrooms. It is unclear whether the women had access to sitting rooms or recreation space before the late 1940s. There are references in inspection reports dating from the early 1950s to providing these spaces, and references to children's playrooms - which might suggest that these are new. Overcrowding eased in the 1950s. Concern with infectious diseases and infant mortality resulted in large dormitories and children's nurseries being divided into smaller units; additional toilets and washing facilities were installed. However until the late 1960s the women continued to sleep in large dormitories without partitions or curtains. These were being installed in Pelletstown and Bessborough at the end of the decade. Reduced numbers meant that dormitories could be converted into shared bedrooms and women were given space to store personal belongings. From the beginning Dunboyne, which opened in 1957, had much better facilities than the other mother and baby homes. It was never as overcrowded as the others; women slept in shared bedrooms. From the beginning it had a recreation room and central heating. An extension built in the early 1960s included several recreation rooms, visitor rooms and ample bathrooms.

217. The conditions in Kilrush which was located in a former workhouse were appalling - no electricity, running water, or sanitary facilities. The cost of carrying out essential improvements was a factor in the decision to close this home. Conditions in Tuam were not dissimilar but it continued to function as a home for children and mothers, without major improvements, until it closed in 1961. The only part of the Children's Home with adequate facilities was the small maternity unit, which appears to have had running water and sanitary facilities, and the laundry. The rest of this institution - which accommodated over 200 children - was lacking in the most basic sanitary facilities. In 1959 there were only two places, other than the laundry and the maternity unit, with hot water on tap; the toilets appear to have

been outdoors and they were probably dry closets. The children's rooms - which were almost devoid of toys - were heated either by open fires or portable radiators that were filled with hot water. Mothers and children slept in traditional workhouse dormitories, and the building was at high risk of fire.

218. Conditions in the county homes were much worse than in any mother and baby home, with the exceptions of Kilrush and Tuam. In the mid-1920s most had no sanitation, perhaps no running water; heating, where available was by an open fire; food was cooked, badly, often in a different building, so it was cold and even more unpalatable when it reached the women. Many county homes had no place for children to play or space for the women to sit. In 1933 the women in the Waterford county home had to eat their meals in the dormitory. There is some evidence that the able-bodied women, who were mainly unmarried mothers, were allocated the worst accommodation, because they were not seen as 'deserving' unlike the elderly and infirm, and their quarters were the last to be improved. Improvements were carried out to mother and baby homes in the 1920s and 1930s, but there is no evidence of significant investment in county homes during these years - other than installing electric lights, and perhaps connecting the home to a town's water and sewerage system. Most county homes continued to lack adequate sanitary facilities, running water, hot water on tap and heating other than open fires until the 1950s - sometimes the end of that decade.

219. Living conditions were poor in Regina Coeli; some parts of the building - a former workhouse - were structurally unsound and the self-contained 'family-units' for mothers and children - in groups of six - were probably cramped. Much of Regina Coeli appears to have been heated by open fires. Reports of children suffering burns from boiling water, suggest that it had to be carried some distance, as opposed to flowing from a convenient tap, but Regina Coeli compensated for poor living conditions by enabling mothers to raise their children and giving them the freedom to come and go, not just to work, but for social occasions.

220. From the 1970s provision for unmarried mothers and their babies was changing. With a growing number of women deciding to keep their children, there was a demand for flatlets, that offered women more privacy and enabled them to become more self-sufficient. Miss Carr's Flatlets which opened in 1972 was the first of the newer mother and baby homes. It was followed by the Belmont Flatlets and The Castle. Women in Denny House in later years were free to go out for social

occasions and spend weekends away, likewise in The Castle and Eglinton House, which was the successor to Pelletstown. When the Good Shepherd Congregation decided to close Dunboyne, they did so in the knowledge that any modern mother and baby home should offer women greater privacy, their own flatlet, and the freedom to integrate into the wider community.

Diet

221. The Commission has not seen information about food in mother and baby homes until the 1940s. The DLGPH laid down dietary regulations for county homes - following the practice in workhouses; however, the diet was meagre. In the 1920s the Minister for Local Government and Public Health instructed the Donegal county home in Stranorlar to reduce the daily rations, with only three meals a day, rather than four and when the medical officer in Kilrush demanded an improved diet for the mothers to enable them to breastfeed their babies, the department claimed it contained excessive quantities of bread, potatoes and butter. This exchange suggests that the dietary scales in Pelletstown and Tuam may also have been subject to departmental regulations but the Commission has not seen evidence of this. There were no dietary regulations for mother and baby homes which were privately-owned.

222. There is some evidence that food in mother and baby homes may have been inadequate during the Emergency years. A diet served to mothers in Bessborough on a 'fast' day in 1943 appears to have been seriously deficient in protein but there is no information regarding the quantities. There is a reference in an inspector's report on Castlepollard, at around this time, to the need to improve the mothers' diet. There were widespread, sometimes, short-term shortages of basic food items during these years and these shortages would have had a greater impact on homes, such as Tuam, Pelletstown and Bethany, that did not have sufficient land to produce food and especially milk.

223. By the late 1940s the diets in county homes appear to have improved, and many of the homes were installing modern cookers. Inspection reports mention orange juice, fruit, and vitamin and mineral supplements suggesting that the professional dietician in the Department of Health was overseeing the children's diets. However, there were also descriptions of food being cooked on open fires and of the children's milk being stored in insanitary conditions and certainly not refrigerated. The quality of milk - which remains unknown - was critical at a time

when many cows were tubercular. There is also evidence that contractors often supplied county homes with spoiled meat and low quality bread and milk with little nutritional value.

224. Mother and baby homes - apart from Tuam - had better cooking and kitchen facilities, so they had better prospects of storing and preparing milk in hygienic conditions. The mothers' diets that are described in inspection reports from the late 1940s appear to be adequate, if monotonous by modern standards. They were not dramatically different to the diet in an average Irish home during those years. Descriptions of Pelletstown and Bessborough from the 1970s indicate that women sat at tables of six. However many women may have disliked the fact that meals were at fixed times and they had no choice about their food.

Work

225. Work was regarded as part of the process of 'rehabilitation' for women in mother and baby homes - in Ireland and internationally. Domestic chores and related activities such as dress-making and laundry were viewed as giving women skills that would enable them to find work when they left. Until the 1970s women in mother and baby homes carried out most of the domestic chores, including laundry for the home, and most of the care of infants. Bessborough women worked in the greenhouses and produce was sold from a shop in Cork. During the war years women saved turf in Sean Ross, and there are rather disconcerting reports of women in Castlepollard and Sean Ross cutting timber. All the homes with adjoining land employed male farm workers and there is no evidence that women were responsible for the main work on the farm though they assisted at busy times such as hay-making and saving turf. An inspection report of Bessborough in 1941 noted that much of the work was carried out by former patients, who had remained in the home, some from the 1920s; they were not paid. With the exception of cutting timber the work carried out by the women in mother and baby homes was similar to the work undertaken by Irish women at this time - whether in their home, or as hired servants. Many Irish women worked in their home until they went into labour, and they resumed their domestic chores and farm duties within 1-2 weeks of giving birth, if not sooner. Women in mother and baby homes appear to have remained in the maternity unit for approximately two weeks following the birth of their child. The key consideration relating to the workload of women in mother and baby homes is the fact that there were a large number of healthy young women to share the work and at any time there was something approaching parity between

the number of women and children. A number of women have alleged that the mother and baby homes assigned useless work to them as punishment, but the Commission has not been able to verify or refute this.

226. The workload for the women in county homes was of a different magnitude to the mother and baby homes. Unmarried mothers were far outnumbered by children, including older children, and by elderly and incapacitated adults. Most county homes did not employ domestic staff so unmarried women were assigned onerous duties that were essential to the running of these homes. There are many contemporary statements by local officials or matrons insisting that unmarried mothers could not be removed from the county home, because there would be nobody to carry out this work. A lack of hot water and sanitary facilities, the old, dilapidated buildings, with stone staircases and corridors, made their work even more difficult and unpleasant. County homes accommodated adults and children with special needs who would have required extra assistance and personal care. Women continued to carry out unpaid work in some county homes until the early 1960s, despite a statement by the Minister of Health in 1952 that this was prohibited.

227. Women in Tuam also carried a much heavier workload than in other mother and baby homes. There was a much higher ratio of children to women; approximately six children to every mother, resulting in a heavy workload of child-care, laundry, cooking and cleaning. Tuam, like the county homes, had poor heating, washing, and sanitary facilities, which further added to the work.

228. Domestic duties in the surviving mother and baby homes became lighter with the introduction of washing machines and other labour-saving devices. By the 1970s with women remaining in mother and baby homes for a shorter time, most of the work was carried out by paid staff.

Infant Mortality

229. The high rate of infant mortality (first year of life) in Irish mother and baby homes is probably the most disquieting feature of these institutions. It is particularly disquieting that the high mortality rate was known to the authorities both local and national and was even described in public reports. As already stated, about 9,000

children died in the institutions under investigation - approximately 15% of all the children who were in the institutions.

230. In the years 1935-45, just under half of all deaths of 'illegitimate' infants, 48.7% occurred in the main mother and baby homes, yet these homes accounted for just over one-quarter, or 25.5% of 'illegitimate' births. The chance of a child born in a mother and baby home surviving until their first birthday, was just over half that of an 'illegitimate' child who was not in a mother and baby home. The adverse impact of mother and baby homes lessened in the next decade: in the years 1946-55, mother and baby homes accounted for 39.6% of deaths of 'illegitimate' children and 30.5% of births. By the 1960s infant mortality in mother and baby homes was equal to, or lower than the national rate for 'illegitimate' children.

231. It is possible that the 'illegitimate' children who were not born in mother and baby homes were born to women from more privileged backgrounds: women who had a healthier pregnancy, and healthier babies. Alternatively, the survival prospects of the 'illegitimate' children who were not born in mother and baby homes, may have been better, because women and infants were not in large overcrowded institutions where they were at acute risk of infection. The statistical analysis set out in Chapter 33A concluded that 'Mortality rates in each of the institutions were very high in the period compared to the overall national rate of infant mortality. Even compared to other locations where infant mortality was relatively high among the general population, such as Dublin city, rates of infant deaths were substantially higher in these institutions'.

232. Most deaths occurred among children who were aged between one month and one year, which is classified as infant mortality. The rate of infant mortality in most mother and baby homes peaked in the early 1940s, at a time when infant mortality in Ireland and especially in urban areas rose decisively. In 1943 infant mortality reached its highest rate in Bessborough, Bethany and Tuam. It fell in the late 1940s, coinciding with a significant fall in the national and urban rates of infant mortality. Delaney and McGovern concluded that 'the data exhibit a marked structural break in the late 1940s or early 1950s, indicating that mortality conditions in the homes had improved significantly during this period in particular'.

233. A number of features of infant mortality in the individual mother and baby homes are worthy of comment. While infant mortality rose in most mother and baby

homes during the 1940s, Pelletstown is an exception, and this is noteworthy given the spike in infant mortality and infectious diseases in Dublin city during those years. The Cork county home also avoided a spike in infant mortality during the 1940s despite the appalling mortality in Bessborough. Infant mortality in Pelletstown was significantly higher than in Dublin city throughout the 1920s, 1930s and most of the 1940s, but in the early 1940s the graphs converge. The lowest rate of infant mortality was in Denny House which was the smallest mother and baby home, and most infants were breastfed.

234. The highest rate of infant mortality recorded in an Irish mother and baby home was in Bessborough in 1943, when 75% of the children died before their first birthday. The exceptionally high mortality among the children of private patients in Bessborough is significant. They accounted for 9% of total admissions, and for 21% of infant mortality. Many of these children were unaccompanied when they died; the fact that private patients were permitted to leave Bessborough without their child appears to have been a major contributory cause of deaths. This contrasts with Castlepollard, where private patients were not permitted to leave without their child and the death rate among the children of private patients was approximately one-third the average for the institution. Infant mortality in Castlepollard was consistently lower than the other homes run by the Sacred Hearts congregation. Part of the explanation may lie in the fact that from 1942 much of the accommodation was in a modern purpose-built hospital. While the evidence is patchy Castlepollard may have had a higher incidence of breastfeeding. Sean Ross had a much higher incidence of mortality from major infectious diseases, such as diphtheria and typhoid, than any other mother and baby home. The transfer of mothers to the local fever hospital where they worked as unpaid nurses, and their return to Sean Ross, where they appear to have transmitted infection to their child, was responsible for the loss of children's lives. The wide disparity in infant mortality between the Bessborough and Castlepollard, which were run by the same religious congregation, and with a similar profile of mothers, suggests that some deaths could have been prevented.

235. The Bessborough statistics suggest that infants who were in a mother and baby home without their mother may have been at higher risk of death. This would appear to have been a factor in Bethany, which recorded an infant mortality rate of 62% in 1943. During the course of Bethany's history, 41% of the mothers were not resident when their infant died. The comparable figure for Bessborough is 21%. In

Sean Ross and in Castlepollard, 93% of the children were accompanied by their mother when they died

236. Statistics for Tuam and Pelletstown are complicated by the fact that both institutions admitted 'legitimate' children, including children with special needs. In Tuam, 45% of children were unaccompanied at the time of death. At least 11% of the children who died in Tuam were 'legitimate', and 20% of deaths were of children who were over one-year old. In the years 1942-47, when 305 children died in Tuam, 12% were unaccompanied at the time of death.

237. 31% of the children who were admitted to Pelletstown were 'unaccompanied' and they account for almost 44% of deaths. In the 1920s a substantial number of these children were foundlings, who had been abandoned in Dublin city; they were generally in poor condition, and many died shortly after admission. From the late 1950s Pelletstown was increasingly used as a long-stay institution/hospice for children with serious and untreatable medical conditions such as spina bifida, or Down syndrome children with serious heart diseases and many of these children died. Almost one in five of deaths in Pelletstown were of children who were over one year.

238. The major identifiable causes of death were respiratory infections and gastroenteritis. Public attention has focused on marasmus, suggesting that it indicated that many children in mother and baby homes died because of wilful neglect. The term marasmus is best seen as indicating that a child was failing to thrive, but medical experts suggest that this was due to an underlying, undiagnosed medical condition.

239. There is no single explanation for the appalling level of infant mortality in Irish mother and baby homes. The children of unmarried mothers were at greater risk, because of stress, and a lack of ante-natal care. There are comments in various documents dating from before 1950, alleging that the children of unmarried mothers were inherently weak and therefore at greater risk of infection and death, arguments that implied that many of these children were doomed. Some doctors suggested that unmarried mothers were at greater risk of premature births, but such comments - at a time when there was no scientific way of determining prematurity - may reflect the fact their babies may have had low birth weights. Most women who were admitted to mother and baby homes in the early years

were poor, (the private patients were an exception); their diet during pregnancy would have lacked essential nutrients, and this may have been exacerbated by efforts to conceal their pregnancy. Many women were admitted in the final weeks of pregnancy, some arrived following the birth of their child, so they would not have received any ante-natal care.

240. During the 1930s, 1940s and 1950s all the mother and baby homes - with the exception of Denny House - were overcrowded on numerous occasions. Overcrowding probably contributed to excess infant mortality, yet mortality in an overcrowded Castlepollard was much lower than in Bessborough and Sean Ross. The large size of most of the homes - again Denny is an exception - the large infant nurseries, with cots crammed together - sometimes only one foot apart - served to spread infection. There was an absence of infection control; a failure to isolate mothers and children who were being admitted, until they were proven not to carry an infectious disease. The risks of infection were exceptionally high in Tuam, which admitted older children, who might be homeless. The practice of isolating new admissions became more widespread during the 1940s, in response to mortality spikes.

241. There would also appear to have been a failure to implement appropriate standards of hygiene in the homes and to educate mothers about this. It would have been extremely difficult to implement proper hygiene in Tuam, given the inadequate sanitary facilities and lack of running water and hot water, but there was no reason why this could not have been achieved in the other homes. However all the homes were lacking in trained staff, with the possible exception of Pelletstown. When mother and baby homes opened in the 1920s there appears to have been little emphasis on a medical/health-care role, and they were run by middle-class women - either religious sisters or religiously-minded laywomen - who often lacked professional training in nursing, midwifery or child-care. The exception was probably Pelletstown which appears to have employed many more trained nurses than the other homes, though fewer than would have been desirable. The absence of professional staff, combined with what must be acknowledged as a general indifference to the fate of the children who were born in mother and baby homes, contributed to the appalling levels of infant mortality. In October 1936 the Bethany matron informed the management committee that five infants had died in the previous month; four from heart failure. She went on to observe that the health 'of all was good, except for one delicate baby'. While

minutes of local authority meetings in county Galway contain many references to Tuam, none refer to the health or mortality of the children. It is more difficult to analyse infant mortality in the county homes. The number of children in an individual home was relatively low, so the picture could be easily distorted by a small number of deaths. However, despite the appalling living conditions, in the 1930s and 1940s they may have posed less of a risk to 'illegitimate' infants than the better equipped mother and baby homes.

242. The sharp decline in the incidence of infant mortality - nationally, and in urban areas - from the late 1940s was due to a variety of factors: antibiotics, immunisation programmes, improved quality of milk, isolation, and better sanitation and housing. Most of these factors would have impacted on the mother and baby homes. There is evidence of additional bathrooms and toilets, and it is possible that overall hygiene practices may have improved. New medical officers were appointed to both Bessborough and Sean Ross.

Maternal Mortality

243. The Commission has identified 200 women who died when they were resident in mother and baby homes or the county homes that were investigated (including women who died in hospital). Some of these deaths occurred more than a year after the birth of a child, and therefore would not be regarded as maternal deaths within the definition employed by the GRO. They include four women who were admitted to Bessborough in the 1920s, and died in the 1950s, 1970s and 1980s (two deaths). The available information shows that up to 57% of the deaths were directly or indirectly associated with pregnancy. The highest number of deaths (including those not associated with childbirth) was in the 1930s. Maternal mortality in Ireland began to fall from the late 1930s, when it became known that sulphonamide was highly-effective in treating puerperal sepsis. The decline in mother and baby homes mirrored national trends; by the 1950s the rate was less than one-quarter of the 1920s figure. Mortality in mother and baby homes and county homes from causes that were directly or indirectly relating to childbirth was higher than the national figure: 1930s - 5.6 per 1,000 births, compared with 4.8 per 1,000 births. However, the excess mortality (which may be overstated) is much less than in the case of infant mortality. There is greater cause for concern in the high mortality of women before 1950 from causes that were unrelated to pregnancy, including infectious diseases. It seems probable that the factors that

contributed to the high rate of infant mortality were also responsible for mortality among the mothers from causes that were not related to childbirth.

244. Until the 1960s or the 1970s, the quality of maternity care in mother and baby homes was probably superior to that available to the majority of Irish women at the time. In the first half of the twentieth century most women gave birth at home, attended by a midwife, and sometimes by an untrained 'handy woman'. They gave birth in houses without running water or proper sanitation, whereas all the mother and baby homes had newly-built or improved maternity units by the late 1930s, and a qualified midwife, though they may have lacked many of the facilities appropriate to a maternity hospital. In 1944 Sean Ross maternity unit did not have sterilising equipment. The facilities in the county homes, where many unmarried mothers were forced to give birth, were often primitive. In 1935 the local medical officer discontinued admissions to the labour ward in Stranorlar because it lacked a bathroom and access to running water.

245. From the mid-1940s women in Bessborough were attended by a qualified obstetrician, and there is evidence in the Bessborough institutional records of women receiving ante-natal care from that time, though many women were admitted to Bessborough and other homes very late in pregnancy. The resident doctor appointed to Sean Ross around this time was a former assistant master in the Coombe. The medical officer in Castlepollard appears to have been assiduous in referring complicated cases to a Dublin maternity hospital. Pelletstown had access to the maternity unit in St Kevin's hospital and they had a visiting obstetrician on call, who was attached to the Coombe. There were few qualified obstetricians in Ireland outside the major cities until the 1970s. Painkillers were not widely used either in home or hospital births. There is no evidence that the women who gave birth in mother and baby homes were denied pain relief or other medical interventions that were available to a public patient who gave birth in a Dublin or Cork maternity unit. There is evidence of women in mother and baby homes being given pain relief, and being stitched following birth. All mother and baby homes, except Tuam, had one or more qualified midwives and a visiting doctor(s) on their staff. Staffing levels were inadequate in the earlier decades, so it is quite probable that women may have been left without qualified nursing care during the early stages of labour, especially at night. It is unclear whether the religious sisters normally carried out night duty.

Post-mortem practices and procedures

246. The Commission's 5th Interim Report outlined its findings in relation to burials in a number of the institutions and its findings in relation to anatomical studies. In spite of serious further efforts ,the Commission has not been able to establish where the majority of the Bessborough children are buried. Chapter 38 contains a report on burials in Sean Ross.

247. While the authorities in the homes kept quite comprehensive records of the arrivals and departures of the residents, a number failed to keep any records of the burials of children who died. The Congregation of the Sacred Hearts of Jesus and Mary are unable to identify where the children from Bessborough are buried; the Commission finds it very hard to believe that there is no one in that congregation who does not have some knowledge of the burial places of the children. Similarly, the Commission considers that there must be people in Tuam who know more about the burials there.

Vaccine trials

248. The Commission has identified a total of seven vaccine trials which took place in the institutions under investigation in the period 1934-1973 and has identified a number of the children involved. It is clear that there was not compliance with the relevant regulatory and ethical standards of the time as consent was not obtained from either the mothers of the children or their guardians and the necessary licences were not in place. There is no evidence of injury to the children involved as a result of the vaccines.

Arrangements for children

249. Until Unmarried Mother's Allowance was introduced in 1973, unmarried mothers had little choice about the long-term outcomes for their children and after that date their choice might be limited by the attitudes of their family. Attitudes changed slowly and access to accommodation remained a serious difficulty until the 1980s. Before legal adoption was introduced, women whose family could afford to pay for her child to be placed at nurse could leave the home after a shorter stay but it is questionable whether they had much say in the decision to place their child at nurse. Poorer women were at the mercy of the local authority, who would determine when and where to board out their child, or send her/him to an institution. Some women in county homes had to work unpaid in return for their child being boarded out. There are reports of mothers refusing to permit their child

to be boarded out, preferring that she/he be in a county home, or an industrial school, where the mother could visit and continue to hope that she might reclaim her child. Some women visited their children who had been boarded out or placed at nurse, but that relationship might prove difficult. Mothers might resent a child bonding with a foster parent, and there are also instances where mothers or a family member sought to reclaim a child when she/he was a teenager and capable of earning money.

Adoption

250. A comprehensive review of adoption did not form part of the Commission's remit. The Commission has concentrated on carrying out a review of the evidence relating to consent and on foreign adoptions.

251. Prior to the introduction of legal adoption in Ireland in 1953, the word adoption was often used to describe informal and non-legally binding arrangements whereby families took responsibility for children. Informal adoptions were also common in other countries before legal adoption was introduced. They were generally organised by voluntary agencies, and with the exception of the Bethany Home, where 111 children, 10.4% of the total are recorded as informally adopted, they played a very minor role in the exit pathways for the children from the homes that were investigated by the Commission. Many foster parents, who engaged in informal adoptions, subsequently adopted the child following the introduction of legal adoption in 1953.

252. Ireland was late in introducing formal legal adoption. Once legal adoption came into effect in 1953, adoption became the most significant exit pathway for children in mother and baby homes. There is documentation to support the view that politicians and others considered that adoption would give an 'illegitimate' child a better life. The rights of the mother were recognised but greater emphasis was generally placed on the needs of the adoptive parents.

Consent to legal adoption

253. An adoption order could not be made without the consent of the child's mother or guardian, or any person having charge of or control over the child. A mother was required to sign two distinct consents: an agreement to place a child for adoption, and a second, consent to the adoption order. The Adoption Board was required to satisfy itself, prior to making an adoption order, that the mother understood the

nature and effect of the consent and of the adoption order. A mother could withdraw her consent at any stage up to the making of the adoption order, though a number of legal cases suggest that mothers were not always aware of this.

254. The Commission has received evidence from some mothers who signed forms consenting to adoption because they had no alternative, because of family circumstances and/or insufficient means to support a baby. Some of this cohort of women are of the opinion that their consent was not full, free and informed. However, with the exception of a small number of legal cases, there is no evidence that this was their view at the time of the adoption. It is clear that for at least the first ten to 15 years of its operation, the Adoption Board did not have adequate resources to properly supervise adoption agencies or examine the consents given. The Commission is satisfied that, at least from the 1970s/1980s, there were adequate procedures in place for ensuring that a mother's consent was full, free and informed.

Foreign Adoptions

255. Institutional and official external records examined by the Commission show that 1,638 children who were resident in the mother and baby homes and county homes under investigation were placed for foreign adoption. The vast majority, 1,427 were placed for adoption in the United States of America. The *Adoption Act 1952* did not regulate foreign adoptions.

256. There was no statutory regulation of foreign adoptions. The only informal supervision was in relation to the issuing of passports for the children to travel to the USA. Archbishop McQuaid and Fr Cecil Barrett, who strictly speaking had no right to be involved at all, were actively involved in trying to control foreign adoptions and did manage to have some standards applied. In the early 1950s they drew up protocols to be applied to applications for passports for children who were travelling abroad for the purpose of legal adoption. The protocol demanded documentary evidence of the adopting parents' character and ability to provide for the spiritual and material welfare of the child. It demanded a home study report prepared by representatives of Catholic Charities or another organisation (in some states these were conducted by the state adoption authority). A list of requirements sent by Galway county council to would-be adopters, apparently dating from 1951, stipulated that the agency placing a child for adoption in the USA should be registered with the state authorities. It is clear from an examination of

the Department of External Affairs files that these rules were observed and exceptions were rarely made. A number of those who were rejected as adopters made representations to the Minister for External Affairs, and the Taoiseach, as did a number of priests based in the USA, but these were unsuccessful. The consular section of the US Embassy in Dublin issued visas enabling children to enter the United States; they also had requirements that would-be adopting parents had to meet before a visa would be issued.

257. Many allegations have been made that large sums of money were given to the institutions and agencies in Ireland that arranged foreign adoptions. Such allegations are impossible to prove and impossible to disprove. One person who was adopted in the USA in the 1950s provided the Commission with documentary evidence of the costs of his adoption. They included an airfare of $273, and a payment of $142 to Sean Ross, which included a contribution to the cost of the airfare of the adult who accompanied the child on the flight. Further costs incurred included payments for a home study report, medical reports and legal costs in finalising the adoption.

258. A number of witnesses to the Commission spoke about donations they believed were sent by their adoptive parents following their adoption in the USA. Such donations were not illegal and could not be described as unethical unless the adoptive parents were trying to adopt another child. The fact that the Daughters of Charity were advised by their director that money or gifts coming from America or elsewhere in relation to adoptions from Pelletstown could not be accepted, either as personal gifts or as donations to community works, indicates that donations were being made. The records of the Bethany Home contain a reference to a substantial donation by an American man who had adopted two Bethany children.

259. For the most part US adoption orders relating to these children were made by the Courts in the state where the Irish-born child was adopted. The Commission has examined a number of these orders and the supporting documentation and was impressed by the scrutiny taken by the US Courts to such applications. In many cases the Court appointed a *guardian ad litem* to represent the child's interests.

Discrimination

260. Throughout most of the period covered by the Commission unmarried mothers and their children experienced widespread discrimination within Irish society. Many

county hospitals would not admit unmarried women to maternity wards until the 1960s, forcing them to give birth in ill-equipped, and often insanitary county homes. The large number of women who were admitted to mother and baby homes, and county homes, and the fact that mother and baby homes continued to exist until the end of the twentieth century is evidence of the discrimination shown towards unmarried mothers and their children in Irish society. The legal status of 'illegitimacy' survived until 1987.

Race and disability

261. Based on a study of Bessborough and Pelletstown, the two largest institutions and both of which survived until the 1990s, the Commission concluded that there was no evidence of discrimination in relation to decisions made about fostering or adoption of mixed race children or children with disabilities. However the decisions that were made with respect to placing these children took account of race or disability. Of the 275 children who were in Pelletstown and Bessborough where race is noted on their records, 56% were placed for adoption. A number of families specifically sought to adopt 'mixed race' children; other families requested children who were not 'mixed race'.

262. It appears that race was a less important factor in decisions relating to adoption than religion or disability. A mother's mental illness or a child's intellectual disability prevented or delayed adoption in a number of cases where the experts believed that adoption was in the child's best interests but there is no evidence of systematic discrimination. The understanding of mental illness and intellectual disability was limited in first half of the twentieth century, and that may have resulted in some children being sent to industrial schools, as opposed to being boarded out. The growing number of pregnant unmarried women who were recorded as suffering from mental illness from the 1960s onwards suggests that there were probably many women in mother and baby homes in earlier decades with undiagnosed and untreated mental illness.

263. One-third of the children with intellectual disabilities in Pelletstown were the children of married couples. The significant number of 'legitimate' children in Pelletstown with serious physical or intellectual disabilities indicates that discrimination/disadvantage could apply more generally to children, and adults with disabilities, regardless of their birth status. The Commission heard no

representations by or on behalf of people with disabilities who were probably the most badly affected by being in institutions.

Religion

264. The issue of discrimination on the basis of religion is complex. Mother and baby homes - not just in Ireland - were run by religious communities and, as noted earlier, the reform/salvation of mothers and children was central to their mission. The evidence presented above about the different mother and baby homes, their funding models, length of stay for mothers and children, and exit pathways for the children indicate that there were some differences between the homes that were run by Protestant charities and those that were controlled by the local government authorities such as Pelletstown and Tuam, or by Catholic religious congregations. However, these differences do not indicate that there was discrimination on the basis of religion.

265. There is no indication of religious discrimination in relation to funding. The South Cork board of health and public assistance entered an arrangement for unmarried mothers and their children to be transferred to Bessborough and maintained there at a capitation rate, which became the funding model for mother and baby homes that were not owned and operated by local authorities. They made a similar arrangement with the Braemar Home in Cork to admit Protestant women. Local authorities had to seek the approval of the Minister for Local Government and Public Health to maintain women and children in a particular home. When Sean Ross and Castlepollard were established it appears that local authorities in their region were contacted and informed about the homes. There is no indication that Bethany or Denny House sought to be included on such a list before the early 1940s; if they had, there is no reason to suggest that they would not have been included. When it was suggested to Bethany in the early 1940s, that they seek approval from the Dublin local authorities to admit Dublin women on this basis, Bethany claimed that Protestant women were reluctant to approach a local authority seeking maintenance.

266. Denny House secured funding from the Local Government Board of Ireland under the Maternity and Child Welfare Scheme and this funding was continued by DLGPH. The grants covered half of the cost of maintaining mother in the home for up to six weeks before the birth, and half the cost of maintaining mother and child

for up to one year after the birth. The only Catholic mother and baby home to receive similar funding was St Gerard's. Funding under the Maternity and Child Welfare Grants was eventually extended to Bethany in the late 1940s; the precise details are not recorded. From the mid-1940s a number of local authorities secured approval to maintain women in Bethany and Denny.

267. The institution that received the least money from central and local government was Regina Coeli, though it should be emphasised that they did not seek a capitation payment. Funding for mother and baby homes developed in an ad hoc manner; the majority of unmarried mothers were Catholics, and they entered institutions that were run by Catholic religious orders. Women were admitted to Pelletstown regardless of their religion; Protestant women were admitted to the Donegal and the Cork county homes, and it is probable that they were admitted to other county homes that have not been investigated by the Commission. There is no evidence of religious discrimination in these cases. When a Dublin Protestant did not wish his pregnant daughter to be admitted to a Dublin mother and baby home, in order to protect her privacy, the department arranged for her admission to Braemar.

Chapter 18: Bessborough

Introduction

18.1 Bessborough mother and baby home was opened in 1922. It was a mother and baby home for the entire duration of the Commission's remit: 1922-98. During that time, 9,768 mothers and 8,938 children were admitted.[1] It was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. The public assistance/health authorities paid for most of the mothers and their children while they were living in Bessborough but a significant number were 'private' patients.

Sources

18.2 The following is a summary of the main sources used for this chapter. A complete list is included in Part 5: Archives.

Institutional records

18.3 Bessborough institutional records are held by the Child and Family Agency (Tusla). As already reported, the Commission made digital copies of these records.

18.4 When a woman entered Bessborough, her personal details and information about her financial situation were recorded in broadly the same way as was done in hospitals and county homes (and, formerly, in workhouses). From 1922 to 1930, the details were handwritten in a type of ledger or copybook. A purpose-designed register was introduced in 1930. The level of detail recorded for each new resident varied somewhat from one person to another and also over time. In general, the following details were recorded: woman's name, age, address, occupation (sometimes noting the rate of pay), by whom referred, and health district. In some cases, the putative father is named.[2] In the 1920s, the civil war affiliation of the mother's family and that of the putative father were sometimes recorded. The woman's education level and the names of her parents were also sometimes recorded. The baby's name and date of birth were also recorded. The date of discharge of the baby and the mother and the place to which they were discharged were also generally recorded. The stated place of discharge may not be where the woman and child actually went. For example, the baby may be described as

[1] A number of women (about 170) are recorded in the Bessborough registers but are not within the Commission's Terms of Reference because they were not pregnant, or they were married or did not stay for one night.
[2] There is anecdotal, and some limited documentary, evidence that the name given may not be accurate.

'placed for adoption' and may subsequently be described as 'adopted' or it may be that the adoption placement did not work out and what happened to the baby is not recorded in these records. Sometimes the mother and baby are described as being discharged to family but there is evidence that, in many such cases, the mother may have returned to her family but the child was boarded out, nursed out or, in later years, placed for adoption.

18.5 On admission to Bessborough women were assigned a 'House Name' and this is recorded in the registers. The theory behind this practice was that it was necessary to preserve the anonymity of the women.

18.6 Admissions and discharges from the Sacred Heart Hospital, Bessborough (see below) and the Bessborough home were separately recorded. Personal details relating to women who spent time in both the Sacred Heart hospital and the Bessborough home are recorded in the registers of both the hospital section and the home section of the institution. The records of women who spent time in both sections therefore show two discharge dates. It has been suggested that this was a means for the congregation to falsely claim maintenance payments from the public assistance authorities for women who had already left the institution. Where two discharge dates were recorded, the first related to a woman's discharge from the hospital and the second related to her discharge from the home, which was generally the final date of discharge.

18.7 The institutional records include:

- Bessborough home Admission Books
- Bessborough Maternity Hospital Admission Books and Maternity Books
- Registration of Births, Bessborough Maternity Hospital
- Records and Particulars Book, Bessborough Maternity Hospital
- Private Patients Admission Book
- Maternity Hospital ante-natal records
- Death Register

Other records held by the Child and Family Agency (TUSLA)

18.8 ***Records of the Sacred Heart Adoption Society***: these include adoption application files; adoption placement files; adoption orders files; minutes of the

adoption society; foreign applications files and foreign adoption files. The combined records span the years 1936-98.

18.9 ***Records of the Catholic Women's Aid Society (CWAS):*** these include records of payments to foster parents books for the years 1920-45; index of babies placed for fostering and adoption for the years 1937-71; and a small number of miscellaneous documents relating to the society.

18.10 ***Records of St Anne's Adoption Society***: Registers are available for the years 1954-99. The registers recorded details of women who were repatriated from the UK to have their babies adopted in Ireland.

Bessborough Baptismal Registers

18.11 A complete set of baptismal registers relating to Bessborough for the period December 1930 to January 2010 are held at the Cathedral of St Mary and St Anne (North Cathedral), Cork. The registers recorded a wealth of information including a child's name, date of birth, date of baptism, mother's name and address, name of the priest and godparent (usually one of the other mothers in Bessborough), date of discharge and discharge pathway and details of any subsequent marriage. The registers also noted if a child had died and the date of death. Interestingly, the registers also recorded the Board of Assistance responsible for the child's maintenance in Bessborough and private patients were designated by the letter 'P'. This information facilitated the Commission's efforts to establish the number of private patients admitted to Bessborough from 1930 to the late 1940s.

Cork Local Authority Records – Cork City and County Archive

18.12 Records relating to the Cork local authorities (the Boards of Guardians, South Cork Board of Health and Public Assistance/Cork Health Authority/Southern Health Board) include:

- Registers of boarded out children 1925-73;
- Cork Board of Assistance payment records for boarded out children 1959-72;
- Registers of children at nurse 1912-65;
- Health authority adoption registers 1935-99;
- Minutes of meetings
- Managers orders

18.13 Cork City and County Archive also held 150 boxes of uncatalogued public health records. A perusal of one box revealed correspondence relating to infant mortality in Bessborough. The Commission sent an archivist to the Cork archives for several months to catalogue this collection for analysis.

Department of Health records

18.14 The Department of Health provided a large amount of material to the Commission. There were very few files available from the 1920s and 1930s but there was extensive material from the 1940s onwards. The main files used for this chapter were:

- CCL/INA/0/485547
- CCP/IMP/0/45492
- CCL/INA/0/488268
- INACT/INA/0/426512
- INACT/INA/0/464099
- NAI, A104/2

Other sources

18.15 Official publications, newspaper reports and other sources are referenced in the text.

Origins

18.16 The Congregation of the Sacred Hearts of Jesus and Mary had been invited to set up a mother and baby home in Cork by Séamus Lankford, who was in charge of the Cork Board of Guardians. In 1921, the matron of the Cork workhouse had made an urgent appeal to the Board of Guardians to provide alternative accommodation for unmarried women and their children in a setting other than the workhouse. Mr Lankford travelled to London to visit a number of relevant services. He was introduced to the Congregation of the Sacred Hearts of Jesus and Mary. After some discussions, the congregation agreed to establish a mother and baby home in Cork. The Archbishop of Westminster agreed to provide financial assistance. It is clear that Bishop Cohalan of Cork approved the establishment of the home and took considerable interest in it, but it is not clear how much involvement he had in the initial decision to establish it. In his 1945 letter (see below) Bishop Cohalan referred to dealings he had had about the establishment of Bessborough with the Department of Local Government and others.

18.17 Mr Lankford identified Bessborough House, a large Georgian house with 210 acres, as being suitable. It was outside the eastern boundary of Cork city and was for sale with 'a very low reserve'. The council of the congregation agreed to buy it for £6,000.[3] Mr Lankford put a deposit of £400 on the property and, according to a congregation member many years later, the rest of the purchase price was provided by the Archbishop of Westminster.[4] When the vendors discovered that Bessborough was to become a home for unmarried mothers they sought to withdraw from the sale, and offered Mr Lankford £2,000 to withdraw his bid.[5] He refused and the sale went ahead. On 1 February 1922 the congregation took possession of the Bessborough estate. The Commission has not been able to find any formal written agreement between the congregation and the Cork Board of Guardians but there almost certainly was such an agreement.

Governance

18.18 Bessborough was one of the first 'special' institutions for unmarried mothers and their children. As already stated, it was owned and run by the congregation but was largely paid for by the public assistance/health authorities. Unlike workhouses and county homes, there were no specific laws or regulations applying to it. The respective responsibilities of the public assistance authorities, the Department of Local Government and Public Health (DLGPH) and the congregation do not seem to have been clearly delineated; this lack of clarity was particularly obvious when attempts were being made to address the very high rate of infant mortality in the 1940s. The congregation has told the Commission that the local and national health authorities had a greater role in the governance of Bessborough than is recognised by the Commission. The Bishop of Cork was involved in many decisions, particularly in the early years, although he had no defined role in the institution.

[3] Congregation of the Sacred Hearts of Jesus and Mary, Council minutes, 10 February 1922. The congregation's September 2019 affidavit states that the purchase price was £9,000 of which the diocese of Westminster contributed £2,000. No source was provided for this.
[4] *Nenagh Guardian*, 13 August 1988.
[5] Siobhán Lankford, *The Hope and the Sadness: personal recollections of troubles times in Ireland*, Tower Books, 1980

The 1920s

Admission to Bessborough

18.19 In July 1922, Cork county council[6] notified all boards of guardians in Cork city and county that 'the mansion at Bessborough, Blackrock, has been recently purchased by a religious order having large experience of rescue work and child welfare' and advised:

> This community will direct their attention towards the reformation of unmarried mothers and their children, and for deserted and orphaned children, but no girls who had a second child will be accepted under any circumstances.

18.20 In the following months the various Cork boards of guardians agreed to recognise Bessborough as an extern institution for the care of unmarried mothers of one child, and children up to three years, and agreed to transfer all such cases from the various union workhouses to Bessborough. Séamus Lankford supervised the installation of equipment necessary for Bessborough's new function and in November 1922 the first women and children arrived from the Mallow, Kanturk, Millstreet, Macroom and Cork union workhouses.[7]

18.21 A letter from the Mother Superior of Bessborough to the Bandon Board of Guardians set out the conditions under which Bessborough would admit an unmarried mother and her two-year-old child who were living in the Bandon union workhouse:

> She will produce a doctor's certificate of health, mental and physical, is willing to remain for twelve months and conforms to the simple rules of our institution. She will be taught knitting, needlework, housework, dairy, and poultry, gardening and necessary laundry for both, also how to care for and treat her child. We hope the Guardians are willing to pay 25/- per week for maintenance of both.

18.22 In this particular case, the woman involved chose not to accept a transfer to Bessborough and subsequently took her discharge from the Bandon workhouse. The indoor registers of the Cork union workhouse show that, of the 76 unmarried

[6] In February 1922, Cork County Council had met to discuss the abolition of workhouses and the institutional treatment of unmarried women and their children and deserted and orphan children. The council decided to set up a County Nursery in one of the disused workhouses to accommodate children from infancy to three years and unmarried mothers of 'first fall' and their infants. This plan was never implemented because of the opening of Bessborough as a mother and baby home.

[7] Lankford, *The hope and the sadness,*

mothers living in the workhouse during 1922, just 11 opted to, or were eligible for, transfer to Bessborough.

18.23 Local Government Board inspectors (see Chapter 1) informed boards of health/public assistance[8] of the services provided at Bessborough and urged them to transfer 'first unmarried mothers' there rather than maintaining them in county homes. On her inspection visits to various local authorities, one inspector, Miss FitzGerald-Kenney, told councillors that the congregation looked after women and discharged them to paid employment, giving them an opportunity to contribute towards the cost of maintenance of their children.[9]

18.24 Many councillors expressed their opposition to the capitation rate levied by the Bessborough authorities. Many more resented the fact that boards of assistance were obliged to maintain unmarried mothers and their children at all. One councillor said:

> Some people may be surprised to learn that the charge is a guinea[10] per head per week for those unmarried mothers. How few decent parents can afford that much on a boarding school for their children?[11]

18.25 The *County Scheme Order, Cork No 1, 1924* gave legal backing to the new arrangements for implementing the poor law in Cork.[12] It provided for the replacement of the various boards of guardians by three boards of health /public assistance - the North Cork county board of health, the South Cork county board of public assistance and the West Cork county board of health. The South Cork board of public assistance was given responsibility for the Cork county home, the Cork district hospital and for Bessborough. The county scheme provided that the Cork county home was to be for 'aged and infirm persons, chronic invalids, idiots and epileptics'. The attached district hospital would treat medical, surgical and maternity cases and those suffering infectious and contagious diseases. It was envisaged that single expectant women would be admitted to Cork county home to

[8] Changes to the poor law saw boards of guardians reconstituted as boards of health/public assistance – see Chapter 1.
[9] *Cork Examiner*, 17 December 1926.
[10] A guinea was £1 1s (£1.05 in decimal currency); while guinea coins have not been in circulation for nearly 200 years, bills, especially those for professional fees, were commonly expressed in guineas until recent times.
[11] *Cork Examiner*, 1 December 1925.
[12] http://www.irishstatutebook.ie/eli/1924/sro/927/made/en/print

avail of maternity services only and then transfer to what the county scheme described as the 'auxiliary home'[13] at Bessborough with their babies.

18.26 The county scheme directed that admissions to homes and other institutions not under the direct control of a county board (that is, extern institutions such as Bessborough), must be authorised by the board or one of its agents. Single expectant women, and unmarried women accompanied by their children, who sought admission to Bessborough under the public assistance system were, in the first instance, required to get a ticket of admission from a board of assistance officer, a dispensary medical officer or the matron of the Cork county home and district hospital. Administrators at Bessborough forwarded admission tickets to the secretary of the South Cork board of public assistance. In order to maintain anonymity, requests for admission to Bessborough were dealt with by the board's secretary alone; they were not discussed openly by the board.[14] When a request for admission was granted, the secretary issued an official order to the Bessborough authorities accepting financial responsibility for the maintenance of the woman and her child. The South Cork board agreed to pay the congregation a weekly rate of 10s 6d for each resident (£1. 1s for mother and child). Boards of assistance did not approve the admission of women to Bessborough routinely. For instance, a manager's order from the North Cork board stated:

> The admission of case No.11 (a) to above Institution at the Council's expense is refused. The patient was not admitted in the proper manner and her guardians would appear to be in a position to pay for her treatment.

18.27 From the mid-1920's, welfare departments in the UK began to contact Bessborough with a view to repatriating Irish women - see Chapter 7.

Leaving Bessborough

18.28 In the early years of Bessborough's operation there was some confusion among members of the South Cork board of public assistance and Cork corporation regarding aspects of the running of the home including the right of women to leave the home. For example, in 1924 two women left Bessborough and sought admission to Cork county home. The board's solicitor advised that the women should be subject to 'the disciplinary rules as they applied to the workhouse' and

[13] The use of the term 'auxiliary home' suggests that Bessborough was being regarded as an integral part of the poor law provisions. It was not an auxiliary home in the sense that Pelletstown was. The 1927 Report recognised that it was not under the control of the Board of Public Assistance.
[14] DLGPH, *Report 1930-31*.

prosecuted 'for disobeying the rules'. The chairman of the South Cork board and the Lord Mayor agreed that both women should be prosecuted. The solicitor told the board that infants born to both women had died in Bessborough and that is why they left. The solicitor said 'these women may not like to remain where their babies had died'. The board voted to reverse their decision to prosecute the women.[15] In fact, the workhouse rules did not apply to Bessborough and women living there were legally free to leave. Women living in Bessborough were almost certainly not aware that this was so and, even if they were, many may not have had anywhere else to go. They were not, of course, necessarily entitled to admission to the county home. They were legally obliged to maintain their children but it is unlikely that they could have been successfully prosecuted for abandonment if they left their children in Bessborough - see Chapter 1.

18.29 Sometimes, family members applied to the board of assistance to have their daughter 'returned' to them. When this happened, the board asked for a medical report from the Bessborough medical officer as to the fitness of the woman for discharge. The board also asked for a report from the local Assistance Officer on living conditions in the family home. Applications generally included a reference from a parish priest to state that the family would look after the woman on her return to the family home. The major problem with these applications for the 'return' of a daughter was that the families were willing to have her return to the family home but were not willing to take her child as well. Board of assistance records include hundreds of applications to the South Cork board from family members wishing to take responsibility for women living in Bessborough. However, the majority of applications stated that they had made private arrangements to have the children fostered. The applications generally included a character reference for the prospective foster parents from a parish priest. All such discharges, and fostering arrangements, were allowed to proceed at the discretion of the board.

Department of Local Government and Public Health view

18.30 The *First Report* of the Department of Local Government and Public Health (DLGPH) 1922-25 gave 'special mention' to the Congregation of the Sacred Hearts of Jesus and Mary and their efforts to deal with the 'very difficult problem of the unmarried mother'. It stated that the congregation had established at Cork city:

[15] *Cork Examiner*, 24 December 1924.

a Home for the reception and reformation of girls who for the first time have had illegitimate offspring, or as they are usually designated - first offenders. The Sisters believe they can influence these cases best by keeping them disassociated from those who have lapsed a second time or oftener.

18.31 It went on to state that the 'girls' were usually 'retained' for about a year and trained for 'useful occupations': housework, cooking, needlework, laundry work, dairy management, poultry rearing, gardening and farming, and that 'their religious and moral instruction receives special attention from the Sisters and Chaplain'. It was stated that at the 'end of the period of detention' the women were placed in situations and that most took their infants with them on leaving. The DLGPH concluded that 'the results are most gratifying; with two or three exceptions all the discharged have done very well'.

Report of the Commission on the Relief of the Sick and Destitute Poor

18.32 On the 26th day of evidence, 9 February 1926, the Commission on the Relief of the Sick and Destitute Poor discussed the arrangements for unmarried mothers in Cork.

18.33 The secretary of the South Cork board of public assistance gave evidence that there were 21 unmarried mothers and 55 deserted and 'illegitimate' nursery children in the Cork county home (Cork city) on 31 January 1926. These 21 were, in most cases, 'second offenders'. The mothers in county homes were required to work in the hospital and to assist in the general cleaning of the institution.

18.34 He said that there were 53 unmarried mothers and 52 children in Bessborough. Only 'first offenders' were sent to Bessborough. The board of assistance considered that it had no direct control over the institution; it simply paid a capitation grant of 3s a day for each mother and child. He said that women stayed at least a year and the Sisters thought two years was desirable. When the mother was discharged she usually took the child with her; in some cases, she left the child in the institution and paid a contribution for its upkeep. Some of the mothers had agreed to pay 5s a week.[16]

[16] The Commission has not seen any other evidence that such agreements were made or implemented.

18.35 The secretary said that Bessborough was considered a thorough success; about 20 women had been discharged at this stage. The Sisters kept in touch with the women who were discharged. The Sisters trained the women in housework, cookery, needle work, laundry work and dairy management. When asked if there was any remunerative work, the secretary replied that the Sisters had a lot of land, they had a dairy and an orchard and they kept all the women employed. He could not say if the institution was run at a profit or a loss.

18.36 He said that the capitation fee was set when the institution was first started; prices were higher then. He pointed out that there were no establishment expenses and no staff paid by the board. When asked if there was an outside committee attached to the institution, he said 'Well, the Bishop looks after the place very closely and takes a great interest in it.' When asked about a visiting committee, the board of assistance secretary said that 'there are some ladies who visit it' but he did not know if they were a properly appointed committee; they were not appointed by his board.[17]

18.37 There were 57 children ranging in age from three to 12 in school and 31 in the nursery in Fermoy County Home. The chair of the commission categorised the Fermoy institution as a home for unmarried mothers and their children.[18]

Bessborough and the South Cork Board of Public Assistance

18.38 In 1927, the South Cork board of public assistance realised that increasing numbers of women from outside the Cork health districts were being admitted to Bessborough and that the cost of their maintenance was borne by the South Cork ratepayers. The South Cork board wrote to the boards of health/public assistance in other counties asking them to contribute towards the maintenance of women and children from their districts who were maintained in Bessborough. This was met with blunt refusals to pay any portion of the costs. The South Cork board decided to limit admissions to Bessborough to women from the Cork health districts (South, North and West Cork) and to direct women from other counties to Cork county home. However, many women from outside the Cork health districts

[17] The Commission has not seen any evidence that there ever was a visiting committee.

[18] Although Fermoy was often described as a 'county home', the *County Scheme Order* categorised Fermoy as a county hospital whose services included maternity services. The 1927 Report noted that part of the old Fermoy workhouse was occupied by unmarried mothers and their children 'whose reception is not contemplated by the Scheme'. It further noted that this accommodation was entirely distinct form the hospital and that 'if these classes are to remain it will be necessary to provide proper sanitary accommodation'.

established addresses in Cork city, usually in a boarding house, in order to secure an admission ticket to Bessborough. By 1930, 25% of admissions to Bessborough were women from outside the Cork health districts and efforts to recoup the cost of maintenance from boards in other counties were largely unsuccessful. The South Cork board asked the Minister for Local Government and Public Health to change the law so that the cost of maintaining women from outside the Cork health districts would either be a national charge, or a charge on a group of counties. Although nine counties subsequently accepted responsibility for the maintenance of women from their districts in Bessborough, disputes regarding the home county address of applicants were frequent.

Maintenance and improvements

18.39 In 1928, the Mother General of the congregation visited Bessborough. She noted that there were about 100 women and their children there. She found the women's sleeping accommodation to be 'unsatisfactory' and consulted an architect to draw up plans for the improvement of the building.[19] The congregation subsequently spent £5,000 undertaking repairs and renovations in a bid to improve the accommodation.[20]

Numbers in the 1920s[21]

18.40 The DLGPH reported that, by 1928, an average of 70 women and 64 children lived in Bessborough and the institution admitted about 25 new women a year. In 1929, women admitted to Bessborough were maintained by the South Cork, Kilkenny, Waterford, Tipperary (North Riding) and Kerry boards. The rate of maintenance remained at three shillings a day for each mother and child 'but if the child dies there is no charge'. The DLGPH lamented that 70% of single women with first-born children continued to be maintained in poor law institutions, such as county homes, 'where they cannot be dealt with apart from other inmates' and stated that 'it is now generally accepted that the number of unmarried mothers in County Homes should be diminished' and that 'encouraging results can be anticipated if special provision is made to help them'. Acknowledging that there was 'a pressing need' for institutions similar to Bessborough, the DLGPH stated:

> By sympathetic help the mother, who is often friendless and inexperienced, can be protected from downgrading influences and enabled to regain her

[19] Congregation of the Sacred Hearts, Annals of the Order, 16 April 1928.
[20] Congregation of the Sacred Hearts, Annals of the Order, 1 October 1928.
[21] A detailed breakdown of the numbers as calculated by the Commission is available in the Appendix.

> footing in the world...The development of training Homes for mothers of first-born children, pre-natal and post-natal, would have splendid results in reducing the numbers that come into the second class. A decline might also be expected in the high death rate of illegitimate infants.

18.41 When it opened in 1922, Bessborough was an institution for unmarried mothers and 'illegitimate' and abandoned children. There were no maternity facilities on site. The records compiled within the institution and analysed by the Commission show that, between its opening in 1922 and 31 December 1929, 221 women and 218 children were admitted. Only one woman was admitted before the birth and she did not return after the birth. The majority of the babies concerned were born in Cork district hospital (county home); 13 were born in Thomastown county home and a small number were born in other places. Usually women were admitted within two to four weeks of the birth but a small number were admitted more than a year after the birth. The length of stay of the mothers who entered Bessborough in the 1920s varied from one day to 61 years; 40 were resident for up to one year, a further 51 were there for up to two years.

The 1930s

The Sacred Hearts Maternity Hospital, Bessborough

18.42 In 1924, the bishop of Cork had asked the congregation to consider admitting single expectant women, as well as women who had already given birth, to Bessborough. The minutes of the congregational council show that the congregation was reluctant to take in expectant women but agreed to do so 'under certain circumstances'. The matter was then dropped until March 1928 when the bishop raised the question again and 'almost insisted' that the congregation would admit single expectant women. The congregational council acknowledged that other religious orders were engaged in providing maternity services and decided to adopt this work also.[22]

18.43 The South Cork board of public assistance proposal to maintain single expectant women in Bessborough was agreed by the Minister for Local Government and Public Health. The minister also agreed to the board's proposal to pay £120 salary for a doctor to attend the births and £100 to employ a qualified midwife.

[22] Congregation of the Sacred Hearts, 'Report of the Superior General', General Chapter, 1933.

18.44 In 1930, the congregation opened a maternity ward in Bessborough. According to a Department of Health note compiled in the early 1950s, this was a separate building but was merely a 'cottage' which, when inspected in 1932, had 24 beds.[23] The Mother Superior asked the South Cork board of assistance for a grant towards equipment for the maternity ward but this was refused. In November 1930, the South Cork board notified hospitals and health officials that all 'first offender' unmarried pregnant women, including women from outside the Cork health districts, were to be sent to Bessborough for their confinements.

18.45 In December 1931, the congregation applied to the DLGPH for a grant from the Hospitals Trust Fund to build a maternity hospital at Bessborough.[24] The congregation argued that a more elaborate structure than the 'cottage' was required. The department agreed to provide a grant of £17,105.[25] The congregational council regarded the grant as 'a gift' and established that its acceptance would not impose any legal obligation on the congregation.[26] The DLGPH also gave £1,500 for equipment. The Sacred Heart maternity hospital opened in 1933 and was certified by the local authority under the *Registration of Maternity Homes Act 1934* in 1934. It had three eight-bed wards and two private rooms.

Admissions, length of stay and infant mortality in the 1930s

18.46 The DLGPH acknowledged that the South Cork board processed applications for admission to Bessborough discreetly to ensure that 'publicity is avoided' and that women would maintain their anonymity. The matron, Sister Martina, advised the department that some 'girls' were 'very weak willed' and were maintained in Bessborough for long periods 'to safeguard them against a second relapse' and that women who were placed in situations 'get on very well, and good reports are received from employers'.

18.47 In the period 1 January 1930 to 31 December 1939 institutional records show that 1,009 women were admitted.

18.48 In July 1931, Sister Martina notified the South Cork board that 12 women and their children had been living in the institution for extended periods, some as long as six

[23] The Commission has not seen a report of this inspection.
[24] They made a similar application for Sean Ross – see Chapter 19.
[25] Hospitals Commission *First General Report 1933-34*
[26] Congregation of the Sacred Hearts, Council minutes, 5 December 1931.

years. Sister Martina said that she was in a position to place the women in paid employment once their children were boarded out. The board advised that they would only maintain women and children in Bessborough for a period of two years, after which time the board instructed the matron to transfer them to Cork county home. In response, Sister Martina said that she considered that women living in Bessborough had a duty to rear their children and that it was important to the women to remain with their children until they reached school-going age. However, the South Cork board decided that they would not bear financial responsibility for women and children for longer than two years. The evidence suggests that women living in Bessborough for more than two years, who had no wish to transfer to Cork county home and who could make no alternative arrangements, remained in Bessborough as unpaid domestic servants until they were in a position to arrange for the future care of their children. The institutional records show that a small number of women remained in the institution for extended periods after their children had been boarded out and, in some cases, after their children had died. The Congregation of the Sacred Hearts of Jesus and Mary received no maintenance payment for such 'old girls' who appear to have remained in the institution as unpaid domestic servants in return for their upkeep. The congregation told the DLGPH that these women 'have a great influence for good over the newcomers'.

18.49 The DLGPH report for the year ending March 1932 stated that 64 women were admitted to the Bessborough home and 79 were admitted to the maternity hospital. One hundred and three births, 89 discharges and 16 infant deaths were notified for this period. The department lamented that although 'every facility was given to Boards of Public Assistance to induce suitable cases to seek shelter and attention at an early stage', large numbers of women continued to present at Bessborough in the last stages of pregnancy. The report stated:

> There is ample evidence that the girls who go to these Homes profit by the training they receive and that the Homes are carrying on useful and necessary work. The natural affection of the mother for the child is fostered and in this lies her greatest hope of safety in the future.

18.50 In the year ending March 1933, the DLGPH reported that 93 women were admitted to Bessborough. Sixty seven women were discharged during this period, 10 of whom took up employment in one of the congregation's institutions in the UK; the remaining 57 women were either discharged to employment or returned to the

family home. Forty nine children were discharged from the institution and a further four died; in each case the cause of death was given as marasmus.

18.51 In the year ending March 1934, the DLGPH reported that:

- 92 women were admitted
- 108 were discharged; eight were placed in employment in one of the Congregation of the Sacred Hearts - run institutions in the UK;
- 34 found employment in Ireland; 29 returned to their family home with their children and 10 women married
- 30 infants died; marasmus and prematurity were the main causes of death.

18.52 The DLGPH commented:

> Deaths of infants at these institutions are generally caused by an epidemic of some kind, measles, whopping cough, etc., which spreads quickly among the children and wipes out the weaklings. The nurseries are laid out to accommodate too many children and the provision for isolation is not adequate.

18.53 Bessborough had the highest infant mortality rate of the four mother and baby homes then in existence (Pelletstown, Tuam, Sean Ross and Bessborough). It is very clear from the reports of the DLGPH that it was fully aware of the very high rate of infant mortality in all mother and baby homes at least from 1933 but it seems to have accepted the deaths as inevitable:

> Doubtless, the great proportion of deaths in these cases is due to congenital debility, congenital deformations and other ante-natal causes traceable to the conditions associated with the unfortunate lot of the unmarried mother.

18.54 The DLGPH reported that, in the year ending March 1935, 120 infants were born in or admitted to Bessborough and 39 infants had died. In the same period:

- 131 expectant women were admitted to the maternity hospital and an additional five women were admitted to the home accompanied by a child
- 64 women were discharged; 21 left with their child
- 40 infants and children were discharged; 22 were informally 'adopted' in the nursed out system, 16 were boarded out and 2 were placed with nurse mothers through a 'Rescue Society'.[27]

[27] This is likely to have been the Catholic Women's Aid Society.

18.55 There was an expectation that a woman who left Bessborough to take up employment would contribute towards maintenance in cases where her child was boarded out. The DLGPH said that the 'generally accepted principle' was that a 'working girl' should be allowed to retain £10 annually for her own maintenance and to contribute the balance of her earnings towards the maintenance of her child. The department determined that, 'on the whole', the mother and baby home system had produced 'satisfactory results' and that 'very few girls who have been in these homes have been admitted during the year to county homes pregnant for a second time'.

18.56 In her report for the year 1934-35, the DLGPH inspector of boarded out children, Miss FitzGerald-Kenney, praised the work carried out for unmarried mothers at Bessborough and other special homes.

> I am convinced that these homes have done much to prevent infanticide. A girl tortured by her sense of shame will take almost any step to keep hidden from the public the knowledge of her fall. The fact she can turn to one of these homes in her predicament gives her a loop hole of escape. It is undeniable that in these specialised homes the character of the inmates is developed, and the girls are given a new and truer outlook on life - an outlook of which they were previously heedless or entirely ignorant. Furthermore, the keeping of mother and child together in these homes has the effect of restraining girls who would be wild and careless if separated from their infants.

18.57 While Miss FitzGerald-Kenney had high praise for Bessborough she advocated training in domestic duties over agricultural work on the basis that domestic work would create more stable employment opportunities while agricultural employment she observed 'leads more easily to further relapses'. She also recommended that skilled instructresses such as those employed in technical schools, should be employed to instruct residents of the home in 'technical training' to allow them to take up remunerative work on discharge. She considered that women should not remain in an institution such as Bessborough for more than two years because, if kept too long, 'they become accustomed to silence and routine and find it difficult to readjust to ordinary life'.

18.58 In her Bessborough Annual Report, Sr. Martina told the DLGPH that:

> The primary object of our institution is the rescue of unmarried women and children...A number of the girls are weak-willed and we are compelled to maintain them for longer periods (free of charge) so as to safeguard against a second relapse...in the case of a child death no charge is made for the mother...It is regrettable that there is one case aged 15 years; her brother is the father of her child. Three others are 16 years...Those placed in situations are getting on splendid, their frequent letters testify to their appreciation of the Home. Have had very good reports from their employers.

18.59 The DLGPH report for 1935-36 reported that, in the year ending March 1936,

- 109 expectant women, and six women accompanied by a child, were admitted to Bessborough;
- 25 infants died;
- There were 127 women and 79 children living there at the end of March 1936.

18.60 The DLGPH reported that, for the year ended 31 March 1937, there was a significant increase in the number of women and children living in Bessborough:

- 150 women and 122 children were living there at the end of March 1937;
- 110 women were admitted and 89 women were discharged during the year;
- 100 births were notified during this period and 22 infant deaths occurred.

18.61 The numbers in residence decreased after this but the infant mortality rate increased. The DLGPH reported that, in the year ending March 1939:

- 80 women were admitted to Bessborough and 120 women and 99 children were resident there in March 1939;
- 81 children were born or admitted during the year and 38 died in the same period.

Leaving Bessborough

18.62 Women who left Bessborough without their children, or without making arrangements for their care, could have been prosecuted for child abandonment (see Chapter 1). In September 1932, two women left Bessborough leaving their children who were then aged 18 months and 22 months, unaccompanied in the institution. The Gardaí were notified but did not locate the women. One woman

was subsequently brought back to Bessborough by her father and the other was never seen again. The Gardaí did not pursue women who 'absconded' from Bessborough with any great vigour as they seem to have considered that the children were in a safe environment and often a better environment than a woman's family home. In 1938, the board's solicitor adopted a more stringent approach to women who left their children in Bessborough. If the mother was located, proceedings were instituted by way of a summons under Section 12 of the *Children Act 1908*. The Commission has not seen any evidence of successful prosecutions.

Putative Fathers and Affiliation Orders

18.63 The *Illegitimate Children (Affiliation Orders) Act 1930* provided that unmarried fathers could be obliged to contribute towards the maintenance of their children if paternity could be established - see Chapter 1. In 1934, the Minister for Local Government and Public Health wrote to the South Cork board of public assistance to enquire why the board had not made use of the powers conferred on it by this Act. An audit of the South Cork board, undertaken by the DLGPH for the period April-September 1934, showed that the board had paid £4,600 to the Congregation of the Sacred Hearts of Jesus and Mary for the maintenance of women and children in Bessborough and the minister directed the board 'to make every effort to recoup all, or part, of such expenditure'. In January 1936, the South Cork board began to forward details of every woman admitted to Bessborough to their solicitor with a view to taking proceedings under the Act. In March 1937, the board's solicitor reported that he had interviewed a large number of mothers of 'illegitimate' children but could not secure corroborative evidence which would satisfy the court should proceedings against a putative father be taken. In 1938, a new firm of solicitors interviewed all new entrants to Bessborough and got sworn testimony identifying the fathers of their children. However, subsequent court proceedings were frequently dismissed, and where orders for payment were secured against putative fathers, the decisions were routinely reversed on appeal.

Underage expectant girls

18.64 In June 1935, the matron of Bessborough wrote to the South Cork board about a 15-year-old resident suggesting that 'the child's seducer should be punished'. It appears that the board had never previously considered such an action. Its solicitors advised that a criminal charge could be brought against the putative

father. The matter was reported to the Gardaí with a view to instituting criminal proceedings. A similar situation arose in October 1935 and, again, the matter was reported to the Gardaí. The Commission has not found any evidence that prosecutions ensued.

The 1940s

Inspections

18.65 As already stated, the Commission has not seen any copy of an agreement between the Congregation of the Sacred Hearts of Jesus and Mary and the Department of Local Government and Public Health (DLGPH) or the Cork board of guardians about the running of Bessborough home. It is highly likely that such an agreement was drawn up but it is not known if any such agreement gave the department and/or the board the right to inspect the institution. However, it is obvious that the DLGPH staff were not clear that they had such rights in respect of Bessborough home. The *Registration of Maternity Homes Act 1934* provided for inspections of registered maternity homes by authorised local authority or departmental officials so there was no doubt about the right to inspect the Bessborough maternity hospital.

18.66 The first detailed inspection reports by departmental officials which the Commission has seen date from the early 1940s.[28] Specific inspections of the maternity hospital were conducted by a departmental doctor or nurse. Inspections of the home and hospital were carried out by the department's local government inspector. In the 1940s and 1950s, this was mainly Miss Alice Litster. The Commission has not been able to establish if these inspections were announced or not.

18.67 In 1941, Bishop Cohalan of Cork advised the congregation about dealing with inspections. He told the congregation that they were a religious community and not 'a department of the Cork County Home and Hospital. You are not a Government Institution'. He accepted that government inspection had to be allowed but 'this inspection must not encroach on your independence as a Religious Community'. He pointed out that the inspection of national schools and industrial schools did not extend to the domestic affairs and the domestic

[28] It is clear that inspections were carried out earlier, but the reports do not seem to have survived; in particular, Miss Litster's comments in 1941 show that she had carried out previous inspections.

expenditure of convents. 'Why should an inspection of Bessboro' extend to the receipts from your land or from charitable sources; or to the expenditure on yourselves, on the inmates, on the Chapel?'

18.68 It seems that the congregation had been asked to give the names of the women who were resident, their home address and their present address; this was for the purposes of the Children's Acts, that is, in relation to children at nurse (see Chapter 1). The bishop's response to this request was:

> I am sure that no Government would knowingly make a demand that would be opposed to Canon Law. In the case of illegitimate births, the name of the mother cannot be inserted even in the baptismal register without her consent, unless the event be public. In all private cases, whether the mother is rich or poor, the illegitimate mother has a right to her name and fame; and the fact of the birth cannot be published without her consent. So you must not give particulars of name and address in cases where the illegitimate birth is not public.

18.69 The bishop went on to say that it might be necessary for him to take this up with government but the Sisters were not to do anything that was contrary to canon law; 'it would be a distinct violation of Canon Law and of natural justice to publish the fact of a secret illegitimate birth, with the mother or father's name, without the permission of the mother and father.'

1941 inspection

18.70 The DLGPH report for 1940-41 recorded that, in the year ending 31 March 1941, 87 infants were born in or admitted to Bessborough and 38 infant deaths were notified for the same period.

18.71 In June 1941, Dr Florence Dillon of the DLGPH inspected Bessborough maternity hospital. There was a standard format for such inspections but there was also scope for the inspector to add comments. In this instance, Dr Dillon added a 'Special Report'.

18.72 Her report was critical of a number of aspects of the running of the maternity hospital including:

- Although it was 'a new and modern hospital', it was overcrowded and understaffed. It was approved for the accommodation of 26 women but

there were 31 resident there at the time of the inspection.[29] There were no 'qualified nurses' employed in the hospital but there were two registered midwives employed.[30] There were no domestic staff employed and the congregation relied on the residents to undertake duties relating to the running of the hospital. Cleanliness was duly observed in all parts of the hospital and members of staff appeared to be 'efficient and capable'. However, the inspector recommended that 'further assistance should be made available'; specifically, one maid was required.

- The Sister in charge of the maternity hospital did not have the necessary qualifications for supervising maternity work; the person in charge should be a qualified midwife.
- There were three baths and five toilets; this would have been adequate were it not for the fact that two toilets had been converted into storerooms and the sink room was used to store mattresses.
- The Maternity Register had not been written up since 1939; as a result, Dr Dillon was unable to get information about miscarriages and deaths in the maternity hospital.
- No register of confinement was kept.
- She was unable to satisfy herself that provision had been made for fire-fighting as the Sister in charge did not afford her proper facilities for inspection.
- There was apparently a tendency to discourage breastfeeding which might have had a bearing on the high infant mortality rate.
- She was treated with discourtesy; the Sister in charge, Sister Kyran, was 'discourteous and obstructive' and there was a general unwillingness to facilitate her in carrying out the statutory inspection.

18.73 The DLGPH subsequently asked Miss Litster to comment on Dr Dillon's report 'as she knows a good deal about this matter'.

18.74 In October 1941, Miss Litster outlined her knowledge of Bessborough and her experiences there. She explained that there were two separate buildings - the home and the hospital.

[29] A departmental note compiled in the 1950s records that the matron had told the department in 1934 that she needed to use single rooms as wards and needed to increase the numbers in the large wards.
[30] Qualified midwives were not necessarily qualified general nurses.

> The whole institution is pleasantly situated in well-matured grounds. There is a fair sized lake, good gardens and ample space for exercise and children's games. The Home is run with a fair degree of efficiency. The general atmosphere, so far as the treatment of the girls is concerned, is one of kindness. That the girls appreciate this, and show an appreciation for the institution, is shown by the presence of some former patients who live in the Home unpaid, apparently quite content to help in the general work. The food appears to be plentiful and good. The children are well-cared for: properly clothed and well-fed. The girls are employed at farm and garden work, butter making, knitting, kitchen and household work generally. A reasonably good training in domestic work appears to be given. The Mother Superior informs me that there is no difficulty in finding employment for discharged patients.

18.75 Miss Litster confirmed that the home was overcrowded and pointed out that this was a feature of all 'special institutions' at that time. She said that there was 'too little interaction' between women and their children in the home.

18.76 She was more critical of the maternity hospital. She said that the matron appeared to be efficient in the actual management of the hospital but 'it appears that there is not the same atmosphere of kindness here as in the Home':

> The Matron appears to be a 'hard' person and has been described by former patients as harsh, domineering and as 'a slave driver'. An inspector, however, is unlikely to see any direct evidence of this side of her character. It must be remembered though, that while under her supervision, these girls are not in a normal condition of body or mind, and it is possible that a certain degree of apparent callousness may be an [illegible], even a necessary characteristic... It is difficult for an outsider to form any definite conclusions to her suitability to be Matron of the Maternity Hospital. Dr Dillon says that she has no nursing qualifications, other than experience. That fact alone seems to decide the point, and as there are qualified nurses in the Order, there should be no difficulty in replacing her by one of those.

18.77 Miss Litster noted that there was a problem of record keeping in both the home and the maternity hospital. She said that, in order to assess the number of residents in the institution on any given visit, she was forced to visit each ward and count the number of occupied beds. Furthermore, the annual returns submitted to

the DLGPH by Bessborough were frequently returned for correction and 'the statistical record relating to the institution bore little resemblance to the facts'.

18.78 There were discussions going on within the DLGPH about the possibility of getting the congregation to replace the matron of the maternity hospital. Miss Litster recommended that the department might ask the Mother Superior of the Bessborough Home, Sister Martina, to place a qualified nurse in charge of the maternity hospital and then, if necessary, raise the matter directly with the Superior General of the congregation in Chigwell. Miss Litster had a letter from the Cork county medical officer of health, Dr Condy, outlining the matron's qualifications and experience. Dr Condy said that the matron did not have a Central Midwives Board (CMB) certificate,[31] or special experience in maternity work. She had 40 years' experience in general hospitals, for example, in London and Australia. He said that there was a lay nurse who did have a CMB certificate. He had been informed that this lay nurse conducted the deliveries under the supervision of the institutional medical officer, Dr O'Connor. This qualified midwife had been in Bessborough for ten years and was the only qualified midwife there.

18.79 In January 1942, the DLGPH wrote to Bessborough outlining the concerns that had been raised by Dr Dillon. In reply, the Mother Superior said that, while the hospital was licenced for 26 patients, there was plenty of room to accommodate the extra five patients and that the former local government inspector had given her permission for the extra beds when pressure for hospital accommodation arose.[32] She said that the maternity hospital had been supplied with a register 'recommended by the Medical Officer of Health' and that this was up to date at the time of inspection; the same applied to the register of confinements. Another register book had been provided but it was too complicated and was not being used. The Mother Superior excused the alleged discourtesy of the matron by saying that she was 'far from her usual health at the time of inspection and that any discourtesy felt was not intended'. The Mother Superior strongly disagreed with the assertion that breastfeeding was discouraged and advised that patients were induced to breastfeed 'even when they feel disinclined to do so'.

[31] At this time, the Central Midwives Board was responsible for certifying that a person was a qualified midwife.
[32] As described above, while the matron had told the DLGPH of her intentions, the Commission has not seen evidence that the department had agreed.

1942

18.80 The DLGPH remained concerned that the control of the maternity hospital was not adequate. In February 1942, the department again wrote to the Mother Superior seeking to have a qualified maternity nurse, subject to the control of the matron of the institution in administrative matters, put in charge of the maternity hospital. The Mother Superior said she would report the complaint of discourtesy by the matron to the Mother General but made no commitment to replace the matron with a qualified nurse. The congregational records show that the Mother General was not happy with the matron's performance and recognised that a 'change may be demanded'.[33] The DLGPH pressed the matter and was told by the Mother Superior of Bessborough that a member of the congregation who was a certified general nurse and was undertaking maternity training in the Cork county home and district hospital would be assigned to Bessborough maternity hospital in June of that year. In July, the DLGPH again wrote to find out if this had happened. It had not; the Sister in question had finished her training but had contracted flu and was unable to work. Miss Litster subsequently reported that this Sister had died. In October 1942, the Mother Superior reported to the department that another Sister was on her way from Chigwell to take up duty in the maternity hospital. However, on her next inspection visit to the institution (see below) Miss Litster noted that the maternity hospital continued to be administered by a matron with no nursing qualifications.

1943

18.81 In June 1943, Miss Litster inspected both the home and the maternity hospital. At the time of the inspection, there were 61 women (36 with babies and 25 waiting to give birth) and 97 children living in the institution. Of the unaccompanied children, 26 were maintained by public assistance authorities, mainly Waterford and North Cork boards of assistance. The rest were 'private motherless children'.

18.82 There were 18 former patients, still living in Bessborough, who were not maintained by a local authority. Nine of these were women whose children were either boarded out or placed at nurse and who were actively seeking paid employment. The remaining nine women were former patients not maintained by a local authority who undertook unpaid work for their keep in the institution and were

[33] Congregation of the Sacred Hearts, Annals of the Order, 10 March 1942.

known as 'old girls'. Miss Litster suggested that these women should be omitted from the annual statistical returns relating to unmarried mothers.

18.83 Miss Litster's report provides a detailed description of Bessborough in 1943. The children's accommodation in the home was as follows:

- A night nursery which was 'clean, airy, bright with ample clothing on cots' housed 15 toddlers and 22 babies;
- A day nursery and playroom with 'ample bath and lavatory accommodation', contained some cots for children taking a mid-day sleep. The day nursery housed 27 infants aged between three weeks and nine months; only eight of the 27 infants were breastfed and only three were 'fully breast-fed'. The greater numbers of the babies were 'miserable scraps of humanity, wizened, some emaciated and almost all had rash and sores all over their bodies, faces, hands and heads'. Their cots 'were clean, and bed-clothing clean and good'.
- The infirmary housed 17 cots: four were occupied by babies covered with rash and sores and one other child with bronchitis. An attendant, who was a resident, stayed up all night to tend to the babies.
- The day nursery housed 33 toddlers and babies many of whom had sores on legs, faces, hands or scalps.

18.84 The condition of the infants and younger children in the institution gave her 'cause for uneasiness'. In the year ending 31 March 1943, 114 children were admitted to Bessborough and 70 had died. All but one of the 70 deaths occurred in infants under one year old. Miss Litster identified the unsatisfactory milk supply to the home and the failure to breastfeed as the main causes of the high death rate and the unhealthy condition of the children. She said that the cows that supplied milk to Bessborough were not tuberculin tested and that the milk produced was not subject to the same standards governing the general milk supply. The number of infants who were wholly breastfed after leaving the maternity hospital was 'negligible'. Miss Litster questioned if the failure to breastfeed was due to incapacity on the mothers' part and if this might be related to an inadequacy in their diet. On the day of the inspection, which she noted was 'a fast day', the dinner served in the home consisted of potatoes, cabbage, cheese, tea, bread and

butter. Tea consisted of bread, butter, lettuce, scallions and tea. Breakfast was tea, bread and butter.[34]

18.85 Miss Litster reported that the 30 older children living in the home were much healthier in appearance than the younger ones: 'all were fairly strong and well-developed'. Although a number of children of school going age were living there, there was no provision for their education. She cautioned the Mother Superior that the retention of children aged six years and over in the home, without making provision for their education, contravened the *School Attendance Act 1926*.[35] The Mother Superior said that the local authorities responsible for maintaining these children 'were slow in obtaining foster homes for them' and that children were routinely maintained in Bessborough 'long beyond the age of two years'. Miss Litster observed:

> It was not intended that these institutions should be utilised as a nursery for children apart from their mothers. I have from time to time notified the different local authorities maintaining children in Bessborough that children must not be kept beyond the age of two years without their mothers.

18.86 Miss Litster recommended that the DLGPH issue a circular letter to county managers asking that an effort be made to withdraw children over the age of two years to suitable foster homes and stating that 'sanction will not be continued for payments for maintenance of children over the age of two years'.

18.87 The women's accommodation in the home was as follows:

- Dormitory 1 had 24 beds all of which were occupied; it was clean and airy; the beds were good; a nun slept at each end of the dormitory.
- Dormitory 2 had 12 beds but 16 occupants. The beds were good but there were no chairs between them and clothes had to be left on the beds.
- Dormitory 3 had 28 beds, all occupied; two nuns slept in cubicles at each end.
- The infirmary had four unoccupied beds.

18.88 Miss Litster inspected all six wards in the maternity hospital. Two wards were retained for private patients and there was one patient in each. An isolation ward was unoccupied. One ward with eight beds was fully occupied. There were seven

[34] Fast days were days on which Catholics were expected to eat only one main meal and two collations.
[35] http://www.irishstatutebook.ie/eli/1926/act/17/enacted/en/print

babies, five of whom were being breastfed. The two remaining wards, reserved for expectant women only, were overcrowded. They were each designed to accommodate eight beds but had 14 beds and 13 beds respectively. All were occupied. On the day of inspection, dinner in the hospital consisted of potatoes, cabbage, egg (baked), stewed rhubarb and coffee.

18.89 Following her inspection, Miss Litster met the Cork county manager to discuss her findings and to request that the county medical officer of health, Dr Condy, would undertake an investigation into the condition of the children in Bessborough and the high death rate among infants there. Miss Litster submitted her report, along with a list of infant deaths during the year ending 31 March 1943, to the DLGPH and asked that the information be given to the deputy chief medical advisor, Dr Sterling Berry. The DLGPH sent extracts from Miss Litster's report to the Mother Superior in Bessborough and asked for her observations and those of the medical attendant of the institution.

18.90 In August 1943, Dr Sterling Berry made the following observations on Miss Litster's report:

> This report discloses a very unsatisfactory state of affairs particularly with regard to infants under one year old. That 60% of these children die would seem to show that very little steps are taken to keep them alive; this is borne out by the fact that the babies still alive are covered with sores. That only three babies are fully breast-fed indicates that absolutely no trouble is taken to induce the mothers to breast-feed. Milk and gruel should be added to the nursing mothers' diet. The over-crowding of the waiting patients in the Maternity Hospital is most undesirable and should be stopped. The Matron of the Maternity Hospital should be a trained nurse. The keeping of children in the institution until school going age is definitely wrong.

18.91 Dr Sterling Berry also voiced his concern that the capitation rates paid to Bessborough by local authorities 'were too low with the prevailing prices' and enquired whether Bessborough had a visiting medical officer. A note to the assistant secretary of the DLGPH said that Bessborough did have a medical officer but also noted that formerly the local authority contributed towards the salary of a medical officer and a nurse for the institution but that this arrangement had been discontinued in 1937.

18.92 In September 1943, the Cork county manager sent the DLGPH a report on infant mortality at Bessborough, undertaken initially by the assistant county medical officer and subsequently by Dr Condy. This reported:

> I investigated this Home and figures obtained were: Deaths-68% (Sixty Eight) of the births. Diagnosis in most of these cases was debility; some were given as gastro enteritis and a small number as prematurity. Most of the deaths were from 2-3 weeks to 3 months. This is the period they leave the Maternity Hospital for the Home. The Sister in charge of this Home has no nursing qualifications and no hospital training in infants and children apart from two months in Temple Street Hospital, Dublin. This may or may not be the cause but I suggest that a qualified nurse and specially qualified in infant feeding should be appointed for 6-12 months. This figure could then be compared with the previous term.

18.93 Dr Condy said that he had visited the home, examined all books and registers and inspected the milk supply. He said that milk at the institution was produced and handled under high standards. He said that between March 1942 and July 1943, 32 infant deaths had occurred.[36] He reported that approximately 80% of these deaths were certified as being due to debility and had occurred in the neo-natal period. He observed that this was the most dangerous stage of a child's life and that the prevention of deaths in infants born in a state of debility or prematurity required skilled medical and nursing attention and that the matron had little success in inducing mothers to breast-feed. In addition, he said:

> All births in the institution are of an illegitimate character, and there is frequently a lack of interest in the child's welfare on the part of the mother concerned.

18.94 He concluded by recommending the provision of a nurse 'possessing adequate training in Infant Welfare and Hygiene' for the care of infants in the neo-natal stage and intimated that the matron and medical officer agreed with this suggestion. As Dr Sterling Berry noted, Dr Condy's report simply corroborated Miss Litster's. However, they did differ about the quality of the milk.

18.95 In September 1943, the Mother Superior, Sister Martina, responded to Miss Litster's findings. She said that the rash and sores, as witnessed by Miss Litster,

[36] This number is more likely to have been between March 1943 and July 1943.

were contagion from a new admission and that 'our doctors are very puzzled and do not understand the cause'. She stated that they were doing their best to induce mothers to breastfeed. She lamented that boards of public assistance found it difficult to find foster homes for children under war conditions. She advised that numbers in Bessborough had fallen dramatically since the inspection. She stated that pregnant and nursing mothers had 'plenty of rest, copious fluids and a good nourishing diet' but were inclined to be 'fretful' and have 'no love for their infants'. She did not address the high levels of infant mortality. A note at the foot of this letter, from the secretary of the DLGPH, to the minister read:

> The replies are not satisfactory. I would like a strong letter drafted. They must get the children out and they must have a Matron with a C.M.B.

18.96 The department wrote to Sister Martina to say that her replies were inadequate and that 'the exceedingly high death rate in the institution and the very poor health of the children are very disquieting'. The department instructed her to furnish lists of children eligible for boarding out to local authorities responsible for their maintenance without delay and again requested an undertaking that a nurse with midwifery qualifications would be placed in charge of the maternity hospital.

18.97 In October 1943, the DLGPH wrote to county managers, whose boards of assistance maintained children in Bessborough (Cork (North, South and West), Kerry, Kildare, Kilkenny, Leitrim, Monaghan, Tipperary (North), Waterford and Westmeath) telling them that the Mother Superior would furnish them with a list of children eligible for boarding out and directing them to expedite arrangements to find suitable foster homes for each child. County managers were advised to inform the department of any delay in getting the list of children. In November 1943, the South Cork board agreed to implement the minister's direction that children would not be maintained in Bessborough when they reach two years and would be boarded out as soon as suitable foster parents were secured. The DLGPH found that some boards were selective in their efforts to find foster parents for children maintained in Bessborough: little consideration was given to older children, or to children with a mental or physical disability. A later inspection by Miss Litster in December 1944 (see below), found that Waterford county council had not found foster homes for eight children, aged between four and eight years, maintained by them in the institution. Similarly, the North Cork board had not found foster homes for eleven children, aged between four and six years. Children maintained by

Kildare and Kilkenny county councils, and eligible for boarding out, also remained in the institution.

18.98 In November 1943, Dr Dillon again inspected the maternity hospital. On this occasion, the matron was a registered nurse and the maternity register and associated books were up to date. She considered that it was adequately staffed - there were two qualified nurses, one midwife and two wards maids employed. The available accommodation was limited to 26 beds, spread over three wards and two private rooms. The bathing and sanitary accommodation was 'adequate'. There were 106 admissions, 24 infant deaths and three stillbirths recorded since the date of last inspection. There was no heating in the hospital at the time of her visit. It transpired that the institution's wartime oil allowance meant that the heating system could be run only intermittently.

18.99 In December 1943, a firm of accountants replied to the DLGPH's September 1943 letter on behalf of their clients, the Congregation of the Sacred Hearts of Jesus and Mary. The accountants' letter confirmed that lists of children eligible for boarding out had been circulated to the relevant boards and that this had been done on many previous occasions but with little effect. They said that a qualified nurse, Sister Redempta, had become the matron of the maternity hospital in September 1942[37] and that she was assisted by a qualified midwife. Another qualified midwife was about to take up duty and the congregation was prepared to hire another external midwife if the department thought it necessary to do so. The letter dealt with infant mortality as follows:

> As to mortality, the Community regrets the high death rate and has taken every precaution in this respect. The Rev. Mother desires to point out that the children at one period suffered from an epidemic of scabies through infection, and at that time the children did in fact look rather emaciated while the epidemic prevailed. It should be noted with satisfaction that the Institution of Besboro' since its inception has never had an epidemic of measles or other contagious diseases other than the scabies referred to. The mortality rate among infants is not peculiar to Besboro' as indicated by the many Press references to this subject. We have the temerity to refer to a press cutting from the Irish Times dated 4th September last. The Community wish to assure

[37] This must be September 1943 as both Miss Litster and Dr Condy noted that the matron was not a qualified nurse in June–August 1943 and Dr Dillon noted that the matron was a qualified nurse in November 1943.

you that this problem is their primary concern and that they share the Minister's anxiety in this connection.

18.100 The *Irish Times* article in question, **'Irish Doctors Baffled'**, related to 241 deaths among Dublin infants between January and September 1943 and stated that Irish doctors were baffled in the search for the bacterial cause of the deaths. The City of Dublin chief medical officer was quoted as saying **that the infant deaths 'were** caused by diarrhoea and enteritis, which in a very serious form, has been attacking children. **The highest mortality is among children under three months'.** The medical officer said that 24 children under two years had died in Dublin in one week alone. He said that no specific bacterial cause had been discovered and advised that the best way to combat the diseases was for mothers to breastfeed their infants.[38]

18.101 The letter from the accountants also included a report on deaths in the Bessborough maternity hospital, March 1942-March 1943 by the visiting medical officer to Bessborough, Dr O'Connor:

> In the Maternity Hospital, two adults died during the above period, one from Puerperal Eclampsia, and one from Purpura and Intestinal Haemorrhage.
>
> The infant deaths were made up of 4 twins born prematurely and in a weak condition. One lived three days and the other lived between two and three weeks. The others were born in a completely weak condition and lived between two and four weeks. One died of Bronchitis when a month old, and one died of Catarrhal jaundice.
>
> The older children who died in the Nursery during the same period, the principal causes of death were Gastro Enteritis, Congenital Venereal Disease and Marasmus. In this latter condition no matter what feeding or medical treatment was given they did not thrive. This is not due to insufficient or defective food, as the most scrupulous attention is paid to the diet, and in every case, unless there is some indication to the contrary, breast feeding is insisted on.
>
> To the children who are artificially fed the milk given is of the best quality. This fact has been established by analysis made by the Veterinary Surgeon attached to the Department of Health of Cork Corporation. It was found on examination to be free of Tubercle Bacilli and to contain a high percentage of

[38] *Irish Times*, 4 September 1943.

fat. This is given suitably adulterated according to age, and every precaution is taken to render it suitable for the infant. Besides milk, various other kinds of food were used, such as Chicken broth, meat juice, Benger's Food, Extract of Malt, cream, Halibut Oil, Cod-Liver Oil and Sister Laura's Food. In spite of this selection some of the children lost weight and died.

An explanation of this is that some children show a remarkable difficulty in digesting food, and this is due to a primary failure of the processes of assimilation, whether for a particular food, or for food in general; even in some cases where the child is breast-fed, they do not assimilate the nourishment of the milk. This is probably more remarkable in illegitimate children.

It must be remembered that the period of gestation of these children is far different to that of the married woman. The girl worries a great deal and is mentally upset over her condition. She is constantly trying to conceal the fact that she is pregnant, and in some cases every effort is made to get rid of the foetus. All this has undoubtedly a most injurious effect on the developing foetus resulting in weak and defective children who have a poor resistance to diseases, and defective powers for assimilating food.

Other causes of death were congenital venereal disease. In numbers of these cases, in spite of treatment, severe marasmus results, caused probably by gross changes in the mucus membrane of the intestine which prevents absorption of food.

Gastro-enteritis caused some deaths. This is a disease common in infants in late Summer and early Autumn, occurring in epidemics and is sometimes very fatal. Considering the number of children in the Nursery the number of deaths was small from this particular affliction.

1944

18.102 Even though all the relevant authorities - the Congregation of the Sacred Hearts of Jesus and Mary, the Cork county manager, the Cork board of assistance and the DLGPH - were aware of the high infant mortality rate in Bessborough, no concrete steps were taken to address it. In April 1944, the congregation notified the DLGPH that 102 infant deaths occurred during the period 1 April 1943 to 31 March 1944. The vast majority, 96%, were infants less than four months old. The main causes of death were certified as marasmus, prematurity, bronchitis and gastro-enteritis.

18.103 In December 1944, Miss Litster again inspected Bessborough. She examined admission and discharge books 'to establish the exact mortality rate among infants

born and admitted to the Institution'. At the time of inspection, 108 women (including 21 expectant women) and 96 children were housed there. The day and night nurseries housed 21 infants aged between three and seven months and were:

> a stronger and healthier lot of babies than when I last visited the nursery. On the other hand, they represent, it would appear from the mortality figures, the survival of the fittest. Few were fully breast-fed; the greater number were partially breast-fed, with supplementary feeds of milk and water. Only three of the 21 were definitely emaciated and sickly in appearance. This nursery was unheated.

18.104 The day nursery also housed 24 older children aged from seven months to two years old. It was also unheated.

> Eleven babies were in cots. Of these eight appeared to be healthy, normal children. One was not thriving and appeared to be delicate, and one seemed to be a mentally defective child. The remaining 13 children were sitting or crawling about the floor. Some of the children wore socks, some were in bare feet. Most appear to be healthy and thriving.

18.105 The day room housed a further 30 children, all over two years old. One boy maintained by Kildare county council was six-and-a-half-years old. Eight children were chargeable to Waterford county council, 11 to the North Cork board and one child was chargeable to Kilkenny county council. Of the 30 children housed here, 21 had spent between four and six years in Bessborough. They did not go out to school and received no education in the institution. All 30 children became eligible for boarding out when they reached two years old and, despite a ministerial directive to do so, the local authorities responsible for their maintenance were either unable, or unwilling, to find suitable foster homes for them.

> These children appeared on the whole to be healthy, vigorous and thriving, and all, except two, seemed to be of normal mentality. These two are evidently mental defectives and should be sent to an institution for mentally defective children.

18.106 The nursery in the maternity hospital housed ten infants aged from new-born to about two months. Six were breastfed and the other four 'appeared to be unhealthy and wasted'. The room was airy and bright but had no heating. In a small, heated room on the upper floors there were three sick infants and in another

there were eight babies aged from two to 11 months in cots. These eight babies had been sent from the maternity hospital to the home but were returned to the hospital for extra care due to delicacy. Miss Litster noted that these children appeared to be healthy enough to return to the home. She recommended that the Bessborough authorities should make provision for nursing and proper care of delicate babies as she found it objectionable that the maternity hospital should be used as a hospital for sick babies.

18.107 Miss Litster checked the infant mortality figures provided to the DLGPH and 'verified that their accuracy can be vouched for'. During the year ending 31 March 1944, 105 infants were born in Bessborough and a further 19 were admitted after birth: a total of 124 admissions. During the same period, 102 deaths among infants under 12 months old were recorded. Miss Litster calculated that this represented a death rate of 82%.

18.108 The infant deaths recorded here did not relate solely to infants admitted during the year under review. Many of these deaths related to infants who were born or admitted before April 1943. The institutional records show that, of the 124 infant births and admissions recorded by Miss Litster, 82 subsequently died. Miss Litster checked the records from 1 April 1944 to the date of her visit on 6 December 1944 and found that 65 infants had been born in Bessborough during this period. Of these, 41 infants (63%) had already died.

18.109 Miss Litster noted that Bessborough differed from other 'special homes' because of the number of private fee-paying patients admitted there. Of the 124 infants born or admitted during the year ending 31 March 1944, 40 were private patients. Of the 102 deaths recorded during the same period, 35 were babies born to private patients. Miss Litster calculated that the infant mortality rate among private patients in Bessborough was in the region of 87%. She suggested that one reason for the higher death rate among infants of private patients was the fact that the mothers were frequently allowed to leave Bessborough a short time after their confinement. Their infants were left in the institution unaccompanied awaiting placement by the Catholic Women's Aid Society.

18.110 Miss Litster reported that the Bessborough authorities took no precautions to guard against the admission of women suffering from venereal disease and did not isolate women and children entering the institution but admitted them directly to the

hospital. She said that the DLGPH had full rights of inspection and control over the Bessborough maternity hospital but had no rights of inspection over the Bessborough home, where she stated 'it is here and not the Maternity Hospital that the majority of the babies die'. While this is correct, at least 25% of infant deaths recorded occurred in the hospital.

18.111 Miss Litster noted that the only 'real control' the DLGPH had over the Bessborough home was the power to prohibit local authorities from maintaining patients there and pointed out that the department had taken such action in relation to Castlepollard in 1941 due to 'the serious state of overcrowding there' (see Chapter 20). She recommended that Bessborough should be closed for new admissions for at least three months, that the Mother Superior should be required to furnish returns of infant deaths on a weekly basis and that a survey of the institution should be undertaken to determine the appropriate number of patients who should be maintained there. If it were closed for new admissions, women would have to be sent to the county homes as Castlepollard, Sean Ross, Tuam and Pelletstown were already at full capacity.

18.112 Cork county council and the South Cork board of public assistance were fully aware of the problem of infant mortality in Bessborough. The South Cork board was responsible for the majority of infants housed in Bessborough. It was notified of every discharge and every infant death.

18.113 In September 1944, the North Cork board of assistance directed the superintendent assistance officer (see Chapter 1) to remove all unmarried mothers and their children from the North Cork county home and hospital, Fermoy. No specific reason was given for this move and the board stated that they would grant the women 'appropriate home assistance allowances' as a substitute for institutional care. However, in May 1945, the North Cork board discovered that all 14 women discharged from Fermoy were living with their children in Bessborough. It is not clear who was paying for them. The superintendent assistance officer interviewed the women separately and explained to them that the board was prepared to grant them adequate home assistance to maintain themselves and their children in their respective districts. However, all the women said that they had nowhere to go, that they had been 'turned out of their homes' by their families and 'told not to return again'. The women were told that, if they did not accept the manager's order, their children would be boarded out and they would be compelled

to leave Bessborough. However, the superintendent assistance officer conceded that the women and their children 'were well-attended' to in Bessborough and had no desire to leave.

1945

18.114 It is clear that, by January 1945, in spite of all concerned having full knowledge of the extraordinarily high infant mortality rate in Bessborough, no serious steps had been taken by either the Congregation of the Sacred Hearts of Jesus and Mary, the South Cork board of public assistance or the DLGPH to address the problem.

18.115 The various suggestions made by inspectors and medical officers were not implemented. Attempts were made to have the older children boarded out but this, while it would have reduced the overcrowding, would not have made any difference to the infant mortality rate because children were not boarded out before the age of two. In January 1945, Dr Ward, Parliamentary Secretary, DLGPH, tried again to encourage more boarding out. He appealed to county managers to arrange suitable foster homes for children maintained by their boards of assistance in Bessborough. However, the replies from county managers made it clear that continuing efforts were being made to find foster parents but there were very few people willing to take boarded out children. The main reason given was that the maintenance rates were too low. In addition, rationing, the increased cost and diminished availability of food, fuel, clothes and household items, and wartime conditions in general, had acted as a major disincentive to those who might otherwise have considered fostering a child. Although the Cork maintenance and clothing allowances had increased year on year since 1941, and stood at 10s a week for each child in 1945, they were still considered to be inadequate and failed to elicit a response. The DLGPH granted increases in the boarding out allowance, 'particularly in areas where the allowances were rather low' with a view to attracting a sufficient number of suitable foster parents. The Cork public assistance authorities resolved to increase maintenance and clothing rates further from April 1945 and advertised for foster parents at the increased rates. The advertisement, 'Foster Parents Required', invited applications from suitable persons to act as foster parents to children aged two to seven years with a maintenance rate of £1 10s a month and an annual clothing allowance of £4 10s a year. The response to the advertisement was reportedly 'poor'.[39] In June 1945,

[39] *Cork Examiner*, 7 June 1945.

further advertisements were placed in the *Cork Examiner* for five children specifically. Two replies were received: assistance officers found one applicant to be 'unsuitable'. Further advertisements placed in the *Youghal Tribune* and the *Southern Star*, publications with more rural readerships, elicited 16 replies. Although some applications came from districts outside the South Cork board's functional area, application forms were sent to prospective foster parents and assistance officers were directed to inspect their homes.

18.116 More direct action was finally taken by the DLGPH in January 1945. Dr Ward decided to implement Miss Litster's recommendation to close the institution to new patients for a period and directed county managers to send expectant women to county homes 'pending a decision on future policy'.[40] This instruction was issued to the relevant health authorities on 10 January 1945. Women admitted to Bessborough, whose applications had not been processed before the direction to close the home to new admissions, were transferred to Cork county home. The DLGPH sent a copy of Miss Litster's December 1944 report to the Cork county medical officer of health, Dr Condy, and requested that he:

- would, in future, investigate the circumstances surrounding every infant death at Bessborough;
- get information about arrangements for medical attendance at the home, including the hours of duty of the medical officer and his terms of employment;
- get weekly returns for the following three months showing infant deaths at Bessborough and the medically certified cause of death in each case.

18.117 In reply, Dr Condy agreed to investigate all future infant deaths at Bessborough.[41] He also provided an overview of the role of Bessborough's medical officer. The Bessborough medical officer had been the institutional medical officer since 1922; he had no fixed hours of attendance and visited twice weekly on average and when called on to deal with an emergency. There was no written agreement about his conditions of service and his annual fee of £120 was paid by the Congregation of the Sacred Hearts since 1937. He did not see every infant on his routine visits and proper medical records such as weight records were not kept for each child.

[40] Dr Ward considered that the policy of keeping mothers for long periods was unsound and wanted children to be boarded out at the earliest possible moment. The Commission has not seen any evidence that he made efforts to have this policy pursued.

[41] The Commission has not seen any evidence that he did do this.

Dr Condy brought this to the attention of the Mother Superior and the Bessborough medical officer and recommended that the Bessborough medical officer should undertake daily visits to the institution as a minimum requirement. Dr Condy also recommended that each patient should be subject to a Wasserman test on admission.

18.118 Dr Ward, the Parliamentary Secretary at the DLGPH, considered that the medical supervision of children in Bessborough, as reported by Dr Condy, was 'criminally casual' and directed Dr James Deeny, the recently appointed chief medical advisor to the department, to inspect children living in the home. On 6 January 1945, Dr Deeny, accompanied by another DLGPH doctor and by Dr Condy visited Bessborough. Dr Deeny reported:

> I inspected Maternity Hospital Block of the Home and found the Institution to be well-maintained and perfectly equipped and seemingly suitably staffed for its present Maternity work. Further inspection of the part of the special home devoted to the children under the care of the order revealed a similar state of affairs. In fact, the whole place was fresh and spotlessly clean. Special inspection of rooms reserved for milk storage and formula preparation also showed cleanliness etc. Owing to the appalling infant mortality I stripped and examined almost all infants in the home and as a result discovered certain facts.
>
> (1) The vast majority of the infants had excoriated buttocks and were grossly inflamed, obviously the result of neglect to change napkins sufficiently.
>
> (2) Most of the napkins were soiled and motions found were almost always green - indicating unsuitable feeding, insufficient feeding or bowel infection.
>
> (3) Most of the children revealed a number of infectious lesions. For instance, the slightest scratch seemed to become infected and turn septic. Many babies apart from the raw buttocks showed numbers of septic sores. This in my opinion is due to a heavy infection of the home with some organism which is transmitted from child to child.
>
> (4) The Rev. Mother was completely unaware of this state of affairs. The clean counterpanes of the sheets etc., satisfied her - she had little or no knowledge of what was hidden below.

(5) The situation revealed gross ignorance on the part of the Sister responsible. No person with even a smattering of knowledge of child health would allow such a state of affairs to continue.

(6) No attempt has been made to help the mothers in the care of their children or if such an attempt has been made the results prove that it was a lamentable failure.

(7) Medical attention must be of a most superficial nature. In this respect I regard the M.O. of the home as distinctly culpable. In view of the death rate he must have known that something was wrong with the care the children were receiving and if he did, he should then have sought the cause which on a simple examination was immediately revealed. There is no doubt that in this case - and in view of the hundreds of children whose lives have been lost - his complacency or ignorance should be regarded as criminal. I am convinced that a continuation of his services would be detrimental to the home and that he should be dismissed.

(8) The Reverend Mother should be replaced with someone with ability to administer an institution dealing with Maternity and the care of infants and children.

(9) The nun in charge of the infant's Dept is both stupid and ignorant. The state of the children under her care is so terrible that they fail to lessen queries of child neglect. She, above all others, must be held primarily responsible for the hundreds and hundreds of babies under her charge who have died in the last few years. She should be removed from her post immediately. I recommend the employment of two nuns or nurses who have training in children's nursing to try to bring up the children to a normal level of health and get rid of the infection.

(10) Dr Condy must keep a close eye on the institution and investigate all deaths, which must be reported to him immediately.

(11) Letter to Superior General as arranged with minor modifications suggested and enclosing excerpts from Miss Litster's report.

18.119 Dr Ward decided that the issues highlighted by Dr Deeny required 'drastic action, and sustained effort' to remedy. He considered that 'interference from an outside agency would not have any lasting effect' and that reform should come from within the institution itself. In January 1945, he wrote to the Superior General of the Congregation of the Sacred Hearts in Chigwell. He said that the very high infant

death rate at Bessborough and the staffing of the institution had been under review by the DLGPH for a number of years and that 'the failure of the authorities at Bessborough to deal with both issues had been very pronounced'. He repeated the department's request for the appointment of a new Mother Superior, qualified in midwifery and child care, and said that local authorities had been instructed not to send any further unmarried mothers and expectant women to Bessborough until acceptable management and staffing arrangements were put in place there.

18.120 The Superior General replied expressing her shock on reading Miss Litster's report and stating that she would have implemented any necessary improvements at Bessborough if the DLGPH had asked her to do so. She said that she understood that the existing Mother Superior was still quite capable of running Bessborough. However, she accepted that the facts presented in the report were 'all too serious' and gave an undertaking to make whatever changes the DLGPH thought necessary.

> I shall make the necessary change as soon as possible and trust that in the very near future the past failures shall be corrected and the complete management of the Home shall reach your expectations.
>
> I am distressed that you should have cause to be alarmed with the present state of the Home, I beg you to have patience with us, we shall endeavour to re-organize as quickly as possible.

18.121 In a follow-up letter, she told the minister that she proposed to transfer Mother Rosemonde McCarthy, the Mother Superior of Sean Ross, to Bessborough as a replacement. Miss Litster considered Mother Rosemonde to be of 'outstanding character and unquestionable ability' but worried that her removal from Sean Ross, even temporarily, would be detrimental to that institution. However, Dr Ward welcomed the proposal and asked to be informed when she took up her position at Bessborough.

18.122 In February 1945, Bishop Cohalan wrote to the DLGPH to complain about the department's role in the removal of the Mother Superior from Bessborough. He argued that this was an ecclesiastical appointment over which the DLGPH had no jurisdiction. Separately and without informing the DLGPH, he asked the Apostolic Nuncio to Ireland to intervene in the matter and to insist that the Mother Superior

be kept in office.[42] However, the Department of Foreign Affairs subsequently advised the Taoiseach, who was also the Minister for Foreign Affairs, that the Papal Nuncio was satisfied that the Mother Superior 'was gravely at fault' and should be transferred elsewhere.[43]

18.123 Having made his ecclesiastical point, the bishop conceded that he shared the department's concern in relation to infant mortality at Bessborough and that the vital matter was to find 'the cause of the evil and the best remedy'. The bishop discussed the issue with the Mother Superior and with a doctor from the Cork District Hospital and acknowledged that 'the seriousness of the problem is realised'. He recommended that a young doctor, a specialist in gynaecology, might be well placed to remedy the cause of infant mortality at Bessborough. In reply to the bishop in March 1945, the DLGPH assured him that the ecclesiastic status of the Mother Superior was not questioned but that her position as matron in an institution where unacceptable levels of infant mortality prevailed could not be tolerated. The letter stated that 'apart from any public scandal which might result' Dr Ward felt that the case called for immediate action to remove her from her post as to allow her to continue as matron would have meant 'acquiescence on his part in the state of affairs which has been disclosed'.

18.124 Despite the Superior General's undertaking to remove the matron, she wrote to the DLGPH again in February 1945 seeking to delay the move until the war ended and to allow the congregation time to arrange their elections so that all superiors would be changed in the normal way. Dr Ward reminded her of the high infant mortality rates which prevailed at Bessborough under the matron's watch and advised that delays or objections to her removal, based on the internal arrangements of the congregation, would not be entertained. He again pressed the point that, unless the administrative changes already agreed were implemented, the department would be forced to reconsider the viability of sending expectant women and unmarried mothers to Sacred Hearts' institutions.

18.125 In March 1945, the Mother Superior told the DLGPH that the Sister in charge of the infants department was giving special attention to the issues raised by Dr Deeny and that she had employed a new medical officer, Dr Sutton, who was a 'specialist

[42] NAI, DFA10/P99

[43] NAI, DFA10/P99; In his memoir, *To Cure and To Care*, Dr Deeny incorrectly identifies the bishop of Cork as Dr Lucey. Dr Cohalan was the bishop from 1916 to 1952 when he was succeeded by Dr Lucey.

in maternity work and children'. She suggested that the department send Dr Deeny to undertake a further inspection of the home 'to ascertain whether the supervision and care of the infants in operation meet with his approval'. In March 1945, Dr Sutton, wrote to Dr Deeny to tell him that he had been appointed medical officer to Bessborough and that after several visits to the institution 'I just don't know where to begin or end'. He indicated that many changes and improvements were needed but claimed to have no jurisdiction over some of them. He asked Dr Deeny to come to Cork to discuss the matter. Dr Deeny replied that he would not be in a position to travel to Cork 'for some time' and forwarded a copy of his January 1945 report to Dr Sutton so that he may 'get to work right away to clean up the place'.

18.126 Dr Ward and the DLGPH were under the impression that Bessborough had been closed to new entrants since 14 January 1945. However, in early March, they became aware that expectant women and babies were still being admitted there. When Dr Condy was asked to explain the situation he said that he had never been advised to refuse admissions. It appears that, although Bessborough had stopped admitting patients maintained by boards of assistance in January 1945, they had continued to admit private fee-paying patients. Furthermore, a number of expectant women in the Bessborough maternity hospital at the time of its closure to new admissions subsequently gave birth there and their infants were transferred to the Bessborough home. The DLGPH did not follow up on this matter until August 1945 when the deputy chief medical advisor wrote to Dr Condy requesting information on the number of private patients in Bessborough, the number of infants born there since the institution 'closed down' and the number of infant deaths which occurred since.[44] He replied that there were 25 private patients in Bessborough and that 39 infants had been born there from the time of its 'closure' on 14 January 1945 to 20 July 1945. He then stated, without comment, that of the 39 infant births recorded in this period, 29 had already died. In this six month period the infants department at Bessborough was under the control of a newly appointed qualified nurse, the institution itself was served by a new medical officer, a specialist in maternity and infant care, and infant deaths at Bessborough were supposed to be under close scrutiny by him. Yet, infant mortality appeared to have continued at a very high rate.

[44] Dr Condy had said in January 1945 that he would investigate every infant death in Bessborough. There is no documentary evidence that he did and, if he did, there is no evidence that he sent the results to the DLGPH.

18.127 Dr Deeny telephoned Dr Condy and asked him to submit a report outlining the conditions responsible for the recent deaths at Bessborough. He also suggested that the matter should be reported to the Cork county manager and he should be advised to withdraw the maternity hospital's licence under the *Registration of Maternity Homes Act 1934*. Dr Deeny noted that events in Bessborough had left Dr Condy in 'an embarrassing position'.

18.128 Dr Condy's initial report on infant deaths during the period January to July 1945 suggested that the 29 recorded deaths (25 in the home, four in the maternity hospital) occurred among the 39 infants born during the same period. However, subsequent analysis showed that of the 39 infants born during this period, 15 had subsequently died; the remaining 14 deaths occurred among infants born before 14 January 1945. All 15 infants who were born and subsequently died in the period January to July 1945 were unaccompanied infants born to private fee-paying patients.

18.129 Dr Condy noted that the majority of these infant deaths were of 'a preventable nature' and that both he and Dr Sutton were of the opinion that the nursing staff at Bessborough was still inadequate and did not have adequate training and qualifications to care for infants. He said that the Mother Superior, who was also the matron, was not a trained nurse and was almost entirely occupied with the administrative control of the institution and attached farm and appeared to have 'little touch with the medical aspect of the Home'. He indicated that a new Mother Superior was due to take up her duties at Bessborough in September and asked Dr Deeny if he would liaise with him, Dr Sutton and the Bessborough authorities to discuss steps which should be undertaken to improve conditions in the home. Dr Condy did not address the question of deregistration of the maternity hospital.

18.130 In September 1945, the Superior General of the congregation wrote to the DLGPH to advise that Sister Rosemonde had replaced Sister Martina as matron to Bessborough. She expressed her wishes that in a very short time, Bessborough would be in a satisfactory state. The department decided to give Sister Rosemonde 'a chance to pull Bessboro together' before pressing for a withdrawal of the maternity hospital licence.

18.131 In October 1945, Dr Deeny inspected the home and the maternity hospital. He noted that infants were still afflicted with a 'chronic skin infection'. He

recommended greater division of the nurseries and separate clothing for each child. He reported that Sister Rosemonde was anxious to satisfy his requests in all aspects of the running of the home and had requested that no new residents be admitted until she was satisfied that everything was in order. Sister Rosemonde stated that she would not admit any private patients until the ban on new admissions was lifted. It was agreed that an additional three trained nurses were required in order to run the home efficiently. The congregation had 'several nuns training as nurses' and Sister Rosemonde gave an undertaking to employ temporary nursing staff until she was in a position to recruit nursing staff from within the congregation. Sister Rosemonde asked for Dr Deeny's assistance in two matters. The first was the institution's oil fuel ration which had been reduced from 840 gallons to 65 gallons a month due to wartime conditions and was not enough to heat the home and the hospital adequately. The second matter of concern was the longstanding problem of finding boarded out places for older children. There were 40 older unaccompanied children in the home despite repeated requests from the DLGPH to county councils liable for their maintenance to find suitable foster homes for them.

18.132 Dr Deeny reported that Sister Rosemonde had asked him to 'use his influence with the Church', in relation to finding foster homes as she feared that the manner of her appointment may have prejudiced Bishop Cohalan of Cork towards her and her work. Dr Deeny subsequently spoke to the director of the Catholic Women's Aid Society (CWAS). The director (who was a priest) cited the views of the bishop and his displeasure at how the DLGPH had handled matters at Bessborough. He set out the considerable difficulties the CWAS was experiencing in getting suitable foster homes during wartime conditions. However, Dr Deeny noted that when the urgency of the situation in Bessborough was explained to him, he 'was appreciative of the necessity of obtaining greater results'.

18.133 By November 1945, county councils who traditionally maintained women and children in Bessborough began to make inquiries about its status. The resident medical superintendent in the Cork county home and district hospital told the DLGPH that since the introduction of the ban on new admissions to Bessborough the maternity section of his hospital was 'frequently congested'. The chaplain to the Cork county home complained that women and children were 'accumulating there at a very rapid rate'. In the same month, Sister Rosemonde told the DLGPH that all required adjustments to the nursery had been made, that three qualified

nurses were now working there and that she had advertised for another qualified nurse to take up duties when admissions resumed. She said that she had numerous applications from expectant women seeking admission to Bessborough and requested that the hospital be re-opened for new admissions.

18.134 In November, the Superior General of the Congregation of the Sacred Hearts of Jesus and Mary and Sister Rosemonde met Dr Ward. The Superior General expressed 'sincere regret' about the conditions that had prevailed at Bessborough and said that all recommendations made by the DLGPH had been carried out. In December 1945, the DLGPH wrote to county councils and boards of public assistance to inform them that the staff at Bessborough had been 'reorganised and considerably augmented', that necessary improvements in the institution had been effected and that public assistance authorities could resume sending unmarried mothers and expectant unmarried women to the institution.

18.135 The authorities at Sean Ross and Castlepollard recouped the cost of a medical officer, nurse and two public health visitors from the DLGPH Maternity and Child Welfare Grants scheme (see Chapter 1). Up to this time, the authorities at Bessborough had made no claims for recoupment of these costs. In February 1946, Sister Rosemonde, who was aware of the grants from her time at Sean Ross, forwarded receipts relating to salaries paid to the medical officer, matron and midwife to the DLGPH for the purposes of recoupment from the fund. The department authorised a grant of £191 on the basis that the unsatisfactory conditions which previously prevailed in Bessborough did not recur. This was half of the relevant salaries which was the maximum available under the scheme.

1946

18.136 Miss Litster's report on her March 1946 inspection described changes in the general layout of the home since her last visit. She noted that an infant's day nursery had been converted into a recreational room equipped with a pianola, book case and seats and was a 'comfortable and pleasant room'. Adjacent to the recreational room, a night nursery had 21 cots and a bed which was occupied at night by one of the patients acting as night attendant. The children's dining room was not in use, as there was insufficient fuel to heat it, and children had their meals in a heated dayroom.

18.137 A long nursery for infants, where the majority of infant deaths occurred prior to re-organisation, had been divided into three smaller rooms each fitted with radiators and a bath for washing babies. Room 1 contained six cots and all were occupied. Only one of these babies was completely breastfed. Cots were adequately supplied with good blankets. Room 2 contained eight cots and four were occupied. Only one infant was fully breastfed. Room 3 was unoccupied. The ten infants 'appeared to be healthy, normal babies' and there was no sign of 'scalding or excoriation'. A nursery for older infants contained 13 cots; 12 were occupied. The room was heated by three radiators and had three windows. These infants were 'plump and healthy' and although some showed the remnants of a rash on their buttocks the condition 'appears to be clearing rapidly'. An isolation nursery housed five babies, three of whom were unaccompanied by their mothers. None of them appeared to be seriously ill. A day nursery for older children housed 21 children; 12 were without their mothers. For the most part they were 'fine, healthy children'. A toddler's playroom housed 18 children aged from two to four years old; all but one were maintained by public assistance authorities. Fourteen were maintained by the Cork boards of assistance; all were healthy and normal and, in Miss Litster's view, should be boarded out.

There is apparently a proposal that those chargeable to the South Cork Public Assistance Authority should be admitted to Cork County Home and their mothers allowed to take their discharge from the Sacred Hearts Home, Bessboro. This procedure would not commend itself to me for the following reasons:

- There are already too-many children in the County Home.
- The mothers in the County Home will be required to attend to motherless children whose mothers have been permitted to take their discharge. This will make neither for proper care of the children nor for good discipline in the County Home.
- One removal, especially when it involves separation from its mother, is sufficiently disturbing for a child. An effort should be made to ensure that only one disruption of his life is necessary. It should be possible to procure a foster home to which he may be removed directly from the Sacred Hearts Home.

18.138 Miss Litster said that the South Cork board undertook to 'prosecute a vigorous boarding out policy' with a view to getting foster homes for children in the Cork

county home and Bessborough. However, the board noted that the stipulation that foster homes must be located in rural areas was making the task difficult and asked that the DLGPH would consider lifting the prohibition on boarding out children in villages and towns to accommodate applicants from such areas (see Chapter 11).

18.139 Miss Litster highlighted other issues which were detrimental to the wellbeing of women and children living in Bessborough. The South Cork board of public assistance would not pay maintenance for women and children once the child was two years old; the congregation accommodated these women and their children without payment. Since the only reason for their continued residence in Bessborough was the South Cork board's failure to secure foster homes for the children, Miss Litster considered the cessation of payment to be unfair.

18.140 At the time of the inspection, 29 unaccompanied infants were living in the home. The majority of these infants were born to private patients and remained in Bessborough unaccompanied under the auspices of the CWAS. Traditionally, infants who remained in Bessborough in the care of CWAS were placed with nurse mothers a week or two after birth. However, the CWAS had found it increasingly difficult to get nurse mothers and foster homes during the war years. This meant that 'motherless' infants were kept in Bessborough for prolonged periods. The congregation decided to discontinue the practice of allowing private patients to leave the institution without their babies and, for all new admissions, it was decided that the mother and her child would be treated as a unit.

18.141 Miss Litster noted that at the time of her visit there were 22 expectant women in the maternity hospital; 18 maintained by public assistance authorities and 4 were private patients. There were seven new-born infants in the nursery, four of whom were completely breastfed. One infant weighed 4.5 lbs. at birth, one was premature and 'otherwise all appeared healthy and normal'.

18.142 The home had 72 beds in total. Two dormitories were located on the second floor. The first contained 24 beds and was large and bright. Ten new wash hand basins had been installed but were not yet connected to the water supply. The second dormitory contained 16 beds; eight new hand basins had been installed but were not yet connected. A top floor dormitory, a long, bright room, had 32 beds. Miss Litster noted that the dormitories were capable of accommodating a larger number

of beds should the need arise. The ground floor housed airy and comfortable workrooms but the refectories were 'somewhat dark and gloomy'. Dinner on the day of inspection, which was a feast day, consisted of fish, vegetables, sweet, a cup of coffee, bread and butter; 'the food is excellent'. On 6 March 1946, 58 women (seven private patients) were living in the institution: 22 expectant and 36 with children.

18.143 In the period 31 March 1945 to 6 March 1946, 48 infants were born in or admitted to the institution and 23 infant deaths had occurred. Three of these deaths occurred in infants admitted to Bessborough after birth. Sixteen of the 23 infant deaths occurred in infants born to private patients. Since October 1945, when Sister Rosemonde had taken charge, there had been six deaths; two of these were neo-natal.

> It is too soon yet to expect any noticeable effect upon mortality of the re-organisation. The general appearance, however, of the infants has improved; instead of emaciated, marasmic babies, as they mostly were on the last inspection visit made, they appear to be thriving and healthy on the whole.

18.144 Statistics submitted by the Bessborough authorities to the DLGPH for the year ending 31 March 1946 showed that 88 women (52 public, 36 private) were admitted to the institution during the year. One case of maternal mortality was recorded; the woman was a private patient. Twenty-four private patients were resident with their infants on the date on which the statistics were compiled which suggests that Sister Rosemonde implemented the policy of retaining private patients in the home until suitable foster homes were secured for their children. Of those women discharged during the year, 65 (29 public, 36 private) were discharged to 'situations' and 17 (seven public, ten private) left the institution with parents or relatives. Thirty-eight infants were born in Bessborough during the year and a further 13 were admitted after birth. Of the infants and children discharged during the year, 24 were boarded out by health authorities and 11 were placed at nurse through the CWAS. A further 17 infants (seven public, ten private) were taken by relatives or friends and three infants (two public, one private) were discharged to hospital.

18.145 In October 1946, the DLGPH wrote to Dr Condy asking him to report on infant deaths at Bessborough for the year ending 31 March 1946 and for the six month period ending 30 September 1946. His report showed that, in the period 1 April

1945 to 31 March 1946, 59 births and 24 deaths were notified. However, for the six month period 1 April to 30 September 1946, 91 births and 8 deaths were notified. An inspection report on Bessborough by Dr Murphy, medical inspector, DLGPH, stated that for the year ending 31 December 1946, 136 births and 12 infant admissions to Bessborough were recorded. In the same period 15 infant deaths were notified. Although Dr Deeny considered the infant mortality rate at Bessborough to be still too high, he acknowledged that there had been 'a tremendous improvement' and that the actions taken by the DLGPH the previous year had been 'completely justified'. Dr Deeny decided to send a letter of congratulations to Sister Rosemonde and to notify the Minister for Local Government and Public Health and Bishop Cohalan of the results.

1947

18.146 During his inspection visit in January 1947, Dr Murphy also undertook a medical inspection of infants and children in Bessborough. He noted that the general layout of the institution remained the same as that reported by Miss Litster on her visit in March 1946. Nursery 1, reserved for infants aged one to three months, housed 14 infants; nine were breastfed. Some had cracks and fissures behind their ears but appeared to be doing well on treatment. All infants in this section were 'normal and well-nourished'. Nursery 2, reserved for infants aged three to six months, housed 20 infants: four were breastfed. One infant was 'premature and progressing satisfactorily' and all other infants were 'normal and well-nourished'. Nursery 3, reserved for infants aged six months to one year, housed 19 infants: four were breastfed; 'all were healthy, well-nourished and doing well'. There were two infants in the isolation nursery; they 'were running temperatures, were not seriously ill and showed no other abnormal physical signs'. The toddler's playroom housed 20 children; they were 'all normal'. He saw 13 infants 'all breastfed and in good condition' in the maternity hospital. There were 34 expectant women housed there along with six puerperal cases. He concluded that the institution 'appeared to be run on very efficient lines'. He said that the reduced number of deaths 'speak for themselves' and that 'in view of the past history of this Institution the results are certainly excellent'.

18.147 In June 1947 the Cork county manager granted an increase in the maintenance rates in respect of the South Cork board's patients housed in Bessborough. The rates, back dated to 1 April 1947, were as follows:

i. Ante-Partum Mothers: 16s a week.

ii. Children: 15s a week.

iii. Mother and Child: 28s.6d a week.

iv. Post-Partum Mothers: 13s.6d a week.

1948

18.148 In June 1948, Miss Litster again inspected the home and hospital; 103 children were living in the institution at the time of her visit. All infants except two were 'healthy and doing well'. She described one infant as 'puny and delicate' and the second as 'the offspring of an incestuous union'. The older infants 'appeared in good health, contented, well-nourished...healthy, normal children, happily at play'. There were 14 children, aged two years and over and eligible for boarding out, living in the home; she again recommended that the county councils responsible for them should be directed to secure suitable foster homes. Although the South Cork board continued to advertise for foster parents in local and regional publications they faced competition from the Cork Branch of the Save the German Children Society who sought to place 50 German orphans in foster homes.[45] In the period 1 April 1947 to the date of inspection on 5 June 1948, 178 infants were born or admitted to the institution; 23 deaths occurred in the same period. Miss Litster noted that no infant death had occurred in the institution in the period between February and June 1948:

> The infant mortality rate in Bessborough compares favourably with that for illegitimate infants in the country as a whole and represents a very considerable drop from that obtaining formerly in the Institution.

18.149 Three of the 23 infant deaths were neo-natal. The remaining 20 deaths were certified as marasmus (four), enteritis (six), pneumonia (six), septicaemia (three) and infantile convulsions (one). Miss Litster undertook a subsequent investigation into infant deaths at Bessborough for the year ending 31 December 1948. In that period, 143 infants were born or admitted to the institution and six infant deaths were recorded.

1949

18.150 In May 1949, Miss Litster again inspected Bessborough. There were 139 women and 114 children living there at the time of her visit. She reported on each ward as follows:

[45] *Cork Examiner*, 24 January 1947.

Dormitory No.1: Four infants about six months old, all healthy in appearance and thriving.

Dormitory No.2: Nine infants about six months old, all healthy and thriving.

Dormitory No.3: Eleven infants under one year. All healthy; except one suffering from a severe cold.

Dormitory No.4: Infants, transferred from the Maternity Hospital at an average of three weeks old, mainly breast-fed. All appeared healthy except one- an infant born outside and brought in after birth. This is not a vigorous baby but is, according to nurses, making progress.

Dormitory No.5: Four infants about ten weeks old. All four babies are breast-fed and all thriving.

Dormitory No.6: Two infants, both are breast-fed. One does not appear to be thriving. The other, a three months old baby, is wizened and unhealthy looking, but is apparently from records not losing ground.

Toddlers Lower age group: All these 29 children, aged twelve months to two years, are healthy, vigorous and normal.

Toddlers Upper Age Group: All 30 children were outdoors. They appear healthy, contented and normal. They are mostly about two to two and a half years. A few are three years old.

18.151 In the year ending 31 March 1949, 135 infants were born in or admitted to the institution and six infants died. The deceased infants were aged between 36 hours and 11 weeks. The certified causes of death were enteritis, cerebral haemorrhage, prematurity, toxaemia, prematurity and chronic infection, and atelectasis. Four infants were transferred from Bessborough to the Cork district hospital for medical treatment during the year and subsequently died there.

18.152 Miss Litster recorded that there were 43 women in the maternity hospital of whom 29 were expectant. The 14 new-born infants housed there were reportedly 'normal and thriving' and all but two were breastfed. The only baby of really unhealthy appearance was a premature infant, another 'offspring of an incestuous union'. The health of the mothers was excellent, and no complaints were made about the quantity and quality of the diet.

The 1950s

18.153 In November 1951, Miss Litster visited Bessborough to make inquiries about infants who had been discharged from the home and subsequently were housed in the Dunscombe private nursing home, Cork. On this occasion she interviewed mothers and examined records of births, admissions and infant deaths. On the date of inspection, 87 infants and children, aged from one month to three years, were living in the home and seven new-born infants were housed in the maternity hospital. For the year ending 31 March 1951, 83 infants were born and a further 19 were admitted after birth. One infant death was notified during this period. Analysis of the 158 infants born in or admitted to Bessborough in the period 1 April 1950 to the date of inspection on 7 November 1951, showed that two infants subsequently died. Miss Litster recommended better ventilation for the playroom and dining room and suggested that smaller shallower baths would be more suited for infants. She also recommended that public assistance authorities in North Cork, North Tipperary and Clare should again be directed to make arrangements for the removal of children eligible for boarding out.

18.154 Miss Litster drew attention to the fact that the local registrar of births was in the habit of writing the word 'maid' in the column where the mother's maiden name would usually appear; Miss Litster took this to refer to the unmarried status of the mother (which would normally have been 'spinster'). The Sisters at Bessborough said that the word 'maid' meant 'domestic servant'. Miss Litster objected to this on the basis that no other institution stated the mother's occupation on a birth certificate and advised that St Patrick's Guild had found it difficult to get foster homes for children from Bessborough because of the entry 'maid' on the birth certificate.

18.155 Subsequent to Miss Litster's visit to Bessborough in November 1951, the Department of Health (the DLGPH split into two separate departments in 1947) instructed Miss Reidy, nursing inspector, to inspect Dunscombe. The department was prompted to take this action based on information garnered by Miss Litster during her interviews with women living in Bessborough. Sister Rosemonde's refusal to allow private patients to leave Bessborough without their infants had induced some private patients to discharge themselves and their infant and then admit the infant unaccompanied to Dunscombe. The infant life protection visitor for the South Cork board had become aware of a large number of infant deaths at

Dunscombe and brought the matter to the attention of Dr Saunders, the chief medical officer to Cork City. On 13 November, an inspector from the South Cork board inspected Dunscombe and reported that all was in order there. On the same day Miss Reidy visited Dunscombe and reported that there were four infants in one room which lacked both air and light and smelled of urine. Miss Reidy asked for nappies to be removed. In every case the buttocks were very inflamed and ulcerated in varying degrees.

18.156 Miss Reidy also found that the owner of Dunscombe had not only failed to notify the board of public assistance of the reception of infants born at Bessborough, a requirement under the *Children Acts*, (see Chapter 1) but had also failed to register infant deaths which occurred there. The South Cork board inspector claimed that she had reported the unauthorised maintenance of infants, born in Bessborough, in Dunscombe, and their poor condition, to the Cork local authority on previous occasions and that they had failed to act. A Department of Health memorandum appears to substantiate this claim.

18.157 The owner claimed that infants who died in Dunscombe had been discharged from Bessborough to Dunscombe in a poor state of health. The Department of Health determined that medical staff at Bessborough bore no responsibility for the condition of infants in Dunscombe and Miss Litster rejected the owner's claims out of hand stating:

> There is no doubt in my mind that the babies who died in the [Dunscombe] Home were not given such care and attention as might induce them to live.

18.158 Miss Litster was also highly critical of the Catholic Women's Aid Society (CWAS) as it had recommended Dunscombe to private patients seeking an early discharge from Bessborough as suitable temporary accommodation for their infants. All but one of the infants born in Bessborough, and who subsequently died in Dunscombe, were born to private patients and were placed in Dunscombe unaccompanied awaiting foster placement under the aegis of the CWAS. Miss Litster made the charge that the society must have been aware of the infant deaths at Dunscombe but took no action. She recommended that the owner should be prosecuted for the neglect of infants in her care but thought it unlikely that the Cork local authority would press the case.

18.159 Miss Litster's report on Bessborough in October 1952 shows that the number of private patients seeking admission to the institution had fallen dramatically. Only two of the 101 women who were resident there on the date of inspection were private patients. Sister Rosemonde's refusal to allow any woman leave the home without her child appears to have deterred private patients from seeking admission to Bessborough. However, the decision continued to make a positive impact on infant mortality there. In 1952, Miss Litster noted that for the period since her last inspection, 7 November 1951 to 2 October 1952, and for the first time in Bessborough's history, no infant death occurred in the home. Two neo-natal deaths occurred in the maternity hospital; in both cases the women were admitted to Bessborough already in labour. All of the 84 infants and children living in Bessborough at the time of inspection 'appeared healthy, normal, plump and well-cared for'. There were 38 infants in cots in a newly built solarium.

18.160 Miss Litster again asked the Department of Health to direct public assistance authorities responsible for maintaining children in Bessborough to arrange suitable foster homes for those eligible for boarding out. The Cork, Clare, Limerick, Kerry and North Tipperary boards replied stating that they had placed advertisements in local newspapers but were unsuccessful in securing suitable foster homes. The North Tipperary board sought permission from the Department of Health to transfer children from Bessborough to an industrial school but the department did not consider industrial schools a suitable alternative to foster homes. The North Cork board advised the department that they had made an application for the committal of a child to an industrial school at the request of his mother who wished to leave Bessborough, after a stay of four years, to take up employment. As the North Cork board had failed to find a foster home for the child, this appears to have been the only option left open to this particular woman. Although counties that maintained children in Bessborough were asked to find foster parents for one, and sometimes two children, they found it almost impossible to do so. All counties involved told the Department of Health that they had secured foster homes for the Bessborough children but when the department followed up on the matter most of these arrangements had fallen through and the children remained in the home.

18.161 In July 1954, Miss Litster again inspected Bessborough. There were 80 infants and children living in the home at the time of inspection and all, except for a two-month-old baby in the infirmary, were outside either in cots in the solarium or at play in the grounds. She noted that on the whole, they appeared healthy and

thriving. Seven older children, aged between three and five years, were living in the home. Three of these children were eligible for boarding out and Miss Litster recommended their discharge to foster homes. Two of the older children were 'mental defectives' and she recommended their discharge to suitable institutions. One of the older children was the 'offspring of incest' and Miss Litster noted that local knowledge of this would make it impossible to find a foster home for her in her mother's county of origin. She recommended that this child be sent to a convent industrial school. Arrangements had been made for the remaining child to be adopted to the USA.

18.162 Miss Litster said that the women's refectory, which was a semi-basement room, had always been 'dark and gloomy' but that efforts had been made to brighten the room with natural light. Dinner served on the day of inspection consisted of beef stew with vegetables and milk pudding. Soup was frequently served and stewed fruit when available. Breakfast consisted of porridge, bread, butter and tea. On Sundays and feast days, sausage and egg, and sometimes bacon, were served. Supper consisted of eggs or salad. The diet appeared to be nourishing and ample.

18.163 There were 26 women in the maternity hospital; 13 were nursing new-borns; all but two of the infants were breastfed. Of the 13 nursing mothers, only one would be remaining in Bessborough until her child was boarded out. The other 12 women had made arrangements for adoption or for placing their child at nurse through a welfare society. Miss Litster noted that expectant women admitted to Bessborough were now coming in immediately before confinement and leaving as soon as possible after the birth.

18.164 In the period between inspections, 2 October 1952 to 7 July 1954, 149 infants were either born in, or admitted to, Bessborough. Three infant deaths were recorded during the same period. All three were neo-natal and occurred in the maternity hospital. No infant deaths occurred in the Bessborough home. In his report for 1953, the Cork county medical officer, Dr Condy, stated that 33 infants and two women had died in other private maternity homes operating in Cork county during the year.[46] Miss Litster noted that for the period 1 April 1950 to 7

[46] The eight other private maternity homes operating in Cork county in 1953 were: St Anne's Nursing Home, Fermoy; Bandon Nursing Home, Millbrook; St Philomena's Nursing Home, South Main Street, Bandon; St Philomena's Nursing Home, North Main Street, Bandon; St Mary's Nursing Home, Youghal; Bon Secour Home, Cobh; St Anne's Nursing Home, North Main Street, Youghal and Braemar House, Old Blackrock Road, Cork.

July 1954, 481 infants had been born in, or admitted to, Bessborough; seven infant deaths were recorded during the same period representing an infant mortality rate of 1.4 %, or 14 per 1,000 births. This compared favourably with the national infant mortality rate which averaged 43 per 1,000 births during the same period.[47]

18.165 Miss Litster's September 1955 inspection shows that infant mortality had further reduced. For the year ending 31 March 1955, 86 infants were born in, or admitted to, the home: one infant death occurred in the same period. Ninety two women, 65 infants and 13 children were living in the institution at the time of inspection. All 65 infants appeared healthy apart from one who was coeliac and one suffering from eczema. Arrangements had been made for the adoption of five infants, one locally and four to the USA. Thirteen older children were living in the home: arrangements had been made for the adoption of seven of them in the USA. Miss Litster reported that inoculation against diphtheria was to be undertaken in the institution and that the health of the women was good.

> The Home is well-run, diet ample and good; beds comfortable. Great attention is paid to the comfort and wellbeing of the patients. Facilities for recreation are good.

18.166 Miss Litster's November 1956 report recorded that 73 women and 67 infants and children were living in the institution at the time of inspection; this was almost half the number of residents recorded in 1948 and 1949. The health of both mothers and children was excellent, the diet was good and that the children were well-cared for. Five cases of polio were recorded among children during the year; none proved fatal, but one child suffered facial paralysis.[48] Four infant deaths were recorded; three deaths occurred in the maternity hospital among infants aged between four and eight hours old. The remaining infant died in the home, aged three weeks. Seven children were legally adopted in Irish homes during the year and local applications from prospective adoptive parents were increasing. She considered that a good deal of the credit for the increasing readiness of local families to adopt was due to the Bishop of Cork, Dr Lucey, who, according to Miss Litster, pressed constantly on priests and people the superiority of adoption over institutional upbringing or boarding out.

[47] *Report of the Department of Health, 1953-54*, (Dublin, Stationary Office, 1955).
[48] There was an outbreak of polio in Cork in 1956.

18.167 The August 1958 inspection was conducted by Miss Reidy, nursing officer, Department of Health. There were 52 women and 55 infants there at the time of inspection. Seven older children were awaiting papers from the Department of External Affairs to travel to adoptive families in the USA. Miss Reidy noted:

> The accommodation of both mothers and children was clean, well-kept and adequately comfortable. They all appeared to be in good health. The only physical defect notable amongst the children was squint eye.

18.168 Miss Reidy reported that for the period between Miss Litster's last inspection in November 1956 to the date of her visit, 132 infants were born in, or admitted to, the institution; 103 were maintained by health authorities. Twelve infant deaths had occurred during the period. The majority of infant deaths were neo-natal and occurred in the maternity hospital. Two infant deaths occurred in the home; both were three months old at the time of death and both died of pneumonia.

18.169 Miss Reidy noted that the majority of the children were recorded as discharged with their mother to the family home or to near relatives of the mother.[49] Adoptions to the USA had decreased and Irish adoptions had increased. Boarding out from the institution had virtually ceased. The infant death rate, 60 per 1,000, was high. The majority of deaths, however, were during the neo-natal period, some attributable to congenital conditions.

The 1960s

18.170 Miss Reidy next visited Bessborough in November 1961. There were 57 women and 60 children there at the time of inspection. Five children were unaccompanied; three of their mothers were in 'mental institutions' and the whereabouts of the other two were unknown. One of the unaccompanied children was described as 'mentally deficient'. She reported that the accommodation for both mothers and children was 'clean, well-kept and adequately comfortable' and that the well-being of all was 'satisfactory'. Since her last inspection in August 1958, 175 infants had been admitted to Bessborough; 160 were born in the institution and 15 were admitted after birth. Over half the children who were

[49] As was often the case, the children were most likely to have been subsequently placed for adoption or boarded out. Statistics recording the final confirmed placement of children born in Bessborough show that just under 75% of those born in the 1950s were adopted; in the 1960s the figure was over 95%.

discharged were placed for adoption. One infant death was recorded during the period under review.

18.171 In April 1964, the secretary of the Cork Health Authority (see Chapter 1) wrote to the Department of Health to advise that it had made arrangements with Bessborough to house children awaiting adoption. The Cork authorities stated that some children in their care were housed in locations not readily accessible to prospective adoptive parents and that they had already transferred children from St Clare's Home, Stamullen, to Bessborough. Miss Reidy had no objection to the move. She said that the Sacred Heart homes were all excellent and that children who had been transferred from The Children's Home, Tuam, whom she described as 'mostly backward' had thrived both physically and mentally in the care of the Sacred Heart community. The department subsequently agreed to the payment of £3 5s a week for the maintenance of children awaiting adoption in Bessborough.

18.172 Miss Reidy inspected Bessborough again in October 1964. There were 44 women and 54 children living in the home. The accommodation for mothers and children was satisfactory and comfortable. In the period since her previous inspection, in November 1961, 408 women (364 public and 38 private) had been admitted. The number of admissions during this period was more than double that recorded in previous years. Twelve infants born during this period subsequently died; one died in the Bessborough home and the others in St Finbarr's Hospital. The majority of the children were adopted through a number of adoption societies. One mother and her infant were transferred to Sean Ross 'for disciplinary reasons'.

18.173 In 1966, the Cork Health Authority asked the congregation if they would admit unaccompanied infants to Bessborough. The congregational council was reluctant to agree to the proposal but expressed concern that a refusal to accept unaccompanied children might lead to the loss of all other work in Cork. The council subsequently agreed to admit unaccompanied infants 'on a small scale'.[50]

18.174 A file relating to an infant living in Bessborough in 1966 contained an infant diet sheet. The diet sheet stated that each infant received ABIDEC (vitamin drops) and Vitamin C daily and that the infant feeding regime was as follows:

7am: Gruel

[50] Congregation of the Sacred Hearts of Jesus and Mary, Council minutes, 12 November 1966.

9am: Rusk in milk

12.30pm: Creamed potatoes, vegetables, minced meat, gravy, milk pudding.

4pm: Bread, milk, whisked egg.

7pm: Rusk in milk.

18.175 In August 1969, the *Irish Times* published an article in which a journalist gave an account of her visit to Bessborough.[51] The Mother Superior told the journalist that she was aware that Bessborough had 'an unpleasant reputation' and that 'many girls from the country still feel that it is a prison'. The journalist noted that this misconception did not distress the Mother Superior in the way one might expect and that her main concern was that such misconceptions prevent women from going there until 'they are frantic with fear and see it as the only place to hide'.

> They do not question the girl too closely about the circumstances of the pregnancy, give her a house name immediately she arrives by which she is known for the rest of her time there, give her an address to which post can be sent, contact her local health authority or County Council with practised discretion, and provide her with medical care before, during and after the confinement, and then with an adoption or fostering service...When a girl arrives at the convent (and they come at many different stages in the pregnancy) she is immediately brought to the Hospital wing for confinement. Two doctors from the city attend there, an obstetrician and a gynaecologist. They do not attend the actual birth, but examine any girl causing the midwives anxiety, and refer difficult or uncertain cases to a city maternity hospital.

18.176 The journalist described the physical conditions as follows:

> The nurseries and dormitories were bright clean rooms for two and three, and even some for one girl alone. Birthday cards stood in a gay litter in one room, framed family photographs appeared in a few others. The stringent cleanliness of the whole place indicates the somewhat unpalatable fact that much of the housework is done by the girls themselves... the first stage room is a little cell with an observation window in the wall. The delivery room, its two beds quilted in green brocade, has none of that paralysing strangeness of hospitals, but still looks comfortingly efficient. The girls are not given any information about labour and delivery until the process has in fact begun...There is a television, a somewhat limited book-case, a large room

[51] *Irish Times*, 7 August 1969.

with a piano where the women dance, a recreation room with card tables...in the nurseries babies were mittened and cosy.

18.177 The Mother Superior told the journalist that they operated a strict rule that the mother must stay until the child was adopted or fostered. This could be a question of months, or longer if the infant's health was uncertain, if the baby was disfigured, or physically or mentally deficient. In such cases, the Bessborough authorities and the responsible health authority worked out suitable arrangements for the care and treatment of the child. She stated:

> Of course, if parents were prepared to accept a girl and her child, long stays in the Home would be really a thing of the past. But our attitudes are not yet so liberal to permit such generosity, or such a realistic solution of what to do with the mother and the baby.

18.178 The journalist spoke to three women living in Bessborough at the time of her visit. One woman, described as 'a tall graceful girl of 24' told her that she would never have known what to do when she realised she was pregnant only for Angela Macnamara's 'Ask Angela' agony aunt column in the *Sunday Press*.[52]

> She had told her boyfriend and he insisted that he was not the only man she had slept with, and refused to admit to any responsibility. She was a clever, hard-working girl and had an excellent job. She decided to go to England; she was putting on weight, and she didn't know what else to do until she read of the existence of the Catholic Protection and Rescue Society. She was directed to Bessborough, where she has been for six months now. Her baby, a girl, is three months old and not yet adopted. Her family know nothing of it all; she writes long letters describing non-existent activities. She prefers it that way. Still, she has been under terrific mental strain, the high point of which will come shortly, as her baby will soon be adopted. She went into town last week to buy her child special clothes for going away. She dreads it, 'it's like a death. I can't describe it'. If she had any help at all, she would have kept the baby. She wrote to the father of the child when she was born, telling him it was a little girl. He never replied. She is still incredulous at his behaviour, for he is an educated man with a responsible civil service job.

[52] See Paul Ryan, *Asking Angela Macnamara: an intimate history of Irish lives*, (Dublin, 2013).

18.179 Another woman, who was described as 'strikingly pretty and intelligent' had decided not to tell the father of the child that she was pregnant.

> I didn't want to marry him, so what was the point? Of course it takes a lot to go through, but the Sisters here support you, and you go through it. And knowing that the child has been placed with adoptive parents helps you. You feel that it is the best you can do for it in the circumstances.

18.180 This woman's family would not have helped her at all and she 'appreciated the protection and security' she had been given at Bessborough. She expressed her hope that in the future a man that she was likely to marry would 'accept this part of her life as a failure and that he would forgive it'. The woman then continued:

> Is it failure really? You know, here you're not treated like that. You're never blamed or reproached. I think we seem to have sinned more against society than anything else. They just have no place for us.

18.181 A third woman, whom the journalist described as 'a serene and sensible young person' had not told her boyfriend that she was pregnant because she did not want to marry him. She was 20, and had been working in England when she became pregnant. She had contacted the Crusade of Rescue and had been referred to Bessborough. She intimated that over 50 of the girls living in Bessborough had been repatriated from England. The journalist noted that the woman was eager to give birth but stated that she had already decided to have the child adopted.

> I don't really want it now, and I hope I don't change when it is born. I'm not ready for a baby. I'm not mature'.

18.182 The journalist concluded:

> The mothers I spoke to were not bitter. They were just sorry that they were not wise enough in time and they would like to see some social acceptance of the unmarried mother and her child... For them it seems as if society is something which they are now safely removed from... The Reverend Mother is reflective. She loves her work, but it involves heartbreak. She would like to see a willingness on the part of the parents to accept the girl and her child, but feels that this will not come for a long time. It is a pity, she thinks, that the man involved can remain free, while the girls are trapped by the consequences of their shared action. She does not know what can be done about it. She only knows that girls in trouble should be aware that there is somewhere for them, while they have nowhere else to go.

The 1970s

18.183 In February 1970, the Mother General of the Congregation of the Sacred Hearts of Jesus and Mary visited Cork. The Sisters working at Bessborough told her that there was no future in the work they were undertaking in the home and asked that the congregational council review the situation. The Mother General met the Bishop of Cork, Dr Lucey, to discuss the matter. Bishop Lucey acknowledged that there was not a large number of women seeking admission to Bessborough but advised that it would be important that the congregation continue its work in Cork. The Mother General was happy to accept the bishop's recommendation to keep the home open.[53]

18.184 In July 1971, Miss Reidy again inspected Bessborough. Seventy five women (49 expectant and 26 post-natal) and 28 children were living there at the time. The premises were 'very clean and well-kept'. Miss Reidy interviewed eight women individually. They 'seemed generally satisfied with conditions in the Home'. In the period 1 November 1969 to 30 June 1971, 246 babies were born in Bessborough and a further 76 women were transferred to St Finbarr's Hospital and gave birth there. Two neo-natal infant deaths occurred; both infants were born with 'multiple abnormalities'. Some dormitory accommodation in the home did not afford much privacy for residents. The matron, Sister Hildegarde, acknowledged that the issue of privacy was a concern and that she was 'gradually having the matter remedied'.

18.185 In December 1972, Sister Hildegarde was interviewed by a reporter from the *Irish Independent.* The article entitled 'Unmarried Mothers - doors are still closed' stated that, after 50 years of operations, Bessborough was still regarded as 'Cork's banishment house'. Sister Hildegarde was quoted as saying that the 'the unmarried mother is no more acceptable to society today than she was fifty years ago'. The article went on to state that 'inmates vary from 13 to 40 years old' and that 'a number of abortions were attempted, by various methods, before the unmarried mother enters the Home'. It was reported that one girl had consumed sheep dip compound in the hope that her baby would be born dead.[54]

18.186 In July 1973, the *Sunday Independent* carried an article informed by a former Bessborough resident who claimed there was 'inadequate food, lack of

[53] Congregation of the Sacred Hearts, Annals of the Order, 11 February 1971.
[54] *Irish Independent*, 10 December 1972.

recreational facilities and minimal medical care' available at Bessborough. The woman's main complaint was that she would have to remain in Bessborough after the birth to look after her baby until a foster mother was secured.[55] Sister Hildegarde said that the complainant had been in the home for five days and was not qualified to make such statements. The chairman of the Southern Health Board said that the accusations were grossly unfair and that the board's senior social worker had said 'we have never come across adverse criticism from the girls there. I think the allegations are terribly unfair and must be a cause of unnecessary worry to the parents of girls there at present'. The editor of the *Sunday Independent* wrote that he had received a number of letters from former, and present, Bessborough residents repudiating the allegations.[56]

18.187 In January 1974, Miss Reidy's inspection report stated that considerable alterations, reconstruction and improvements had been carried out since her last visit and that 'the position in relation to the lack of privacy is greatly improved'. Dormitory spaces had been converted into individual cubicles with wardrobes and lockers. In addition, recreational activities had also been improved and residents could avail of a TV room, recreation room, smoking room and a record room for playing music. All recreational areas were decorated with 'colourful tapiflex[57] and Marley tiles'. Forty-five women were living in Bessborough at the time and six expectant women were absent having gone to spend Christmas with friends. In the period 1 November 1971 to 3 January 1974, 361 babies were born in Bessborough and a further 94 women were transferred to St Finbarr's Hospital to give birth. Three neo-natal infant deaths occurred during this period; the certified causes of death were gross congenital deformity, prematurity, and pneumonia.

18.188 Miss Reidy again interviewed eight women individually and reported that all spoke well of conditions in Bessborough in general and all expressed 'much appreciation' of the Sisters, particularly the community's 'appreciation of their problems and their efforts to iron out difficulties'. Four of the women interviewed said that their parents were not aware of their whereabouts. Two women said that only their mother knew where they were. Some criticisms aired by the interviewees related to 'a lack of bath cleaning materials' and 'under-heated dormitories'. Miss Reidy noted that while one complaint was easily remedied, the under heating was the

[55] *Sunday Independent*, 1 July 1973.
[56] *Sunday Independent*, 8 July 1973.
[57] A type of vinyl flooring.

result of a nationwide shortage of fuel due to the 1973 oil crisis. Miss Reidy herself raised concerns about the amount of light wood which had been used in the provision of cubicles. It was not clear whether fire experts had examined the area and she recommended that the Southern Health Board might clarify the matter. At the city architect's suggestion, a fire escape corridor was added to the area housing the new cubicles.

18.189 In May 1978, Miss Reidy conducted another inspection. Her report has only partially survived. She noted that, at the time of her visit, 'the wellbeing of mothers and infants appeared very good'. The premises were clean and well-kept and records were available and 'properly posted'. In addition, she observed:

> My visit coincided with the warm sunny spell. From what I could observe the 'girls' took full advantage and spent most of the day out sunbathing. They give little, if any assistance in routine work. The staff are hard at it full-time, and in my opinion are barely adequate for the volume of work involved in Infant Care and to maintain proper standards of cleanliness and hygiene.

18.190 At the time of the visit, there were 28 staff working at Bessborough. The maternity hospital was staffed by five qualified nurses (four of whom were also registered midwives), one midwife and three ancillary staff. The nursery had two qualified nurses and five ancillary staff. Five staff were involved in administration. One Sister and two ancillary staff ran the laundry. One Sister and two ancillary staff ran the kitchen. The matron was qualified in general nursing and midwifery. Dr Sutton remained as consultant gynaecologist and there was also a consultant paediatrician. The community was looking for additional staff and Miss Reidy recommended that the Southern Health Board help them to find extra staff.

18.191 In March 1978, the capitation rates at Bessborough, which were £3.00 per day for women and £1.50 per day for infants, were increased to £25.20 a week for mothers and £12.60 a week for infants. The matron wrote to the Department of Health to acknowledge the increased rates but argued that they were still inadequate considering the level of service provided. It was pointed out that the increased rates failed to match capitation rates prevailing in other similar institutions. A Department of Health memorandum acknowledged that capitation rates paid to mother and baby homes were not standardised and a note stated 'we

always felt that the discrepancy in rates would arise at some time'.[58] Furthermore, the matron stated that Bessborough was 'heavily subsidised in terms of finance and personnel by the Order' and that their finances were so poor that 'Sisters involved full time on a professional basis are unable to draw their salaries'. She cautioned that although the congregation was most anxious to continue its work, financial difficulties might force it to 'curtail or reduce the present level of service provided'.

18.192 In May 1978, two staff attached to the finance unit of the Department of Health visited Bessborough to examine the institution's finances. The institution was stated to have had a deficit of £11,465 in 1977. When salaries owed to the religious staff were taken into consideration for 1978, the deficit would be £78,940. It was also considered that the number of staff employed was below acceptable levels and the matron stated that she required funding to employ an additional five permanent staff. Miss Reidy subsequently confirmed that staffing levels 'fall short of what would be considered acceptable by present day standards'. In his report to the Department of Health, one of the finance staff recommended that the Southern Health Board provide a grant to the institution to cover some of the maintenance costs and advised that a standard policy on pay and personnel, particularly in relation to religious staff, 'should be evolved as a matter of urgency'. Miss Reidy's report for 1978 noted that 12 of the 14 nursing staff at Bessborough were members of the Congregation of the Sacred Hearts of Jesus and Mary.

18.193 Between 1 January 1976 and 19 May 1978, 418 women were admitted to Bessborough. In that period, 247 babies were born in the institution and a further 229 women were transferred to St Finbarr's Hospital and gave birth there. Two infant deaths occurred. One was recorded as 'very premature' and perinatal hyaline membrane was given as the cause of death of the second infant. There were four unaccompanied children there. One child, aged 13 months, had been abandoned by its mother and the health board struggled to find a foster home as the child suffered from outbreaks of eczema. A six-month old infant had also been abandoned by its mother and the health board was trying to contact her. An 11-month-old infant admitted from St Finbarr's Hospital was awaiting adoption. The fourth child, aged 14 months, had a physical handicap and adoption had been postponed pending surgical intervention.

[58] Capitation rates were always higher in Dunboyne – see Chapter 35.

18.194 In February 1977, a fruit and vegetable shop in Cork city, owned by the congregation and run on their behalf by two lay women, was closed. It would appear that the shop premises had been bought by the congregation in 1930 for £350 to sell their farm produce.[59] The farm at Bessborough does not appear to have been in operation after 1960. The money held in the shop's bank account was split between the congregation and the shopkeepers. In 1979, the local authority told the congregation that the land directly in front of the main house at Bessborough was required for a water main for a proposed new development. This work was eventually undertaken in 1982 and the congregation received compensation of £18,000 as the land was out of commission for a number of years. The congregational council decided to give £5,000 of this money to set up a separate bank account for the Sacred Heart Adoption Society (which operated from Bessborough). However, the council envisaged that the adoption society would be phased out over the coming years due to falling birth rates. A request from the Mother Superior, Sister Martha, for the construction of a swimming pool at Bessborough was refused by the congregational council because of the uncertain future of the home and on the basis that women spent relatively short periods in the institution.[60]

The 1980s

18.195 In April 1981, Miss Reidy reported that substantial work had been undertaken at Bessborough. The institution had been fitted out with a new boiler, washing machines and tumble dryers and the kitchen was fitted with a cold room and dish washer and a new gate to allow ambulance access. The major work undertaken was in relation to fire safety which saw fire escapes fitted to the upper floors of the home, seven fire exits installed in the maternity hospital, the complete electrical re-wiring of the nursery and the application of fire-proof plaster board to wooden partitions. Miss Reidy reported that the premises were clean and well-kept, records and registers were up to date and the wellbeing of the residents was satisfactory.

Residents included two third level students respectively, one second level and one art student. Where coaching is necessary it is undertaken on a voluntary basis by teachers. Examination candidates are few and in the main attend the

[59] Sisters of the Sacred Hearts, Annals of the Order, 19 August 1930.
[60] Sisters of the Sacred Hearts of Jesus and Mary, Council minutes, 1977-83.

local examination centre. On one occasion, special consent had to be given to appoint an invigilator to supervise the examinee in the Home.

18.196 In the period since her previous visit in April 1978, 194 babies were born in Bessborough. A further 101 women were transferred to St Finbarr's Hospital, and 12 to the Erinville Hospital for delivery there. Five stillbirths occurred among women transferred to St Finbarr's Hospital. Two infants died in Bessborough during this period; the causes of death were given as prematurity and brain haemorrhage. By this time, Dr Pillay had succeeded Dr Sutton as consultant obstetrician to Bessborough - see below.

18.197 In May 1981, the Department of Health wrote to the Southern Health Board (SHB), about the rates of perinatal mortality at Bessborough. The SHB reply, sent in March 1982, stated that the facts were as reported by Miss Reidy: six neonatal deaths occurred in the period mentioned, two in Bessborough itself and four in St Finbarr's Hospital, and five stillbirths occurred in women transferred to St Finbarr's. The SHB acknowledged that this perinatal mortality rate was twice the national average. The Director of Community Care for Cork investigated the deaths and determined that 'little could have been done in any of these cases'. Four of the women involved had an average age of 17 years. Of the neonatal deaths, two showed 'gross deformity' after birth, and one was 'extremely premature'. Of the other three cases, 'one involved extreme toxaemia, another pneumonia and another was transferred in labour and delivered as breach (sic)'. The SHB advised the department that it was considering the future of obstetrical services at Bessborough.

18.198 The Sacred Hearts Home, Hospital and Adoption Society, *Report 1982*,[61] stated:

> Our aim is to help the girl accept the new life within her. We do this by helping her understand her situation, to restore her feelings of self-worth and esteem. At the same time, we are acutely conscience of the pressures on the single pregnant girl, from family, boyfriend and from society. There are no easy solutions to these complex and deeply human problems. We do provide a comprehensive programme that takes into account the welfare of the girl and of her baby.

[61] The Commission has not seen such reports for other years.

18.199 The report said that in 1982, services offered by Bessborough included: medical and obstetrical care; child care; individual/group counselling; group living; continuation of school education; adoptions; fostering; post-adoption family counselling and help with extra-marital pregnancies. The maternity hospital was staffed by a matron, six nurses and four visiting doctors. Services included prenatal classes with a psychoprophylactic exercise programme along with information sessions on nutrition and child development. Classes in child care were offered for women who planned to keep their babies. Nurses were available for personal health counselling and the identification and treatment of medical problems. Residents were examined by a resident midwife and by a specialist obstetrician at weekly clinics.

18.200 The report said that in 1982, 218 women were admitted to Bessborough. They were referred by Health Boards (35%); General Practitioners (22%); St Anne's Adoption Society (17%); direct referrals (14%); Catholic Protection and Rescue Society (7%) and priests (5%). The Congregation of the Sacred Hearts placed a further 23 expectant women with families in the community. One hundred and eighty eight babies were born during the year; 150 were delivered in Bessborough and the remaining 38 were born in outside hospitals. Ten women had made prior arrangements with city hospitals for the delivery of their babies and the remaining 28 were transferred to St Finbarr's Hospital due to twin pregnancies, foetal distress, breech deliveries, disproportion and toxaemia. No stillbirths, neonatal or maternal deaths occurred in Bessborough during 1982.

18.201 In 1982, 135 infants were discharged from the Bessborough home; 95 were placed for adoption; 36 were discharged with the mother and four extra-marital babies 'were dealt with'. Infants who were not discharged during the neonatal period were cared for in the home on a short term basis 'giving the mother time to come to a mature decision about her baby's future'.

18.202 This report stressed that the main characteristic of the home was 'Group Living'. The authors acknowledged that some 'girls' found group living difficult and women who could not settle in the home were placed with a family in the community until they went into labour. The report stressed that group living was designed to make each woman entering Bessborough aware that her situation was not unique, that she would benefit from the support and understanding of her house mates and that she would see different ways of dealing with her pregnancy in its different stages.

18.203 A section of the report, accredited to a resident of the home, said that group living was, for many, 'a strange and difficult experience fraught with tensions and frictions' caused by 'clash of personalities' and the fact that 'many women were under immense emotional strain'. However, the woman went on to state that communal activities such as helping in the nursery, attending shorthand/typing courses and parties organised by a local youth group 'allowed staff and residents to communicate in an easy and relaxed atmosphere'.

> Finding oneself alone and pregnant is a shattering experience especially in a society where one is frowned upon and condemned. It is therefore relieving and comforting to know of the existence of the Sacred Hearts Mother and Baby Home, a refuge where one can have one's baby away from the knowing stare and the pointed finger... It is consoling to know that 'I am not the only one', and supporting to be with others in a similar situation and sharing the same experiences, pregnancy, rejection, etc.

18.204 With regard to the decision to adopt or keep a child, the 1982 report stated:

> This is a decision that every single girl has to face. It depends on the personal situation of each individual and the particular circumstances of each case. In some cases Adoption would prove the correct procedure, while in other cases keeping the baby is a practical alternative. The decision should be a well-informed one carefully made by the girl herself once she has weighed up all the pros and cons guided by her Counsellor. It should not be a hasty one made largely in response to family and media pressures.

18.205 If the woman decided on adoption, the baby was placed with Bessborough's adoption team, headed up by Sister Sarto. In her evidence to the Commission, Sister Sarto said that, in her role as social worker at Bessborough in the 1980s, she counselled birth mothers to help them to come to decisions about the future, both for herself and the child. She and two other social workers at Bessborough helped women to evaluate their options including the possibility of keeping the baby, taking the baby back to the mother's family home, setting up home with the father of the baby or giving the baby up for adoption. Sister Sarto said that a nursery housed older infants, who were, in the main, children of women who had not yet made up their minds whether to keep their babies or to have them adopted. The women chose to leave their infants in the nursery while they took time to consider future possibilities for themselves and the baby with their families and partners.

18.206 When a woman decided that adoption was the best option for her child her appointed social worker explained the legal procedures for adoption to her. Sister Sarto told the Commission that when a baby was handed over to the adoptive parents it was a 'joyful time' for the new family and a 'sad time' for the birth mother. The women who placed their infants for adoption required much emotional support to cope with the sadness they experienced on parting with the child.

> In the early days the mothers would not be present when the babies were handed over to the adoptive parents but as time went on each mother could choose to be there or not... In later years the birth mother could meet the prospective adoptive parents and even choose which family the baby would go to... The mother could also choose the social background of the adoptive couple.

18.207 Women who chose to keep their children were assisted with finding accommodation. Sister Sarto told the Commission that she obtained two houses for women leaving Bessborough with their children in the Mahon area from Cork county council which housed four women and their infants. In other cases, she helped women to find private rented accommodation and helped them to pay their rent. She stated that annual fundraising activities supported these initiatives and facilitated the procurement of prams, buggies and clothes for women and their babies. In 1984, the congregational council was asked if they would purchase a newly built house in the vicinity of Bessborough to convert into flats for mothers and their toddlers. The congregational council did not agree but gave a commitment to procuring rental accommodation to accommodate women and their babies who had no other options regarding accommodation when they left Bessborough.[62]

Educational opportunities

18.208 Sister Sarto told the Commission that, in response to increasing numbers of schoolgirls becoming residents, Bessborough's education centre ran classes based on the secondary school curriculum and that social workers tried to provide girls, still in full-time education, with the means to continue their education through Vocational Educational Committee (VEC) schemes. In addition, AnCO, the Industrial Training Authority, ran a commercial course in the home.[63] Women

[62] Sisters of the Sacred Hearts of Jesus and Mary, Council minutes, 1984-85.

[63] An Chomhairle Oiliúna (AnCO) was established by the *Industrial Training Act 1967* to provide industrial and commercial training. It was abolished in 1987 by the *Labour Services Act 1987* and replaced by An Foras Áiseanna Saothar (FÁS). FÁS

could take courses in typing and hairdressing and a course in electronics was introduced in 1983. An AnCO tutor at Bessborough said that women who took a course were 'happy and very interested in what they were doing' and were all 'anxious to get themselves back to work'. During 1982, 97 women availed of classes in the Bessborough Education Centre: 40 took an AnCO course; 33 took non-examination subjects; 13 were second level students and 11 were third level students. Exam subjects which could not be provided for in Bessborough were undertaken in a nearby secondary school. A preventive education programme, developed by social workers at Bessborough, was presented to teenage school children, male and female, in 14 schools during 1982. Sister Sarto told the Commission that the VEC provided the services of a psychologist who offered individual counselling at Bessborough and the Southern Health Board financed group therapy sessions facilitated by a 'variety of professionals, many from UCC'.

Concerns about costs

18.209 A Southern Health Board (SHB) memo, dated April 1985, stated that Bessborough had two functions: (a) as a mother and baby home, and (b) as a registered adoption society, 'which has twice been struck off the register and reinstated later on both occasions'. The SHB was unhappy with the cost of providing the Bessborough services; the cost was given as £450,000. The memo also suggested that the length of stay in Bessborough was generally too long and cited examples where 'unmarried mothers who received Unmarried Mothers Allowance, and were also involved in AnCO training courses, were receiving free accommodation etc., in Bessborough'. The SHB 'hoped to cut their £450,000 operating budget to ribbons'. The congregation's council minutes show that, by 1987, the Bessborough budget has been reduced to £100,000.[64]

Closure of maternity hospital

18.210 In April 1985, the general hospital services division of the Department of Health wrote to Miss Reidy to say that a 'nun/midwife' working in Bessborough had been in contact in a private capacity to state that deliveries of babies should be discontinued there and that women should be transferred to a fully staffed maternity unit when they went into labour. The department considered that Bessborough was 'more or less' a matter for the Southern Health Board 'who don't

was itself replaced by An tSeirbhís Oideachais Leanúnaigh agus Scileanns (SOLAS) under the *Further Education and Training Act 2013*. In general, participants in training courses were paid a training allowance.

[64] Congregation of the Sacred Hearts, Council minutes, 9 January 1987.

seem to have a high regard for it'. The letter asked Miss Reidy to keep an eye on Bessborough and added:

> I would be interested in hearing any developments re discontinuance of deliveries, a move which the Division would favour in light of overwhelming medical opinion and evidence re non-consultant staffed units.

18.211 In August 1985, the Department of Health directed the Southern Health Board to take steps to phase out obstetrical services at Bessborough. The decision was taken in the interests of the safety of women and their babies and to bring services in the home in line with those provided in similar homes throughout the country. Mother and baby homes should have a 'social function only':

> Serving as a refuge for unmarried mothers and their children and providing them with counselling and accommodation during the latter months of pregnancy and for a short period after delivery... For the unmarried girls who reside in 'mother and baby homes', and their babies, pregnancy and delivery carry a much higher than average degree of risk and this is particularly so during the perinatal period. The significant reduction in perinatal and neonatal mortality rates in recent years has been due to the vast improvement in maternity and neonatal services. To continue to carry out deliveries of this high risk group in a non-consultant staffed unit, funded by a Health Board, would appear to be contrary to the Department's clear policy on deliveries.

18.212 In September 1985, the Department of Health noted that the Congregation of the Sacred Hearts of Jesus and Mary had agreed to discontinue obstetrical services at Bessborough and the Southern Health Board had made arrangements to transfer women for confinement in St Finbarr's Hospital. The congregation records show that it favoured this change and agreed with the SHB proposal that women could stay in St Finbarr's with their babies for up to four days. The SHB also stipulated that the maximum period for a post-natal stay in Bessborough would be six weeks. However, some of the women who gave birth in St Finbarr's were requesting transfers back to Bessborough two to three hours after delivery. This combined with the compulsory discharge of the mothers after six weeks meant that nurseries at the home quickly became crowded with unaccompanied new-born babies. The SHB accepted that their new policy was not working and agreed to maintain women in the home for periods longer than six weeks. As a trade-off, the SHB insisted that Bessborough would also cater for women with extra-marital pregnancies and women on their second pregnancies. In addition, the SHB

decided that if a woman had decided to keep her baby that she would be obliged to care for her child 'as any other mother in a home situation - feed, prepare feeds, wash etc. total care' while living in Bessborough. The SHB also directed the Bessborough authorities that no woman was to be allowed re-enter the home to participate in an AnCO training course and that such courses were to be undertaken on a non-residential basis. The SHB stated their concern that single mothers claiming social welfare payments would also use the Bessborough address to claim a training grant.

Tracing

18.213 The congregational council minutes show that there was a significant increase in the number of people contacting Bessborough 'seeking their roots' and looking for documentation and information relating to their time in the home. It was noted that this work was time intensive and that the sisters had received around 100 tracing inquiries in the last six months of 1987.[65]

Rationalisation of mother and baby homes

18.214 In February 1986, the Department of Health child care division drew up a rationalisation programme for mother and baby homes and infant nursing homes. The stated rationale of the proposals was to bring the facilities in question 'in line with modern-day thinking and needs' and to provide scope for 'the re-deployment of any surplus resources into the development of support services for these families, in their own communities'. Among other things, this programme suggested closing Bessborough. The department stated that 'greater tolerance and compassion' towards the single pregnant girl, along with the development of voluntary organisations providing support, advice and information to single mothers who wished to keep their children, had accelerated a drop in demand for mother and baby homes. The introduction of the Unmarried Mothers Allowance in 1973, the falloff in the number of children being placed for adoption and the rise in the number of Irish women seeking abortions in the UK were cited as further factors which influenced the demise of the mother and baby homes.

18.215 The department noted that there were only 14 women in Bessborough in December 1985. The department proposed that services at Bessborough would be gradually phased out and replaced with a scheme providing ten supervised

[65] Congregation of the Sacred Hearts, Council minutes, 4 January 1988.

flatlets supported by 'a strengthened community social work service' and 'an expanded fostering programme'. It was envisaged that this scheme would cost in the region of £60,000 each year and would represent a significant saving to the Southern Health Board, which had provided funds of £444,300 to Bessborough in 1984. It was suggested that the surplus resources would be allocated to other child care services.

18.216 In April 1988, the congregation began to develop other services at Bessborough. Sister Sarto formed the Blackrock Heritage Committee whose stated aim was to develop the Bessborough estate as a 'cultural, educational and leisure amenity and tourist attraction'. The congregation also planned to extend its services for one parent families with a focus on improved accommodation, additional counselling and guidance facilities and wider access to second and third level educational courses.

18.217 In January 1989, a Department of Health official visited various institutions in Cork, including the Bessborough home. In her report, the official stated that, despite an agreement between the Southern Health Board and the congregation, reached three years earlier with a view to phasing out services in the home, institutional services for women and their babies had continued at Bessborough. Furthermore, the Southern Health Board had allocated £300,000 to Bessborough for 1989. There were 22 expectant women living in Bessborough at the time of her visit, two of whom 'were on their second pregnancy and had toddlers staying with them'. She noted that most of the women attended an onsite FÁS Training Centre during the day.

18.218 In 1991, a report on Bessborough by two members of the congregation noted the varied work which was being carried on there. They noted that the congregation was actively involved in training and educating the pregnant women and that an onsite social welfare officer advised women, and those undertaking training courses, about their social welfare entitlements. In addition to the hostel for single expectant women, the Sisters operated a day nursery and crèche for working mothers and maintained three flats for mothers and babies waiting for housing and a number of short stay flats for mothers and their new-borns. Of the ten infants housed in the nursery at the time of their visit, one or possibly two were going for

adoption. They noted that Sister Sarto was kept busy dealing with ever increasing queries from former residents.[66]

18.219 The congregational council minutes for 1996 noted that, due to the negative attitudes towards the religious in Ireland, the authorities at Bessborough did not see fit to undertake fund raising activities. It was also noted that a negative programme broadcast on Irish radio relating to living conditions in Bessborough during the 1950s further impacted on their ability to raise funds. The Mother General donated £10,000 to the home to help bridge the shortfall.

18.220 Bessborough continued to provide services for single women and their children, as well as married women with extra-marital children. In the period 1986 to 1992, 826 women, or an average of 118 women a year, were admitted to the institution. By 1998 this had dwindled to just 37 admissions. In July 1998, Sister John Vincent wrote to the registrar of the Adoption Board to say that the congregation had decided to withdraw from the placement of babies for adoption but wished to continue its work of 'search and reunion' and the care of expectant women. The last single expectant woman was admitted to Bessborough in November 1998 and the last woman and child were discharged in November 1999. Other services for vulnerable women and children continue to be provided.

Evidence of former Bessborough staff

Sister Mary McManus, was in Bessborough 1948-69 and 1970-1998.

18.221 Sister Mary was born in 1926. She entered Bessborough in 1948. She worked in one of the nurseries in the home looking after toddlers. She said that the hospital was completely separate from the home and was run by a matron. The women gave birth in the maternity hospital and were transferred to the home with their babies after around six weeks. The four nurseries in the home were overseen by four registered nurses from among the congregation. Sister Mary said that the social stigma associated with single motherhood at the time was 'terrible, shocking'. She described the women:

> They came in very distressed, very sad and they didn't want anybody to know about them and we tried to protect them all the time. I was trying to make up stories for them and help them, do all I could, you know, so that the

[66] Congregation of the Sacred Hearts, Council Minutes, January 1991.

neighbours or the parents or family nobody wanted to know them... Well, we pretended that they were in England or pretended they were in Scotland and the Sisters abroad, we sent the letters over and the Sisters would stamp them... and they would stamp the letters and send them back and pretend that they were working in England... They were rejected by society, it was very sad, shocking and they were lovely girls.

Many women entering Bessborough gave false names to protect their identity. This became obvious when a tracing inquiry was made. In relation to 'house names', she said:

> That is what they wanted; God help them that is because they didn't want - it was all confidentiality. All the time to protect them, all the time to protect, all my life trying to protect them.

18.222 She remembered that girls as young as 14 were admitted. She remembered one girl turning up at the convent covered in grass and carrying a baby having given birth in a field. In another instance:

> This girl came, this girl came at 1 o'clock in the day. She came - now, this was in the early 80s, she came at one o'clock in labour. I answered the door to her and she said to me "do you think I could be back at 6 o'clock in the evening?" I said "I am sure you will". So I took her down to the labour ward and she gives a list. "Will you ever go down to the shop and get the groceries for me because my mother is in bed an invalid and she doesn't know I am having the baby". I brought her over and handed her over to the midwife and she had her baby and she was back at 6 o'clock. And we couldn't hold her... We got the doctor and we couldn't hold her. And she went away and she went off and she didn't live too far away and she went back and the mother never knew a thing about her. And then she came back after a couple of weeks and sorted things out with us. We rang her doctor and we did everything... She went away after the baby was born, that was the pressure of society on her.

18.223 Sister Mary stated that she was responsible for dress making and sewing in the institution and that, in the early years of the institution, all women dressed the same.

> And we, you see, some of them would - we didn't - some of them came in with clothes, some came in just with what they had on them. And we didn't want ...

> one looking down on the other and that is why we had them all in the same dress... Until I think it was the 60s then, the girls decided and we decided that [they could wear their own clothes]

18.224 She said that the women's clothes were made from simple patterns made from either blue or red fabric. Many women helped to make the clothes and some brought their own patterns with them. She taught women tapestry, marquetry and lace making.

18.225 Sister Mary said that, when the nursery at Bessborough became overcrowded, children were transferred to St Finbarr's Hospital [Cork County Home] and children who could not be adopted were transferred there also. The women's relatives did not help in any way and they did not want their children at all. Prior to the introduction of legal adoption, the Catholic Women's Aid Society placed babies in the nursed out and boarded out informal adoption systems.

18.226 Sister Mary remembered that the nights at Bessborough were often 'great craic'. The ballet dancer Denise Moriarty often put on shows at the home along with singers and other performers and they had regular concerts in the home. Danny Hobbs used to show films in the home. The atmosphere in the home was 'great' and she heard few complaints.

> I did my very best to make them happy, I knew that they were sad and lonely and tried to help them and support them best I could. I really loved them and I gave my whole life to them and I would do it all over again.

18.227 Sister Mary remembered the two Department of Health inspectors, Miss Litster and Miss Reidy, visiting the institution. Dr Sutton [gynaecologist] and a paediatrician worked at Bessborough for most of her time there. Dr Sutton visited the maternity hospital Monday to Friday at 10am. She did not recall any child dying in Bessborough during her time there.[67] She worked in a nursery with toddlers and older children and there were no deaths among this group. She explained that a woman whose child died in the maternity hospital would not be admitted to the home section of the institution. She never encountered such women as they were discharged directly from the maternity hospital. Sister Mary did not know anything about infant burials but stated her belief that infants were buried in the same onsite

[67] However, her name is given as the informant on a number of deaths registered with the GRO.

cemetery as the nuns. (See the Commission's 5th Interim Report) Sister Mary did not agree with the allegations made by June Goulding in her memoir (see below). She was particularly upset by the assertion that women in Bessborough were 'treated like criminals' and that they were in Bessborough solely 'to atone for their sins'.

> They were sinned against, the girls never sinned. They were just used. Poor little creatures, God help them... my heart went out to them.

18.228 Sister Mary said that, when she returned to Bessborough in the 1970s, she was on the committee of the Sacred Heart adoption society. She drove members of the committee around the country to interview prospective foster parents.

> When the people would write in about adoption, we would ask them to come in and visit us. And we would ask them all about their - why did they want to adopt, all this sort of thing, you know. And we would give them a questionnaire and they would take it home and fill it in. And had a Garda report and all sorts of Garda references and finance and all that and their relationship with each other, did they want to adopt and why did they want to adopt, all that sort of thing. And then they would come in, the couple would come in together and we do, Sister would interview them and then we would bring them in quite a few times. The mother - the lady, the wife would come in on her own and the husband would come in on his own and then we would meet them again, you know, to see everything was in order and all that sort of thing. To make sure they really wanted a baby, you know, things like that. And what else, you know and then we visit the home and see was the home okay and all that sort of thing. And we'd visit the home several times before they got the baby to make sure.

18.229 She said that women in Bessborough put their babies up for adoption of their own 'free will'. She stated that she had a good relationship with the women and that the decision to place a child for adoption 'came from themselves'.

> If a girl was leaving and she had the baby adopted, she would sign the Form 10, she would sign the Form 10: that was the first. Given the consent we could place the baby. And then when she signed the Form 10 if we - we could place the baby when she signed it. And then when the baby was six weeks old she could sign the final paper but she could still reclaim the baby until the adoption order was made. That could be six months could be 12 months, could be two years.

18.230 She said that 'once a baby went' the mothers left Bessborough. The women were free to leave the home then with no restrictions whatsoever.

Sister Úna Mulvey, [Sister Celeste] Bessborough, 1970-85[68]

18.231 Sister Celeste worked as a midwife in Bessborough from 1970-85. She worked in the nursery with two lay nurses. Both lay nurses were salaried and, as far as she was aware, were paid by the congregation. Dr Pillay was the visiting obstetrician and Dr Eithne Conlon was the visiting GP during her time there. It was the policy to have one of the midwives present with the obstetrician.

18.232 Sister Celeste said that she observed changes in attitudes towards single motherhood in Ireland during that period. The introduction of Unmarried Mother's Allowance was 'a very big thing' for women because previous to that most single women did not have the financial means to keep their babies. She also stated that there was more social acceptance of single motherhood in the 1980s .

> So a number of them then began to rethink and they thought maybe they might keep their babies, you know, because that made a difference. So they were applying for the Unmarried Mother's Allowance. It was much more acceptable to be pregnant. That was one of the differences I think. I suppose between the time I started there and the time I finished, by the time I finished I saw that, I began to wonder, do we really need to actually do deliveries here [in Bessborough] because most of the women coming no longer needed to hide. It was acceptable to be pregnant and they were out every day anyway down in the town and, you know, all places.

18.233 She said that in 1978 practically all the woman who passed through Bessborough put their children up for adoption but by 1985 a large percentage of women (she estimated 25%) were opting to keep their babies.

18.234 Sister Celeste said that she undertook a survey in 1984 to ascertain if women had any objection to being admitted to St Finbarr's Hospital in the first instance to have their babies. All but one woman expressed no concerns regarding this suggestion. The woman who did raise an objection was a teacher from the Cork area and it was important to her that she would not be recognised because she feared that it might affect her position in the school.

[68] Sr Mulvey died in May 2020 RIP.

18.235 When Bessborough ceased to provide maternity services in the mid-1980s, they kept St Finbarr's antenatal forms in the home to be dispatched with the women when they were transferred to St Finbarr's for delivery. They were careful to maintain the women's anonymity when filling in the antenatal forms.

> When somebody needed to go to St. Finbarr's I just sent the notes you see because on the notes that we had in the maternity there was nothing that was confidential, you know. It was all to do with the pregnancy and the mother and the baby, the growth of the baby and all that. There was nothing about her background or anything so it was safe enough for that to go with the mother.

18.236 Women continued to be admitted to Bessborough in the antenatal period. Most needed the time to come to terms with their pregnancy and most were 'unwanted pregnancies'. Many women had been ousted from their family homes and many others had lost their jobs because they were single expectant women. Their time in Bessborough gave them an opportunity to consider their options.

18.237 Sister Celeste acknowledged that some women found institutional living conditions challenging.

> Some of the girls would have, you know they would find it difficult, you know, to be with other people like if they were an only child and they suddenly, you know ... and especially if they had been rejected and now they are with a crowd and, you know, they might find mixing difficult. So we would listen and we would see what we could do to help the person and that kind of thing.

18.238 She said that Sister Philomena undertook renovations at Bessborough as she was anxious that women would have some privacy while in the home. She put measures in place to ensure that women had their own rooms rather than living under dormitory conditions. Women did not work in the maternity hospital:

> From my memory there was no mother, and I put my hand on the Bible, there was no mother who did housework of any description in the maternity. What happened in the rest of the house I cannot say ... I don't ever remember a mother taking a brush in her hand.

18.239 Sister Celeste recalled that a woman who had been transferred to St Finbarr's Hospital in the 1980s had told staff there that she had been involuntarily 'digging potatoes' and 'scrubbing floors'. Sister Celeste stated that there was no farm in

operation at Bessborough during her time there and that floors in the institution were carpeted. There were employed staff in the maternity hospital 'for cleaning and everything else'. She said that during her time at Bessborough women were busy undertaking AnCO courses and were paid £15 a week. Women could choose courses such as pottery, hairdressing, cooking, horticulture and typing. Many women living in Bessborough in the 1980s were doing the Intermediate and Leaving Certificates.

18.240 Sister Celeste said that she met and examined every expectant woman admitted to the maternity hospital during her time there. The regular contact with women allowed her to form a bond with them and their babies.

> You know it is amazing, you know, if you are a midwife and when you are ... a baby in the womb and you know if you are in an outside hospital and you know they are just coming in once in a while, you mightn't see the same women the next time, but in Bessborough, you not only knew the mother, you began to know the baby. You almost had a relationship with the baby because you knew how they were kicking ... We knew them so well and we had a good relationship with them and they were so confident.

18.241 There was one infant death in the maternity hospital during her time there. Dr Pillay had been called to assist and performed a forceps delivery. The baby was born with the umbilical cord knotted around the neck and died after ten minutes.

> I remember it so well and I remember Dr Pillay and the two of us we sobbed, we cried. It was the little girl in the bed who consoled us. The mother was the one consoling us. It was only afterwards I knew everything was back to front. We should have been consoling her and she was consoling us we were so upset.

18.242 She believed that the infant was buried in a family plot in St Michael's Cemetery.

18.243 Sister Celeste stated that the infants born in the maternity hospital were moved to a larger nursery after about ten days. The mother might have gone home at this stage to consider her options. After a couple of weeks, infants were transferred to the nursery in the home and remained there until they were around 12 weeks old. She remembered that one child had been left in the nursery for five months as the mother had not come to a decision about its future. The sister in charge of the

home nursery felt that this was too long for the child to be unaccompanied but they had no interaction with the mother or the prospective adoptive or foster parents.

18.244 Sister Celeste remembered driving Sister Sarto to a farm to speak to a woman about a tracing request. Sister Sarto put some potted plants in the back of the car so that they could pretend to be selling plants when they arrived at the woman's house. The woman in question had entered Bessborough under a false name but Sister Sarto had managed to locate her. Having arrived at the farmhouse, Sister Sarto asked the woman to sit in the car with her and then revealed who she was and stated her business. Sister Celeste stated that the woman was shocked and upset. The woman said that she thought about her time in Bessborough and the child she had there every day. She said that every night she had planned to tell her husband that she had had a child before she met him but could not bring herself to do so. She said that she could not let her children and grandchildren know this about her. Sister Sarto pleaded with the woman stating 'the woman [her daughter] just wants to meet you'. The woman replied 'I cannot meet her. Please leave and don't ever come back'. Sister Celeste stated that the woman who initiated the tracing was contacting Sister Sarto regularly looking for news and subsequently arrived at Bessborough from America. She stated that Sister Sarto told the woman that she could not bring her to meet her mother and that this caused the woman to become 'angry'. Sister Celeste stated that Sister Sarto was very upset by the case and felt that the woman held her responsible. She stated that this was just one case and that there were 'lots more' tracing cases which ended in this fashion.

18.245 Sister Celeste recalled one woman who arrived at Bessborough in labour. She had her immediately transferred to St Finbarr's hospital. She arrived back to Bessborough with her child the following day. Later that day, Sister Celeste was told that this woman had 'put her suitcase out the window' and she was attempting to leave the home via an upstairs window. Sister Celeste told the woman that she was free to leave by the front door. She cautioned the woman that she may still experience some bleeding so soon after the birth and advised her to stay in Bessborough for postnatal care. The woman could not be convinced to stay in the maternity hospital. She agreed to sign a note stating that she was discharging herself contrary to medical advice. She left without her baby. Sister Celeste said that this woman subsequently returned to Bessborough to put her child up for adoption. The woman was insistent that the paperwork relating to the adoption be

done expeditiously and, as Sister Philomena was away, she drove the woman to a solicitor to sign the adoption papers. Sister Celeste said that about three years later this woman took a legal case against the congregation claiming that Sister Celeste had 'forced her to sign an adoption order'. Sister Celeste produced the 'self-discharge' document. There was a significant time gap between the date of the woman's discharge and the date on which she had returned to Bessborough to sign the adoption papers and the case against the congregation subsequently failed. Sister Celeste took umbrage with the woman's claim that her child had been subject to a 'forced adoption'. However she stated that in her opinion 'the woman should have got her baby back'.

Sister Sheila Buckley, Bessborough 1971-74 and 1977-90

18.246 Sister Sheila was transferred to Bessborough, along with two nurses, when Castlepollard closed in 1971. There were between 40 and 60 women living in Bessborough at that time. At Bessborough, she worked with Dr Sutton, who visited the home once a week, and Dr Eithne Conlon. Sister Hildegarde was the Mother Superior at that time.

18.247 She did not remember a working farm during her time at Bessborough but there were greenhouses. The women living there were asked if they would prefer to work in the greenhouses or in the home. No woman ever refused to do work incidental to the running of the home and the women 'weren't really troublesome'. She never heard any complaints from the women and Sister Hildegard was very sympathetic with them. She described the atmosphere:

> Well they were always wary, when they came in, they made great friends among each other, the other girls that were there, you know. They were always very happy and contented there. They had a smoke room. They smoked a lot in those days, inside and outside. I mean they would play games and cards and that kind of thing. You would hear them laughing all over the place so they weren't really very unhappy. You would be saying be quiet and don't wake the babies in the nursery and things like that to them, you know. They were young as well, you know. But they seemed quite happy and contented, yes.

18.248 She said that Sister Isabella was in charge of the women while they were in Bessborough. Sister Isabella would refer them to a midwife if they were anxious

about their pregnancy. She arranged their meals and clothes and supervised the dining room.

> She [Sister Isabella] was very kind to them really. She'd mothered them more than anything I would say. She was very considerate to them and always made sure that they had, you know, clean clothes and looked after their hygiene and things like that.

18.249 Sister Sheila said that there were no uniforms in Bessborough during her time there and that women wore their own clothes.

18.250 She was not aware of any infant deaths in Bessborough during her time there. However, she stated that infants who died in the home were buried in the congregational burial ground onsite at Bessborough.

18.251 In her second period working in Bessborough, Sister Sheila was assistant to Sister Philomena who arranged adoptions from the home. She remembered that women signed an adoption form before they went home but that they could claim the child back at any stage before signing the final adoption papers.

> You would talk to them obviously, find out what the reasons behind it all were. Very often it would be the family, you know, that made them change their minds when they went home... Well you would go and approach the adoptive parents and tell them the mother had changed her mind. It all became very upsetting obviously for the adoptive parents but there was nothing that could be done about that.

18.252 Sister Sheila stated that neither she nor Sister Philomena ever put pressure on a woman to have her child adopted. Such pressure came from their families and 'from society in general'. Women would often tell her that their decision to place their children for adoption was influenced by their own mothers or grandmothers. The women returned to Bessborough when they had made a decision and Sister Philomena would talk with them to make sure that they were happy to proceed with the legalities of adoption. Sister Philomena would then take the woman to a solicitor to sign the final adoption papers.

> She would phone to say she was coming back, the mother would, yes, or write, you know ... She might stay overnight a night or two but the ones I remember they just came in the morning and, you know, had their mind made

up and just went in and signed the paper, provided the solicitor was available, yes.

18.253 She described the process of handing over a child to adoptive parents:

> In a normal case, well if the baby went from the Neonatal Ward where I would be working, I would dress the baby, the mothers provided the clothes, I would dress the baby and take the baby to the parlour. I would meet Sister Philomena and she would do the handing over of the baby... She [the mother] wouldn't be present where the adoptive parents were but she would know. She would be dressing the baby with me if she was still in the home... she would know the parents were coming that day for the baby. She would be with you but she wouldn't go to the parlour with you, not in my time.

18.254 Sister Sheila acknowledged that this was a distressing time for many mothers. The women would have a certain amount of information regarding the background of the adoptive parents but, as far as she was aware, never actually met them.

18.255 There were few supports available to women who wished to take their babies home with them and women who did so would have been dependent on the support of their families.

Dr Pillany Pillay: Visiting Consultant Obstetrician to Bessborough in the early 1980s

18.256 Dr Pillay trained in the Royal College of Surgeons Ireland and qualified in 1965. From 1974 to 1980, he was a Consultant Obstetrician at St Finbarr's Hospital, Cork. He became involved with Bessborough through his association with Dr Sutton who also worked in St Finbarr's Hospital. Dr Sutton was visiting Obstetrician to the Bessborough Hospital from 1945 until his death in January 1980. Dr Pillay said that women from Bessborough attended St Finbarr's for antenatal classes. After Dr Sutton died, the Bessborough administrators would call Dr Pillay to attend at a difficult labour and his association with Bessborough grew from there. He stated that there was no official appointment but he received a 'small cheque' from the Congregation of the Sacred Hearts every month. Dr Pillay recalled that Sister Martha was the Mother Superior at Bessborough during his time there, Sister Sarto 'administered' the institution and Sister Celeste was the resident midwife. Dr Pillay said that Sister Celeste was extremely competent. He said that the women from Bessborough did not like attending St Finbarr's for

antenatal treatment as they feared being recognised so he decided that he would conduct the antenatal care in Bessborough.

18.257 He also attended deliveries at Bessborough and women were transferred to St Finbarr's only in exceptional cases. Sister Celeste delivered the majority of the babies and Dr Pillay was called if an episiotomy required repair or if a woman suffered from pre-eclampsia. He said that there was oxygen and nitrous oxide (gas and air) available to women at Bessborough but there were no epidurals available to them; epidurals were not available in St Finbarr's Hospital at that time either.[69] Local anaesthetic was used in cases where he repaired a birth passage. He said that women in Bessborough were well-fed and healthy. He understood that they did some work in the grounds of the institution and always seemed to him to be 'quite a happy lot'.

A social worker worked in Bessborough for three months in 1984

The witness grew up near Bessborough and recalled that 'it was kind of a local fear that if you stepped out of line you go to Bessborough'. She recalled walking through the grounds as a child, with her mother, who told her not to look at the women who were working there. She said that she was an intern trainee social worker at Bessborough. She recalled that there were three social workers there at that time: Sister Sarto and two lay women. There were a number of training courses, such as gardening and secretarial skills, being offered at Bessborough during her time there and she sat in on these during her working day. In the run up to Christmas 1984, she was engaged in making holly wreaths with women living in Bessborough and another social worker. She remembered one girl in particular. She stated:

> She was a teenager. She was definitely under 16. I was told initially by Sister Sarto I think it was, or one of the other staff members, that her family had dumped her at the door with her suitcase because she was pregnant as a result of incest and she had an intellectual disability, and I just remember her.

18.258 She also remembered two other expectant women who were waiting for their boyfriends to visit. She said that she did not know how to support them but sat with them as they waited. One man walked up the driveway to the main house and

[69] Epidurals did not become available on request in Holles Street hospital until the early 1990s: Peter Boylan *In the Shadow of the Eighth*, Dublin, 2019.

both women ran out to greet him. Neither woman knew that this man had fathered each of their children.

18.259 She never saw the living quarters at Bessborough but stated that she had her meals with the women and staff every day. She recalled:

> I never went beyond the dining room. There was a private, kind of where they were living, I was never allowed in there, but I had my meals there every day and I remember the food was really nice... We would have a three course dinner every day.

18.260 She remembered seeing some old women at Bessborough. Some appeared to be as old as 80 and she thought that they had been there all their lives and were institutionalised.

18.261 She said that she sat with the women making holly wreaths and they talked about their issues and about moving into independent accommodation. She stated that the conversations were about 'typical stuff, boyfriends, labour pains and babies names and things like that'.

> One might be kind of crying because her boyfriend didn't write and someone else might be thinking of what she was going to call the baby.

18.262 She remembered visiting some accommodation on the north side of Cork city to see if it was appropriate.

> The women who I went to see accommodation with were from the north side of Cork city... They were kind of going back to the area, back to their own area but very much they were going to support in the community. Like, they were setting up home for themselves. It was kind of a positive thing.

18.263 The women did not use their real names during their time in Bessborough; they felt that this was in their own best interest. She never saw a doctor visiting Bessborough but she remembered that the women used to talk about Dr Pillay.

> They used to talk about him in a very positive way. That he was gentle and I remember them explaining to me because I hadn't a clue. They were telling me about the different doctors and how it was good to get him. He was the one they were all hoping for.

18.264 The women in Bessborough during her time there were admitted three to six months before their due date. She never witnessed any mistreatment or maltreatment of the women in Bessborough and she recalled that any upset was always more to do with the boyfriends and the women's own families. She did not see any relatives visit during her time there. She described the general atmosphere:

> Well from what I could remember it seemed okay. I was probably glad to get out of there in the evenings but I suppose because I had grown up expecting all this awful stuff it seemed fine you know. It seemed comfortable and it didn't seem like - you know the classrooms didn't seem different to anything else you know. It didn't seem to be a problem... Now I went home when it started to get dark and I wasn't there at weekends or anything but during the day it seemed ok.

18.265 She remembered that visitors did call to see women in Bessborough. However, these were always planned to avoid lots of visitors arriving together. The women did not speak freely when she was in their company and she was regarded as an outsider. Women formed their own relationships with other women in the home and there was a mix of young girls and 'older, more streetwise women: they had little in common apart from the fact that they were pregnant'. She remembered some women talking about the processes of adoption and stating that they would have no control over it. She said that this had nothing to do with Bessborough and was determined by each woman's specific set of circumstances. There was a general assumption that adoption would be the normal kind of outcome. However, she stated:

> I think the girls that I went to the house with they stood out. They were kind of breaking the norm at that time. Maybe it was the beginning of people moving out into supported accommodation or whatever but they seemed to be, they stood out because they were doing something different.

18.266 These women were preparing to move into rented accommodation together and to live independently with their babies. She remembered that one of the social workers advised the women on the type of state assistance that was available to them. She stated that the social workers at Bessborough were confident that the women's families would re-engage with them once they were settled in their own communities.

> Yes, the girls were from Cork City. They were definitely from Cork City because I know the area we went up to and it was very near where they were living you know and I know the talk at the time with [other social workers] was that eventually their families would start kind of engaging with them and support them...It was a rented flat. It was nice...there was great excitement about it...Those girls; again I'd say they were young enough. You know I don't think they were even eighteen. They would have been quite young, or they might have just been eighteen, but they were young, but they knew one another so it wasn't just one in isolation.

18.267 She stated that some women had no other option. She did not see women receiving counselling but that that did not necessarily mean that there was no counselling available. Two of the social workers sat with the women every day during their classes.

18.268 She recalled being asked to assess the home of a prospective foster parent and she felt that she should not have been asked to do this due to her lack of experience.

18.269 She said that placentas were burned in an incinerator at Bessborough every Thursday and 'you could smell them burning all over the grounds'. She wondered what that was like for women who had given birth there.

18.270 She recalled that the holly wreaths were sent into the city to be sold. However, she did not remember the Congregation of the Sacred Hearts operating a shop nor were women expected to sell anything. She said that there was no pressure on women to work quickly and that they sat working and chatting. She said that the older social workers were 'kind, laid back and gentle' and were a great support to the women.

18.271 She said that her time in Bessborough as a social worker left a completely different impression than the one she had grown up with and from what she had read about the institution. She remembered that the women living in Bessborough supported each other in their shared experience. She had no 'heart-breaking or emotional' memories of Bessborough. She was eager to stress that she was not 'glamourising' Bessborough, and that she had been there by choice. However,

she said that if it had been awful she would not have stayed there for three months.

Sister Sarto, 1981-98.

18.272 Sister Sarto worked in Bessborough from 1981 to 1998 as a social worker. She graduated from University College Cork and obtained a postgraduate qualification in social work from Glasgow University. She said that she oversaw Bessborough's transition from a 'medical' to a 'holistic' system of dealing with women and their babies. She explained that maternity services at Bessborough ceased at the behest of the Southern Health Board around 1986 and that 'because society was changing' women could have their babies in St Finbarr's Hospital and then return to Bessborough to be 'looked after'.

> When I say "holistic" I mean the whole lot. I did out a chart of all of the things, which was; the girl, the girl becomes pregnant but she has other problems as well. She may be a very young girl; she may be continuing her education. I approached the VEC and we got teachers who would do their exams. At that stage it was the Inter Cert and the Leaving Cert. If there was a third level student UCC would offer assistance. That would be, that would be education. Again as time was moving on and more and more girls were keeping their babies there were two, there were two nurseries, nurseries for the older child. The older child, when I say "older" maybe weeks or months, where a girl could not make up her mind whether she would have the baby adopted or not, or could she, we offered her all of the different choices that were available to her. Again as time was changing a lot of the girls were keeping their babies so what we needed was, and they were growing up, and what we needed was a crèche, so we started a crèche again.

18.273 Sister Sarto said that there were two other qualified social workers working at Bessborough during her time there. Their salaries were paid for out of a grant from the Adoption Board but she herself was unsalaried. She described the placement of children for adoption:

> Well, first of all, the couple who were interested would have to write to us and we would reply to them, ask them to come for a visit and explain the procedure of adoption. In all we were obliged by the Adoption Board that three meetings had to take place; one to the home and two separate meetings, but it always meant that you would go back a second, maybe a third and a fourth time to see them... We would explain what they needed to

have; like birth certificates, baptismal certificates, character references, all those, Garda clearance, all of that. They would produce all of that. When we had all that all in place we would bring them back in again and discuss with them. We told them that we had a committee and in the committee was people of different disciplines and that we would decide how, what, what criterion would fulfil the need of the girl? The girl in the meantime would be, would be counselled by one of the social workers, [...] and then we had other social workers would come in for a short while. Together we would, the social workers and ourselves would sit down and these are the families, this is what the girl wants. She might not want; she may not want her baby to be placed in the country. She may want the baby to be placed - she may want a professional background or she may not want a professional background... The natural mother would have the control. I just wanted to say too that with the different professionals that we had on the Board they would do their own investigation. Like we had [...] who was a Superintendent of the Guards, he would be asked if there was any question of anything inappropriate he would do the investigation. For example, maybe somebody's husband might have an alcohol problem or whatever or would be known. He would do the investigations from that angle. Dr Conlon from a medical point of view, if there was anything on the medical because they were also asked for medical examination. Garda clearance also would come in. References from the employer. Income, whether the income that they were on would it be sufficient to support a child... In the process then the social worker would be, would be looking after the girl, the girl herself. This would all take place before the baby was born. If a girl came in at whatever time, two months, three months, at any time they would come in, the Social worker would look after her and try to get her to accept what is the best thing for this child, for your child... She would work that through with the mother. Was there a chance of maybe getting married, maybe keeping the baby, maybe the baby going home to grandparents? All of the options that were open to the girl they would be explored by the social worker and given time to absorb all of that. For herself, she would be a disturbed young woman coming in and giving her time to weigh up what she, the knowledge that she was given.

18.274 Sister Sarto said that all children were medically examined before placement for adoption. Any illnesses or physical and mental health issues were always disclosed to potential adoptive parents. The adoption process started when the

woman had made a decision on the matter and once the child was old enough for placement. In cases where a woman could not make her mind up about adoption, Sister Sarto said:

> What we would say to a girl is go home if you can and make your mind up. See what it is going to be like if you go home with a baby and to take as long as she possibly could to make her decision. If it was going beyond the stage of maybe three months, four months then the social workers would become worried here is a child and it does not know where it is going. So again we would try and make contact with the birth mother to make, you know not to pressurise her but to make a decision for the sake of the child.

18.275 The Sacred Heart adoption society liaised with various health boards and other adoption agencies when considering the placement of a child.

> ... we had meetings with the Adoption Board at least once a year. We also had meetings with the Southern Health Board; Kerry, Waterford, Dungarvan and Wexford. If there was a family there that were a more suitable family for a baby then we would liaise with the social worker or the social worker from, we will just say from Kerry, might say well you can't place that baby in Kerry because it will be well known, its family would be well known so they would say will you place the baby for adoption... We would do that. So there was a lot of interaction going on between us. Also the Catholic Protection in Dublin, we had a lot of dealings with them in the past because some of the girls would come, would go to Dublin and get pregnant there, be sent to Cork. So we had a fair amount of dealing with the, I don't know what they are called now but they were called then the Catholic Protection and Rescue.

18.276 According to Sister Sarto, the mother's wishes were paramount when it came to placing her child; it always came down to the same question 'What did the mother want?' Women were generally given a choice of three potential adoptive parents. The woman would be given alternative options if, having met the prospective parents, she did not like them. This was not always the case, particularly in the early 1980s when a relatively high number of women continued to seek admission to Bessborough. As the number of admissions reduced, women had more of a choice. Sister Sarto explained that the reduction in the number of women who sought admission to Bessborough in the late 1980s was due to 'societal reasons' and that parents had become more accepting of their unmarried daughters having babies. She acknowledged that the availability of state benefits to single mothers

was also an important factor. She had approached Cork Corporation in the early 1980s and asked them to provide two houses close to Bessborough to house women who were leaving the home with their babies but had nowhere to go. There were four flats in Bessborough that were also used as temporary accommodation for women who were keeping their babies.

> I went to the Corporation and I asked for houses for the girls and they were, they gave me two houses. The girls who were keeping their babies needed more attention and they would be - we had, in the beginning the two houses there were three mothers and three babies in each house but then we found that three was too many so we cut it down to two. Then after that we had, we had hopes of building social housing for the babies but that didn't happen and the bust came... We would also have other houses that we might have an eye on. We had a house ourselves down the road, so we tried to cope with the girls who didn't have anywhere to go.

18.277 Women stayed in these houses until their social worker found accommodation for them. Women who needed 'a lot of support' tended to stay in these houses for longer periods.

18.278 Sister Sarto said that the use of 'house names' allowed women to maintain their anonymity while in the home and after leaving the institution but stressed that there was no compulsion on women to do so.

> It was for the sake of the girl herself that she would require that, but if she wanted to keep her own name that was perfectly all right. The reason being that should they meet afterwards, two girls might meet afterwards, one may not care who knew it but the other may be conscious of it... and the same with us if we met a girl outside unless she approached us we wouldn't approach her.

18.279 She said that some women who sought admission to Bessborough did not want to stay in the home itself as they did not want to be recognised by other women living there at the same time. In these cases, women were placed with families in the community until the baby was born.

18.280 Two infants died in Bessborough during her time there. She said that both were buried in the congregational cemetery at Bessborough. A third infant had been disinterred from elsewhere and buried in Bessborough also. A plaque in memory

of the children who had died in Bessborough was placed on the folly in 1986 or 1987 and the congregation had organised a commemorative event at that time:

> We had a special ceremony for it; we had a little hymn composed in their honour. We had a full day of celebration of this... we had a film director whose child had died. He had a special celebration there as well. So we had a full day of celebrating the deaths of the babies in my time, I think it was about 1986/87.

18.281 Sister Sarto did not know where children who died in Bessborough from the 1920s to the 1970s were buried. She said that she had visited cemeteries in Cork in a bid to ascertain where the children had been buried but could not settle the matter. Many women gave birth in St Finbarr's hospital and, if a baby was born in St Finbarr's and subsequently died there, she was not able to find out where they were buried.

18.282 The women admitted to Bessborough during her time there were generally referred by a doctor, priest, teacher or self-referred. The women were assigned a social worker and received counselling during their confinement.

> Now when the baby is born a decision would have to be made what was best for her, for baby? If she decided on keeping, we would find accommodation for her and the social worker would continue to help her through any problems she had. In the meantime in the hospital they would be doing all of these exercises; what to do with the baby and how to look after the baby. If the girl, then if she went home she went home and she lived with her parents, stayed with her parents maybe and if she was not they would try to find a place for her. So the social worker would be dealing with all of that; getting her to acknowledge what has happened, to come to terms with what has happened and what is the best thing for your child, and taking her through all of that. Then a decision would be made.

18.283 In the latter years of her time at Bessborough the families of women living in the home became more involved. Mothers and grandmothers would visit women and, on seeing the baby, would advise the mother not to go through with the adoption. This became a more regular occurrence in the latter years of the home's operation and the congregation encouraged family involvement in the decision making process relating to adoption. The social workers at Bessborough discussed the options available to women that might help them to consider keeping the baby

such as the prospect of marriage or hopes that the father of the child might become involved. More and more boyfriends were becoming involved and willing to support the women and their babies in this period.

18.284 Sister Sarto explained the adoption process:

> If she decided look this is what I want to do we would produce Form 10 and take her through Form 10 and what it meant, and that she had a right to withdraw that consent at any time if she wished even though the baby was gone for adoption. She was told about the legal side of that, that she had a right and the adoptive parents have a right to take a Section 3 case... So the Form 10 would be explained to her. She was told did she want her baby to go, when does she want the baby to go? She just couldn't walk off and leave it and we would be reminding her to make, to make her decision, whichever way it was. If she decided then on adoption she signed Form 10 and a social worker or anybody could, well the social worker could witness that Form 10. Then it would be explained to her that after three months that she, you know she would be making a decision, a final decision. Now if she was not ready that three months could be extended. Eventually if she wanted to continue and say, yes, this is what I want to do we would explain to her that she would have to see a solicitor... The social worker would accompany her to the solicitor, introduce her to the solicitor, he would have the Form 4 adoption in front of him and he would explain to her, her legal rights. If she wanted to continue and sign the paper she would sign. She would be told and this finishes, you know you are no longer the mother.

18.285 Sister Sarto explained that a child was not placed with a family immediately after a woman signed a Form 10. The congregation encouraged women to go home and to think about their decision. Sometimes a woman would return to Bessborough with a family member and they would take the child home. If the woman could not make a decision then social workers at Bessborough would advise her not to sign the adoption forms. If a woman had signed a Form 10 and subsequently decided to keep her baby, the Form 10 was 'torn up'. When a woman had made a decision to put her child up for adoption, she was brought to a solicitor to complete the process. This involved only the woman and the solicitor but a social worker sat with the woman if requested to do so. The solicitor would always ask a woman if she 'understood what she was signing' and that it was 'what she wanted'.

Landscaper, Bessborough, c.1983-2003.

18.286 The witness was contacted by Sister Sarto in 1983 to assist with landscaping and other work at Bessborough. He was a civil servant and he worked in Bessborough in a voluntary capacity. Sister Sarto had set up AnCO employment schemes which took on local unemployed men. When he started there, the farm had been neglected for over 40 years and the 'place was a wreck'. The farm buildings were renovated under the AnCO schemes and he built a garden and courtyard for the women living in the home. He helped to design and build a heritage park at Bessborough in 1986 or 1987. He built a 'Celtic garden' with a waterfall feature to the south east of the congregational graveyard in the area adjacent to the folly, a feature he called 'the Keep'. He dug up trees in the area surrounding the graveyard and folly garden feature.

> So, I did a lot of excavation in that area around the graveyard... They've actually cut some of those trees down but it's around, all around the back of the walled-in graveyard. There is an old Keep there. An old stone keep, a natural stone keep and it is all around that, the back of the ... actually where the Nuns are buried in the graveyard.

18.287 He used a JCB to excavate the ground surrounding the graveyard and folly. He had to dig five or six feet deep to dig up the roots of trees. He was never told that he could not undertake ground works in any particular area at Bessborough. Some years later an archaeologist told him that the area surrounding the Sisters' graveyard and folly was suspected to be a children's graveyard. He frequently found large bones while digging in this area; he believed these to be the 'very old bones of animals'. Because of their large size, he was satisfied that they were the skeletal remains of a cow and that he found nothing that resembled a human bone.

> I would say that I did a lot of excavation down there and I came across nothing at all...That's why I am here really. To say that in my time down there...I came across nothing that would say that that was a child's bones or a child's skull or anything like that. I came across nothing like that.

18.288 He was not aware of any children's burial ground at Bessborough and he never heard anyone speak about a children's burial ground during his time there. As far as he knew, children were buried in St Finbarr's cemetery during the time that he worked there and he 'never saw any funerals down in Bessborough of babies'.

> I dug up the water pipe twice, going into the place. So I did, as I said, a lot of excavation. When I went there the place had actually been neglected for

many, many years. So there was a lot of trees had grown up in the wilderness basically. So, when I was clearing the wilderness with the JCB, so I did quite a lot of excavation, but never came across any bones that I could say were children's bones.

18.289 He was working in Bessborough in the period when land to the east of the Bessborough estate, and adjacent to the congregational graveyard and folly, was sold to a private developer. The development of this parcel of land was halted by the economic downturn. He witnessed different stages of the development of this site and he remembered the mounds of earth that were dug up during the site clearance. He stated that he did not hear of any human bones being unearthed during this work.

18.290 He dug a crater 30 to 40 feet wide and around nine feet deep to create a pond in the area to the west of the congregational graveyard and north of the avenue leading to the folly. No human bones were unearthed during this work.

18.291 The witness used maps and aerial photography of the Bessborough estate, dating from 1951 to the present, to provide the Commission with in-depth information on various developments which took place on the Bessborough estate during his time there.

Evidence of former Bessborough residents

The experiences described by the former residents who gave evidence to the Commission are largely set out in their own words. In some cases, particular information which might identify the witnesses has not been included.

Resident A: Mother early 1960s

18.292 Resident A became pregnant when she was aged 18. She travelled to London and told a priest that she was pregnant. The priest put her in contact with the Crusade of Rescue who made arrangements for her return to Ireland. She felt that she should have stayed in England as she would have been able to keep her baby there. She was met at Cork harbour by a car and driver who took her to Bessborough.

I had never been to Cork before and knew no one there. I had no idea where I was going and did not know that once I had gone there [Bessborough] I would not be able to leave again.

18.293 On her arrival at Bessborough, she was given a uniform 'canvas overall'. She said that her belongings and life savings were taken from her. She said that she was not allowed to leave the home as there were bars on all the windows and the doors were locked.

Even without these measures it would have been impossible to leave: all of our things had been confiscated, we had no clothes and no money. From time to time we were allowed outside but were always escorted by nuns... They marched us around like soldiers. These are the only times I remember being allowed outside.

18.294 She said that she had no rights in Bessborough. She was given a 'house name'. She never saw anyone from the outside and she was not allowed to maintain contact with family and friends. She wrote letters to her mother which were sent to London first and then posted to her mother in Ireland. The nuns supervised and censored her letters and coerced her to write positive things about the home while she and her baby were ill. She stated that there was a 'rule of silence' in Bessborough and that those who broke it were 'reprimanded'.

At Bessborough we got up at 5am every morning and went to mass. Afterwards we fed the babies in the nursery, but never our own. For the rest of the day we were assigned duties. I scrubbed the stone floors of the long halls and passageways. At around 7pm we were put to work in the community room where 20 or 30 of us sat around embroidering Christmas cards... We were put to bed at 9pm... We worked in this fashion every single day. We were never paid for the work we did. We were made to work even if we were very ill, as I was. No excuses were ever accepted-it was just as if the nuns had no hearts at all. There was no education given to us and no time for recreation. During the day we worked and prayed, prayed for forgiveness... I was often given night duty on the labour ward. If the labour ward was not busy I was made to scrub long, cold stone-flagged passages on my hands and knees all through the night.

18.295 She said that there were about 30 beds in her dormitory and that it was 'always cold and draughty'. The women whispered to each other at night but were made to stand by the bed as punishment.

> You could hear the girls crying at night. We went to bed frightened and always woke up frightened.

18.296 They were able to bathe but were seldom allowed to.

> I really only remember eating potatoes during my time there, though we had sausage on Sunday mornings. The sisters lived in the Convent and definitively did not eat the same food we did. They had us to serve and wait on them and lived a beautiful life compared to us... You had to show respect to the nuns every time they passed, and each time they would demean you.

18.297 Most girls 'towed the line' and learned how to stay out of trouble. Some tried to 'escape' but were 'captured, brought back and punished'. Women were 'routinely denied contact with their children' as punishment.

18.298 She said that she received no medical care during her pregnancy in Bessborough and never saw a doctor or a nurse. She stated 'I had none in Bessborough, no care at all. I never remember being examined'. She said that her work in Bessborough included scrubbing the hallway and attending in the labour ward at night. There was no one in the labour ward to assist women in labour at night and the nuns only attended for 'daylight care'.

18.299 She did make friends at Bessborough. She recalled, 'they were beautiful girls. I mean that's all we had, we only had each other'. She said that one woman's mother sent her food. She said that, when she went into labour, she was locked in a room alone for 72 hours. She was afraid and in terrible pain and when she screamed or called for help she was 'abused'.

> I was screaming with the pain, three days screaming with the pain and all you got was, "Oh you should have thought about this nine months ago." "You have got to suffer for your sins and you have got to put up with it." And the more you screamed the more she abused you, which I call abuse now.
>
> On my second day in labour I was given an injection by Sister Veronica Cleary [midwife]. To this day I do not know what the injection was but I believe that this was what caused my baby's death and almost caused my own.

18.300 She said that she overheard two nuns arguing and one accused the other of injecting her with a dirty needle which had caused an infection. She said that she developed an abscess at the injection site and that she became unwell soon afterwards. Dr Sutton lanced the abscess.

> I had an abscess half the size of a football; it was protruding and at the very end I was terribly ill. I could only sit on one side of my bottom and painful even then to sit and I was made to go to church, go to Holy Communion. I was terribly embarrassed, you know, to say the pain. But finally the doctor, Dr Sutton was called: a cruel, cruel individual because I wasn't turned over properly. He never said who he was, never said my name. He just flung you over on the side and brandished this long thin knife in front of me and then there was no preparation, there was no nothing, he just cut you and then went out. I could hear the poison pouring on the floor. They were all just inhuman.

18.301 She said that she wanted to give her son a specific name but the nuns refused to allow her to do so as the chosen name was a 'protestant name'.[70]

18.302 She said that Bessborough was always cold and that she was forced to feed her infant in a cold passageway outside the nursery. She was not allowed into the nursery for reasons unknown to her. After two or three days the child 'would not eat, would not drink his bottle and would not swallow'. She had developed an abscess on her breast and the baby was being bottle-fed. She said that a nun took the child from her, told her that 'she was not feeding him properly' and 'almost smothered the baby by stuffing the bottle down the child's throat'.

18.303 She subsequently became ill herself. She developed a lame leg, a high fever and a pain in her head but said that the nuns did not want to know. She asked for a nurse for herself, but she was ignored and given nothing to relieve the pain. She was told 'It was your suffering, your sin and you had to cope with it'. She 'was left there to die' and she will never understand 'the cruelty'. She described the nuns at Bessborough as 'the most cruel, barbaric individuals' she ever met.

18.304 The baby was transferred to St Finbarr's Hospital aged 19 days. He died there 19 days later. The cause of death was given as renal failure and septicaemia.

[70] A number of boys born in Bessborough were christened with this name; Resident A's son was given this as his second name.

> My son died at six weeks... My son was a beautiful, blonde-haired boy; perfect. I believe he died as a result of the neglect he suffered from those at Bessborough... Another woman told me that they had kept my son in a dying room. I begged the nuns to take my son to hospital but they only did so after two weeks had passed. My son died in hospital.
>
> I was told by one of the girls that my baby was held in the dying room after he died and I asked where he was kept and I was told by a girl, who had a two-and-a-half year old baby herself that was in another part of the convent that he was in the dying room. I cannot get over this and this is one of the horrors that stays with me... I wasn't prepared for this inhumane treatment.

18.305 One of the nuns told her that her child was buried in the small cemetery at Bessborough.

> ...she told me my baby had died and I asked her could I go to my baby's burial and I was told I couldn't go, even though I was 100 feet, 100 feet away from the burial now I know he was buried 100 feet from where I was, I wasn't allowed to go with him. I don't know if he was buried in a coffin. I don't know if he was buried in a gown or what he was buried in. I don't know if there were prayers said over him. I have no information.

18.306 She said that if she herself had died she would be buried in an unmarked grave like her baby. A doctor was never called to attend to her or to her baby. She believes that she was discriminated against because she was 'illegitimate' herself.

> I am sure there were other girls that were left out as well and other girls did disappear and, overnight with their babies and we presumed they had died.

18.307 She said that, after her child died, she was made to bottle feed other children in the nursery. It was always mothers who had lost their children who were given this task.

> The conditions we were in were worse than a prison - prisoners have rights but we had no rights at all. They did whatever they liked to us and said whatever they liked to us. They were unbelievably cruel and could get away with anything because people in those days put them on a pedestal and believed everything they were told. There was nothing we could do about it.

18.308 She was discharged from Bessborough a week after the death of her child.

> I could not accept how my baby had been allowed to die without any medical care. There was never even a kind or sympathetic word spoken to me and I was not allowed to attend his burial. The nuns believed in suffering for our sins.

18.309 Resident A was concerned that she did not get full information about her time in Bessborough. She said that other women were given full files relating to themselves and their children's time in Bessborough but that she 'received nothing'. Her records contained no information in relation to the injection she received or the treatment she received from Dr Sutton. She returned to Bessborough in the early 1990s to get information on her time. She met Sister Sarto who gave her some information. Sister Sarto brought her to the Bessborough cemetery and told her that she believed that her baby was buried there.[71]

Resident B: Mother, early 1970s

18.310 Resident B was a student aged 19 when she became pregnant. Her parents brought her to the Catholic Protection and Rescue Society, South Anne Street, Dublin, who recommended that she admit herself to St Patrick's Mother and Baby Home on the Navan Road (Pelletstown). She did not want to do this as her parents considered the institution 'too close to home' and feared that her identity might become known. She finished her university examinations and her father made arrangements for her to live with an elderly couple in London, who it was proposed 'would nurse her through her pregnancy'. She stayed there for two months:

> It was awful. I was actually scrubbing floors and so on. It wasn't what I expected. I was so unhappy in London and lonely and isolated that I rang home and said look, okay, I will go to Bessborough. That's it. So I came back. I was seven months pregnant when I arrived there and I was surprised, because for me anyway, it was a bit like going to Boarding School, and I had all these girls around me who were pregnant, and I know this flies in the face of everything you read and so on, but some of the time, we had a great time. Some of the time we had midnight feasts and you know we went out roaming around the grounds and getting up to mischief. Just being, we were basically kids.

[71] The Commission has since established that this child was not buried in Bessborough.

18.311 On her admission she was told to choose a 'house name'. She said she lost her identity in Bessborough and the residents were forbidden to tell each other their real names. She said that there was a two tier system in place at Bessborough:

> So, there were the nice middle class girls like myself, sitting around doing absolutely nothing, we had no occupations. We knitted. We went out for walks on the grounds and we were bored. We knew that there were other girls in the kitchens and in the laundries and that there were babies somewhere, but it was all very secretive, and we didn't know, and I suppose the whole culture was that you didn't ask questions. You just got on with it.

18.312 She was a private patient; her family paid for her maintenance there. She did not mix with the public patients; private patients were segregated from them.

> So you know we were the privileged few and as soon as our babies were born we left whenever we wanted. You know so long as the Adoption Society or whoever was organising it, had made arrangements, you could leave. But we knew that there were other girls that didn't leave.

18.313 Initially, she shared a room with an older woman. This woman had 'serious problems' and Resident B found this experience to be 'traumatic'. She said that she was 'absolutely terrified' of this woman.

> She used to masturbate every night. And was very loud. She had apparently had had several children. She had come in pregnant and had been kept in and I think she was intellectually challenged. She didn't speak to me at all. She grunted, she was a very strange person but the other girls, you know the gossip was that she used to go down, there was a farm in the grounds of Bessborough. She used to go down to this farm at night and sleep with the farmhands. So, she had several children and just stayed in the convent and had her children.

18.314 The other girls told her to speak to the midwife to put somebody else in with her. Resident B recalled that the midwife, Sister Martha, was the only nun with whom she built up a relationship. She said that Sister Martha was a 'very kind woman' and 'very competent at what she did'. In contrast, Resident B said that the visiting Medical Officer was 'awful' and that his whole demeanour suggested that he didn't want to interact with the women: 'He looked on us as fallen women'. She said that the doctor was 'gruff and old' but that all the women loved Sister Martha because she was kind and helpful. Resident B said that she 'pestered' Sister Martha to

allow her to assist at some of the births. Sister Martha subsequently agreed. Resident B said that this took her mind off her own situation and gave her an insight on what to expect during her own labour. She said that there was no antenatal training in Bessborough at the time. Her aunt had given her a book on a painless childbirth method, but it was all 'gobbledygook' to her.

18.315 Resident B said that she visited Bessborough in 1990 and met Sister Martha. Sister Martha told her that 'it broke her heart over and over again to help the women in Bessborough to give birth knowing that they were going to be separated from their babies'. She said that she came to the Commission to state that not all her memories were bad. However, she acknowledged that other women did not have the means to leave Bessborough as soon after the birth as she did.

18.316 She recalled that the food in Bessborough was like that served in a boarding school 'good but bland, and healthy enough at the time'. The women asked their visitors to bring food for some variety; roast chicken was a favourite. She said that public and private patients wore their own clothes and that they received adequate medical attention including Pethidine pain relief during labour. She said that the women's biggest fear was that they would be transferred to Cork district hospital (St Finbarr's) due to a complication. She recalled that single expectant women transferred from Bessborough to Cork district hospital shared a ward with other women who had people coming to visit them with presents for their new-born babies. She said that women from Bessborough were left in a corner on their own and found the whole experience to be upsetting.

18.317 Resident B's baby was christened immediately after birth. She asked the nuns to choose a name for the child as she knew that it would be changed on adoption. Initially, she had planned to keep her child and her parents were supportive of her wishes. Her mother had offered to give up work to mind the child so that she could return to college. However, she was visited by three aunts who 'ganged up' on her and told her that she would destroy her mother's life, that her neighbours would stop speaking to her, that the child would be treated 'as a bastard' and have a dreadful life and that nobody would ever marry her if they knew she had an 'illegitimate' child. She said that the adoption society (CPRS) also pressurised her and told her not to be selfish and to 'think of the child and not yourself'. She 'caved in to all the pressure'. A few weeks later she and the baby travelled to Dublin by train. She was met by her mother who took the baby to CRPS in South

Anne Street. She subsequently had a nervous breakdown and was hospitalised for a 'sleep cure'. A year later, she signed adoption papers and emigrated.

Resident C: Mother, early 1970s

18.318 Resident C became pregnant at age 18. She and her boyfriend travelled to their hometown to tell her parents. Her mother told her not to tell her father and said that she would 'fix this'. Resident C felt that she and her partner were independent enough to deal with the situation and she did not want her mother to interfere. Following sustained parental pressure, she was admitted to Bessborough as a private patient. Her parents gave a false name and county of origin to the Bessborough authorities. She left Bessborough without her parents' knowledge and went to Dublin to be with her boyfriend. When her parents found out they brought her home for a week and then re-admitted her to Bessborough. Resident C said that her mother was 'controlling her' at this stage and she 'instilled a deep sense of shame' in her. She was given a 'house name' and spent her days looking after babies in the hospital. She said that she was happy to look after the babies, that she had 'companionship' in Bessborough and that she was able to discuss aspects of her pregnancy with other girls. She said there were no antenatal classes and there was no discussion about what would happen during labour. Her mother did not discuss the matter with her and remained in complete denial that her daughter was having a baby. Her parents made it known to her that there was no option other than adoption. The option of bringing the baby home was never discussed. She agreed to place her baby for adoption but planned to return to Cork after a few days to reclaim him. She took care of her baby for ten days at Bessborough. On returning to the family home, her mother made her promise that she would not return to Cork to reclaim her child. Her partner went to her home and told her that they would both go to Bessborough and reclaim their child. However, she felt 'fearful and shamed' because of the 'damage' she had done to her family and she did not want to go against her parents' wishes. She felt 'brainwashed' and had 'damaged her parents'. Her parents put her on sedatives and never discussed the baby with her. They brought her to a solicitor where she signed adoption papers. She recalled that she was 'too-sedated to fight for her child'. Her parents never acknowledged the child as their grandchild and there was never any option other than adoption considered. The legalities of adoption were not explained to her and she does not feel that she gave her voluntary consent to have her child adopted. Her parents took total control over her and

never allowed her to express her feelings. The adoption proceeded without her having a say in the process.

Resident D: Mother, early 1970s.

18.319 Resident D was herself born in Sean Ross and subsequently adopted through St Patrick's Guild. She was 'very much loved' by her adoptive parents and she had 'the most wonderful life'. She became pregnant at age 18. It broke her parents' hearts, particularly her father's. She was regarded as an outcast by her family and her friends' parents who warned their children not to associate with her. A neighbour arranged for her to stay with a family but this arrangement only lasted two months. She does not know who arranged it, or how it happened, but she found herself in Bessborough. She later recalled that her father drove her there about four months before she gave birth. She was not sure if she was a private or public patient but thought that her parents probably paid for her maintenance there.

18.320 She was not made to change her name. She and another girl worked cleaning the chapel. She said that Bessborough ran a 'Magdalen Laundry' and that she remembered seeing a large number of women working there.[72] 'It was tough going'. She said that, to the best of her knowledge, women working in the laundry were not pregnant.

> There was one girl, God love her, she'd had her babies. I don't know, maybe ten years prior. She stayed on. I don't think they gave her much choice.

18.321 Her accommodation was in a four bed dormitory. It had four wrought iron beds and four lockers and the living areas were not separated with curtains. Some rooms had six beds. The top floor of the building had four baths and women bathed twice a week. She was used to these living conditions as she had been to boarding school.

> They were nicer to me in Bessborough than they were in [the boarding school] and as I said before. [the boarding school] treated us dreadfully, absolutely dreadfully. If you were caught reading a comic, and I was in national school in [...], you were locked up. You were made sit in the church and you were locked up in the sacristy. I saw so many girls, including myself who was

[72] The Commission recognises that there was not a Magdalen laundry in Bessborough. The laundry was for internal use only.

caught I can tell, locked up in the sacristy, key locked, everything, left there overnight…I ran away from it twice. They kicked me out in the end.

18.322 She felt a sense of relief when she entered Bessborough. At home, her parents and her boyfriend's parents met to discuss matters and she was left out of the conversation. She felt that an awful lot went on behind her back. Her father hated her boyfriend's parents with a passion and he had threatened to shoot her boyfriend with his double-barrelled shotgun. Both sets of parents meant well, but didn't know how to deal with the situation. Getting away to Cork was 'a blessing in disguise'.

> But it was a great sense of relief for me when I went to Bessborough because I discovered that I wasn't this only girl in the entire world this has happened to because I really felt that prior to going down, do you know what I mean, that I was the only girl. And I didn't know, like, I mean I know I was nearly 19 but I hadn't got a clue. I was so … I thought I knew everything, but you know what I mean, I was naive about pregnancy things and knew everything else about riding horses and going on motorbikes.

18.323 Resident D said that the day in Bessborough began at 7.30/8 am and the women attended Mass every morning. The priest, who did not live on site, was 'very nice'. All women had to attend Mass on a daily basis and 'we all just kind of nearly rolled with it'. The nuns in Bessborough were 'fully garbed' but she reiterated that they were nicer that the nuns in the boarding school. They would line up for breakfast in the canteen with the other women and had porridge and boiled eggs. The food was generally 'ok' and some women helped in the kitchen. They were served dinner in the afternoon, which consisted of meat, vegetables and potato and in the evening they had bread and jam with tea. She witnessed some fights between women in the canteen.

> And a couple of times fights would break out in it with girls, you know. Girls slagging off other girls that might have had a hard time having their babies. I remember one big fight broke out where one girl - 'did you hear [...] had her baby and she roared crying and she screamed' because she had the baby in the home.

18.324 One or two of the nuns were qualified midwives and they were assisted by a lay woman who was a long-term resident in Bessborough. The women got 'gas and air'. She was examined by the nuns and a doctor visited on a regular basis.

18.325 Although the days in Bessborough were very structured, women were allowed to walk around the grounds, to go to a shop outside the convent and to go into Cork city. They had to get permission to go offsite but their movements were not restricted. She met her mother and aunt on a few occasions in Cork city. She remembered going to Roches Stores where she had to buy two baby outfits, one for a boy and one for a girl, for when her baby would be handed over for adoption. Her father never visited her 'He wasn't happy with this at all'.

18.326 She said that there were many women living in Bessborough, whose parents thought they were living and working in England. These women wrote letters to their families while in Bessborough. The nuns sent the letters to one of their convents in England who then sent the letters to the woman's parents in Ireland. She also said that the telephone operators in the Cork telephone exchange made parents believe that a phone call from their daughter was coming from England, when in reality the woman was ringing from Bessborough.

> They were really great guys, like, we never ever met them, but they were - you know, you'd nearly ring them just to talk to them because they were nice, you know what I mean, they weren't judging us, you know.

18.327 Many women who pretended to be in England stayed in Bessborough for extended periods after their children were adopted 'because they couldn't just pop up'. Other women stayed on in Bessborough after their babies were adopted because they were 'very traumatised and didn't know which way to go'. These women worked for their keep.

18.328 She received many letters from her family and friends and her boyfriend. She does not believe that her mail was interfered with or censored. Women were free to walk to the nearest Post Office in Blackrock Village to post mail themselves. However, she remembered that residents of the area did not like to see women from Bessborough in the community and she always felt that she was being judged by them.

18.329 When she went into labour, there were complications and she was transferred to St Finbarr's Hospital by ambulance. She was administered a lot of drugs in St Finbarr's and felt that they prioritised married women over her. She remembered St Finbarr's maternity hospital as being overcrowded and she remembered seeing 'babies on trollies in the corridors'. She was put into a room with other maternity

patients who inquired where her husband was. She was discharged with her son to Bessborough the day after his delivery.

18.330 She had visited the Catholic Protection and Rescue Society with her mother and her boyfriend before she travelled to Bessborough and had decided at that stage that her baby would be put up for adoption. She never had any intention other than to place her baby for adoption. She stated that Father Colleran of the Catholic Protection and Rescue Society counselled her and told her that she may change her mind when the child was born. **However, she said that she was 'firm set' and that adoption was the road that she was taking.**

18.331 After the birth, she contacted Father Colleran to tell him that the child was born and that she wanted to be home for Christmas. He told her that no prospective adoptive parents were looking for baby boys at that time and that she would have to stay in Bessborough until he could place the child. She told him that she would be travelling home for Christmas regardless, with or without her child. When she **told him that she would let the Sacred Heart Adoption Society handle her son's** adoption, he agreed to arrange transport for her and her child to Dublin.

18.332 She and her son were met at the railway **station by her boyfriend's parents and** sister. Her boyfriend was not with them: his parents thought it best that he did not see the child. She went straight to the Catholic Protection and Rescue Society where she handed over her son and signed the initial adoption papers. Six months later she signed formal adoption papers.

> **I had made up my mind. ... and it's not out of that I didn't love him or I didn't** care for him, I just wasn't maternal. I wasn't reared up with small - I knew more about a cow having a calf than I would have known about... I know it sounds cruel what I am saying, but that's why I knew what I did was right for **him...I knew about the wonderful life I had...** So I only could see the same **thing happening with [my son]...So that's what my decision was, and it was** right.

18.333 Her decision was fully supported by her boyfriend; they subsequently married. Her parents accepted her back wholeheartedly and she went to work with her father in his business.

Resident E: Mother, early 1970s

18.334 Resident E discovered that she was pregnant at age 18. She convinced her parents, who did not know she was pregnant, to allow her to travel to London to live with her aunt. Her older sister had become pregnant previously and 'all hell broke out at home'. Her parents told her that her sister had died and that she 'was never to mention her name again'. She and her siblings had been beaten 'profoundly' at home and she and her sisters were sexually abused by their father. She applied for a job in London and found out for certain that she was pregnant during a medical examination. She was offered an abortion in a hospital in London but decided against it. Her aunt overheard that she was pregnant and looked after her. She pleaded with her aunt not to let her mother know that she was pregnant. Her aunt rang her mother without her knowledge and told her about the pregnancy. She said that one day 'three people in black' were standing in her aunt's kitchen, 'forced her into a car' and told her she was going back to Ireland. It transpired that her mother and aunt had contacted the Catholic Crusade of Rescue who made arrangements to repatriate her to Ireland. She said that she was 'forced on a plane against her will' in Heathrow and flown to Cork. She was met by two nuns at Cork airport, one of whom was from St Anne's Adoption Society and taken to Bessborough.

> I remember the grandeur of the desk and the chairs. That is when I met the thing that ran it and she just looked over her glasses at me. I was sick. I was dizzy. I didn't know where I was, nothing. She asked me my name. I said "my name is [...]". She got very angry with me. I repeatedly kept saying "my name is ..." and she wouldn't believe me. She kept saying "that is not a name, don't be stupid"...I believe her to be the person called Sarto.[73]

18.335 She was given a bed in an eight-bed dormitory. She worked in the laundry and the kitchen during her time at Bessborough. She was flown to Cork and 'escaped' from Bessborough after about a month.

18.336 She said that she experienced some 'spotting' during her pregnancy but that the nuns at Bessborough refused her medical attention. She said that she received no medical attention of any sort at Bessborough. She was never seen by a doctor and no doctor ever visited the institution. She got some comfort from talking to the statue in the grotto at Bessborough. However, she had considered committing

[73] Note: Sister Sarto started work in Bessborough in 1981.

suicide by throwing herself out a window. She said that women were not allowed to leave the main house at Bessborough but that they were allowed visitors. She was visited weekly by a woman from St Anne's Adoption Society who told her that adoption would be the best option for her baby. Her boyfriend found out that she was in Bessborough and helped her 'escape'. She went to her sister's house in Dublin. Her mother found out where she was and drove her to St Patrick's Home, Navan Road (Pelletstown). She gave birth there and her child was adopted through St Anne's Adoption Society.

Resident F: Mother, mid 1970s

18.337 Resident F became pregnant at age 30. She visited a doctor in a town 20 miles from where she worked who directed her to a local curate. She said that curate was very nice to her and told her about Bessborough. She told her parents that she was pregnant. While they were upset, they did not throw her out. She stayed with her parents for a while after giving up her job. She stayed with friends over the Christmas period. She drove to Cork and was admitted to Bessborough early in 1974. She met a nun on arrival and was given scrambled eggs and brought to her quarters.

> I had experience of being in boarding school, where you just had a curtain in the cubicle but this was a completely enclosed private place with a door and a key. So nobody could come in. So it was very basic with a wardrobe and a table at the bedside and a single bed.

18.338 Her job was to make bottles for feeding babies. She and another woman made up 60 or 70 bottles a day. Her afternoons were free and she regularly drove to the local shopping centre for coffee and to read the newspaper; she had her own car. At least one other woman at Bessborough had her own car. She could come and go 'as she pleased'.

> I mean my remembrances of the place was that it was pretty grim and the food was basic but when I was thinking about it, I don't remember either being hungry or cold and it reminded me very much of boarding school, although of course I was older. The whole thing that was hanging over me then the whole time was, what was I going to do with my baby?

18.339 Her mother wrote to her regularly during her time in Bessborough and she spoke to her family on the phone. She recalled that her mother was glad that she had taken another name at Bessborough so that people in her family's local post office would

not get suspicious. Her pregnancy would have been regarded as 'a slur on her whole family'. She worked as a primary school teacher and she would not have been able to get a teaching position in a Catholic school as a single mother. She said that she had no money, no job and no place to stay. Although her parents never told her that she could never bring her baby home, she knew that was never an option. She thought about various scenarios where she would be able to keep her child but none of them seemed viable. She discussed her options with Sister Mary at Bessborough. However, the advice she got at Bessborough was 'leaning towards adoption'.

> Now you could look at that two ways, in that like I am a very practical person and it was definitely the practical solution to have the baby adopted. That's the way it worked out in the end... Because I wanted to be absolutely sure. So when it was coming up to the birth I had decided at that stage that I would give the baby away for adoption but I kept thinking to myself you know maybe I'll just do that now for the moment and see how things go... I knew myself I could change my mind if I hadn't signed the adoption papers.

18.340 The nuns at Bessborough 'weren't falling over themselves to be nice'. However, she never heard any nun say 'awful things to a girl'. She said that the 'crippling sense of shame' expressed by other women who resided in Bessborough was evident during her stay there and she never felt that she was in Bessborough 'to be reformed'. She did not recall any infant deaths during her time there. Her time in boarding school prepared her for life away from home and living with nuns. She felt that this was a more traumatic experience for other women.

18.341 She remembered that when she went into labour she was brought to a small room. She remembered being assisted by a midwife and another woman. She was given Pethidine when her labour pains increased. She was not given any painkillers after that and gas and air were not available. She had not changed her mind about putting her child up for adoption and did not breastfeed. She felt that the more she did with the baby the more difficult it would be to part with him.

> I had seen girls who have stayed in the place for two or three months after, maybe even longer and they were going to have their babies adopted and they were feeding their babies every day and changing them and I thought to myself, there is no way I can do that. There is no way and then give the baby away after a couple of months. So, I had said to [...] that I wanted the baby to go quite soon after the birth.

18.342 Her baby was removed to a foster home when five days old and he was placed with an adoptive family soon afterwards. She signed preliminary adoption papers before she left Bessborough and signed the final consent to adoption forms six months later .

> So then I kept the papers as I say and one time then, just before Christmas, I decided yes, I am happy with this now. This is what I want to do. So, I can remember well the night I walked down after posting them and said that's it now. That's it.

Resident G: Mother, mid 1970s

18.343 Resident G became pregnant at age 17 while she was a second level student. She was six months pregnant when she told her father. A few days later she was on her way to Bessborough with her school books. Her father made the arrangements for her admission without discussing the matter with her. They did not tell her mother about the pregnancy. She said that she would not accept a house name in Bessborough, and she was allowed to use her own name while living in there. Her accommodation was an individual cubicle with a bed, locker and table. Other women were in wards with, four, six or nine beds. On one occasion she was brought into a room with other residents to see the body of a dead infant.

> We were brought into a room just off the ward where one or two babies had died and they were laid out in a little, I can't say it was a coffin but on a bed with a kind of a lily flower draped, they were dressed in white and a lily flower and to this day I actually don't understand why they would want you to go in and see a dead baby...I had said what happened to the baby? They said she was born with Spina Bifida but I don't understand the thinking behind marching pregnant girls in to look at dead...[74]

18.344 Other residents told her stories about the labour ward and the lay midwife who delivered babies at the hospital.

> So when somebody went into labour in that room and it was like the atmosphere in the hospital section completely changed because you knew

[74] The Bessborough institutional records show that there was one infant death in Bessborough during Resident G's time there. The infant had been born with Myelomeningocele Spina Bifida at St Finbarr's Hospital. The child's mother returned to Bessborough without her child and was subsequently discharged to her family home. Medical records show that doctors at St Finbarr's did not consider the child fit for surgery. The child was subsequently admitted to Bessborough unaccompanied aged 16 days; she died 5 weeks later. It would appear that the scene described was a prayer vigil/funeral service for the child.

that somebody was at the hands of this midwife and the whispering that went on in the washroom was that this woman wouldn't give any sedation. She wouldn't give any painkilling. She was cutting the girls down below and just would tell them this is your punishment for what you have done and you are never doing this again.

18.345 She said that she became very 'fearful of being at the hands of this woman, the midwife' and that the stories about her had made her 'so terrified' that she told the nuns that she had been very sick as a child so that she would be sent to St Finbarr's Hospital for her delivery. In relation to ante-natal care she said:

> A doctor would come during the week. I don't know whether he was a gynaecologist or a GP. There was a room, an examination room where you would queue up in the corridor and go in to be examined by him. He was quite an old gentleman and from what I remember you wouldn't be given any information about yourself or how baby was doing or how many weeks you were but he would just examine you and then you were told you can go back to your room.

18.346 Resident G said that she did not undertake any work in Bessborough and spent her time studying. There were other school-going girls in the hospital and a teacher came in once a week to help them with their studies. She could not recall much about the food at Bessborough except that there were lots of turnips and she remembered having cornflakes for breakfast.

18.347 She was taken to St Finbarr's Hospital in an ambulance with another expectant woman. The staff at St Finbarr's Hospital did not explain anything to her and she was 'terrified'. Her time in St Finbarr's Hospital was deeply upsetting.

> The night he was born they put me in a ward with other mothers and family were coming in and loving their new little arrivals naturally and I can see myself in the bed, it was just in the door, on the right hand side, and I was able to turn my face to the wall. I was absolutely distraught. So, I was crying so much they took me back out and they brought me back down to a side room of some kind but I just - oh my heart was broken. I just, the whole night I just moaned for him...moaned for him all night. The loss of him...I was just heartbroken. I was absolutely heartbroken.

18.348 No friends or family member visited her while she was in St Finbarr's and she felt very lonely. She did not see her baby until she was in an ambulance heading back to Bessborough. A nurse in the ambulance with her was holding two babies. She experienced post-partum haemorrhaging and was returned to St Finbarr's Hospital for some days. When she returned to Bessborough she was brought to the nursery where she held her baby for the first time. She said that her child was baptised by a priest at Bessborough and that she was forced to attend Mass every day.

> We had committed a mortal sin and we were unclean and the only way to atone for your sin of becoming pregnant was to pray and pray and pray for forgiveness. That was the over-riding feel of it.

18.349 She had two visitors while she was in Bessborough - her school chaplain and a nun who was a friend of her father. Both visitors told her that her only option was to put her son up for adoption. No other options were discussed with her. She subsequently signed her child over for adoption and a year later she travelled to Cork where a legal adoption was finalised. She said that she did not fully understand the legalities associated with legal adoption and that they were never explained to her.

> I was informed that when I signed the paper I was going to sign my rights away. That's what I do remember. Signing that form. I don't remember anyone coming forward to me to say or stand me aside to say are you sure this is what you want to do. It was almost that this was a standard journey... I know I was a student. Financially, I wasn't in a position to take care of him but it - I suppose for me an over-riding feeling of the whole thing is there was no support there for me at the time... There was no options available to me other than adoption... No option whatsoever. Therefore I just felt completely overwhelmed as a young person, and pressured into the baby being adopted... I was railroaded into signing these documents.

18.350 She said that before she gave birth she was sent into Cork city to buy an outfit for her baby that he could wear when he was handed over to his adoptive parents.

> They would have sent us out to buy an outfit in a shop in Cork. So the baby would wear the outfit you have bought him when he was going to be adopted. That was the outfit that was going to be given, put the baby in to be handed over to the parents. So you can imagine going into Cork City, buying a little

suit, knowing that the suit that you were buying was what he was actually going to be given away in. The thinking behind it is just horrendous.

18.351 Her family never spoke of her pregnancy, her child or his adoption again except when her father was dying, **he apologised 'for putting me through what he put me through'.**

To this day, I think I might have mentioned it there, I still feel a shame. If you ask me where is that coming from, it is like just something in my soul, that people - that I was 17, and I know that you were unmarried and you have done this terrible thing. I can't get my head around it.

Resident H: Mother, mid 1970s. This former resident was accompanied by another woman and they are both active in a helpline for adopted people and mothers

18.352 Resident H became pregnant at age 21. She went to London and got a job in a hotel. When she was sent for a medical she told the nurse that she was pregnant. **The nurse told her to contact 'some sort of agency'.** She contacted an agency:

I went in there and they said to me - of course it was all that was bothering me was nobody would know; this would be over and done with. It was like it **wasn't a baby, it was a problem...** That is all it was, it was a problem, nothing to do with a baby at all. They said to me that I could go to Cork or Dublin and **I said 'well nobody knows me in Cork'.**

18.353 She said that there was no option for her to enter a mother and baby home in England. The agency arranged for her to travel to Ireland by boat. She was met by a nun in Cork who drove her to Bessborough. She has little recollection of entering Bessborough but said that she had her own cubicle and that women wore **their own clothes. She remembered 'the secrecy, the fear, the not having a mind of your own, not having an opinion'. She remembers the feeling of 'being scared all the time'.**

18.354 Her family did not know that she was in Bessborough and thought that she was working in Scotland. She wrote letters to her family and the nuns arranged for the letters to be posted from Scotland. Her sisters subsequently found out that she was in Bessborough and travelled there. She said that an adoption agency **'brainwashed her family' into agreeing that adoption would be the best route for** her.

> Their main thing was not to upset mammy and daddy that was all, their only motivation was not to upset mammy and daddy. So they became part of the whole railroading of me into adoption.

18.355 She said that when she walked in the door, she lost everything and someone else made all the decisions for her. The 'whole set up in the place was powerlessness'. She was made change her name and told not to tell the other women anything about herself. She said that there was a class system at play in Bessborough.

> There was a definite class; there was a class system in place. I was considered to be from a respectable family, a country family. I think they had this idea that girls who were from the city, well they would have been Cork girls, you know most of them were Cork city girls, they were of a lower calibre and they were sort of looked down on because there was this idea that oh those city ones they'll keep the babies because they're irresponsible and they don't care about these children. You know the good; the good country girl will just do what she is told and hand over her baby. That was the sort of mentality there.

18.356 She said that working class women regularly left Bessborough with their babies and that they knew all about the social welfare payments available to them. Women were never told about the Unmarried Mothers Allowance in Bessborough and the nuns working there actively dissuaded women from any thoughts of living independently with their babies.

18.357 The nuns asked her:

> What are you going to do? Are you going to be in a flat in Dublin with a baby on your own? What are you going to live on? What are you going to do? You're going to have to give him back after a couple of weeks because you won't be able to cope.

18.358 Resident H said that the work women were asked to do in Bessborough was based on their backgrounds. If they were from an agricultural/labouring background women were expected to work on the farm and 'middleclass' women worked in the nursery. She said that 99.9% of callers to the helpline she now helps to run did not know that the State was paying for their maintenance in mother and baby homes.

> Everybody who worked there assumed they were paying for their keep and atoning for their sins but mainly paying for their keep actually. So, they never

questioned when they were asked to perform certain duties; they accepted it without question whatsoever. One image that stays in my mind is the human lawnmower...it is in June Goulding's book... Well basically the girls were asked to mow the lawn by kneeling and moving forward plucking the grass because this would save getting a man in with a lawn mower to mow the lawn in front of the Bessborough house.

18.359 She said that a doctor called to Bessborough on a weekly basis to examine expectant women. She had heard 'horror stories' about the lay midwife working in Bessborough and stated that she 'was a witch'. She had a good relationship with Sister Anthony who arranged for her to give birth in St Finbarr's Hospital. She had an 'absolutely terrible' experience in St Finbarr's.

Terrible, absolutely terrible. I never will - it was the most demoralising experience of my life. I remember being left in the room on my own at one stage with my feet in stirrups, freezing cold and nobody with me at all. I was absolutely butchered. I ended up with these big hooky things. They just split me open to deliver the baby. I was given very little pain relief. Now after he was born they put him into the room with me and I couldn't cope at all, I couldn't cope. I said "this is so unfair"... Then the next day I think Sister Anthony rang me and I said "get me out of this place, I'm going to go crazy", because it just felt like I was being treated like I was a second class citizen. I had been left, I was told to shut up a few times when I was crying in pain.

18.360 Sister Anthony arranged for her and her baby to be returned to Bessborough that same day. Sister Anthony told her that there was a bug going around the nursery and that she had arranged a private room for her and her baby.

18.361 The woman who accompanied Resident H was never in a mother and baby home. She said that she sometimes felt jealous of callers to the helpline who had been in a mother and baby home as they offered refuge that she was not afforded during her own pregnancy.

I used to be jealous of the women on the helpline, you know? I know it sounds odd. Sometimes I would think to myself if I had that refuge, I mean I know that they were cruel places but if I had that refuge I might have been able to keep my daughter you know, maybe... For some it was a refuge. I mean in an ordinary physical way...

18.362 Resident H said that she felt safe in Bessborough. She recalled walking the grounds and going out to the shop. She remembered travelling into Cork city to buy a christening outfit for her baby. She contemplated suicide and tried to throw herself in front of a bus in Cork city. She felt that if she was dead that her parents would raise her child.

18.363 Her baby was taken for adoption by St Anne's Adoption Agency aged three weeks.

> I still have nightmares of that car. You know what the car looks like? I think my father used to call them Model T because he was mad into cars. I can still see this woman going off in this black Model T from the front of Bessborough with my baby.

18.364 She went to London with one of her sisters to collect her belongings. She 'was out of it' at the time and did not know that she had flown back to Dublin and not Cork. She was met by one of her sisters who took her to their uncle's house. Her family were keeping her away from Cork and were convincing her that adoption was the 'right thing to do'. Her sisters 'colluded' to make sure that she went through with the adoption. They 'pressurised her' into signing adoption papers and they kept telling her that the longer she put it off the harder it would be. She did sign the adoption papers. She thought that she could go back to Bessborough at any time and reclaim her child. However, she was drinking heavily at the time and felt that she 'wasn't in control of her life'.

Affidavits received by the Commission

The Commission received a number of affidavits from former residents. These are sworn statements and are reported largely in the words used by the former residents. Unlike those who gave direct evidence, the Commission did not ask any questions of these former residents.

Resident I Mother, early 1960s

18.365 Resident I grew up in a traditional Catholic household in Liverpool. She stated that she was sexually abused from the age of 11 and became pregnant at age 13.

> I did not know what was happening to me but when it became apparent to my mother that I was pregnant she was ashamed and arranged with our local parish priest that I would give birth in Ireland. My mother and aunt told me that I was going on holiday with them and we travelled together to Ireland when I was about five months pregnant.

18.366 Her mother admitted her to Bessborough as a private patient and she remained there for four and a half months. Her mother visited her once but otherwise she had no contact with her friends or former life. She stated that she could send and receive letters but that they were 'opened and checked by the nuns'.

> I remember that it was very strange and lonely for me in Bessborough. I couldn't use my own name or wear my own clothes. The other girls looked after me and helped me because I was so young and didn't know what was happening to me.

18.367 Resident I said that she did not receive any education at Bessborough and occupied herself in a day room with books, sewing materials and wool. She said that she was let off some of her work because she was a private patient. She did scrub floors and collected potatoes from the farm and she worked before and after the birth of her child.

> Life was fairly basic in Bessborough, I was warm enough and the food we received was adequate. I was allowed to walk around the grounds accompanied and although there was a rule of silence it was only at certain hours, just before lunch and during 'quiet time' in the afternoon.

18.368 She said that the nun in charge, Sister Pius, was very kind to her but remembered that the delivery nun, Sister Veronica, was 'stern and cold' and that 'none of the girls liked her'. She said that she received no medical care in Bessborough and that her child was delivered by Sister Veronica. She never saw her baby as he was taken away immediately after birth. On the day after the birth she was told 'in a matter of fact way' that her baby had died.

> During this time I carried on with my former work duties and also helped feed the babies in the nursery. It is hard to explain how I felt after the death of my own child; it was heart-breaking.

18.369 She believes the information regarding her child's death, as contained in the Bessborough records, is incorrect. She believes that there was 'widespread trafficking of babies in Bessborough by these nuns and their associates' and she wonders if her child might have lived. She stated that she did not receive a death certificate for her child.[75] She found a report in the *Irish Examiner* regarding 'discrepancies' in the notification of infant deaths at Bessborough to be unsettling.

[75] The Commission has established that the child's death was notified to the General Register Office.

Resident J Mother mid 1960s

18.370 Resident J was 19 when she became pregnant. Her parents considered that she had brought disgrace on the family and they drove her to Bessborough when she was three months pregnant. They told her that she must never speak about her pregnancy and that she 'must never come back home again'. She said that, on her admission to Bessborough, she was told:

- never to speak of her identity or where she came from;
- that she was not allowed to have contact with the outside world;
- if she left Bessborough without permission she would be brought back by the Garda.

18.371 She said that she witnessed one woman who left the institution and was returned by the Garda. She also recalled that one woman fell to her death while trying to 'escape' from the institution through a very high window.[76]

18.372 She felt that she was stripped of all her human rights and dignity when she entered Bessborough. She said that she was not allowed to tell anyone her real name and was given a fictitious name which she can no longer remember.[77] She said that there was a rule of silence in the institution; no visitors were allowed; she was not allowed to send or receive letters; and she was not allowed to listen to the radio. She was subject to 'psychological abuse' in Bessborough; the nuns 'constantly' told her that she was 'evil' and that no one would ever want to marry her. She suspects that her hearing loss was a result of the abuse she suffered at Bessborough. She considers that she suffered 'severe trauma' at Bessborough and that she continues to have panic attacks because of her time there.

18.373 She slept in a dormitory which had six to eight beds. She had a single bed with a bedside locker and there was a communal wardrobe. She said that there were no recreational activities and women had to wear 'a big loose cover-up'. She said that she wore her 'cover-up' during her time at Bessborough and that it was never washed. There were one or two bathrooms for each dormitory and, although there were baths available, she could use them only 'when told to'. She stated that women attended mass every morning and undertook work for the rest of the day. Her days were 'very repetitive'.

[76] There were no maternal deaths notified from Bessborough during Resident J's stay there.
[77] The institutional records indicate that her 'house name' was the same as her actual name.

I arrived in Bessborough in mid-July and during the summer months my job was cutting the lawn with scissors. I did this every day in a line with a group of other women. We were not allowed to stop when we felt tired. In the winter months I had to polish and scrub the corridors. Other women were sent to work in the laundries. The work was especially difficult given that I and the other women were pregnant. I worked seven days a week until I went into labour.[78]

18.374 She said that the food at Bessborough was 'not nutritious'. She was given 'watery porridge' for breakfast, bread and cheese or jam for lunch and stew for dinner.

It was not nice. I doubt that the nuns ate the same food as us as there was a big farm there with all fresh produce. There was no food available between meals.

18.375 She said that, when women required medical attention, they were taken to St Finbarr's Hospital, Cork. She was never examined by a doctor during her time at Bessborough [five months]. She was attended to by 'a nun and another mother' when she gave birth.

I went into labour while polishing the corridors. Later that evening, as the pain progressed, I was locked in what I can only describe as a cell. There was a single bed in it and a commode and the door had a small window in it, like a prison cell. I was left there all night with no attention. In the morning a nun came into the cell to check on me. My baby's head was presenting and so she made me walk across the corridor to a room where there was a table for you to lie on. I was unable to get up on to the table and so I lay across it and that's how I gave birth. After I gave birth to my son he was immediately taken away from me and put in the nursery.

18.376 She said that the only time that she was allowed to spend time with her son was when she fed him. A bell would ring to announce the start of feeding time and she would feed him and change his nappy. She said that women were told to 'face the wall' while breastfeeding.

[78] The allegation that residents were obliged to cut the grass with scissors was made in June Goulding, *The Light in the window*, (Ebury Press, London, 2005). Miss Goulding was a newly-qualified 22 year old midwife at the Bessborough maternity hospital from September 1951 to June 1952. Her book was the product of a creative writing class. It is not factually correct about a number of issues and many of its allegations are impossible to prove or refute.

> I vividly remember one day going to the nursery to pick up my son as he was screaming because he was very wet and dirty. He was clearly distressed and I believe that it was because he had been in that wet and dirty nappy for some time. As far as I am aware the nuns did not go in between feeding times to comfort the children if they were distressed or crying.

18.377 She said that sometimes the children of women who were unable to breastfeed did not get fed. She said 'they were hungry; screaming, hungry'. She stated that bottle-fed babies were given the 'bare minimum'. She said that one nursery at Bessborough housed children aged one to five years old and that they were kept 'four to a cot'. These children were sometimes wheeled outside in their cots but were never allowed to get out of them.

18.378 Her baby was taken from her when he was six or seven weeks old.

> When my baby boy was six-seven weeks old, he was wrenched from my breast by one of the nuns whilst I was feeding him and taken away for adoption... I ran after the nun down the corridor, but there were two big doors that women weren't allowed to go through and so all I could do was bang on those doors. About an hour later the nun came back and told me that my baby was gone...At no time did I give my consent to my son's adoption.

18.379 Her parents collected her two days later and put her on a plane to the UK. She later made contact with her son.

18.380 Resident J disagrees with every date relating to her admission and discharge and the birth of her son as recorded in the Bessborough records.

18.381 In a separate statement Resident J said:

> I was incarcerated in Bessborough Mother and Baby Home in Cork from [for approximately a year and a half]. During my time I vividly recall a woman telling me she was from Donegal, she had given birth to a mixed race baby boy. At the time I met her, her baby was approximately two and a half years old. I visited the nursery with her one day to meet her son, the room had babies from birth to approximately three years old, they were all mixed race. I cannot give a factual figure as to how many, I would estimate up to ten. I recall a nun stating to me and others that 'those coloured babies will be here

for a long time as nobody wants them'. I often thought whatever came of these babies and that of their mothers.

Resident K, Mother early 1980s

18.382 Resident K became pregnant at the age of 18 and was taken to Bessborough by her aunt when she was six months pregnant. On arrival, she had her clothes taken from her and was given a 'smock' to wear. She was given a 'house name' and was allocated a job, which was to 'polish the wooden floors in a long corridor'.

> No one had a choice as to what jobs they were given. We were not allowed to speak to each other. We had to be on our knees to polish the floor...if a nun passed we had to stand up and say 'excuse me sister' as if we should not have been there.

18.383 The women went to mass daily and to confession weekly. There was 'silence at all times' and she did not remember ever leaving the grounds 'or even being outside'. She remembered having enough to eat and she never recalled being cold. They had recreation time once a week, when music was played. However, she said that she had spoken with another former Bessborough resident, who was living in the home at the same time, who told her that there was 'no recreation time and no music'.

18.384 Her only means of communicating with the outside world was by writing letters. Her incoming letters were open when she received them. She didn't write many letters because 'there wasn't anything to say'. She could not write anything about Bessborough 'because the nuns were reading her letters'. 'The only thing I could say was that I was OK'. Her uncle visited her in Bessborough but her father and her aunt did not.

18.385 The nuns were 'tough, strict and straight'. She was not aware of anyone being punished by the nuns but that 'we were all afraid of them'. 'We were reminded every day that we were sinners and that we were at Bessborough for our sins'.

18.386 She developed toxaemia during her pregnancy and she was attended by a nun who was a midwife. On the day prior to giving birth, the nuns had told her to scrub the kitchen floor 'to bring the labour on'. There was no doctor present when she gave birth but she was attended to by a midwife and a helper. Her baby was full term and the midwife 'took the baby away quickly'.

> I never got a chance to see or hold the baby. They told me that the baby was a boy and that he was still-born. There was no more mention of the baby after I gave birth and I accepted that he was dead. I was not invited to the burial nor was I given any details of how the remains were being dealt with. I was not given a death certificate.[79]

18.387 She didn't receive any aftercare in Bessborough. Her aunt came to collect her. She suspects that her aunt 'paid for me to be released'.[80]

18.388 She visited Bessborough on three occasions in a bid to get information about her time there and records relating to her child's death and burial. On one occasion a nun told her that her child was buried in the congregational burial ground onsite. She 'mistrusts the accuracy of the [Bessborough] records' provided to her. She also stated that she understood that she may have been 'the subject of vaccine trials carried out in the 1960s on behalf of the Wellcome Foundation'.[81]

Resident L, Mother, early 1980s

18.389 Resident L became pregnant at age 17. She entered Bessborough, stayed for two months and left before her baby was born.

> Bessborough was a solitary place. When I arrived I was shown my room and I spent most of my time in there or in a common area with a television... I refused to work in the nursery where they kept the new-borns. There was no one else to talk to except the other girls, but everyone seemed to ignore one another... The nuns generally kept their distance from us... Other than the social worker, I received no other visitors.

18.390 She said that there was a hierarchy of the girls at Bessborough and some were treated quite well. The women who worked in the home were getting a 'state allowance' and 'generally got what they wanted'. Because she refused to work in the home, she was 'quite low on the ladder'. She said that when she began to outgrow her clothes all she was given was a safety pin.

> We were only provided with basic provisions. The food was non-descript, and the only antenatal care we received was from one sister who took our blood

[79] It was not possible to register stillbirths at this time.
[80] This resident was a public patient maintained in Bessborough by Kerry County Council. Women routinely left Bessborough after experiencing a stillbirth or child death.
[81] The Commission can confirm that no vaccines trial was undertaken in the period that this resident was living in Bessborough; adult residents were not subject to any vaccine trials.

pressure and carried out urine tests. There were no opportunities given to us to do any sort of exercise or recreational activity.

18.391 She said that she had been told that she might be able to complete her Leaving Certificate at Bessborough. She attended one lesson but the teacher 'paid no attention' to her so she left and never went back. She considered Bessborough to be a 'holding pen' where young women were kept until they gave birth. She stated:

> Although I never suffered any physical abuse in the home, I felt like you were only there because nobody wanted you.

18.392 She said that no woman left Bessborough with her baby and that she herself was not sure that she wanted to give up her baby for adoption. She felt that leaving the institution would be difficult and there seemed to be very little help for girls once they left Bessborough.

> To try to leave on your own was one thing, but to leave with a baby with no support was impossible. I did not know if I was entitled to any welfare support, but I just knew I had to leave if I wanted to keep my child.

18.393 She told one of the maternity sisters that she was leaving for Galway. She said that the Sister tried to get her to change her mind but that she had made up her mind to leave with another girl. She stated 'we simply walked out the door and left'.

Child Residents 1949; 1959; 1961; 1962; 1965; 1969; 1971; 1976

18.394 The evidence of children born in Bessborough was mainly about adoption and tracing. Some recounted what they had been told by their birth mothers about conditions in Bessborough.

18.395 One, who was born in 1949, said that her mother told her that mothers were allowed contact with their babies only when breastfeeding. Babies in the nurseries were left to cry 'without being given any attention'. The babies' nappies were made of a rough material and caused them to suffer from nappy rash. Conditions were hard and punishments included 'being told to cut the lawn with a scissors'. She herself was in Bessborough for over two years. She was then fostered for a brief period and then sent to an industrial school where she remained until she was 16.

18.396 Another, who was born in 1962, thinks that her grandmother arranged her adoption through the Catholic Women's Aid Society. Her mother told her that £100 was paid to Bessborough 'so that she could leave the home'.[82] She said that Sister Sarto went that 'extra mile' to trace her birth mother. She subsequently met her mother and has a good relationship with her. However, she stated that her mother could not bring herself to tell her husband and their children about her.

18.397 Another child resident found her birth mother but her mother did not want her existence known to her husband and other children.

18.398 Some suspected that they might have been involved in vaccine trials. One who was born in 1959 suspected that she may have been involved and she also suspected that a relative who was born a few months earlier may have been involved.[83]

18.399 One who was born in 1961 said that she never met her birth mother but her half-siblings told her that her mother had told them that the nuns in Bessborough treated her very well and that 'it was not at all like the portrayal of Mother and Baby Homes in the media'.

[82] This was most probably the £100 adoption fee charged by the Catholic Women's Aid Society.
[83] The Commission has established that this resident was not involved in vaccine trials but her relative was.

Chapter 38: Addendum to Burials report

Introduction

38.1 The Commission's 5th Interim report, which was finalised in March 2019, described all that the Commission then knew about the burials of children who died in the main mother and baby homes. Since then, a number of individuals and organisations have contacted the Commission with information and submissions about the issues raised. Most of the information provided was already known to the Commission or is entirely anecdotal and impossible to prove. With the exception of the report on Sean Ross, there is very little extra known to the Commission about infant burials. The Commission remains convinced that there are people who have further information but they have not come forward.

Sean Ross

38.2 In its 5th Interim Report, the Commission stated in respect of Sean Ross:

> There is a designated child burial ground in the grounds of the institution. The Commission was made aware of concerns about this burial ground and decided to undertake a geophysical study and subsequently a test excavation of the site. The results of this excavation are currently being examined.

38.3 The Report of Forensic Archaeological Investigations at Sean Ross Abbey Mother and Baby Home was completed in September 2019 and is published in full as an Appendix to this chapter. The following paragraphs give a very brief summary of the report:

38.4 The objective of the forensic archaeological investigation was to establish if human remains were present at the designated child burial ground and, if so, had these remains been disturbed by potential later insertion of utilities or drainage works at this location.

38.5 The investigation commenced with the least intrusive methods to inform a subsequently more intrusive, targeted test-excavation. A desktop review was conducted which surveyed historical mapping, aerial photography, and Tipperary County Council planning files that were relevant to the site. A geophysical survey took place in January 2019 and an independent inspection of the existing drains in proximity to the site was conducted in February 2019. The test excavation took place in February and March 2019. Seven trenches were opened during the test

excavation, representing about 10% of the total available area within the designated burial ground.

Human remains

38.6 Buried infant human remains were located during this excavation; all individuals were less than one year old. The skeletal remains of 21 individuals were uncovered. The remains of a further 11 coffins, indicating undisturbed burials, were evident. Four potential grave cuts were also identified and at least six individuals were identified through disarticulated skeletal remains. Therefore, the potential minimum number of possible individuals identified through the test-excavation was 42.

38.7 Coffins or evidence of coffins were located with the majority of skeletal remains (84%). Burials appear to have some organisation, in terms of layout, and there appears also to be concentrations of interments in particular locations within the burial ground. A number of the coffins appear to have been painted white. There were no coffin or name-plates in evidence.

38.8 Radiocarbon dating of 13 samples of skeletal remains provided estimated dates-of-death for those individuals in the 1930s, 1940s, 1950s and 1960s, the time of the operation of the mother and baby home in Sean Ross.

38.9 The Commission is satisfied that the report provides clear evidence that the coffined remains of children under the age of one are buried in the designated burial ground. There can be 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. The Commission does not consider that further investigation is warranted.

Disturbance of remains by drainage

38.10 An independent survey of the waste-water drains in the vicinity of the burial ground was conducted by a drain specialist. This survey found that there had been upgrading and redirection of some pipe work in close proximity to the burial ground. This correlated with information from council planning files that saw the rerouting of waste water into a newly inserted main drainage pipe in around 1996. A salt glazed ceramic pipe was found on the geophysical survey and in the drain

inspection survey that skirts the southern corner of the site. The drain inspection found this pipe to be now defunct. A more modern junction had been inserted to the northwest that reroutes this drainage to run parallel with the burial ground toward the northeast where it eventually joins the local drain network to the north of St Anne's Sean Ross Abbey building complex.

38.11 The evidence indicates that the human remains that have been uncovered were not disturbed by the insertion of drainage works, field-drains or waste-water pipes.

Bessborough

38.12 The Commission remains perplexed and concerned at the inability of any member of the Congregation of the Sacred Hearts of Jesus and Mary to identify the burial place of the children who died in Bessborough. The concern of the congregation about marking the graves of the children who died in Castlepollard (see below) does not seem to have applied to the children who died in Bessborough.

38.13 A number of people and organisations have made suggestions about possible locations for children's graves both in the area which is currently part of the Bessborough estate (roughly 60 acres) and in areas which were sold in earlier years (the total area was once about 200 acres). During 2019, the Commission followed up on some of these suggestions.

38.14 In April 2019, the Commission's solicitor and archaeologist walked the grounds of Bessborough with a man who had lived nearby. He pointed out the area in the grounds where he believes he saw a graveyard marked with white crosses. He subsequently swore an affidavit setting out his recollections. A similar exercise was conducted in October 2019 with a man who had played in the grounds as a child. He pointed out an area where he said he had seen open graves with the bodies of young children exposed. This was marked on a map and he subsequently swore an affidavit to this effect.

38.15 Also in April 2019, a man who had done building work in Bessborough in 2008 told the Commission that there was a cavern/chamber underneath the church on the site. The work had been carried out on behalf of the HSE so the Commission issued a direction to the HSE seeking minutes of the meetings between the HSE and the builders involved in the site. These minutes were provided by the HSE in

August 2019. The minutes note that the space was referred to as an underground tank and was found to contain water and petrol-contaminated silt. It appears there was no archaeological significance to the tank.

38.16 A detailed submission was received from the Cork Survivors and Supporters Alliance in March 2020. This dealt with two aspects of the Commission's 5th Interim report - the law on burials (see below) and the issue of the Bessborough burials. The submission dealt in considerable detail with the available mapping of the Bessborough estate, the interpretation of that mapping and its potential to identify possible burial grounds.

38.17 The Commission and its forensic archaeologists had been aware of all these possible locations when the 5th Interim report was compiled. The Commission recognised then and still 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.

Burial records relating to St Finbarr's Hospital held at Cork University Maternity Hospital

38.18 The Commission continued its efforts to establish if any of the Bessborough children were buried in other locations. In its 5th Interim Report, the Commission reported that a 'Burial Book' relating to deaths in St Finbarr's Hospital may have been held in Cork University Maternity Hospital (CUMH). The Commission issued a discovery order in respect of these records. In May 2019, HSE South informed the Commission that they had located records relating to St Finbarr's Hospital including burial records and mortuary records. Three of the collections located at CUMH were relevant to the Commission's work.

Mortuary Book (1969-79)

38.19 The Commission undertook a line by line search of this book and identified a number of children born in Bessborough who subsequently died in St Finbarr's Hospital.

Folder of Burial Records/Burial Index Card Box

38.20 These records were the mortuary index cards flagged by a former administrator of St Finbarr's Hospital. The collection comprised physical Burial Index Cards created by the mortuary attendant at St Finbarr's Hospital and a folder detailing the

information recorded on the cards. The collection of mortuary index cards held at CUMH covered the years 1968-85. The Commission has established that mortuary index cards relating to the 1940s and 1950s were held in St Finbarr's Hospital in the late 1990s but have not been located to date. The Commission analysed the extant mortuary index cards and identified 26 infants and children born in Bessborough who subsequently died in St Finbarr's Hospital. The Commission also identified 11 stillborn infants delivered in St Finbarr's Hospital to women transferred from Bessborough.

38.21 The mortuary index cards compiled at St Finbarr's Hospital recorded patient details including name, last address, date of death, name of undertaker and place of burial. Index cards relating to 'illegitimate' infants who died in St Finbarr's Hospital in this period stated that all were buried in St Michael's Cemetery. The Commission examined the burial registers at St Michael's Cemetery on two occasions but found no burial record for the infants identified on the mortuary index cards. Further analysis of the mortuary index cards revealed that in some instances deceased infants were buried in the coffins of deceased adult patients. In other instances, infants were buried in coffins containing amputated limbs.[1] The Commission established that the Cork health authorities were buying burial plots in St Michael's Cemetery since its opening in 1948. These burial plots were used to bury the unclaimed remains of patients who died in Cork County Home/St Finbarr's Hospital. The Commission has not established when the health authorities began the practice of burying 'illegitimate' infants in coffins with adult remains or with amputated limbs. The Commission has also not established why the names of infants buried in this manner were not recorded in the burial register at St Michael's Cemetery. However, it is clear from a collection of correspondence between the health authorities and staff and administrators of maternity hospitals in Cork that the practice was commonplace.

Box file of miscellaneous emails/Southern Health Board plot purchases/cemetery plans

38.22 As part of the Inquiry into Post Mortem Practices and Organ Retention,[2] a Post Mortem Enquiry Helpline was set up at Cork University Hospital (CUH) in 2001. It appears that maternity records from hospitals in Cork were transferred to CUH at

[1] HSE, Cork University Maternity Hospital, Burial index card box/folder of burial records 1968-85.
[2] The Report of Dr Deirdre Madden on Post Mortem Practice and Procedures is at https://www.lenus.ie/handle/10147/43373

that time. The helpline was to assist parents of stillborn children and parents of deceased infants who were the subject of post mortem examination. Most letters from parents related to instances where a hospital had arranged the burial of a deceased child and where parents requested information on the place of burial. It is clear from this collection of correspondence that Southern Health Board officials did not know how hospitals in the city dealt with foetal and infant remains. A letter from a consultant obstetrician/gynaecologist to the Secretary, Erinville Maternity Hospital, in 1984 acknowledged that foetal remains from Cork Regional Hospital (CUH) were 'normally placed in a coffin with other corpses' and subsequently buried in consecrated ground. The doctor stated that he found the practice 'unsatisfactory' as parents would never locate or visit their child's grave.[3] The Commission has established that health authorities in Cork engaged in such burial practices from at least the 1960s and had continued to do so until the late 1980s. In 1992, the Southern Health Board made arrangements for the burial of foetal and infant remains at Kilcully Cemetery, Cork. The administrator, St Finbarr's Hospital, advised the Secretary, Miscarriage Association of Ireland, that when requested by parents, foetal and infant remains were placed in a small coffin and buried in Kilcully, where the cemetery supervisor kept a register of such burials. Parents who sought information on the burial of a child prior to 1992 received a standard letter from the Southern Health Board which read:

> Following discussions with relevant staff and an exhaustive search to locate the burial place of Baby X, it was the practice at that time for St Finbarr's Hospital to bury babies on behalf of the parents in St Finbarr's Cemetery, Glasheen Road, Cork. The cemetery records are unable to pinpoint the actual burial place as there were a number of different plots.

38.23 The Commission examined Burial Records relating to St Finbarr's Cemetery on two occasions and found burial details recorded for three 'illegitimate' children associated with Bessborough. Two related to child deaths which occurred in 1923 and the third to a child death in 1989. All three children were buried in 'poor ground' local authority owned burial plots. If it was the case that the Cork Health Authority/Southern Health Board did 'bury babies on behalf of parents in St Finbarr's Cemetery' it appears that their burials were not recorded in the cemetery burial records. The Commission found that details relating to burials of 'illegitimate'

[3] HSE, Dr E.P.J McGuinness to A. Gosnell, Secretary, Erinville Hospital, 13 August 1984.

children are conspicuously absent from burial records associated with cemeteries with local authority burial plots.

38.24 In 2001, the Southern Health Board endeavoured to locate the burial places of five infants whose parents had contacted the Post Mortem Enquiry Helpline. The infant deaths had occurred on dates between 1973 and 1985 and the place of death was St Finbarr's Hospital or the Erinville Hospital, Cork. Senior Southern Health Board staff engaged with cemetery supervisors in Cork city and hinterland and former administrators of maternity hospitals in the city in a bid to establish the location of the infant burials. Following intensive inquiries, the Southern Health Board stated, based on anecdotal evidence, that it was likely that infants who died in the 1980s were interred in St Finbarr's Cemetery, but concluded that 'cemetery staff are unable to pinpoint the actual burial place'.

38.25 The Commission has encountered similar difficulties in locating the burial places of children who died in the Cork institutions under its remit: Cork County Home/St Finbarr's Hospital and the Bessborough Home/Sacred Heart Maternity Hospital. As highlighted above, it appears that the practice of burying deceased infants in coffins with adult remains was common practice in the city's main maternity hospitals until the late 1980s. Furthermore, the associated practice of neglecting to record such infant burials in cemetery Burial Registers appears to have been common practice also. The Commission spent considerable time and resources trying to establish the burial places of more than 1,400 infants and children who died either in Cork County Home/St Finbarr's Hospital or the Bessborough Home/Sacred Heart Maternity Hospital in the period 1922-98. The Commission identified the burial places of 101 infants who died in one or other of these institutions. While most burial places were confirmed by an actual burial record (mainly in the 1920s) others were identified through disparate historical sources created by Cork health authorities or hospital personnel. Given the burial practices adopted by maternity hospitals in Cork in the mid to late twentieth century, the Commission considers the task of locating the burial places of the remaining 1,300 plus infants and children who died in Cork County Home/St Finbarr's Hospital and the Bessborough Home/Sacred Heart Maternity Hospital to be a difficult one.

Castlepollard

38.26 In its 5th Interim Report, the Commission stated that it had no reason to doubt that the children who died in Castlepollard were buried there in the marked burial ground. After the publication of that report, the Congregation of the Sacred Hearts of Jesus and Mary provided the Commission with copies of correspondence between it and the Midland Health Board in the 1990s which further clarified what occurred in the 1990s. In 1994, the congregation contacted the Midland Health Board (which had owned the site since 1971) to say that it wanted to remove the wall between the Sisters' and the children's burial plots and wanted to install a memorial to the children. The congregation pointed out that, while there was a memorial stone to the Sisters who died there and to the mother who died there, there was nothing to mark the fact that children were also buried there. The congregation was concerned about this. The Midland Health Board agreed to the congregation's proposals. It seems that the works were not carried out until 1996/7 and they were then carried out by the health board. The congregation agreed to pay the costs involved. This correspondence corroborates what local people told archaeologists in 2017 and which is reported in the Commission's 5th Interim report.

Tuam deaths and anatomical studies

38.27 In its 5th Interim Report, the Commission reported that a number of infant remains had been sold to the Galway Medical school by the porter in the Central Hospital, Galway. The Commission did **not** report that these bodies were those of children from the Tuam Children's Home. The Commission did consider this possibility as it was obliged to do under its Terms of Reference but, as the names of the children are not known, it is not possible to establish where they were from. The dates of their deaths makes it highly unlikely that any of them were former residents of the Tuam home.

38.28 In the chapter on anatomical studies, the 5th Interim Report stated at paragraph 7.35:

> The current head of the Galway Anatomy Department told the Commission that, when he took up this post in 1995, there were many "wet" infant anatomical subjects preserved in the department. These unidentifiable infant remains were buried together in Rahoon Cemetery, Galway in 1995 with full funeral rites and with the permission of the Coroner.

38.29 This was based on information supplied to the Commission at an earlier date. The errors in this statement were brought to the Commission's attention by the head of the anatomy department but, regrettably, the Commission did not correct it. The correct information is as follows:

> The current head of the Galway Anatomy Department told the Commission that, when he took up this post in 2005, there were many "wet" infant anatomical subjects preserved in the department. These unidentifiable infant remains were buried together in Bohermore Cemetery, Galway in 2005 with full funeral rites and with the permission of the Coroner.

38.30 The Commission apologises for its failure to correct this before submission of its 5th Interim report and acknowledges the assistance of the head of the Galway Anatomy Department in its investigation.

The law on burials

38.31 The Cork Survivors and Supporters Alliance submission argued that the common law placed various obligations on the Congregation of the Sacred Hearts of Jesus and Mary in respect of burials and these obligations had not been met. The Commission's 5th Interim report outlined only the statutory provisions and the submission argued that these did not replace the common law duties. The Commission accepts that the common law may have placed obligations on the congregation in respect of burials but it is not clear what exactly those obligations were and in what way, if any, they were different from the statutory obligations.

38.32 The submission further argued that it was wrong to conclude that burial grounds operated by religious institutions (such as at Bessborough) were not regulated by the 1878 Act. The submission makes an arguable case for this but it is clear that the 1888 Rules and Regulations did not apply to burial grounds such as Bessborough.

38.33 The points raised by the submission in relation to the law on burials are interesting. However, the Commission decided not to pursue the matter further because of time constraints (the submission was received in March 2020 when this report was almost complete) and because its primary concern was to try to establish where the children were buried.

CORK SURVIVORS AND SUPPORTERS ALLIANCE

(CSSA)

OPENING STATEMENT

SCHEME OF A CERTAIN INSTITUTIONAL BURIALS

(AUTHORISED INTERVENTIONS) BILL

14 March 2021

Executive Summary and Introduction

1. The Cork Survivors and Supporters Alliance (***"the CSSA"***) represent a group of survivors of Bessborough Mother and Baby Home, including former residents and family members of women and children who resided within the Institution. The CSSA's membership includes family members of children who died while resident at Bessborough, and whose burial location is not recorded and their supporters. Many of these children were buried within the grounds of Bessborough in unmarked graves.

2. It should be noted that the CSSA *do not* seek for the remains of the children buried at Bessborough to be excavated, exhumed or otherwise removed from the site.

3. While the exhumation of remains in other sites, such as Tuam, may be an appropriate response, it is not appropriate for Bessborough.

4. Rather, the CSSA seek for the remains of children buried on the grounds to be preserved in place.

5. Exhuming and moving the deceased children of the site, in a way it is just a direct means of dispersing the children that died there.

6. It is the opposite of memorialisation.

7. It is not the appropriate way to mark their lives and deaths at the place where the events took place.

8. The Bill in placing exhumation and removal as a central purpose of the Bill, runs the risk of being well-intentioned but achieving precisely the wrong thing.

9. In one way, it could be said that it is just a convenient way of making the children disappear from sight again, and it is precisely the wrong response to what happened.

10. The CSSA seeks that site be appropriately cared for and memorialised.

11. There should be appropriate fencing of the burial ground (to prevent animals accessing the site or people inadvertently and unknowing walking on graves), and appropriate marking and/or commemoration of the children's burial places.

12. These are the standards that are currently applicable to burial grounds, in accordance with the Public Health (Ireland) Act 1878 Act (as amended) and the Rules and Regulations for the Regulation of Burial Grounds 1888.

13. A core issue is that these were not respected or applied in Bessborough House, despite applying to the burial ground there, and that remains the position.

14. Given the failure to apply the Rules, which are a statutory instrument to date, the Rules should be elevated to the level of Act.

15. There should be no difference of treatment between the burial grounds of the children at Bessborough, and mother and baby homes generally, and other childrens' burial grounds.

16. **The CSSA seeks the maintenance, preservation and memorialisation of the children's burial ground on the site of the former Bessborough Mother and Baby Institution, and in the absence of legislative intervention the issue remains unsettled.**

17. In addition, there is in law a right of reasonable access for the survivors and family members of children buried on the grounds of Bessborough which should also be recognised in the Act.

18. What underpins this is universal huma need and legal right – is something we all share - and is best expressed in the following quote:

> *The right of every person to be buried in a dignified manner in accordance with the traditions and customs of his family hardly requires special justification or even to be secured in written form in law. This right is clearly self-evident and stems from human nature as, perhaps, no other natural right. Equally natural and uncontested is the right of every person to conduct the burial of a person who is related and dear to them, to have an opportunity to perform one's moral duty and display one's human qualities, to bid farewell, to grieve, mourn and commemorate the deceased, however he may be regarded by society and the state, to have the right to a grave, which in all civilisations represents a sacred value and the symbol of memory.*
>
> European Court of Human Rights, *Arkhestov and others v. Russia*, quoting from Judge A.L. Kononov of the Russian Constitutional Court.[1]

19. As things stand, the lands have been sold and the current plan is to place an apartment block where the Childrens' Burial Ground is located.

A. Burials at Bessborough

20. Between the years of 1922-1998, more than 900 children died while resident in Bessborough.[2]

21. The Congregation of the Sacred Heart of Jesus and Mary **("*the Congregation*")** did not record the burial locations of the '*vast majority*' of the children who died in Bessborough.[3]

22. The burial places of 14 women who died while resident at Bessborough were similarly not recorded by the Congregation.[4]

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[1] *Arkhestov and others v. Russia* (App. No. 22089/07, Judgment of 16 January 2014), [2014] ECHR 53 at [43].
[2] Fifth Interim Report of the Mother and Baby Home Commission of Investigation (March 2019) at [4.5].
[3] Fifth Interim Report (March 2019) at [1].
[4] Fifth Interim Report (March 2019) at [4.49].

Cork Survivors and Supporters Alliance

23. The Final Report of the Mother and Baby Home Commission of Investigation Mother and Baby Home Commission of Investigation ***("the Commission")*** concluded that it was "*highly likely*" that burials took place in the grounds of Bessborough.[5]

24. With the assistance of the Ordnance Survey Ireland, the CSSA identified the location of a '*Childrens' Burial Ground*' at Bessborough, in line with contemporaneous Ordnance Survey Ireland mapping evidence. A copy has been provided to the Committee.

25. The Commission of Investigation establishes the following:

    a. Many of the children who died during the years of operation of Bessborough Mother and Baby Home were stillborn or died very soon after being born.
    b. Prior to March 1929, children who died in Bessborough were buried in St Joseph's Cemetery. At this time expectant mothers who were resident in Bessborough House did not give birth there, but usually gave birth in Cork District Hospital.
    c. After March 1929, children who died in Bessborough ceased to be buried in St Joseph's Cemetery. In 1930, a maternity ward was created within the home, and in 1935, the Sacred Heart Maternity Hospital was built alongside the Bessborough home.

26. The Commission was tasked with investigating various matters concerning the Bessborough Mother and Baby Home and other institutions. The CSSA provided a submission to the Commission in relation to the location of a Children's Burial Ground at Bessborough, which can be summarised as follows:

    a. The Children's Burial Ground was established sometime between 1932 and 1950, most likely between the years of 1932-1935 following the establishment of the Sacred Heart Maternity Hospital on the Bessborough grounds.

[5] Final Report of the Mother and Baby Home Commission of Investigation (12 January, 2021), *Chapter 38: Addendum to Burials Report* at [38.12].

b. In accordance with contemporary mapping evidence found by OSI Ireland, a Children's Burial Ground existed at Bessborough House. The Children's Burial Ground is specifically and deliberately identified in a 1950 Ordnance Survey Ireland trace map, available on request at OSI headquarters. The Children's Burial Ground is located in an area north west of the Folly.

c. The Sisters of the Sacred Heart were subject to the Public Health (Ireland) Act 1878 Rules and Regulations for the Regulation of Burial Grounds 1888, but were treated as if they were above the law (which they were not). The burial ground at Bessborough breaches the 1878 Act and the Rules, and that remains the position.

27. The Commission's Final Report included the following comments concerning burial arrangements at the Bessborough Mother and Baby Home.

> *The Commission remains perplexed and concerned at the inability of any member of the Congregation of the Sacred Hearts of Jesus and Mary to identify the burial place of the children who died in Bessborough. The concern of the congregation about marking the graves of the children who died in Castlepollard (see below) does not seem to have applied to the children who died in Bessborough.*[6]*...*
>
> *A detailed submission was received from the Cork Survivors and Supporters Alliance in March 2020. This dealt with two aspects of the Commission's 5th Interim report - the law on burials (see below) and the issue of the Bessborough burials. The submission dealt in considerable detail with the available mapping of the Bessborough estate, the interpretation of that mapping and its potential to identify possible burial grounds.*
>
> *The Commission and its forensic archaeologists had been aware of all these possible locations when the 5th Interim report was compiled.* ***The Commission recognised then and still recognises that it is highly likely that burials did take place in the grounds of Bessborough.*** *The only way that this can be established*

[6] Final Report of the Mother and Baby Home Commission of Investigation (12 January, 2021), *Chapter 38: Addendum to Burials Report* at [38.12].

> *is by an excavation of the entire property including those areas that are now built on.*[7]

28. The Commission appears to suggest that the children's burial place at Bessborough cannot be identified in the absence of an excavation of the entire property.

29. The CSSA strongly disagrees, in circumstances where contemporaneous, reliable OSI mapping evidence clearly indicates the location of the *'Childrens' Burial Ground'*.

30. The OSI has confirmed the location of the burial ground is recorded on a revision map, that the recording is reliable and accurate, and that the location would have to have been approved by the then occupiers, Sisters of the Sacred Heart (in what is termed the Name Book, and what is called a Form 1.6 would also have to be completed, before any entry on a map could be made).

31. The children and relatives are buried at this location, unless the mapper who attended at the site in 1950 wrongly recorded the site of the children's graveyard, the Sister of the Sacred Heart wrongly signed off on the location, which is improbable to say the least, and not a view supported by the OSI, the State's expert mapping service.

32. It is noteworthy that the interim report of the Commission had failed to identify the original trace drawing and showed significant confusion about the mapping evidence and what it meant and showed, all of which was omitted in the Final Report following the receipt of the CSSA submission.

33. The CSSA does <u>not</u> seek for the *'Childrens' Burial Ground'* to be excavated and does not seek for the children's remains to be exhumed and reinterred elsewhere.

34. Rather, the children's remains should be preserved in place, with appropriate marking and memorialisation, and a right of access for relatives wishing to access the graves.

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[7] Final Report at [38.17].

35. In the case of Bessborough the CSSA's members view excavation as desecrating the last burial place of the children, a placed where they have rested, together, for 40, 50 and 60 years.

B. Legal Framework Governing Burials at former Residential Institutions

36. The CSSA made a submission to the Mother and Baby Home Commission of Investigation setting out the relevant law on burials, including common law obligations, relevant statutory instruments, and the European Convention on Human Rights[8] and Bunreacht na hÉireann, 1937[9].

37. The rights of surviving family members to locate, identify and bury their deceased relatives as well as the right to access ancestral and familial burial sites has been recognised to various degrees by the European Court of Human Rights[10], the United Nations Human Rights Committee[11], the Inter-American Court of Human Rights[12] and national courts and tribunals[13]. These cases demonstrate the recognition across cultures

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[8] See, *inter alia*, *Solska and Rybicka v. Poland* ECHR case 30491/17 20/09/2018; Referencing: *Pannullo and Forte v. France* no. 37794/97, ECHR 2001-X, *Estate of Kresten Filtenborg Mortensen v. Denmark* ((dec.), no. 1338/03, ECHR 2006-V, *Hadri-Vionnet v. Switzerland* no. 55525/00, 14 February 2008, *Girard v. France* no. 22590/04, 30 June 2011; *Elberte v. Latvia* no. 61243/08, ECHR 2015, *Pannullo and Forte v. France*, no. 37794/97, §§ 31–35, ECHR 2001-X, *Maskhadova v. Russia* (2016) 63 E.H.R.R. 22; *Sabanchiyeva v. Russia* (2014) 58 E.H.R.R. 14; *Arkhestov and others v. Russia* (App. No. 22089/07) - [2014] ECHR 22089/07; *Zalov v. Russia and Khakulova v. Russia* ECHR case 7988/09 16/01/2014, *Hadri-Vionnet v. Switzerland*, no. 55525/00, § 52, 14 February 2008.

[9] The survivors of Residential Institutions have a right to know the location of the gravesites of their deceased children and family members, and the right to visit familial graves, pursuant to Articles 40.1 (equal treatment), 41.3.1° (personal rights) and 42 (family) of Bunreacht na hÉireann, 1937.

[10] See, *inter alia*: *Maskhadova v. Russia* (2016) 63 E.H.R.R. 22; *Sabanchiyeva v. Russia* (2014) 58 E.H.R.R. 14; *Arkhestov and others v. Russia* (App. No. 22089/07) - [2014] ECHR 22089/07; *Zalov v. Russia and Khakulova v. Russia* ECHR case 7988/09 16/01/2014.

[11] See, *inter alia*: Views of March 17, 2006, Communication No. 1044/2002, *Shukurova v. Tajikistan* at [10]; Views of 28 March 2006, Communication No. 1159/2003, *Sankara v. Burkina Faso* at [14]; Views of April 3, 2003, Communication No. 887/1999, *Lyashkevich v. Belarus*; Views of 30 March 2005, Communication No. 973/2001, *Khalilova v. Tajikistan*; Views of 16 November 2005, Communication No. 985/2001, *Aliboev v. Tajikistan.*

[12] See, *inter alia*: Case of the Moiwana Community v. Suriname, *Members of the Moiwana Village v. Suriname*, Preliminary objections, merits, reparations and costs, IACHR Series C No 124, IHRL 1508 (IACHR 2005), 15th June 2005, Inter-American Court of Human Rights [IACtHR]; Concurring Opinion (par. 5) in the case of the *Haitians and Dominicans of Haitian Origin in the Dominican Republic* (Provisional Measures of the Inter-American Court of Human Rights, of 18.08.2000).

[13] See, *inter alia*: *The Queen v. The Burial Board for the Parishes of St John, Westgate, and Elswick, in the Borough and County of Newcastle upon Tyne* (1862) 121 ER 1232; *Foster v. Dodd & Anor* (1865) LR 1 QB 475;

and jurisdictions of the human right to locate, identify and bury a loved one, the right to mourn and visit a grave, and the right to access familial burial sites.

38. The Public Health (Ireland) Act 1878 and the Rules and Regulations for the Regulation of Burial Grounds 1888 (as amended) attempted to provide for and regulate what was already required by common and natural law, but not being adhered to universally in Ireland. The common law imposes the following duties:-

    i. Common law duties and obligations existed requiring the provision of a 'decent' or 'dignified' burial throughout the time period identified in the Commission's Terms of Reference (1922-1998). During the relevant time period, the indicia of a decent and dignified (Christian) burial included:

        - A burial (as distinct from mere *disposal* of remains);
        - A grave (or crypt);
        - A marking of the grave (or burial place);
        - Use of a burial ground – dedicated for that use, fenced off from livestock, and inadvertent alternative uses;
        - Burial in consecrated ground (when baptised);
        - Some element of ceremony (blessing, prayer);
        - Participation of the family;
        - A record of the burial, including: their name, their date of death, the location of the grave;
        - Access after burial for family.

    ii. These common law duties to provide a 'decent' or dignified' burial are reflected in Irish legislation, in international human rights law[14] and in Bunreacht na

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Rugg v. Kingsmill (1865) LR 1 A & E 343; *Moreland v. Richardson* (1856) 52 ER 1238; *Hines v. State* 149 S.W. 1058,1059 (Tenn. 1911); *Richards v. Nw. Protestant Dutch Church*, 20 How Pr. 317, 317 (N.Y. Sup. Ct. 1859); *Hunziker v. State* 519 N.W.2d 367 (1994).

[14] The principle of respect for the dead and for their graves is *"...**common to all humanity**"* and exists in different forms across many cultures. *Elli Poluhas Dödsbo v. Sweden*, no. 61564/00; ECHR 2006-I at [20]. The principle of respect for the dead includes the right for family members to locate, identify and bury their dead. Proper identification and recording of information regarding the dead is a means of fulfilling the legal, cultural and religious rights of human beings not to lose their identity after death. Family members have a 'right to know' the fate of their loved ones and the location of their remains. This is part of the State's duty to protect and guarantee human rights. See, inter alia, *Hopu and Bessert v France*, Merits, Communication No 549/1993, UN Doc CCPR/C/60/D/549/1993/Rev.1, IHRL 2148 (UNHRC 1997), 29th July 1997, United Nations [UN]; Human

hÉireann, 1937. The duties and obligations applied equally in respect of burials on the grounds of institutional residential settings, such as Mother and Baby Homes, County Homes, Magdalene Laundries, Industrial Schools, Psychiatric Institutions etc.

iii. The treatment of deceased infants and children at many of the former Mother and Baby Institutions failed to comply with these common law duties surrounding burial. In particular, the Congregation at Bessborough failed:

- To provide for any form of decent or dignified burial (what occurred was rather the disposal of remains);
- To provide the children, and some of the adult women who died in servitude, with a grave;
- To provide any marking for their grave or resting place;
- To fence off or segregate the burial ground, allowing animals to roam over it;
- To place baptised children in consecrated ground;
- To contain any element of ceremony (blessing, prayer) – the disposal appears to have been delegated to ground staff;
- To give an opportunity to the children's mothers or family to attend, who were excluded as a matter of course,
- To record the locations of the children's burial places, their names, their date of death;
- To allow access for family members after burial.

39. These common law duties and obligations continue to apply regardless of the owner of the property.

40. The fact that the duty to provide a '*decent*' or '*dignified*' burial was not respected in the past, is no reason to disrespect the deceased children now.

Rights Committee [CCPR]; *Barake v. Minister of Defence of Israel and ors*, Original petition to the high court of justice, HCJ 3114/02, ILDC 369 (IL 2002), 14th April 2002, Israel; Supreme Court.

41. Removing the children from their burial ground, so that the lands can be developed - by building apartment blocks - is an anathema to those that would see their memory preserved.

42. As a country and a people, we do not build apartment blocks on children's burial grounds, though that is what is proposed now.

43. That this is the current plan for the lands is raw evidence that the survivors and their relatives are not being listed to.

44. The plans were submitted to An Board Pleanala without any consultation with the CSSA or survivors.

45. The Public Health (Ireland) Act 1878 Act (***"the 1878 Act"***) ensures that the burial of persons is dignified and decent, to reduce and limit burials which were not in accordance with '*public decency*' and 'to *prevent a violation of the respect due to the remains of deceased persons*', and to ensure '*public health*'. The purpose of the 1878 Act is to give further effect to the common law ideas around burial and to regulate burial grounds so that burial of persons is dignified and decent. The 1878 Act (as amended) remains in full force and was in force for the duration of the period 1922-1998, including when the Congregation at Bessborough created the '*Childrens' Burial Ground*'.

46. Similarly, the Rules and Regulations for the Regulation of Burial Grounds 1888, as amended, (***"the Rules"***) were in force for the duration of the relevant period, and apply to the children's burial ground at Bessborough. The Rules were amended from time to time by way of statutory instrument, including in 1919, 1929 and 2013. See for example, S.I. No. 144/2013 Burial Ground (Amendment) Regulations, 2013. The 1878 Act and Rules still apply, and provide a basis for regulation in respect of burial grounds that have not been maintained in accordance with the standards and requirements imposed by the 1878 Act or the Rules.

47. Section 170 of the 1878 Act is an express recognition in the 1878 Act of the right of relatives to have a say over the graves of their deceased relatives and for families to be buried together. The purpose of the provision is obvious; it allows the living to visit their deceased in one place, and it allows the living know they will be buried with loved ones. It fulfils a basic human need. The section reflects the common law and natural law, and demonstrates the sensitivity of the time (by legislators). Things are no different today and the Act for this reason remains in force as the governing Act.

48. The idea that a burial ground should be fenced, and therefore a distinct place, different from others and excluding other uses, is also evident in the 1878 Act. In that regard, s. 171 should be read in conjunction with s.185, which reflects the objective of ensuring that animals are not free to graze on a burial ground. Section 185 suggests that any burial ground not being attached or contiguous to any such church, chapel or place of worship nor situate as aforesaid is without any sufficient fence or is not kept in decent order, the burial board of the district may, by notice in writing, require the area to be properly fenced or put same in *decent order*.

49. Although many residential institutions, such as the former Bessborough Mother and Baby Home, did not comply with these obligations, this does remove or reduce the requirement to comply with the 1878 Act.

50. In that regard, these rights have been entirely ignored and breached, and that continues today, and given the level of public anger and scrutiny, require the Oireachtas to intervene.

51. By burying children in the manner in which it was done, by failing to separate and mark the existence of the burial ground, or the graves, the families have been denied their rights and traditions. The physical failure to mark out the burial ground or their graves, or to otherwise afford the children and their families the long-standing feature of a dignified death and burial, persists today. It needs to be corrected and requires Oireachtas intervention.

52. The failure to mark the burial ground, or the graves, is failure to acknowledge that the children were born or existed; the effect has been to treat the children as if they did not exist and had no life of their own, did not come from a family or a mother.

53. The children did live and did exist.

54. And, it important for the families and for Irish society, that this fact be given concrete expression in accordance with our common cultural and societal standards, which are to mark out and separate the burial ground, and allow appropriate commemoration of the burial, including access to the burial site for relatives.

55. The CSSA are not asking for anything other than what is afforded to deceased children, and their families, who did not live and die in Mother and Baby Homes.

56. The right to equality of treatment is protected by A. 40.1 of the Constitution which this Committee is mandated to uphold. .

57. The CSSA are not asking for any special treatment, simply equal treatment; treatment in accordance with our common tradition to afford their deceased loved ones a dignified burial and resting place, which is marked out and can be visited.

58. The CSSA makes the following recommendations:

    a. ***Recommendation:*** *burial grounds at former residential institutions must be preserved and respected to an appropriate standard, as with any burial ground. The difference in treatment is wholly unjustified and contrary to the guarantee of equality under A. 40(1) of the Constitution*

    b. ***Recommendation:*** *Any future use of burial grounds at former residential institutions must comply with the Public Health (Ireland) Act 1878 Act (as amended) and the Rules for Burial Grounds 1888 as amended. As this has not happened, and continues to be flouted, the intervention of the Oireachtas is sorely needed.*

c. ***Recommendation:*** *There must be provision for reasonable access to the family members of the deceased. If this right is not protected and vindicated by the Oireachtas, it will have failed to deal with the controversy and to have addressed its constitutional function.*

59. The following quote encapsulates the desire of survivors and relatives of survivors:-

> "We want somewhere to go to remember our children and siblings. To go up, sit on a bench, lay a flower, have a moment."

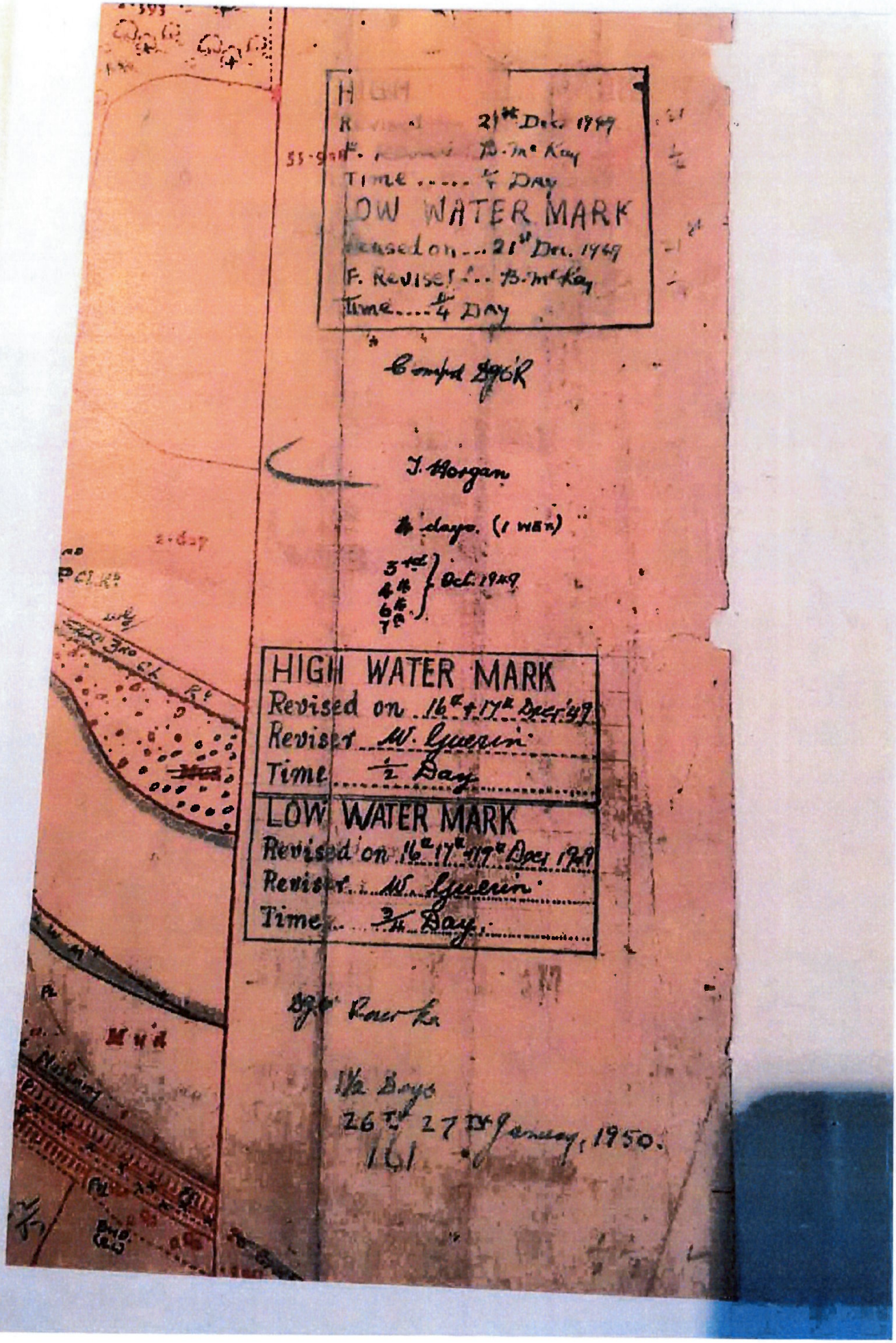
And:

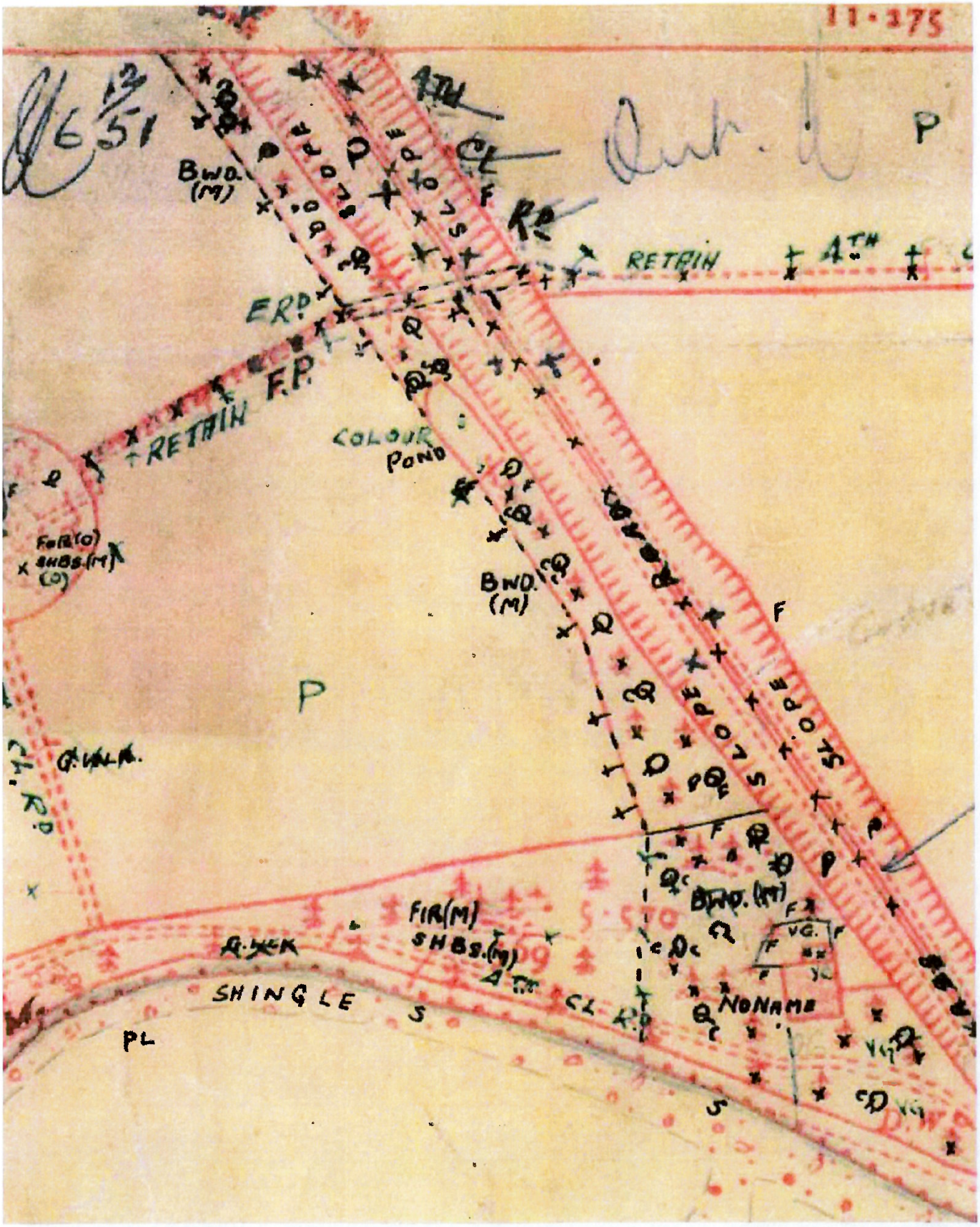
> "Bring flowers. Say a prayer. Talk to them – talk - sit down. That is the way it should be in Cork."

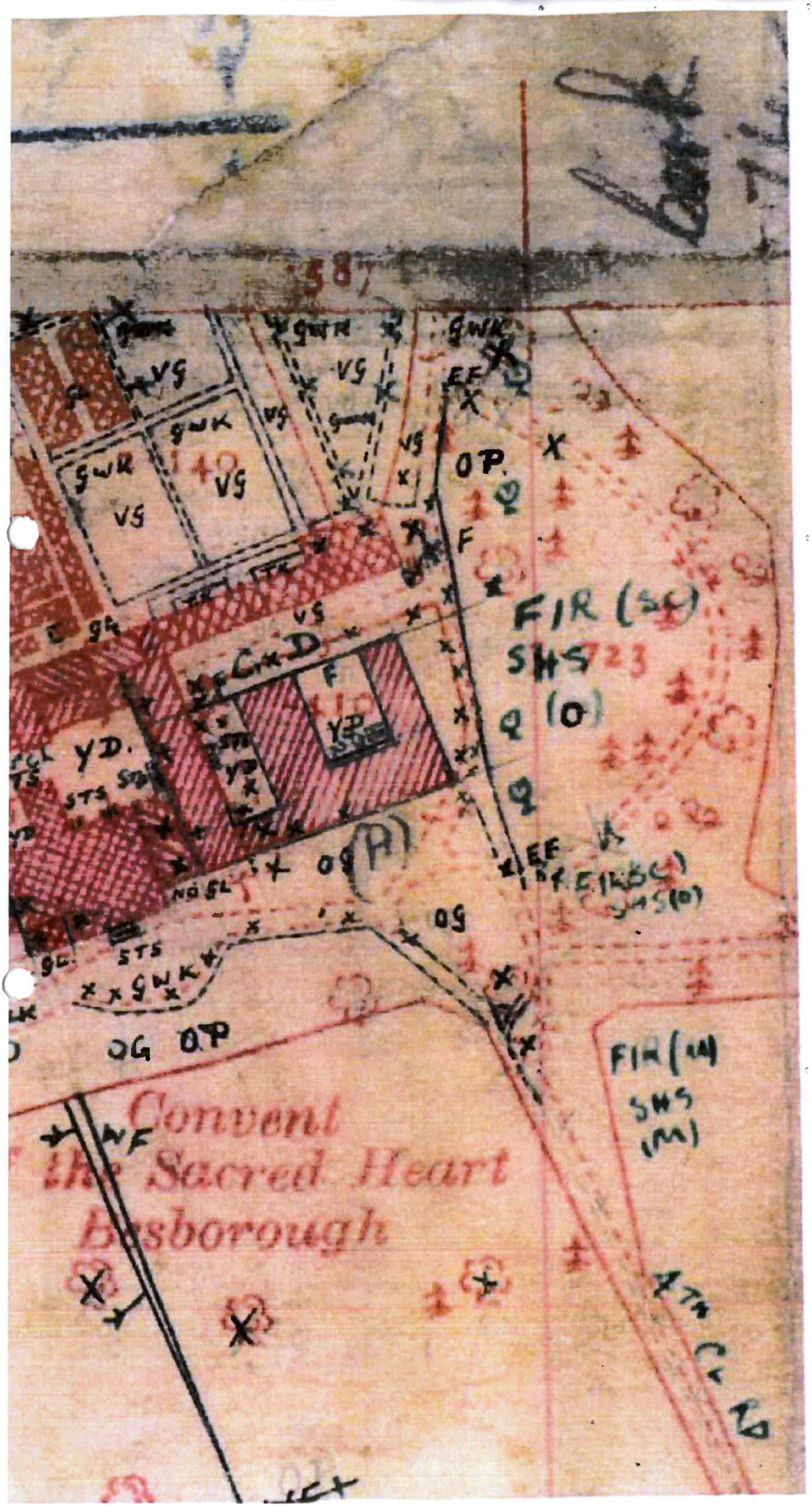
The CSSA has been supported by the Public Interest Law Alliance ("PILA") which engaged KOD Lyons Solicitors, David Dodd BL and Céile Varley BL, Bar of Ireland, to advise and assist the CSSA in their more detailed written submission on the draft heads, which has been submitted to committee.

Cork Survivors and Supporters Alliance

Appendix: Map


HIGH
R 21st Dec. 1949
Time ..... ¼ Day
OW WATER MARK
Revised on ... 21st Dec. 1949
F. Revised ... B. Mc Kay
Time .... ¼ Day
Compld 896R
J. Morgan
4 days. (1 week)
3rd
4th
6th
7th
Oct. 1949
HIGH WATER MARK
Revised on 16th & 17th Dec. 49
Reviser W. Lyneen
Time ½ Day
LOW WATER MARK
Revised on 16th 17th & 19th Dec 1949
Reviser W. Lyneen
Time ¾ Day
896 Race Ks
1½ Days
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20 March 2026

To whom it may concern:

RE: Large Scale Residential Development proposal, "The Farm" (Cork City Council Planning Ref. 25/44442), at Bessborough, Ballinure, Blackrock, Cork

We, the undersigned, write in support of the appeal by Bessboro Mother and Baby Home Support Group against the grant by Cork City Council to Estuary View Enterprises 2020 Limited on 24 February 2026 of Conditional Permission for a Large-Scale Residential Development at a site located at Bessborough, Ballinure, Blackrock, Cork (Planning Ref. 25/4442).

In summary, we submit:

1. The State is aware of a situation of mass disappearance and the probability that some of the disappeared are buried in the grounds of Bessborough Mother and Baby institution. An Bord Pleanála and An Coimisiún Pleanála have refused planning permission for this site numerous times since May 2021 due to the lack of clarity regarding the whereabouts of 878 children and mothers (in total) who were confined in Bessborough.

2. The State is obliged under the European Convention on Human Rights (ECHR) to investigate the deaths of children and mothers who were confined in Bessborough, and to ascertain the whereabouts of the disappeared and return their remains to relatives. The EU Charter of Fundamental Rights (CFR) protects—in several cases more explicitly than in the ECHR text—the equivalent rights which, according to the jurisprudence of the European Court of Human Rights (ECtHR), give rise to such obligations (CFR arts 1, 2, 4, 6, 7, 11, 20, 21, 24, 33, 42, 47). These legal obligations are reinforced by international human rights law sources and standards, including as interpreted by eight United Nations Human Rights Council-appointed Special Procedures directly in relation to the deaths and disappearances of individuals previously confined in Ireland's Mother and Baby institutions. Irish Constitutional caselaw supports the existence of these obligations, also.

3. The State has not complied with its European human rights law obligations in respect of the deaths and disappearances of children and women who were confined in Bessborough

Mother and Baby institution. The Mother and Baby Homes Commission of Investigation (MBHCOI) proceeded in private and offered no opportunity to bereaved mothers or relatives to see or comment on, or suggest lines of inquiry further to, the evidence it received and considered. The MBHCOI did not publish its archaeological assessment of the grounds at Bessborough; it kept its entire archive relating to Bessborough confidential from bereaved mothers and relatives. The MBHCOI's archive remains inaccessible to affected people and the public, and neither An Coimisiún Pleanála nor the members of Cork City Council have access to the documents and other evidence underlying the MBHCOI's observations and conclusions. Furthermore, the MBHCOI did not use all reasonable means to search for the disappeared children and women of Bessborough: it did not undertake geophysical surveys using methods such as ground-penetrating radar / electrical resistivity / magnetometry, and there is no indication in its Reports that it undertook test excavations or soil chemistry or decomposition analysis. The State has not established any other investigation into the disappeared children and mothers of Bessborough.

4. An Coimisiún Pleanála is obliged to uphold the State's European human rights law obligations, which cannot be displaced or delegated by way of conditions on a grant of planning permission to a private property developer.

5. Cork City Councillors have acknowledged the State's responsibility for the Bessborough site, unanimously agreeing that a Compulsory Purchase Order is necessary in relation to the entire remaining site.

This letter reproduces some of the contents of the following publications, which ACP may wish to consult further:

- Sarah-Anne Buckley, Vicky Conway, Máiréad Enright, Fionna Fox, James Gallen, Erika Hayes, Mary Harney, Darragh Mackin, Claire McGettrick, Conall Ó Fátharta, Maeve O'Rourke and Phil Scraton, 'Joint Submission to Oireachtas Committee on Children, Equality, Disability and Integration' (Dublin: Justice for Magdalenes Research, 26 February 2021)[1]
- Maeve O'Rourke, 'A human rights framework: Background Research for the Truth Recovery Design Process' (Belfast: Truth Recovery Design Panel, 27 September 2021)[2]
- Maeve O'Rourke, 'The Manipulation of "Vulnerability": State Responses to So-Called "Historical" Abuses in Ireland' (2021) 43(3) Human Rights Quarterly 435

[1] Available at https://jfmresearch.com/wp-content/uploads/2021/03/Institutional-Burials-Bill_Joint-Submission-26.2.21.pdf.
[2] Available at https://researchrepository.universityofgalway.ie/server/api/core/bitstreams/1b76cc1f-3a72-40b8-855a-3ad67ab2b5c3/content.

1. The State is on notice of mass disappearances and 'highly likely' burials at Bessborough

1.1 MBHCOI findings

The MBHCOI's reports (the Fifth Interim Report published in March 2019,[3] and the Final Report published in January 2021[4]) found the following in respect of mothers and children in Bessborough Mother and Baby institution:

Population

- Bessborough housed 9,768 girls/women and 8,938 children between 1922 and 1998.[5] It opened in 1922.[6] It 'was a large Georgian house initially on over 200 acres of land.'[7]
- Within the network of Mother and Baby institutions under investigation by the MBHCOI, Bessborough admitted the second largest number of girls below the age of 18.[8]

State involvement

- Bessborough 'was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. It was financed by capitation payments from the local health authorities and received capital funding from the Hospitals Trust Fund.'[9]
- The *Registration of Maternity Homes Act 1934* 'gave the DLGPH/Department of Health the authority to inspect all places where women gave birth, or received nursing care following a birth. All maternity homes were required to register, and registration was the responsibility of the local authority.'[10]
- 'The evidence suggests that the Cork local health authorities did not properly monitor Bessborough and did not take appropriate action when it became aware of the very high rate of infant mortality.'[11]

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[3] Mother and Baby Homes Commission of Investigation (MBHCOI), Fifth Interim Report (March 2019), https://www.gov.ie/en/department-of-children-disability-and-equality/publications/commission-of-investigation-into-mother-and-baby-homes-and-certain-related-matters-fifth-interim-report-march-2019/.
[4] MBHCOI, Final Report (January 2021), https://www.gov.ie/en/department-of-children-disability-and-equality/publications/final-report-of-the-commission-of-investigation-into-mother-and-baby-homes/.
[5] MBHCOI, Final Report, Executive Summary para 90.
[6] MBHCOI, Final Report, Chapter 18 para 18.1.
[7] MBHCOI, Final Report, Executive Summary para 93.
[8] MBHCOI, Final Report, Executive Summary para 3.
[9] MBHCOI, Final Report, Executive Summary para 94.
[10] MBHCOI, Final Report, Executive Summary para 27.
[11] MBHCOI, Final Report, Executive Summary para 94.

Deaths

- 923 children who were associated with Bessborough died.[12] This 'includes children who died in the Bessborough home and Sacred heart hospital [in Bessborough]; children who were born in or admitted to Bessborough who subsequently died elsewhere and children who were never admitted to Bessborough but whose mothers had been resident in Bessborough prior to their birth'.[13]
- 'Most (761) died in Bessborough, either in the Bessborough home or in the Sacred Heart Hospital.'[14] A further 129 children died in Cork District Hospital/St Finbarr's Hospital, 15 children died in other city hospitals, 12 children died in private addresses - mainly foster homes - following their discharge from Bessborough, and 4 children died in a 'private mother and baby home' following discharge from Bessborough.[15]
- 'Through the institutional records, the Commission identified 31 deaths among women admitted to Bessborough'.[16] 'The Commission found GRO records for 29 of the 31 maternal deaths.'[17]

Mortality rates

- In the early 1940s successive inspections carried out by the Department of Local Government and Public Health (DLGPH) under the *Registration of Maternity Homes Act 1934* revealed major shortcomings in Bessborough[18] 75% of the children born in Bessborough in 1943 died within the first year of life.[19] This was the 'highest rate of infant mortality in an Irish mother and baby home'.[20] 'In the years 1940-44, 330 children died in Bessborough. Deaths recorded during these five years accounted for 36% of all child deaths associated with Bessborough in its 76-year operation.'[21]
- In late 1944 or early 1945, 'Dr Ward, the Parliamentary Secretary at the DLGPH, considered that the medical supervision of children in Bessborough, as reported by Dr Condy, was "criminally casual"'.[22]
- 'In the years 1958-60 infant mortality increased to around 10%: representing nine deaths on average in these years.'[23]

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[12] MBHCOI, Final Report, Executive Summary para 95.
[13] MBHCOI, Final Report, Chapter 18A p34.
[14] MBHCOI, Final Report, Chapter 18A p38.
[15] MBHCOI, Final Report, Chapter 18A p38.
[16] MBHCOI, Final Report, Chapter 18A p10.
[17] MBHCOI, Final Report, Chapter 18A p10.
[18] MBHCOI, Final Report, Executive Summary para 28.
[19] MBHCOI, Final Report, Executive Summary para 62.
[20] MBHCOI, Final Report, Executive Summary 234.
[21] MBHCOI, Final Report, Chapter 18A pp34-35.
[22] MBHCOI, Final Report, Chapter 18 para 18.118.
[23] MBHCOI, Final Report, Chapter 18A p36.

Burial records and burial places of mothers

- 'The Commission found burial records for 12 women in St Joseph's Cemetery, Cork.'[24]
- 'The Commission has established that, between November 1927 and January 1985, 12 adult women, all former residents of the Bessborough Home, were buried in a Congregation of the Sacred Hearts of Jesus and Mary owned burial plot at St Joseph's Cemetery. This plot is marked by a headstone. However, the headstone lies in three broken pieces and the inscription is unreadable. It is unlikely that the headstone bears the names of women buried in this plot. The women buried here remained in Bessborough for extended periods working as domestic servants; their deaths were not childbirth related. One woman entered Bessborough in 1922, aged 20 years, and remained there until her death in 1984 - a period of 62 years. Another entered Bessborough in 1924, aged 21 years, and remained there until her death in 1985 - a period of 60 years.'[25]

Burial records of children

- 'Bessborough failed to keep a register of infant burials and the burial location of the majority of children who died there is still unknown.'[26]

Burial places of children

- 'It is not known where the vast majority of the children who died in Bessborough are buried...Despite very extensive inquiries and searches, the Commission has been able to establish the burial place of only 64 children.'[27]
- 'The Commission remains perplexed and concerned at the inability of any member of the Congregation of the Sacred Hearts of Jesus and Mary to identify the burial place of the children who died in Bessborough.'[28]
- 'The Commission...recognises that it is highly likely that burials did take place in the grounds of Bessborough.'[29]

Rationale for conclusion that burials in Bessborough are 'highly likely': process of elimination

- 'There is a small burial ground in the grounds of Bessborough. This was opened in 1956 for members of the congregation. It seems to have been assumed by former residents and advocacy groups that this is also where the children who died in Bessborough are buried as there are occasional meetings and commemoration ceremonies held there. The vast majority of children who died in Bessborough are not buried there; it seems that only one child is buried there.'[30]

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[24] MBHCOI, Final Report, Chapter 18A p10.
[25] MBHCOI, Fifth Interim Report, paras 4.49-4.50.
[26] MBHCOI, Final Report, Executive Summary para 97.
[27] MBHCOI, Fifth Interim Report p8 para 1.
[28] MBHCOI, Final Report, Chapter 38A para 38.12.
[29] MBHCOI, Final Report, Chapter 38A para 38.17.
[30] MBHCOI, Fifth Interim Report p8 para 1.

- 'At an early stage, the Commission thought it unlikely that all the children who died in Bessborough were buried in this burial ground as it was not nearly large enough for the number of children involved and, in any event, it would be unlikely that children would be buried in the same burial ground as members of the congregation.'[31]
- The Commission examined:
  - Three collections of records from St Finbarr's Hospital[32]
  - The burial records for seven of the eight burial grounds that were in operation in Cork city and surrounding hinterland between 1922 and 1998:[33]
    - St Joseph's Cemetery, Tory Top Road, Cork..
    - St Finbarr's Cemetery, Glasheen Road, Cork.
    - St Michael's Cemetery, Mahon, Cork.
    - Douglas Municipal Cemetery, Douglas, Cork.
    - St Mary's Cemetery, Curraghkippane, Cork.
    - St Catherine's Cemetery, Kilcully, Cork
    - Rathcooney Cemetery, Glanmire, Cork.
  - The Commission was 'unable to locate the burial records for Cork District Cemetery, Carr's Hill'[34] despite extensive efforts.[35]

Other rationale for conclusion that burials in Bessborough are 'highly likely'

- 'The Commission considers that it is likely that some of the children are buried in the grounds but has been unable to find any physical or documentary evidence of this. In particular, during the 1940s (when many of the deaths occurred) and when petrol was scarce, it would have been very expensive to arrange off-site burials. However, as no physical evidence of possible locations was found, the Commission did not consider it feasible to excavate 60 acres not to mention the rest of the former 200 acre estate.'[36]

1.2 Previous planning decisions

The recent grant of planning permission by Cork City Council at Bessborough stands in stark contrast to three decisions taken previously by An Coimisiún Pleanála (ACP) and An Bord Pleanála (ABP) in respect of the site.

[31] MBHCOI, Fifth Interim Report para 4.14.
[32] MBHCOI, Final Report, Chapter 38A paras 38.18-38.25.
[33] MBHCOI, Fifth Interim Report para 4.30.
[34] MBHCOI, Fifth Interim Report para 4.31.
[35] MBHCOI, Fifth Interim Report paras 4.40-4.47.
[36] MBHCOI, Fifth Interim Report para 7.

In May 2021, in ABP-308790-20, ABP refused permission for the following reason:

> Having regard to the Fifth Interim Report (2019) and the Final Report (2020) [sic] of the Commission of Investigation into Mother and Baby Homes, and on the basis of the information submitted in the course of the application and oral hearing, the Board is not satisfied that the site was not previously used as, and does not contain, a children's burial ground and considers that there are reasonable concerns in relation to the potential for a children's burial ground within the site, associated with the former use of the lands as a Mother and Baby Home over the period 1922 to 1998. In this context, the Board considers that it would be premature to grant permission for the proposed development prior to establishing whether there is a children's burial ground located within the site and the extent of any such burial ground.[37]

Simply put, ABP refused permission precisely because so little was known about the location of children's burials at Bessborough. The situation remains unchanged since ABP's decision in ABP-308790-20 and since the publication of the MBHCOI Final Report. The burial place of 859 children and 19 mothers is still not known. It has still not been established 'whether there is a children's burial ground located within the site and the extent of any such burial ground'.

This was acknowledged in ABP's refusal of permission in ABP-315820-23, in September 2024, for two reasons—one of which was the following:

> Having regard to the Boards decision to refuse permission for a previous application (ACP-308790-2-), the Board is satisfied that no new material information or evidence has been presented in this application to substantiate a different conclusion following that previous decision. The Board considers that the potential exists for the presence of human remains and/or burials at this proposed development site associated with the former use of the lands as a Mother and Baby Home over the period 1922 to 1998. The Board considers it would therefore be premature to grant permission for this proposed development prior to establishing the extent of human remains and/or burials, if any, and that such matter extends beyond the scope of normal planning conditions particularly having regard to the impacts this may have on the development as proposed. The proposed development would, therefore, be contrary to the proper planning and sustainable development of the area.[38]

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[37] An Bord Pleanála, Board Order ABP-308790-20 (25 May 2021) https://www.pleanala.ie/anbordpleanala/media/abp/cases/orders/308/d308790.pdf?r=285984457966

[38] An Bord Pleanála Board Order ABP-315820-23 (13 September 2024) https://www.pleanala.ie/anbordpleanala/media/abp/cases/orders/315/d315820.pdf?r=589201902105.

ACP again refused permission in ABP-313206-22, in July 2025. The Inspector's Report stated the following:

> 10.4.9. In conclusion, no new or significant evidence has been presented since the Board's decision on ref no. 308790 (decision in 2021), which had been based on a considerable body of evidence that was robustly tested at the oral hearing, which would be sufficient to overcome the Board's reason for refusal. Furthermore, nothing has changed on the ground in respect of addressing the considerable uncertainty regarding the potential for unrecorded burials within the lands, including the site of the current proposal, that had given rise to this decision, i.e. no excavations have been carried out. Notwithstanding the appellants' claims that the area of concern was largely confined to the area north and west of the folly and on lands not within the applicants' ownership, it has been widely accepted by the Board, the Commission of Investigation and by the applicants' own experts, that the extent of the area to which the uncertainty persists regarding the potential for unrecorded burials is significant.
>
> 10.4.10 In relation to dealing with the issue by way of condition requiring forensic research and monitoring, the Board had also considered the question of granting planning permission subject to a condition requiring forensic excavations to be carried out prior to commencement of construction, as is currently proposed as a solution to the uncertainty, but had rejected this proposal on the basis of the significant degree of uncertainty on this matter, the need for a rigorous standard of oversight which would be beyond the scope of the planning authority, and the potential consequences for the development should human remains be discovered in *situ*.
>
> ... 10.4.12 Conclusion on Legacy: It is acknowledged that the application site is removed from the lands that were subject to both ref no. 308790 and 318520. I would also acknowledge that a significant portion of the site, is dominated by existing structures of considerable age that may pre-date the use as a Mother and Baby Home and the majority of new structures fall within the footprint of such. Notwithstanding such and having regard to the fact that application site is part of the historic curtilage of Bessborourgh House and does include existing open areas, which has a history of use as a former Mother and Baby Home, it is considered that the issues raised by Board's reason for refusal for development subject to ref no. 308790 and 318520 on lands also within the historic curtilage of Bessbough House are relevant in this case. I do not consider that the proposal addressed this issue satisfactorily with no additional information of any material significance has been presented to the Board in the intervening period. In light of the significant uncertainty regarding the location and extent of unrecorded burials on the lands associated with Bessborough House site, as highlighted in the Fifth Interim Report (2019) and the Final Report (2020) of the Commission of Investigation into Mother and Baby Homes, and to

the reasonable concerns raised by the Board in relation to the potential for a children's burial ground on these lands, it would be premature to grant permission for the proposed development prior to establishing if there is a children's burial ground within the site, the extent of such a burial ground and the implications for the delivery of the development as proposed. For these reasons, the proposed development should, therefore, be refused.[39]

2. The State's human rights obligations

2.1 Letter to the Government from eight United Nations Human Rights Council-appointed Special Procedures

In a letter to the Irish Government on 5 November 2021, no fewer than eight United Nations Human Rights Council-mandated Special Procedures criticised the State's response to the deaths and burials of individuals who were confined in Mother and Baby homes and analagous institutions.[40] Making reference not only to international treaties and customary international law but also the provisions of the European Convention on Human Rights, the Special Procedures emphasised the need to 'effectively facilitate victims and relatives' access to information about the circumstances of their relatives' burials' and stated: 'Given the conclusions in the Commission's report concerning the higher mortality rates in the Mother and Baby Homes, it is critical to ensure that provisions are made for the holding of inquests to investigate the deaths that occurred'.[41]

Highlighting the State's particular obligations in respect of disappearances, the Special Procedures' letter observed that 'the right of the relatives to know the truth of the fate and whereabouts of the disappeared persons is an absolute right, not subject to any limitation or derogation'[42] and continued:

> The State's positive obligations in relation to enforced disappearances are stated in international human rights treaties, and customary international law, and raise questions

[39] An Bord Pleanála, Inspector's Report ABP-313206-22 (23 May 2025) https://www.pleanala.ie/anbordpleanala/media/abp/cases/reports/313/r313206.pdf?r=489345265325.
[40] Letter of 5 November 2021 from Luciano Hazan, Chair-Rapporteur of the Working Group on Enforced or Involuntary Disappearances; Mama Fatima Singhateh, Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material; Tomoya Obokata, Special Rapporteur on contemporary forms of slavery, including its causes and consequences; Nils Melzer, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; Siobhán Mullally, Special Rapporteur on trafficking in persons, especially women and children; Fabian Salvioli, Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence; Reem Alsalem, Special Rapporteur on violence against women, its causes and consequences; and Melissa Upreti, Chair-Rapporteur of the Working Group on discrimination against women and girls (Letter of 5 November 2021 from 8 UN Special Procedures), https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=26772.
[41] Letter of 5 November 2021 from 8 UN Special Procedures, 4.
[42] Letter of 5 November 2021 from 8 UN Special Procedures, 9.

> also in relation to the State's responsibility under the ECHR, specifically Articles 2 (right to life), Article 3 (prohibition of torture), Article 5 (right to liberty and security), Article 8 (right to respect for private and family life) and Article 13 (right to an effective remedy). Reference is also made to Articles 6, 7, 9, 10, 16 of the ICCPR, read alone and in conjunction with Article 2.3 and, where minors are involved, also Article 24.1. In addition, we would like to recall the obligation of the State under Article 20 of the Declaration on the Protection of All Persons from Enforced Disappearance, which requires that measures be taken to prevent and suppress the abduction of children of parents subjected to enforced disappearance and of children born during their mother's enforced disappearance. It also requires that the State devote their efforts to the search for and identification of such children and return them to their families of origin. Further, Articles 13 and 19 of the Declaration respectively require States to conduct prompt, thorough and impartial investigations into allegations of enforced disappearance and to provide victims and their family with adequate redress for the harm suffered. Article 17 of the Declaration clarifies that enforced disappearances shall be considered a continuing offence as long as the perpetrators continue to conceal the fate and the whereabouts of persons who have disappeared and these facts remain unclarified.[43]

Regarding the timeframe in which deaths took place in Ireland's Mother and Baby institutions: in addition to their above-noted clarification that a disappearance constitutes a continuing situation, the Special Procedures observed:

> In relation to the relevant international law, we draw your Excellency's attention to the international legal instruments, in force at the time of the events occurring, and relevant peremptory norms of international law (*jus cogens* norms), that also form part of customary international law and were binding upon the State. Specifically, these include, and are not limited to: Right to life, right to be free from torture, inhuman and degrading treatment, the prohibition of forced labour and servitude, the prohibition of racial discrimination, the prohibition of enforced disappearance, and the right to liberty and security of the person, including the right to be free from arbitrary detention. We also note that the procedural duty to carry out an effective investigation under Article 2 ECHR has evolved into a separate and autonomous duty and may bind the State even when the death took place before the critical date of ratification.[44]

2.2 Report of the Special Rapporteur on Child Protection, Geoffrey Shannon, in 2018

In December 2017 then Minister for Children, Katherine Zappone TD, requested then independent Special Rapporteur on Child Protection, Geoffrey Shannon, to provide a report on *Human Rights*

[43] Letter of 5 November 2021 from 8 UN Special Procedures, 10.
[44] Letter of 5 November 2021 from 8 UN Special Procedures. 12 (citations omitted).

Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway. That report, published in April 2018,[45] contains extensive European, Irish Constitutional, and international human rights law analysis that relates also to the deaths and disappearances at Bessborough Mother and Baby institution. Shannon's report discusses, *inter alia*:

- Public bodies' obligation to perform their functions compatibly with the ECHR, pursuant to the European Convention on Human Rights Act 2003;
- The right under Article 8 ECHR to know the fate of family members, including information surrounding the death and/or burial of loved ones;
- The State's obligation under Articles 2 and 3 ECHR to investigate effectively when a death occurs in suspicious circumstances or where an individual has gone missing in life-threatening circumstances;
- The meaning of an 'effective investigation' according to ECtHR jurisprudence, including that State authorities must take the initiative to investigate once the matter has come to their attention, that the approach must be comprehensive and steps must be taken to secure all relevant evidence in relation to the death, and that the investigation must be open to public scrutiny and must involve relatives of the deceased to a sufficient degree to safeguard their legitimate interests;
- The importance of dignity under the Irish Constitution, in particular in relation to circumstances of death; and
- The question of the inherent jurisdiction of the High Court to determine whether and how remains should be dealt with.

2.3 Irish Human Rights and Equality Commission

The Submission of the Irish Human Rights and Equality Commission (IHREC) on the *General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill* dated February 2021[46] is relevant to the instant appeal; it recognises that:

> The discovery of the mass grave site at the former Mother and Baby Home at Tuam in 2017 and the findings of the *Mother and Baby Homes Commission of Investigation Final Report* (2020) that many of the Mother and Baby Homes did not properly record the burials of children who died in these institutions engage serious human rights and equality issues both for the deceased and their family members.[47]

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[45] Geoffrey Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway*, 12 April 2018, https://assets.gov.ie/25217/0abb576368b14c2081c447b417544fb2.pdf.

[46] Irish Human Rights and Equality Commission, 'Submission to the Joint Committee on Children, Disability, Equality and Integration on the General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill' (February 2021), https://www.ihrec.ie/downloads/Submission-to-the-Joint-Committee-on-Children-Disability-Equality-and-Integration-on-the-General-Scheme-of-a-Certain-Institutional-Burials-Bill.pdf.

[47] Ibid 2.

The IHREC Submission notes that the situation in Bessborough (among other analagous institutions) raises wide-ranging human rights issues under the Irish Constitution, European human rights law and international human rights law. These include 'the importance of dignity under the Constitution', the recognition at common law 'of the right to a decent burial, and of a range of rights and duties concerning dead bodies', the 'positive procedural obligation upon states to investigate' under Articles 2 and 3 ECHR, the rights of family members of deceased persons under Article 8 ECHR 'to have their loved one's body returned to them and the right to know the fate of their family members, including information surrounding the death and/or burial of their loved ones', the right 'to know the truth', and various international human rights standards and best practice guidance applicable to mass graves.[48] IHREC's Submission recommends a 'transitional justice response for the survivors of the Mother and Baby Homes and families of those who died within these institutions'.[49]

2.4 Human rights guarantees

The following section gives further consideration to human rights guarantees under the Irish Constitution, the ECHR (which should be taken also to mean the CFR in the context of the application of EU law to planning decisions, bearing in mind Article 52(3) CFR[50]), and international human rights law.

Right to an effective investigation

The deaths of children in Bessborough in the mid-1940s occurred in an institutional environment that a senior Government official called 'criminally casual'.[51] The disappearance of the vast majority of those who died while associated with Bessborough is a situation of extreme seriousness, demonstrating systemic neglect (if not worse), discrimination and denial of human dignity—not only on the part of the Sisters of the Sacred Hearts of Jesus and Mary but also by the State authorities that paid for and placed girls, women and their children in the custody of the religious congregation and that had legal responsibilities to inspect and regulate their treatment. In *Makaratzis v Greece* the ECtHR held that Article 2 ECHR places a 'primary duty on the state to secure the right to life by putting in place an appropriate legal and administrative framework to deter the commission of offences against the person, backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions'.[52] In addition to the

[48] Ibid 3-6.
[49] Ibid 8.
[50] Charter of Fundamental Rights of the European Union [2012] OJ C326/391, Art 52(3): 'In so far as this Charter contains rights which correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, the meaning and scope of those rights shall be the same as those laid down by the said Convention. This provision shall not prevent Union law providing more extensive protection.'
[51] MBHCOI, Final Report, Chapter 18 para 18.118.
[52] *Makaratzis v Greece* (2005) 41 EHRR 49 para 57.

requirement of general regulation and inspection, and criminal law enforcement, the ECtHR has held that Article 2 requires the State to take practical steps to prevent loss of life in specific situations where it knows or ought to know that there is a real risk of death.[53] In *Nencheva and Others v Bulgaria*, the ECtHR found that Bulgaria had violated the right to life of fifteen children and young adults who died at a home for young people with disabilities as a result of cold and shortages of food, medicines and basic necessities. The manager of the home had tried without success on several occasions to alert all the public institutions which had direct responsibility for funding the home and which could have been expected to act.[54]

The right of relatives to an effective investigation is an established aspect of both the right to life and the right to freedom from torture and other inhuman or degrading treatment under Articles 2 and 3 ECHR, respectively. In *Salman v Turkey*, recognising that '[p]ersons in custody are in a vulnerable position and the authorities are under a duty to protect them',[55] the ECtHR held that states are obliged to carry out an effective official investigation into deaths in custody or detention even if no agent of the state was involved in the incident resulting in death. This was confirmed in *Musayeva v Russia*.[56] Furthermore, in *Oneryildiz v Turkey*, where numerous deaths were caused by an environmental disaster, the ECtHR held that the investigative obligation arises 'when lives have been lost as a result of events occurring under the responsibility of the public authorities, which are often the only entities to have sufficient relevant knowledge to identify and establish the complex phenomena that might have caused such incidents'.[57]

It is a matter of settled ECHR law that the obligation to carry out an 'effective investigation' arises wherever there is an 'arguable claim' that an unlawful death has occurred whether at the hands of state agents or private individuals.[58] An 'arguable claim' exists where the 'allegations could not be discarded as being prima facie untenable'.[59] In *Fernandes v Portugal*, the ECtHR confirmed that the investigative obligation arises wherever a death occurs 'in suspicious circumstances, even when the State has no direct responsibility for the death'.[60] The obligation to establish an 'effective investigation' further arises wherever there is an 'arguable claim' that a violation of Article 3

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[53] See for example *Oneryildiz v Turkey* (2005) 41 EHRR 20; *Osman v United Kingdom* (2000) 29 EHRR 245; *Opuz v Turkey* (2010) 50 EHRR 28.

[54] *Nencheva and Others v Bulgaria* App no 48609/06 (ECtHR, 18 June 2013).

[55] *Salman v Turkey* (2002) 34 EHRR 425 para 99.

[56] *Musayeva v Russia* (2008) 47 EHRR 25 para 77.

[57] *Oneryildiz v Turkey* (2005) 41 EHRR 20 para 93

[58] Council of Europe, *Guide to good practice in respect of domestic remedies (adopted by the Committee of Ministers on 18 September 2013)* (2013) 31.

[59] *Nuri Kurt v Turkey* (2007) 44 EHRR 36, para 117.

[60] *Fernandes v Portugal* App No 43098/09 (ECtHR, 15 December 2015) para 70. See also *Tunç v Turkey* App no 24014/05, (ECtHR, 25 June 2013) para 171; *McCaughey v United Kingdom* App No 43098/09 (ECtHR, 15 December 2015).

ECHR (right to freedom from torture or inhuman or degrading treatment or punishment) has occurred.[61]

In *Mocanu v Romania* the ECtHR held that the responsibility is on the state, not the victim of torture or ill-treatment, to initiate an investigation—and this is especially the case where the state has witnessed the abuse in question.[62] The procedural obligation to investigate under both Articles 2 and 3 ECHR is non-derogable: in other words, it cannot be displaced for any reason. Guidance issued by the Registry of the ECtHR states:

> Article 2 ranks as one of the most fundamental provisions in the Convention, one which in peace time, admits of no derogation under Article 15. Together with Article 3, it enshrines one of the basic values of the democratic societies making up the Council of Europe (Giuliani and Gaggio v. Italy [GC], 2011, § 174). As such, its provisions must be strictly construed (McCann and Others v. the United State Kingdom, 1995, § 147).[63]

Regarding the temporality of the State's obligations, the ECtHR has held that the state is under a continuing obligation to investigate apparent unlawful death which allegedly occurred prior to the Convention's entry into force if the gap between the alleged abuse and the Convention's entry into force is not more than ten years and much of the investigation took place or ought to have taken place in the period following the entry into force of the Convention.[64] The examination of deaths and burials by the MBHCOI creates a 'critical date' for activating Convention jurisdiction.[65]

The UN Committee Against Torture (CAT) has clarified that states' obligations under the Convention Against Torture to investigate, and to ensure access to justice and reparation in respect of, apparent torture or ill-treatment apply retrospectively. According to the CAT's General Comment No 3, 'States parties shall ensure that all victims of torture or ill-treatment, regardless of when the violation occurred or whether it was carried out by or with the acquiescence of a former regime, are able to access their rights to a remedy and to obtain redress.'[66] The CAT's reasoning is that: 'For many victims, passage of time does not attenuate the harm and in some cases the harm may increase as a result of post-traumatic stress that requires medical, psychological and social support, which is often inaccessible to those whom have not received

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[61] *Aksoy v Turkey* (1997) 23 EHRR 553 para 98; *Assenov and Others v Bulgaria* (1999) 28 EHRR 652 para 98; *Kaya v Turkey* (1999) 28 EHRR 1 para 107.
[62] *Mocanu v Romania* (2015) 60 EHRR 19 para 265.
[63] Council of Europe, European Court of Human Rights, 'Guide on Article 2 of the European Convention on Human Rights: Right to life' (31 August 2025) 6 https://ks.echrcoe.int/documents/d/echr-ks/guide_art_2_eng.
[64] *Jovanowiec and Others v Russia*, Apps nos 55508/07 and 29520/08 (ECtHR, 21 October 2013) paras 146-147; see also *Silih v Slovenia* App no 71463/01 (ECtHR, 9 April 2009) para 163.
[65] *Janowiec v Russia*, Application No 39630/09, Merits and Just Satisfaction (ECtHR, 13 December 2012).
[66] UN Committee Against Torture (CAT), General comment no. 3, 2012: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment : implementation of article 14 by States parties, 13 December 2012 para 40.

redress.'[67] The CAT has explained that 'victims' of torture and ill-treatment include 'affected immediate family or dependants of the victim as well as persons who have suffered harm in intervening to assist victims or to prevent victimization.'[68]

State obligations in respect of disappearances

In our view, the circumstances in Bessborough can be characterised as 'disappearances' as that term is used in both ECtHR jurisprudence and international human rights law: due to the deprivation of liberty to which mothers and their children were subjected in Bessborough Mother and Baby institution.[69] The following paragraphs explain that for as long as information about a relative's whereabouts is withheld from their family members, the disappearance continues. It is a continuing situation and frequently understood as a combined violation of rights: depending on the circumstances including the rights to life, freedom from torture and inhuman or degrading treatment, liberty, and respect for private and family life.

An 'enforced disappearance' is defined in international human rights law as occurring where:

> persons are arrested, detained or abducted against their will or otherwise deprived of their liberty by officials of different branches or levels of Government, or by organized groups or private individuals acting on behalf of, or with the support, direct or indirect, consent or acquiescence of the Government, followed by a refusal to disclose the fate or whereabouts of the persons concerned or a refusal to acknowledge the deprivation of their liberty, which places such persons outside the protection of the law.[70]

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[67] The CAT's multiple Concluding Observations directed at the UK and Ireland in relation to the Magdalene and Mother and Baby institutions, and its admissibility decision in *Elizabeth Coppin v Ireland* (UN Doc CAT/C/68/D/879/2018, 14 January 2020), demonstrate that as of the date of the UNCAT's coming into force, those who have suffered in the past are included in the obligations under articles 12, 13 and 14.

[68] CAT, General comment no. 3, 2012 : Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment : implementation of article 14 by States parties, 13 December 2012 para 3.

[69] Maeve O'Rourke, 'A human rights framework: Background Research for the Truth Recovery Design Process' (Belfast: Truth Recovery Design Panel, 27 September 2021) 26-29, https://researchrepository.universityofgalway.ie/server/api/core/bitstreams/1b76cc1f-3a72-40b8-855a-3ad67ab2b5c3/content; 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* (Clann Report) (Dublin: Justice for Magdalenes Research, Adoption Rights Alliance, Hogan Lovells, 15 October 2018) paras 4.48-4.52, https://clannproject.org/clann-report/; Clann Project, Press Release, 'Irish High Court declares that Mother and Baby Homes Commission of Investigation treated survivors unlawfully: Survivors and Clann Project call on Government to amend Redress Scheme to recognise all human rights violations' (Clann Project, 17 December 2021) https://clannproject.org/wp-content/uploads/Clann-Press-Release_17-12-21.pdf; Máiréad Enright and Aoife O'Donoghue (eds), 'Mother and Baby Homes Commission of Investigation Alternative Executive Summary (2025) 14(1) *Feminists@law* 37-41, https://journals.kent.ac.uk/index.php/feministsatlaw/article/view/1396/2444.

[70] United Nations Declaration on the Protection of All Persons from Enforced Disappearances, UNGA Res 47/133 (1 December 1992) UN Doc A/RES/47/133.

The ECtHR recognised a situation similar to an enforced disappearance—which it described as a 'disappearance'[71]—in the 2015 case of *Jovanovic v Serbia* where a state-run hospital had taken a woman's new-born son from her in 1983 and from then on:

> the body of the applicant's son was never released to the applicant or her family, and that the cause of death was never determined. Furthermore, the applicant was never provided with an autopsy report or informed of when and where her son had allegedly been buried, and his death was never officially recorded. The criminal complaint lodged by the applicant's husband would also appear to have been rejected without adequate consideration and the applicant herself still has no credible information as to what happened to her son.[72]

The 1992 UN Declaration on the Protection of All Persons from Enforced Disappearances explains that '[a]cts constituting enforced disappearance shall be considered a continuing offence as long as perpetrators continue to conceal the fate and whereabouts of persons who have disappeared'.[73] A similar definition is used by the ECtHR, which noted in *Varnava and Others v Turkey* that a 'disappearance is a distinct phenomenon, characterised by an ongoing situation of uncertainty and unaccountability in which there is a lack of information or even a deliberate concealment and obfuscation of what has occurred'.[74] In *Jovanowiec v Russia*, the ECtHR emphasised that the 'essence of the issue...lies...in the authorities' dismissive reactions and attitudes in respect of that situation when it was brought to their attention' or in 'the failure of the authorities to respond to the quest for information by the relatives or from the obstacles placed in their way, leaving them to bear the brunt of the efforts to uncover any facts'.[75]

Crucially, the ECtHR has held that the state is obliged to assist in the discovery of a missing relative not only where the state was involved in the disappearance but also in cases where non-state actors were involved. In *Varnava and Others v Turkey*, the ECtHR found that a state will violate the Convention where, regardless of who is responsible for the disappearance, the state's response to relatives' requests for assistance 'may be regarded as disclosing a flagrant, continuous and callous disregard of an obligation to account for the whereabouts and fate of a missing

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[71] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013) para 47.

[72] ibid para 71 (references within the paragraph to earlier paragraphs in the judgment which establish these facts are omitted).

[73] United Nations Declaration on the Protection of All Persons from Enforced Disappearances, UNGA Res 47/133 (1 December 1992) UN Doc A/RES/47/133, Article 17(1).

[74] *Varnava and others v Turkey* App nos 16064/90, 16065/90, 16066/90, 16068/90, 16069/90, 16070/90, 16071/90, 16072/90 and 16073/90 (ECtHR, 18 September 2009) [GC] para 148.

[75] *Janowiec v Russia* (2014) 58 EHRR 30 para 178.

person'.[76] In *Jovanovic*, the ECtHR acknowledged that '[t]he mutual enjoyment by parent and child of each other's company constitutes a fundamental element of "family life" within the meaning of Article 8 of the Convention' and that Article 8 not only prohibits 'arbitrary interference' with family life but also imposes positive obligations on the state to assist in the discovery of a missing relative.[77] It is worth noting that other ECtHR case law has recognised sibling relationships,[78] and the relationship of uncles and aunts with their nieces and nephews,[79] to comprise 'family life' within the meaning of Article 8.[80]

Notably, Article 9(4) of the UN Convention on the Rights of the Child explicitly requires that where the separation of parent and child:

> results from any action initiated by a State Party such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.[81]

The ECtHR has recognised that for as long as there is a 'continuing situation' of a Convention violation the right to a remedy remains.[82] The UN Human Rights Committee, similarly, has found that the ICCPR applies to a situation of 'enforced disappearance' which may have begun prior to the Convention's entry into force in respect of a particular country but continued or continues to exist afterwards.[83]

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[76] *Varnava and others v Turkey* App nos 16064/90, 16065/90, 16066/90, 16068/90, 16069/90, 16070/90, 16071/90, 16072/90 and 16073/90 (ECtHR, 18 September 2009) para 200.

[77] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013) para 70. Note that the unmarried mother's constitutional right to the custody of her child has been recognised by the Irish courts as an unenumerated right: *G v An Bord Uachtala* [1980] IR 32. See also *I.O'T v. B* [1998] 2 IR 321. The ECtHR has also held that Article 8 protects the right to know and be cared for by one's parents: *B v United Kingdom* (1987) 10 EHRR. 87.

[78] *Custafa and Armagan Akin v Turkey* App no 4694/03 (ECtHR, 6 July 2010), para 19; *Boughanemi v France* App no 22070/93 (ECtHR, 24 April 1996) para 35.

[79] *Butt v Norway* App no 47017/09 (ECtHR, 4 March 2013) paras 4, 76; *Jucius and Juciuviene v Lithuania* App no 14414/03 (ECtHR, 25 February 2009) para 27.

[80] However the ECtHR frequently notes that 'the existence or non-existence of "family life" is essentially a question of fact depending upon the real existence in practice of close personal ties': deriving from *K and T v Finland* App no 25702/94 (ECtHR, 12 July 2001) para 150.

[81] Ireland ratified the UNCRC in 1992; the Convention applies to all situations that were continuing at that date as well as all that arose afterwards.

[82] *Mocanu v Romania* (2015) 60 EHRR 19 para 261.

[83] UN Human Rights Committee (HRC), *Jegatheeswara Sarma v Sri Lanka* , Communication No. 950/2000 (16 July 2003), UN Doc. CCPR/C/78/D/950/2000 para 9.4.

In addition to violating numerous rights of the disappeared individuals themselves,[84] continuing situations of enforced disappearance have been found by the ECtHR and UN Human Rights Committee in several cases to give rise to a continuing situation of inhuman or degrading treatment of relatives on account of the suffering caused by their inability to discover their loved one's fate and whereabouts.[85]

Right to respect for private and family life

The ECtHR has repeatedly found the Article 8 ECHR rights of a living relative to be violated where a state has failed to return, or delayed unjustifiably in returning, the body of a deceased person to their family.[86] The ECtHR has also found Article 8 to be violated where parents have been denied information about the final resting place of their stillborn child.[87] The right to respect for private and family life is acknowledged by the ECtHR to have a particular connection with the concept of human dignity.[88] In *Jovanovic v Serbia* the ECtHR held that 32 years after a woman's newborn son had been removed from her in hospital (and notwithstanding the fact that the child's removal occurred prior to the ECHR entering into force with respect to Serbia), the woman was still experiencing a continuing violation of her right to respect for her private and family life because the State had never informed her of whether, how, or when the child had died, or whether, when and where he was buried.[89]

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[84] Council of Europe: Commissioner for Human Rights, *Missing persons and victims of enforced disappearance in Europe*, March 2016, 17-18: 'Enforced disappearance is a crime under international law and a violation of multiple human rights, including the right to personal liberty and security, the right to recognition as a person before the law, the right not to be subjected to torture or other cruel, inhumane or degrading treatment or punishment, the right to a fair trial, and the right to life. Enforced disappearance also violates the economic, social and cultural rights of the disappeared person and his or her family.' See also Working Group on Enforced or Involuntary Disappearances (WGEID), 'Study on enforced or involuntary disappearances and economic, social and cultural rights', UN Doc A/HRC/30/38/Add.5 (9 July 2015).

[85] *Kurt v Turkey* (1999) 27 EHRR 373; *Bazorkina v Russia* (2008) 46 EHRR 15; HRC, *María del Carmen Almeida de Quinteros et al v Uruguay*, Communication No 107/1981 (21 July 1983) UN Doc CCPR/C/OP/2.

[86] *Pannullo and Forte v France* App no 37794/97 (ECtHR, 30 October 2001), *Girard v France* App no 22590/04 (ECtHR, 30 June 2011). See for discussion of these cases, Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (n 45) 32-33. See also the discussion in O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69) 114 of the following cases: *Hadri-Vionnet v Switzerland*, App No 55525/20 (ECtHR, 14 February 2008); *Sabanchiyeva and Others v. Russia* App no 38450/05 (ECtHR, 6 June 2013); *Maskhadova and Others v Russia* App no 18071 (ECtHR, 6 June 2013).

[87] *Hadri-Vionnet v Switzerland*, App No 55525/20 (ECtHR, 14 February 2008). See discussion of this case in O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69) 114 and Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (n 45) 35.

[88] See for example *Pretty v United Kingdom* App no 2346/02 (ECtHR, 29 April 2002) para 65; *McDonald v United Kingdom* App no 4241/12 (ECtHR, 20 May 2014) para 47.

[89] *Jovanovic v Serbia* (2015) 61 EHRR 3.

In its 2010 *Assessment of the Human Rights Issues Arising in relation to the 'Magdalen Laundries'*[90] the Irish Human Rights Commission (IHRC) concluded that Article 8 ECHR was engaged by the State's failure to ensure the identification of the bodies of women who were buried in a communal grave and thereafter exhumed and cremated.[91] The IHRC noted that 'respect for private and family life under Article 8 of the ECHR includes and encompasses the concept of personal integrity and that nothing can be more private, personal and integral to a human being than a person's identity including their name.'[92]

Right to respect for human dignity

Respect for human dignity (in other words, the inherent and equal worth of all persons) is not only the basis of international and European human rights law but also a fundamental underpinning principle of the Irish Constitution.[93] It is explicitly guaranteed by Article 1 CFR.

Shannon observes that Irish constitutional law jurisprudence makes 'clear that dignity is highly relevant to the experience of death and dying'.[94] In the Supreme Court case of *Re Ward of Court* Denham J identified the existence of a right to dignity in life and death,[95] and in *PP v HSE*[96] the High Court rejected the notion that dignity was irrelevant once a person had died, as follows:

> This does not mean that the Court discounts or disregards the mother's right to retain in death her dignity with proper respect for her autonomy with due regard to the grief and sorrow of her loved ones and their wishes. Such an approach has been the hallmark of civilised societies from the dawn of time. It is a deeply ingrained part of our humanity and may be seen as necessary both for those who have died and also for the sake of those who remain living and who must go on. The Court therefore is unimpressed with any suggestion that considerations of the dignity of the mother are not engaged once she has passed away.[97]

The MBHCOI Report's contents demonstrate a clear difference in how various institutions—not only the Sisters of the Sacred Hearts of Jesus and Mary, who ran Bessborough, but also hospitals and cemeteries—treated people in death, depending on whether or not they were born outside marriage or had given birth outside marriage. The discriminatory nature of these practices can

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[90] Irish Human Rights Commission (ICHR), *Assessment of the Human Rights Issues Arising in relation to the "Magdalen Laundries"*, November 2010.
[91] ibid paras 101-102.
[92] ibid para 102.
[93] See O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69), para 4.20; Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (n 45) 88.
[94] Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (n 45).
[95] *Re Ward of Court* [1996] 2 IR 79.
[96] *PP v HSE* [2014] IEHC 622.
[97] *PP v HSE* [2014] IEHC 622. See also Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (n 45) 90.

easily be understood to have violated what a majority of the Supreme Court in *Quinn's Supermarket v Attorney General* found to be the constitutional 'guarantee of equality as human persons...related to their dignity as human beings and a guarantee against any inequalities grounded upon an assumption, or indeed a belief, that some individual or individuals or classes of individuals, by reason of their human attributes or their ethnic or racial, social or religious background, are to be treated as the inferior or superior of other individuals in the community.'[98] The ECtHR has on several occasions, including in the case of *Johnston v Ireland*,[99] held that discrimination on grounds of non-marital family status violates the ECHR.[100]

Right to an effective remedy

The Irish Supreme Court has held that there exists a right to a remedy under the Constitution for breach of a constitutional right.[101] Article 13 ECHR, meanwhile, explicitly protects the right to an 'effective remedy' for violations of the rights enshrined in the ECHR. Article 47 CFR provides the equivalent. The vast majority of the other international human rights law treaties to which Ireland is a party also guarantee the right to a remedy for breaches of the State's obligations under those instruments.[102]

The ECtHR[103] and the United Nations General Assembly,[104] among many other human rights actors,[105] have identified the right to the truth as a core element of both the right to an effective remedy and the meaning of reparation in contexts of gross or systematic human rights violations. Truth-telling, as a form of accounting to the wronged person for wrongful actions, contributes to the restoration of respect for the human dignity of those who have suffered rights violations—as the United Nations Committee Against Torture (CAT) has highlighted.[106] The United Nations Special Rapporteur (UNSR) on the promotion of truth, justice, reparation and guarantees of non-recurrence has emphasised the necessity of truth-telling and education for the achievement of other

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[98] *Quinn's Supermarket v Attorney General* [1972] IR 1, 13.

[99] *Johnston v Ireland* (1986) 9 EHRR 203.

[100] *Mazurek v France* (2006) 42 EHRR 9; *Marckx v Belgium,* Series A, No. 31 (1979) 2 EHRR 330.

[101] *Byrne v Ireland* [1972] 1 IR 241. See also *The State (Quinn) v Ryan* [1965] IR 70 at 122.

[102] See for example Article 2 of the International Covenant on Civil and Political Rights, Article 6 of the International Convention on the Elimination of All Forms of Racial Discrimination, Article 14 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and Article 39 of the Convention on the Rights of the Child.

[103] *El Masri v Macedonia* App No 39630/09 (ECtHR, 13 December 2012).

[104] *UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*, UNGA Res 60/147 (16 December 2005) UN Doc A/RES/60/147. Available at: http://legal.un.org/avl/ha/ga_60-147/ga_60-147.html

[105] including the United Nations Special Rapporteur on truth, justice, reparations and guarantees of non-recurrence, https//www.ohchr.org/en/issues/truthjusticereparation/pages/index.aspx and the Committee Against Torture (CAT): see CAT, General Comment No 3, 'Implementation of article 14 by States parties' (13 December 2012) UN Doc CAT/C/GC/3 para 2, http://www.refworld.org/docid/5437cc274.html

[106] CAT, General Comment No 3, ibid, para 16.

core aspects of reparation, notably guarantees of non-repetition and memorialisation.[107] Regarding methods of truth recovery and truth-telling: it is of paramount importance that those directly affected by human rights violations are centrally involved in the process given that, as the CAT notes, 'the restoration of the dignity of the victim is the ultimate objective in the provision of redress.'[108] The UNSR on the promotion of truth, justice, reparation and guarantees of non-recurrence has repeatedly emphasised, meanwhile, the centrality of archival access to effective truth recovery and truth-telling.[109]

In *El Masri v Macedonia*,[110] which involved extraordinary rendition and inhuman and degrading treatment, three ECtHR judges in a concurring opinion contended that 'the "right to the truth", that is, the right to an accurate account of the suffering endured and the role of those responsible for that ordeal'[111] is both 'broadly implicit' in the investigative obligation and also, in itself, a requirement of the right to an 'effective remedy' where human rights violations are gross and systematic. The judges contended that the right to the truth includes 'a right of access to the relevant information about alleged violations, both for the persons concerned and for the general public'.[112] In this case, the right to the truth with its requirement of public information disclosure arose because of '[t]he scale and seriousness of the human rights violations in issue, committed in the context of the secret detentions and renditions system, together with the widespread impunity observed in multiple jurisdictions in respect of such practices'.[113]

Right to freedom of expression

Related to the right to the truth is the right of victims and survivors to freedom of expression, which is engaged by the investigative practices of the State. The text of Article 10 ECHR and Article 11 CFR includes the freedom '*to receive and* impart information and ideas' (emphasis added). The ECtHR has held that 'it is an integral part of freedom of expression to seek historical truth',[114] and in *Kenedi v Hungary* the Court found a violation of Article 10 where the government (in defiance of court orders) refused to disclose certain documents which a historian needed to

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[107] United Nations General Assembly (UNGA), *Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Fabián Salvioli, on memorialisation processes*, UN Doc A/HRC/45/45 (9 July 2020), https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/175/70/PDF/G2017570.pdf?OpenElement

[108] CAT, General Comment No 3 (n 105) para 4.

[109] UNGA, *Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Pablo de Greiff, Annex: Set of General Recommendations for Truth Commissions and Archives*, UN Doc A/HRC/30/42, https://digitallibrary.un.org/record/803412?ln=en#record-files-collapse-header.

[110] *El Masi v 'The Former Yugoslav Republic of Macedonia'* app no 39630/09 ECtHR 13 December 2012

[111] Ibid para 1.

[112] Ibid para 4.

[113] Ibid.

[114] *Fatullayev v. Azerbaijan* App No 40984/07 (ECtHR, 22 April 2010) para 87; *Monnat v Switzerland* App No 73604/01 (ECtHR, 21 September 2006) para 57.

write a study on the functioning of the Hungarian State Security Service in the 1960s.[115] The ECtHR held that 'access to original documentary sources for legitimate historical research was an essential element of the applicant's right to freedom of expression'.[116] The ECtHR has also found that Article 10 ECHR imposes positive as well as negative obligations on states, and in *Dink v Turkey* the Court held that states must create a favourable environment for participation in public debate by all concerned, enabling them to express their opinions without fear.[117] Arguably, the right to freedom of expression requires that those subjected to gross and systematic human rights violations must be facilitated to fully contribute to the national historical record, including by receiving and being in a position to comment on any records that concern them.

The United Nations Updated Set of principles for the protection and promotion of human rights through action to combat impunity (Orentlicher Principles) explain that the right to know can be facilitated by mechanisms that are additional to—and, importantly, that enhance the functioning of—the ordinary existing justice mechanisms of the state. Crucially, specialised truth-telling mechanisms are not a substitute for existing justice mechanisms, which must also operate in response to the state's knowledge of gross human rights abuse. The Orentlicher Principles emphasise the importance of 'a truth commission or other commission of inquiry' providing access to archives, stating that:

> Appropriate measures to ensure this right [to truth] may include non-judicial processes that complement the role of the judiciary. Societies that have experienced heinous crimes perpetrated on a massive or systematic basis may benefit in particular from the creation of a truth commission or other commission of inquiry to establish the facts surrounding those violations so that the truth may be ascertained and to prevent the disappearance of evidence. Regardless of whether a State establishes such a body, it must ensure the preservation of, and access to, archives concerning violations of human rights and humanitarian law.[118]

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[115] *Kenedi v Hungary* App no 31475/05 (ECtHR, 26 August 2009).

[116] Ibid apara 43.

[117] *Dink v Turkey* Apps Nos 2668/07, 6102/08, 30079/08, 7072/09 and 7124/09 (ECtHR, 14 September 2010) para 137, translated and summarised in Council of Europe/European Court of Human Rights, Research Report: Positive obligations on member States under Article 10 to protect journalists and prevent impunity, December 2011, 5.

[118] UN Commission on Human Rights, Updated Set of principles for the protection and promotion of human rights through action to combat impunity, UN Doc E/CN.4/2005/102/Add.1 (8 February 2005), Principle 5.

3. The State has not met its human rights law obligations

3.1 The MBHCOI's confidential process and sealed archive are not an 'effective investigation'

Requirements of an effective investigation

Here, we highlight particularly salient requirements of an 'effective investigation', according to ECtHR jurisprudence (which is supported by an array of international law standards). A more detailed account of the 'effective investigation' requirements espoused by the ECtHR can be found elsewhere.[119]

Promptness: The ECtHR has repeatedly held that where an investigation is required, it should be undertaken in a prompt and timely fashion in order to maintain public confidence.[120] According to the ECtHR, the obligation to investigate 'is not dependent upon the lodging of a formal complaint' by the victim or next-of-kin 'or their suggesting a particular line or inquiry or investigative procedure'.[121]The UN Principles on the Effective Investigation of Torture state, similarly, that: 'States shall ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation shall be undertaken if there are other indications that torture or ill-treatment might have occurred.'[122] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (Minnesota Protocol) notes, however, that 'The failure of the State promptly to investigate does not relieve it of its duty to investigate at a later time: the duty does not cease even with the passing of significant time.'[123]

Thoroughness: The ECtHR commonly states that in order to be 'effective', an investigation 'must be capable of leading to the establishment of the facts'.[124] The ECtHR has held that the authorities must always make a serious attempt to find out what happened and should not rely on hasty or ill-founded conclusions to close their investigation or to use as the basis of their decisions.[125] They

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[119] Maeve O'Rourke, 'A human rights framework: Background Research for the Truth Recovery Design Process' (Belfast: Truth Recovery Design Panel, 27 September 2021) 26-38, https://researchrepository.universityofgalway.ie/server/api/core/bitstreams/1b76cc1f-3a72-40b8-855a-3ad67ab2b5c3/content; HM Courts and Tribunals Service, Chief Coroner's Guidance for Coroners on the Bench (Bench Guidance), Chapter 20: The Article 2 inquest (30 July 2025) https://www.judiciary.uk/guidance-and-resources/chapter-20-the-article-2-inquest/.

[120] See *Gulec v. Turkey* (1999) 28 EHRR 121; *McKerr v United Kingdom* (2002) 34 EHRR 20.

[121] *Nachova v Bulgaria* 2005-VII; 42 EHRR 933 GC; see also *Finucane v United Kingdom* (2003) 37 EHRR 29. See also *Rantsev v Cyprus and Russia* (2010) 51 EHRR 1 para 288 and Edwards v United Kingdom (2002) 35 EHRR 19 para 69.

[122] OHCHR, Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Recommended by UNGA Resolution 55/89 of 4 December 2000, Principle 2.

[123] 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, 7.

[124] *Armani Da Silva v United Kingdom* App no 5878/08 (ECtHR, 30 March 2016) para 233.

[125] *El Masri v Macedonia* (2013) 57 EHRR 25, paras 183-185; See also *Assenov v Bulgaria* (1999) 28 EHRR 652 para 103 ; and *Batı v Turkey* (2006) 42 EHRR37 para 136 (extracts).

must take all reasonable steps available to them to secure the evidence concerning the incident, including, inter alia, eyewitness testimony and forensic evidence.[126] Any deficiency in the investigation which undermines its ability to establish the cause of injuries or the identity of the persons responsible will risk falling foul of this standard.[127]

Powers to secure and compel the production of evidence: The ECtHR has held that the investigation should not be reliant solely on evidence or information from the source being investigated.[128] It should have full investigatory powers to compel witnesses and it should be capable of securing evidence.[129] In the Article 2 context, the ECtHR has held that 'The authorities must take whatever reasonable steps they can to secure the evidence concerning the incident, including, *inter alia*, eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of the clinic findings, including the cause of death.'[130] The UN Principles on the Effective Investigation of Torture state the requirement thus: 'The investigation must have all necessary budgetary and technical resources for effective investigation and the authority to summons witnesses and demand the production of evidence'.[131]

Involvement of the victim and access to evidence: The ECtHR has held that 'the victim must be involved to the extent necessary to safeguard their legitimate interests'.[132] The UN Principles on the Effective Investigation of Torture specify that: 'Alleged victims of torture or ill-treatment and their legal representatives must be informed of and have access to any hearing, have access to all information relevant to the investigation, and be entitled to present other evidence.'[133] The Istanbul Protocol states, similarly, that: 'Those alleging that they have been tortured and their legal representatives should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings reflects the especially important role his/her interests play in the conduct of the investigation…Parties to the inquiry should be allowed to submit written questions to the commission.'[134]

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[126] See *Tanrıkulu v Turkey* (2000) 30 EHRR950 para 104; and *Gül v Turkey* (2002) 34 EHRR28 para 89.
[127] See *Boicenco v Moldova* App no 41088/05 (ECtHR, 11 July 2006) para 123.
[128] See for example *Keenan v. United Kingdom* (2001) 33 EHRR 913.
[129] See for example *Khan v. United Kingdom* (2001) EHRR 1016.
[130] *Armani Da Silva v United Kingdom* App no 5878/08 (ECtHR, 30 March 2016) para 233.
[131] OHCHR, Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Recommended by UNGA Resolution 55/89 of 4 December 2000, Principle 3(a).
[132] See for example *Güleç v Turkey* (1999) 28 EHRR 121; see also *El Masri v Macedonia* (2013) 57 EHRR 25 para 185.
[133] OHCHR, Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Recommended by UNGA Resolution 55/89 of 4 December 2000, Principle 4.
[134] OHCHR, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol), 2004, HR/P/PT/8/Rev.1 para 116.

In the case of *Edwards v United Kingdom*,[135] the ECtHR found that the parents of a man killed in prison were denied their right to an effective investigation notwithstanding that an inquiry, chaired by independent experts and assisted by lawyers, was commissioned by the Prison Service, Essex County Council and North Essex Health Authority and sat for 10 months and heard from about 150 witnesses. The parents were not 'involved to the extent necessary to safeguard their interests' on the grounds that the inquiry was held in private and:

> The applicants, parents of the deceased, were only able to attend three days of the inquiry when they themselves were giving evidence. They were not represented and were unable to put any questions to witnesses, whether through their own counsel or, for example, through the Inquiry Panel. They had to wait until the publication of the final version of the Inquiry Report to discover the substance of the evidence about what had occurred.[136]

Access to information about a deceased or disappeared family member: The Minnesota Protocol, which concerns potentially unlawful death, states that: 'Family members have the right to seek and obtain information on the causes of a killing and to learn the truth about the circumstances, events and causes that led to it. In cases of potentially unlawful death, families have the right, at a minimum, to information about the circumstances, location and condition of the remains and, insofar as it has been determined, the cause and manner of death.'[137]

Transparency: According to the ECtHR, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.[138] Transparency also assists victims' involvement as well as holding the investigation to account more broadly. As the Minnesota Protocol states:

> The right to know the truth extends to society as a whole, given the public interest in the prevention of, and accountability for, international law violations. Family members and society as a whole both have a right to information held in a state's records that pertains to serious violations, even if those records are held by security agencies or military or police units.
>
> Investigative processes and outcomes must be transparent, including through openness to the scrutiny of the general public and of victims' families. Transparency promotes the rule of law and public accountability, and enables the efficacy of investigations to be monitored externally. It also enables the victims, defined broadly, to take part in the investigation … Any limitations on transparency must be strictly necessary for a legitimate purpose, such

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[135] *Paul and Audrey Edwards v the United Kingdom* App No 46477/99 (ECtHR, 14 March 2002).
[136] Ibid para 84.
[137] 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, 4-5.
[138] ***Jordan v United Kingdom* (2003) 37 EHRR 2 para 109.**

as protecting the privacy and safety of affected individuals, ensuring the integrity of ongoing investigations, or securing sensitive information about intelligence sources or military or police operations. In no circumstances may a state restrict transparency in a way that would conceal the fate or whereabouts of any victim of an enforced disappearance or unlawful killing, or would result in impunity for those responsible.[139]

The MBHCOI does not meet the ECtHR's requirements for an 'effective investigation'

During a February 2026 debate on the Institutional Burials (Amendment) Bill 2022, Minister for Children, Disability and Equality, Norma Foley TD characterised the MBHCOI's efforts as 'extensive'.[140] We respectfully highlight, however, that that the MBHCOI proceeded entirely in private—it did not conduct any hearings in public; nor did it share any of the evidence it received with affected people so that they could comment on it or suggest further lines of inquiry—and its archive is now inaccessible in the Department of Children.[141] These are fundamental breaches of the State's obligations discussed above.

The MBHCOI's findings are not supported by a published archive. The MBHCOI did not publish its archaeological assessment of the grounds. It has not been possible for relatives of the deceased and disappeared, or members of the public—nor indeed An Coimisiún Pleanála or members of Cork City Council—to see, pursue, test or query the documents or other evidence behind the following reporting, observations and findings of the MBHCOI in relation to Bessborough:

- 'A number of people and organisations have made suggestions about possible locations for children's graves both in the area which is currently part of the Bessborough estate (roughly 60 acres) and in areas which were sold in earlier years (the total area was once about 200 acres). During 2019, the Commission followed up on some of these suggestions.'[142]
- 'In April 2019, the Commission's solicitor and archaeologist walked the grounds of Bessborough with a man who had lived nearby. He pointed out the area in the grounds where he believes he saw a graveyard marked with white crosses. He subsequently swore an affidavit setting out his recollections. A similar exercise was conducted in October 2019 with a man who had played in the grounds as a child. He pointed out an area where he said

[139] 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, 4-5.
[140] Seanad Éireann debate, Institutional Burials (Amendment) Bill 2022: Second Stage (25 February 2026), https://www.oireachtas.ie/en/debates/debate/seanad/2026-02-25/speech/179/.
[141] O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69) 129-133; Letter from Yasmin Waljee and Faye Jarvis, Hogan Lovells International LLP, to Kathleen Funchion TD, Chair, Oireachtas Committee on Children, Disability, Equality and Integration dated 30 July 2021, https://clannproject.org/wp-content/uploads/Hogan-Lovells-Letter-to-Childrens-Committee_30-07-21-1.pdf.
[142] MBHCOI, Final Report, Chapter 38A para 38.13.

he had seen open graves with the bodies of young children exposed. This was marked on a map and he subsequently swore an affidavit to this effect.'[143]

- 'Also in April 2019, a man who had done building work in Bessborough in 2008 told the Commission that there was a cavern/chamber underneath the church on the site. The work had been carried out on behalf of the HSE so the Commission issued a direction to the HSE seeking minutes of the meetings between the HSE and the builders involved in the site. These minutes were provided by the HSE in August 2019. The minutes note that the space was referred to as an underground tank and was found to contain water and petrol-contaminated silt. It appears there was no archaeological significance to the tank.'[144]
- 'As already stated, the Congregation of the Sacred Hearts of Jesus and Mary do not know where the children who died in Bessborough are buried. The Commission finds this very difficult to comprehend as Bessborough was a mother and baby home for the duration of the period covered by the Commission (1922 – 1998) and the congregation was involved with it for all of this time. The Commission finds it very difficult to understand that no member of the congregation was able to say where the children who died in Bessborough are buried.'[145]
- 'The congregation was unable to explain why there were designated child burial grounds in Castlepollard and Sean Ross but not in Bessborough. The congregation provided the Commission with an affidavit about burials generally and specifically about the Castlepollard and Sean Ross child burials but very little evidence was provided to support the statements in it. The affidavit was, in many respects, speculative, inaccurate and misleading.'[146]
- 'A number of members of the congregation provided affidavits and/or oral evidence to the Commission. They were able to provide remarkably little evidence about burial arrangements.'[147]
- 'A member of the congregation who was in Bessborough for most of the period 1948- 1998 told the Commission that she did not remember any child deaths during her time there but she implied that the children who did die there were buried in the congregation burial ground. In the years 1950-1960 (inclusive), 31 children died in Bessborough so it is rather surprising that she does not remember any deaths.'[148]
- 'Another congregation member who was in Bessborough from 1978-1985 told the Commission that one baby died during her time there. She said that the manager of the maternity hospital (who was also a member of the congregation) "took over the arrangements for the burial". She "vaguely remembered" that the mother wanted the baby buried in St Michael's Cemetery but she did not know where the baby was actually buried.

[143] MBHCOI, Final Report, Chapter 38A para 38.14.
[144] MBHCOI, Final Report, Chapter 38A para 38.15.
[145] MBHCOI, Fifth Interim Report para 5.
[146] MBHCOI, Fifth Interim Report para 3.4.
[147] MBHCOI, Fifth Interim Report, para 4.16.
[148] MBHCOI, Fifth Interim Report para 4.18.

The Commission has established that there is no record of this baby in St Michael's burial records. She did not remember if the mother's family was involved in the burial arrangements but she was clear that the congregation had bought the coffin for the baby.'[149]

- 'In evidence to the Commission, a member of the congregation who was there in the 1980s said that there were two children buried in the burial ground during her time there and a third was disinterred elsewhere and reinterred in this ground. Another member of the congregation who was in Bessborough for a period in 1971 and again between 1975 and 1981 swore an affidavit in which she said that she remembered one child who died and was buried in the congregation's plot in the grounds. The recollections of these two congregation members seem to be incorrect. In fact, it would appear that there is only one child buried in the congregation's burial ground and that burial took place in 1994. The burial ground has some individual memorials to other children who died in Bessborough but it is unlikely that they are buried in this plot.'[150]
- 'Early in 2018, the Commission issued a national public appeal seeking information from individuals who may have personal knowledge, documentation, or any other information concerning the burial arrangements and/or burial places of children who died in Bessborough. Members of the public contacted the Commission, with mostly second-hand information, suggesting that children were buried in different parts of the estate. All of this information was followed up and the locations identified as possible burial sites by members of the public were assessed by forensic archaeologists. Some of these locations have been built on. To date, no physical or documentary evidence has been produced which suggests that any of the sites identified by members of the public contain human remains.'[151]

Continuing disempowerment of bereaved mothers and relatives

Through the secrecy it imposed over its investigation save for its interim and final conclusions, the MBHCOI's treatment of mothers and other relatives of the deceased and disappeared children and women of Bessborough continued a prolonged pattern of dismissal and denial of human dignity that characterised the women's confinement, the deaths of their children and their decades-long pursuit of truth and justice.

Illustrating this pattern, the MBHCOI Final Report records the testimony of *Resident K,* who gave birth at Bessborough in the early 1980s, as follows:

> I never got a chance to see or hold the baby. They told me that the baby was a boy and that he was still-born. There was no more mention of the baby after I gave birth and I accepted

[149] MBHCOI, Fifth Interim Report, para 4.19.
[150] MBHCOI, Fifth Interim Report, para 4.20.
[151] MBHCOI, Fifth Interim Report para 4.27.

> that he was dead. I was not invited to the burial nor was I given any details of how the remains were being dealt with. I was not given a death certificate.[152]

According to the MBHCOI's Final Report, *Resident K* 'visited Bessborough on three occasions in a bid to get information about her time there and records relating to her child's death and burial. On one occasion a nun told her that her child was buried in the congregational burial ground onsite. She "mistrusts the accuracy of the [Bessborough] records" provided to her'.[153]

The Clann Project received testimony from a *Witness 47,* who gave birth to her son in Bessborough in 1963. She told the Clann Project that the day after her son's birth in Bessborough she went to the nursery to see him and was told 'in a completely matter of fact way "your baby died". I was absolutely stunned'.[154] *Witness 47* said that there are significant discrepancies between her own recollections and the available records. She said that on the records her son's cause of death 'is given as "cerebral haemorrhage" and show that he had lived for two days. I have many unanswered questions about this. Why was I told on the day after his birth that my son had died? If he was "poor at birth" why did they not call for a doctor or send him to hospital?'

Witness 47 explained that her son's birth 'was not registered until nine days after the day on which they say he died with his death registered five days after that. It seems logical to me that they would have registered the birth and death at the same time yet this is not what happened'. *Witness 47* asked 'why is there no record of a burial or grave?' The discrepancies, combined with the absence of a burial record and grave have contributed to a great deal of uncertainty for Witness 47, who has no final resting place to visit and who 'can't help but wonder' if her son lived.[155]

In the documentary film published in 2025, *Testimony* (Dir: Aoife Kelleher), Madeleine Marvier recounted the death and disappearance of her son, William, in 1960. Madeleine said that, after William's birth:

> I got very ill, very feverish. I did have an injection. I don't know what it was. … William got ill about the second day. I don't know how he got the infection. It was either through me or through the needle. They took William away. I don't know where he was kept. I used to get up at night and go around searching the doors. The last week I didn't see him at all. … I cried every day for my baby. They wouldn't let me have him. The nun came and she said, 'William died'. And I said, 'When did he die?' She told me he was buried. He was buried in Bessborough.

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[152] MBHCOI Final Report, Chapter 18: Bessborough, para 18.386
[153] MBHCOI Final Report, Chapter 18: Bessborough, para 18.388
[154] O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69) para 1.174.
[155] O'Rourke, McGettrick, Baker et al, *Clann Report* (n 69) para 1.175.

Madeleine's daughter, Carmel Cantwell said that when her mother visited Bessborough:

> The nun decided to take her down to the graveyard. She wouldn't allow my mum inside, my mum had to look over the wall. And the nun tapped her foot on a spot and said, 'Your baby's buried here'. We always questioned this small little graveyard—how could it hold so many children? Eventually we found out that he's not buried there at all. William was buried in All Saints Cemetery, Carr's Hill, a famine grave where 30,000 people are buried. We have no idea on this five acre site where he is. We just go and lay flowers at the gates. The first time I took my mother up there, oh it was pitiful because she just wandered through the whole site, trying to see any evidence of a grave anywhere. At 80 years old with brambles scratching her legs, searching a field.

Madeleine continued:

> 60 years we've missed not taking flowers or telling them why or explaining why. You want to know where your child is buried. I'd like to go and sit down, sit down where he's buried, sit down for two or three hours with him and talk to him. He needs us, he's been on his own all this time. Really they were monsters, absolute monsters.

The MBHCOI did not use all means at its disposal to investigate

It is clear from its Fifth Interim Report that the MBHCOI did not use all reasonable means to search for the disappeared children and women of Bessborough. The Commission used desk-based and visual landscape assessment techniques. However, it did not undertake geophysical surveys using methods such as ground-penetrating radar / electrical resistivity / magnetometry, and there is no indication in its Reports that it undertook test excavations or soil chemistry or decomposition analysis.

The MBHCOI reported the following:

- 'The Commission tried to establish where the Bessborough children were buried. Cartographic and landscape assessment was undertaken of possible unrecorded burial arrangements in the Bessborough grounds. A site survey was also conducted. It is clear that there are a number of locations within the grounds where burials could have taken place. However, there is no significant surface evidence of systematic burial anywhere except for the congregation burial ground.'[156]

[156] MBHCOI, Fifth Interim Report, Summary of Findings, para 6.

We reproduce the relevant part of the Fifth Interim Report in full here:

> 4.22 The Commission engaged forensic archaeologists to carry out a cartographic and landscape assessment of possible unrecorded burial arrangements in the Bessborough grounds. As already stated, the grounds measure approximately 60 acres. It is also possible that burials took place in the grounds that no longer form part of the Bessborough estate, that is, a total area of 200 acres.
> 4.23 The forensic archaeologists and the Commission's researchers reviewed all available cartographic sources and aerial images in order to identify possible burials within the grounds of Bessborough. A site survey was also conducted. It is clear that there are a number of locations within the grounds where burials could have taken place. However, there is no significant surface evidence of systematic burial anywhere except for the congregation burial ground.
> 4.24 The third edition Ordnance Survey Map for the Bessborough area was produced in 1949/50. This identifies a southeast portion of the site as a "Children's Burial Ground". Such a label is not uncommon on this edition of maps and usually denotes a cillín (see Introduction). It is possible that, in this case, the label may refer to the area north-west of the Keep folly, a small rectangular enclosure to the north-east or the wider field in which the label is located.
> 4.25 In the intervening years, groundwork has left this area in a highly disturbed state and there is nothing physical to mark it as a former burial ground. The Commission interviewed a landscaper who undertook extensive groundwork on the Bessborough Estate over a period of almost thirty years. The witness stated that he had personally undertaken excavations in the area marked "Children's Burial Ground". He said that it was necessary for him to dig six to eight feet deep across this site and that he found no evidence of human remains or any evidence to suggest that the site was formerly used as a burial ground.
> 4.26 The Commission examined vertical aerial photography taken by the Irish Air Corps in 1951. This series includes high resolution aerial photography of the Bessborough Estate.36 The majority of child deaths at Bessborough occurred before 1951 (over 700) and it would be reasonable to expect that, if there were burials there, an aerial photograph taken in February 1951 would show up some ground disturbance, or anomaly on the landscape. If over 700 children were buried on the Bessborough Estate before 1951 the aerial photograph would be expected to give some indication of where the remains are located. The aerial photographs of the Bessborough site were examined by forensic archaeologists who determined that no visible features on the Bessborough landscape were indicative of any obvious site hosting the remains of such a large number of children.
> 4.27 Early in 2018, the Commission issued a national public appeal seeking information from individuals who may have personal knowledge, documentation, or any other information concerning the burial arrangements and/or burial places of children who died in Bessborough. Members of the public contacted the Commission, with mostly second-

hand information, suggesting that children were buried in different parts of the estate. All of this information was followed up and the locations identified as possible burial sites by members of the public were assessed by forensic archaeologists. Some of these locations have been built on. To date, no physical or documentary evidence has been produced which suggests that any of the sites identified by members of the public contain human remains.

3.2 The State has not established any other investigation

As far as we are aware, there has been no Garda investigation into the continuing disappearance of 878 children and mothers (in total) who were associated with Bessborough. The Garda Commissioner announced in April 2021 that he did not plan to commence an investigation into the matters summarised in the 2,865-page MBHCOI Final Report because the MBHCOI's anonymisation of its findings meant that 'there is insufficient detail in the report to commence an investigation.'[157] The Garda Commissioner urged survivors of Mother and Baby institutions to come forward with their testimony while cautioning that 'there will be limitations as to the action we can take in some cases due to matters such as the loss of evidence over time or suspects and witnesses being deceased.'[158] An Garda Síochána is statutorily barred from accessing the entire archive of records gathered by the MBHCOI, pursuant to the inquiry's underpinning legislation.[159] In evidence to an Oireachtas committee in early 2021, Martin Parfrey, a survivor of Bessborough, stated: 'more than 850 burials in Bessborough [Mother and Baby Home] are unaccounted for and we regard those babies as illegally missing. Accordingly, a full Garda investigation should be initiated, and it should include Garda access to the archives of the religious order and investigate all living personnel, no matter what age.'[160]

We are not aware of any Coroner's inquest having been initiated in relation to the deaths and disappearances of children and mothers of Bessborough, although in December 2025 the Cork South Coroner's Court agreed in response to a High Court judicial review application to reconsider a request by Madeleine Bridget Marvier to hold an inquest into the circumstances of her son

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[157] RTE News, '*Appeal for Information About Crimes at Mother-and-Baby Homes*' (29 April 2021), https://www.rte.ie/news/mother-and-baby-homes/2021/0429/1212798-mother-baby-appeal/.

[158] An Garda Síochána, Press Release, 'Garda Appeal re Mother and Baby Homes' (29 April 2021), https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/press-releases/2021/april/garda-appeal-re-mother-and-baby-homes.html.

[159] Commissions of Investigation Act 2004, section 19. This legislation underpinned the MBHCOI and specifies that no 'statement or admission' made to the MBHCOI, nor 'document given or sent to [the MBHCOI] pursuant to a direction or request,' nor 'document specified in an affidavit' is admissible as evidence against a person in any criminal or other proceedings.

[160] Oireachtas Joint Committee on Children, Disability, Equality and Integration: General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill: Discussion, Evidence of Martin Parfrey (14 April 2021) https://www.oireachtas.ie/en/debates/debate/joint_committee_on_children_disability_equality_and_integration/2021-04-14/3/.

William's death.[161] Irish legislation throughout the twentieth century mandated an inquest where a death appeared unexplained or unnatural; current legislation additionally requires a coroner's inquest in every instance where a person has died while in state custody or detention[162] and permits the Attorney General to direct the holding of an inquest wherever it is deemed 'advisable.'[163] The authors of this letter have advocated to Government previously for the holding of Coroners' inquests in relation to deaths and disappearances connected to Mother and Baby institutions (and other related institutions).[164]

Finally, successive Ministers for Children have refused to exercise their statutory power pursuant to the *Institutional Burials Act 2022* to appoint a Director of Authorised Intervention in relation to Bessborough. On 25 February 2026 during a Seanad debate the current Minister for Children, Norma Foley TD, asserted that 'the evidential standard for full forensic excavation under the Act' is not met insofar as Bessborough is concerned.[165] We are aware that Carmel Cantwell made a formal, reasoned request of Minister Roderic O'Gorman TD on 2 October 2023. On 18 April 2024, the Minister responded, stating:

> Section 7 of the Act requires that in order to establish an Office of Director of Authorised Intervention in respect of a particular area of land associated with an institution the Government must be satisfied that burials have taken place there and must have evidence that those burials are manifestly inappropriate.
>
> The investigation of burial arrangements in Mother and Baby institutions, including the former institution in Bessborough, was part of the work of the Commission of Investigation into Mother and Baby Homes and certain related matters. Sadly, despite cartographic and landscape assessments and public appeals for information, the Commission was unable to find any physical or documentary evidence of burials at the Bessborough site…

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[161] 'Court to reconsider baby's death shortly after birth at Bessborough after conceding High Court action' *BreakingNews.ie* (16 December 2025), https://www.breakingnews.ie/ireland/court-to-reconsider-babys-death-shortly-after-birth-at-bessborough-after-conceding-high-court-action-1842681.html.

[162] Coroners Act 1962 (as amended), section 17.

[163] Ibid section 24(1).

[164] Sarah-Anne Buckley, Vicky Conway, Máiréad Enright, Fionna Fox, James Gallen, Erika Hayes, Mary Harney, Darragh Mackin, Claire McGettrick, Conall Ó Fátharta, Maeve O'Rourke and Phil Scraton, 'Joint Submission to Oireachtas Committee on Children, Equality, Disability and Integration' (Dublin: Justice for Magdalenes Research, 26 February 2021), https://jfmresearch.com/wp-content/uploads/2021/03/Institutional-Burials-Bill_Joint-Submission-26.2.21.pdf; Oireachtas Joint Committee on Children, Disability, Equality and Integration, General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill: Discussion, Evidence of Maeve O'Rourke (14 April 2021) https://www.oireachtas.ie/en/debates/debate/joint_committee_on_children_disability_equality_and_integration/2021-04-14/3/.

[165] Seanad Éireann debate, Institutional Burials (Amendment) Bill 2022: Second Stage (25 February 2026), https://www.oireachtas.ie/en/debates/debate/seanad/2026-02-25/16/#spk_179.

In reply on 13 June 2024, Ms Cantwell reiterated her request and raised many of the arguments we also make in this letter.

4. An Coimisiún Pleanála is obliged to uphold the State's European human rights and Constitutional law obligations, which cannot be delegated to a private developer

As an 'organ of the state' under the European Convention on Human Rights Act 2003, An Coimisiún Pleanála (ACP) is obliged to 'perform its functions in a manner compatible with the State's obligations under the Convention's provisions'.[166] Similarly, in applying EU planning law in the course of its decision-making on this appeal, ACP must act in accordance with the CFP interpreted by reference to the ECHR. The Constitution also applies.

The State's obligations as set out in this letter cannot be displaced or delegated by way of Conditions on a grant of planning permission to a private property developer.

Notably, in his response on 18 April 2024 to Ms Cantwell's above-mentioned formal request for the appointment of a Director of Authorised Intervention in Bessborough under the Institutional Burials Act 2022, then Minister for Children, Roderic O'Gorman TD, stated:

> It should be noted that the Minister has publicly emphasised that any proposed development at the Bessborough site should have due regard to the Commission's reports and give adequate consideration to the views of all survivors and family members.
>
> Furthermore, in November 2022 the Minister for Housing, Local Government and Heritage wrote to all local authorities requesting that Development Plan processes give adequate consideration to incorporating appropriate measures to ensure the protection of unrecorded burial sites associated with an institution.

5. Cork City Councillors have recognised the State's responsibility for the Bessborough site

The State's responsibility for the Bessborough site has been acknowledged unanimously by Cork City Councillors, who agree that a Compulsory Purchase Order is necessary to protect the entire remaining Bessborough lands. The submission of Cllr Peter Horgan dated 3 February 2026, on the instant planning permission application,[167] explains that Cork City Council has unanimously passed the following motion:

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[166] European Convention on Human Rights Act 2003, section 3.
[167] Peter Horgan, 'Objection to The Farm LRD – Bessborough, Blackrock, Cork – file 25/4442' (3 February 2026) https://planningapi.agileapplications.ie/api/application/document/CORKCITY/5JKYPFR846P7CQ6RQJ8VEZT8N233TE8W9DLU7YP5N2RZQEVGPNC6AAS4Y8L4BTECG7KW42Q4W4EZF.

That this Council will seek to begin a process with the relevant Government Departments to CPO the entire land at Bessborough in order to make it a new public park and memorial to the history of the site.

We commend the position of the Councillors and wish to reiterate our support for the appeal by Bessboro Mother and Baby Home Support Group against the grant by Cork City Council on 24 February 2026 of Conditional Permission for a Large-Scale Residential Development at Bessborough. For the above reasons, we request that ACP allow the appeal.

By way of a final note: Our engagement with affected people and peer support networks indicates that the proposed development lacks the support of both the population connected to Bessborough and the wider community of people affected by forced family separation and institutionalisation in Ireland. There is a strong consensus that the developer's proposed memorial lacks legitimacy, not least because any development at Bessborough carries a significant risk of encountering undocumented burials.

Please do not hesitate to contact us with any queries, c/o maeve.orourke@universityofgalway.ie.

Yours faithfully,

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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

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[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]

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[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

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[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

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[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".

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[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

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[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

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[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

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[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

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[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

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[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

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[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

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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

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[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

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[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, states 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

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[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

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[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.

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[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] Conditions • 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] Conditions 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



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A human rights framework: Background Research for the Truth Recovery Design Process

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Maeve O'Rourke

September 2021

A HUMAN RIGHTS FRAMEWORK: BACKGROUND RESEARCH FOR THE TRUTH RECOVERY DESIGN PROCESS

Maeve O'Rourke[1]

27 September 2021

Introduction

This Background Research Report supports Chapter 2 of the Truth Recovery Design Panel's Report and the Panel's recommendations and rationale (which are derived from victims-survivors' and relatives' submissions, contextualised by the applicable human rights law framework and research regarding comparative investigation and reparation models). The paper focuses on the human rights violations that are continuing today as a result of the gender-based institutional and family separation system that operated in Northern Ireland (NI), with cross-border and international elements, during the 20th century. The most clearly apparent of these ongoing forms of human rights violation are: continuing disappearances, continuing denial of the right to identity, continuing interference with freedom of expression, continuing discrimination, and a continuing lack of an effective investigation and other measures to ensure access to justice and redress for widespread, systematic and gravely harmful human rights abuses.

Part 1 of this paper provides a summary of the international and European human rights treaties that applied in the past and continue to apply today to the actions of the United Kingdom (UK) and NI state authorities, including the State's actions (or lack thereof) to prevent and respond to abuse by non-state / 'private' individuals and organisations.

Part 2 explores human rights case law (primarily that of the European Court of Human Rights (ECtHR)) to illuminate the meaning of disappearances, denial of the right to identity, unlawful interference with freedom of expression, and discrimination.

Part 3 explains, again by reference primarily to ECtHR case law, the circumstances in which the state is obliged to establish a human rights-based, 'effective investigation'. These circumstances are, in summary, where the state has reason to believe that serious human rights violations have occurred concerning the right to life; the right to freedom from torture and other cruel, inhuman or degrading treatment or punishment; the right to freedom from slavery, servitude and forced or compulsory labour; the right to liberty; or the right to respect for private and family life.

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Part 4 outlines the requirements of an 'effective investigation' according to European human rights law and a range of other international human rights law instruments and documents. The Republic of Ireland's (ROI) legal responsibility to facilitate and cooperate with an investigation in NI is also discussed in this part.

Part 5 discusses the additional access to justice and redress measures that the state authorities must implement given the extensive evidence of serious and systematic human rights violations, including continuing human rights violations, arising from the 20th century system of gender-based institutionalisation and family separation.

1. Overview of the UK and NI authorities' human rights law obligations

The human rights treaties which applied to the UK (Great Britain and Northern Ireland) during the period of the institutions' operation include:

- the Forced Labour Convention 1930, which came into effect in 1932 and the UK ratified on 3 June 1931,[1]
- the European Convention on Human Rights (ECHR), which came into effect in 1953 and the UK ratified in 1951,[2]
- the Abolition of Forced Labour Convention 1957, which came into effect in 1959 and the UK ratified in 1957,[3]
- the Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery, which came into effect in 1957 and the UK ratified that same year,[4] and
- the International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social and Cultural Rights (ICESCR), both of which came into effect in 1976 and the UK ratified that same year.

In addition, the UK became bound by the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[5] in 1986, and by the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT)[6] in 1988—shortly before the last Mother and Baby institution closed. Since the institutions closed, the UK has become party to the Convention on the Rights of the Child (UNCRC) (which entered into force in 1990 and the UK ratified in 1991)[7] and the Convention on the Rights of Persons with Disabilities (which entered into force in 2008 and the UK ratified in 2009).[8] The NI and UK state authorities must today treat victims and survivors and the relatives of those who experienced institutionalisation and family separation in a way that complies with these treaties also.

These human rights treaties apply to the state only: they do not impose duties on 'private' individuals or organisations. However, the state's responsibility under international human rights law is extensive. As the ECtHR has repeatedly held, a state cannot 'absolve itself from responsibility by delegating its obligations to private bodies or individuals'.[9] The state is

directly responsible not just for the actions of bodies and personnel exercising legislative, executive or judicial powers, but also for the actions of:

- any other person or organisation which the state has empowered to exercise elements of governmental authority (while they are acting in that capacity);
- any person or group acting on the instructions of, or under the direction or control of, the state; and
- any person or group of persons in fact exercising elements of governmental authority in the absence or default of the official authorities and in circumstances such as to call for the exercise of those elements of authority.[10]

In addition, the state is obliged by all of the above human rights treaties to take positive steps to prevent abuse at the hands of 'private' actors—as explained further below.[11]

Therefore, both the state's own participation in institutional and family separation abuses *and* its failure to prevent non-state organisations and individuals perpetrating these abuses are essential aspects of the state's responsibility under human rights law. Today, the state has obligations relating to its own actions and those of non-state actors: as explained further below, these obligations are (1) to bring an end to continuing situations of human rights abuse, (2) to establish an 'effective investigation' into apparent gross and systematic human rights violations, and (3) to ensure comprensive access to justice and redress.

It is important not to view the human rights abuses perpetrated in the institutional and family separation system as solely 'historical', for two key reasons. First, several forms of abuse that began in the institutions can be said to be continuing, such as the disappearance of relatives, the unlawful denial of information about one's identity and the circumstances of their separation from family, and the discrimination that these experiences constitute. Second, continuing human rights violations arise also from the state's failure over many decades to respond by way of an 'effective investigation' and other measures of access to justice and redress to what it has known and ought to have known about the abuses previously perpetrated in the institutions and family separation system.

Some survivors raised with the Panel the question of whether human rights laws apply to the experiences of those who suffered abuse in institutions and/or through family separation before the ECHR entered into force in 1953. In the Panel's view, the abuses suffered prior to 1953 *do* deserve a human rights-based response—first, because the Forced Labour Convention applied from 1932 onwards; second, because discrimination against any survivors and relatives in the state's design of its investigation and other access to justice and redress measures must be avoided; and third, because many people who suffered prior to 1953, and/or their relatives, are still undergoing abuse or state failures to respond to previous abuse which violate present-day human rights law obligations. The ECtHR has recognised that the European Convention applies to a 'disappearance' which began prior to the Convention coming into force but continued after that date. The UN Human Rights Committee, similarly, has found that the ICCPR applies to a situation of 'enforced disappearance' which may have begun prior to the Convention's entry

into force in respect of a particular country but continued or continues to exist afterwards.[12] In addition, according to the ECtHR, the state is under a continuing obligation to investigate apparent unlawful death which allegedly occurred prior to the Convention's entry into force if the gap between the alleged abuse and the Convention's entry into force is not more than ten years and much of the investigation took place or ought to have taken place in the period following the entry into force of the Convention.[13] The principles espoused by the ECtHR concerning the obligation to investigate under Article 2 ECHR violations are generally understood also to apply to Article 3 ECHR violations (which concern torture or inhuman or degrading treatment or punishment), and to serious violations of Articles 4, 5 and 8, as explained further below.

The UN Committee Against Torture (CAT) has clarified that states' obligations under the Convention Against Torture to investigate, and to ensure access to justice and reparation in respect of, apparent torture or ill-treatment apply retrospectively. According to the CAT's General Comment No 3, 'States parties shall ensure that all victims of torture or ill-treatment, regardless of when the violation occurred or whether it was carried out by or with the acquiescence of a former regime, are able to access their rights to a remedy and to obtain redress.'[14] The CAT's reasoning is that: 'For many victims, passage of time does not attenuate the harm and in some cases the harm may increase as a result of post-traumatic stress that requires medical, psychological and social support, which is often inaccessible to those whom have not received redress.'[15] This reasoning explains the CAT's repeated recommendations to the UK and ROI to implement the states' Convention Against Torture obligations towards survivors and relatives affected by the Magdalene, Mother and Baby and related institutions. Furthermore, the CAT has explained that 'victims' of torture and ill-treatment include 'affected immediate family or dependants of the victim as well as persons who have suffered harm in intervening to assist victims or to prevent victimization.'[16]

As for abuses which occurred *after* the entry into force of a particular human rights treaty in respect of the UK but nonetheless a long time ago: the state's legal obligations regarding these abuses have not disappeared over the decades during which it did not provide remedies. As noted already, for many people, abuse which began decades ago is still continuing. The ECtHR has recognised that for as long as there is a 'continuing situation' of a Convention violation the right to a remedy remains.[17] Regarding forms of abuse that ceased decades ago, the ECtHR has agreed to hear complaints that relate to torture or ill-treatment suffered many years or decades in the past.[18] In *Mocanu v Romania* the ECtHR held that the responsibility is on the state, not the victim of torture or ill-treatment, to initiate an investigation—and this is especially the case where the state has witnessed the abuse in question.[19]

Finally, regarding timeframes, survivors have also raised the question of whether the Human Rights Act 1998 (HRA 1998) is relevant to the abuses arising from the 20th century institutional and family separation system. The HRA 1998 came into force in October 2000 and incorporates the ECHR into UK law by requiring, insofar as is possible, all 'public authorities' to act compatibly with the ECHR and all legislation to be interpreted compatibly with the ECHR. What is clear from UK case law is that the HRA 1998 applies to all actions of public authorities

and legislation since 2000 and into the future, including insofar as they relate to historical events. In the 2011 case of *McCaughey*, the UK Supreme Court held that where, following the HRA 1998 coming into effect, the state decides to hold an investigation into a potentially unlawful death which occurred many years or decades ago the HRA 1998 requires the investigation to comply with ECHR standards.[20]

2. Continuing situations of human rights violations

Disappearance

It may be the case that disappearances are occurring where girls or women were detained in institutions and their fate and whereabouts are still being withheld from their relatives by either state or non-state actors (e.g. through a lack of disclosure of burial information or other personal records). Disappearances may also be occurring where a parent and child were unlawfully separated, i.e. without due process of law or through extreme coercion which negated consent, and they are still being prevented from discovering what became of each other.

An 'enforced disappearance' is defined in international human rights law as occurring where:

> persons are arrested, detained or abducted against their will or otherwise deprived of their liberty by officials of different branches or levels of Government, or by organized groups or private individuals acting on behalf of, or with the support, direct or indirect, consent or acquiescence of the Government, followed by a refusal to disclose the fate or whereabouts of the persons concerned or a refusal to acknowledge the deprivation of their liberty, which places such persons outside the protection of the law.[21]

The ECtHR recognised a situation similar to an enforced disappearance—which it described as a 'disappearance'[22]—in the 2015 case of *Jovanovic v Serbia* where a state-run hospital had taken a woman's new-born son from her in 1983 and from then on:

> the body of the applicant's son was never released to the applicant or her family, and that the cause of death was never determined. Furthermore, the applicant was never provided with an autopsy report or informed of when and where her son had allegedly been buried, and his death was never officially recorded. The criminal complaint lodged by the applicant's husband would also appear to have been rejected without adequate consideration and the applicant herself still has no credible information as to what happened to her son.[23]

The 1992 UN Declaration on the Protection of All Persons from Enforced Disappearances explains that '[a]cts constituting enforced disappearance shall be considered a continuing offence as long as perpetrators continue to conceal the fate and whereabouts of persons who have disappeared'.[24] A similar definition is used by the ECtHR, which noted in *Varnava and Others v Turkey* that a 'disappearance is a distinct phenomenon, characterised by an ongoing situation of uncertainty and unaccountability in which there is a lack of information or even a

deliberate concealment and obfuscation of what has occurred'.[25] In *Jovanowiec v Russia*, the ECtHR emphasised that the 'essence of the issue...lies...in the authorities' dismissive reactions and attitudes in respect of that situation when it was brought to their attention' or in 'the failure of the authorities to respond to the quest for information by the relatives or from the obstacles placed in their way, leaving them to bear the brunt of the efforts to uncover any facts'.[26]

Crucially, the ECtHR has held that the state is obliged to assist in the discovery of a missing relative not only where the state was involved in the disappearance but also in cases where non-state actors were involved. In *Varnava and Others v Turkey*, the ECtHR found that a state will violate the Convention where, regardless of who is responsible for the disappearance, the state's response to relatives' requests for assistance 'may be regarded as disclosing a flagrant, continuous and callous disregard of an obligation to account for the whereabouts and fate of a missing person'.[27] In *Jovanovic*, the ECtHR acknowledged that '[t]he mutual enjoyment by parent and child of each other's company constitutes a fundamental element of "family life" within the meaning of Article 8 of the Convention' and that Article 8 not only prohibits 'arbitrary interference' with family life but also imposes positive obligations on the state to assist in the discovery of a missing relative.[28] It is worth noting that other ECtHR case law has recognised sibling relationships,[29] and the relationship of uncles and aunts with their nieces and nephews,[30] to comprise 'family life' within the meaning of Article 8.[31]

In addition to violating numerous rights of the disappeared individuals themselves,[32] continuing situations of enforced disappearance have been found by the ECtHR and UN Human Rights Committee (HRC) in several cases to give rise to a continuing situation of inhuman or degrading treatment of relatives on account of the suffering caused by their inability to discover their loved one's fate and whereabouts.[33] Additionally, in *Jovanovic v Serbia* the ECtHR held that the mother's right to respect for her private and family life was being breached continuously due to her inability to access information about her child.

Notably, Article 9(4) UNCRC explicitly requires that where the separation of parent and child:

> results from any action initiated by a State Party such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

Denial of identity

Identity rights are a core aspect of the right to respect for private and family life which is protected by Article 8 ECHR and Article 17 ICCPR.[34] In *SH v Austria* the ECtHR held that:

> respect for private life requires that everyone should be able to establish details of their identity as individual human beings and that an individual's entitlement to such information is of importance because of its formative implications for his or her personality. This includes obtaining information necessary to discover the truth concerning important aspects of one's personal identity, such as the identity of one's parents.[35]

In *Gaskin v United Kingdom*[36] the ECtHR confirmed that Article 8 ECHR also protects the right to access records about one's treatment as a child in state care; the Court acknowledged that the applicant's care file 'no doubt contained information concerning highly personal aspects of the applicant's childhood and history and thus could constitute his principal source of information about his past and formative years.'[37]

The right to respect for private and family life is not an absolute right; however, there are strict criteria for permissible interferences with it. Article 8 ECHR allows a public authority to interfere with the right *only if* the interference is 'in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the protection of health or morals, or for the protection of the rights and freedoms of others.'

'In accordance with the law' has been explained by the ECtHR to mean that there must be a national law basis for the interference in order for the interference to be lawful. This does not necessarily require primary legislation (judge-made law will satisfy the requirement, for example[38]). Whatever the form of law is, it must be 'adequately accessible' in that 'the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case',[39] and the texts of the legal rules must be available to those affected.[40] The law must also be 'formulated with sufficient precision to enable the citizen to regulate his conduct'.[41] A discretionary power that is wholly unconfined in its terms, even if formally subject to judicial scrutiny, will not satisfy this test.[42] The law must 'indicate the scope of any such discretion conferred on the competent authorities and the manner of its exercise with sufficient clarity, having regard to the legitimate aim of the measure in question, to give the individual adequate protection against arbitrary interference'.[43]

Meanwhile, the requirement that the interference is 'necessary in a democratic society' means that the interference must be 'proportionate to the legitimate aim pursued'.[44] An interference might lack proportionality if there has been minimal consideration by Parliament of its implications for those it affects;[45] or if there are less restrictive methods available to the state to achieve the relevant public interest;[46] or if the interference does not represent 'a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights'.[47]

In addition to requiring the state to refrain from unlawfully interfering, Article 8 ECHR also requires the state to take positive steps to enable individuals to enjoy their privacy rights and

to prevent other, non-state actors from impinging on them.[48] In *Gaskin v United Kingdom*,[49] for example, the ECtHR held that the state must have in place a clear regulatory regime with an independent decision-maker that can ensure that a person's information is not improperly or disproportionately withheld where professionals involved in their care do not proactively consent to its release.

In *Mikulic v Croatia*[50] the ECtHR held that a state is required to have in place a system capable of determining a child's genetic origins. In this case, which concerned the question of a child's paternity, the Croatian legal system had no way of forcing a person to comply with a court order requiring them to take a DNA test—and while that was not itself a breach of the Convention, the ECtHR held that a violation of Article 8 ECHR arose from the fact that there were no 'alternative means enabling an independent authority to determine the paternity claim speedily'.[51] According to the ECtHR, the State's inaction where the putative father did not consent over the course of several years to a DNA test left the child 'in a state of prolonged uncertainty as to her personal identity' and thus violated Article 8 ECHR.

In *Jäggi v. Switzerland*[52] the ECtHR found that the Article 8 ECHR rights of a 67-year-old man were violated when he was denied permission by the state authorities to have a DNA test carried out on the remains of the person whom he believed to be his father. The Court held that 'persons seeking to establish the identity of their ascendants have a vital interest, protected by the Convention, in receiving the information necessary to uncover the truth about an important aspect of their personal identity'.[53] The Court also emphasised that 'an individual's interest in discovering his parentage does not disappear with age, quite the reverse'.[54] While the Court held that this interest must be balanced fairly against any competing interests—meaning that states could not be required to force living persons to undergo DNA testing[55]—the Court also noted that 'the deceased's family had not cited any religious or philosophical grounds for opposing the taking of a DNA sample, a measure which is, moreover, relatively unintrusive.'[56] Noting that deceased persons do not have rights under the Convention, the Court reiterated its finding in a previous case that '[w]ith regard to the deceased's own right to respect for his private life…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.'[57]

The UNCRC contains specific identity rights protections. Article 8 requires states 'to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference' and specifies that 'Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.' Although the UNCRC explicitly refers to 'children', it is notable that in a case concerning an adult—the 2020 case of *Habte v Minister for Justice and Equality*[58]—the the Irish Court of Appeal referred to the Convention to support the finding that there is an unenumerated constitutional right to have one's identity correctly recognised by the state.

Other continuing Article 8 ECHR violations: deaths and burials

The ECtHR has found violations of the right to respect for private and family life to exist where state authorities, having custody of a deceased person's body (e.g. for autopsy purposes), have failed to return it or delayed unjustifiably in returning it to their family who wished to bury their relative in accordance with their own traditions.[59]

Article 8 ECHR has also been violated, according to the Court, where the state has buried a child in a communal grave without the consent of its parents and without legal authority.[60]

In addition, in *Znamenskaya v Russia*,[61] the ECtHR found a violation of Article 8 ECHR where the state authorities refused to allow the registration of paternity of a stillborn infant in circumstances where the mother wished to place the name of the infant's father, who was now deceased, on the infant's grave. The Court noted that 'there were no interests conflicting with those of the [mother]'[62] and 'the domestic courts did not refer to any legitimate or convincing reasons for maintaining the status quo'.[63]

Freedom of expression

The text of Article 10 ECHR, which protects the right to freedom of expression, includes the freedom 'to *receive and impart* information and ideas' (emphasis added). The right of victims and survivors to freedom of expression is thus engaged by the archival, investigative and other truth-telling practices of the state.

The ECtHR has held that 'it is an integral part of freedom of expression to seek historical truth',[64] and in *Kenedi v Hungary* the Court found a violation of Article 10 where the government (in defiance of court orders) refused to disclose certain documents which a historian needed to write a study on the functioning of the Hungarian State Security Service in the 1960s.[65] The ECtHR held that 'access to original documentary sources for legitimate historical research was an essential element of the applicant's right to freedom of expression'.[66] The ECtHR has also found that Article 10 ECHR imposes positive as well as negative obligations on states, and in *Dink v Turkey* the Court held that states must create a favourable environment for participation in public debate by all concerned, enabling them to express their opinions without fear.[67] Arguably, the right to freedom of expression requires that those subjected to gross and systematic human rights violations must be facilitated to fully contribute to the national historical record, including by receiving and being in a position to comment on any records that concern them.

Discrimination

To the extent that people are experiencing the above situations of human rights abuse on account of their gender, the circumstances of their birth or the circumstances in which they became pregnant and gave birth, they are also being subjected to grave discrimination that interferes with their right to respect for their equal human dignity. The equal dignity of all human beings is the founding principle upon which the current international human rights regime is based. The ECtHR has held on several occasions that discrimination on grounds of

'illegitimacy' and discrimination against unmarried mothers and their children violates the ECHR.[68] In *Johnston v Ireland*,[69] Ireland's discriminatory succession law was found to be in breach of the ECtHR. Albeit an Irish legal precedent, it is worth considering the definition of unconstitutional discrimination provided by the majority of the Irish Supreme Court in *Quinn's Supermarket v Attorney General*:

> The provisions of Article 40, s. 1, of the Constitution ... is not a guarantee of absolute equality for all citizens in all circumstances but it is a guarantee of equality as human persons and (as the Irish text of the Constitution makes quite clear) is a guarantee related to their dignity as human beings and a guarantee against any inequalities grounded upon an assumption, or indeed a belief, that some individual or individuals or classes of individuals, by reason of their human attributes or their ethnic or racial, social or religious background, are to be treated as the inferior or superior of other individuals in the community. This list does not pretend to be complete; but it is merely intended to illustrate the view that this guarantee refers to human persons for what they are in themselves rather than to any lawful activities, trades or pursuits which they may engage in or follow.[70]

3. Continuing violation of obligation to investigate

The State's obligation to investigate

It is clear from extensive ECtHR case law that the state must in circumstances of apparent grave human rights violations establish an 'effective investigation'—the precise requirements of which are discussed further below.

Investigating Article 2 ECHR violations

Under ECHR law, the obligation to carry out an 'effective investigation' arises wherever there is an 'arguable claim' that an unlawful death has occurred whether at the hands of state agents or private individuals.[71] An 'arguable claim' exists where the 'allegations could not be discarded as being prima facie untenable'.[72] According to the HRC, Article 6 ICCPR also obliges the state to investigate allegations of deprivation of life by State authorities or private individuals or entities.[73]

In *Fernandes v Portugal*, the ECtHR confirmed that the investigative obligation arises wherever a death occurs 'in suspicious circumstances, even when the State has no direct responsibility for the death'.[74] In *Salman v Turkey*, recognising that '[p]ersons in custody are in a vulnerable position and the authorities are under a duty to protect them',[75] the ECtHR held that states are obliged to carry out an effective official investigation into deaths in custody or detention even if no agent of the state was involved in the incident resulting in death. This was confirmed in *Musayeva v Russia*.[76] Furthermore, in *Oneryildiz v Turkey*, where numerous deaths were caused by an environmental disaster, the ECtHR held that the investigative obligation arises 'when lives have been lost as a result of events occurring under the responsibility of the public authorities, which are often the only entities to have sufficient

relevant knowledge to identify and establish the complex phenomena that might have caused such incidents'.[77]

In the same vein the United Nations Minnesota Protocol on the Investigation of Potentially Unlawful Death applies where:

> (a) The death may have been caused by acts or omissions of the State, its organs or agents, or may otherwise be attributable to the State, in violation of its duty to respect the right to life...(b) The death occurred when a person was detained by, or was in the custody of, the State, its organs, or agents...[or] (c) The death occurred where the State may have failed to meet its obligations to protect life. This includes, for example, any situation where a state fails to exercise due diligence to protect an individual or individuals from foreseeable external threats or violations by non-State actors. There is also a general duty on the state to investigate any suspicious death, even where it is not alleged or suspected that the state caused the death or unlawfully failed to prevent it.[78]

The 'essential purpose of such an investigation', according to the ECtHR, 'is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility'.[79]

State responsibility for death arises where a state actor has directly participated in the unlawful killing of a person *or* where the state has failed to discharge its positive obligations under the Convention to protect the right to life, including from death in 'private' settings.

In *Makaratzis v Greece* the ECtHR held that Article 2 ECHR places a 'primary duty on the state to secure the right to life by putting in place an appropriate legal and administrative framework to deter the commission of offences against the person, backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions'.[80] In addition to the requirement of general regulation and inspection, and criminal law enforcement, the ECtHR has held that Article 2 requires thesState to take practical steps to prevent loss of life in specific situations where it knows or ought to know that there is a real risk of death.[81] In *Nencheva and Others v Bulgaria*, for example, the ECtHR found that Bulgaria had violated the right to life of fifteen children and young adults who died at a home for young people with disabilities as a result of cold and shortages of food, medicines and basic necessities. The manager of the home had tried without success on several occasions to alert all the public institutions which had direct responsibility for funding the home and which could have been expected to act.[82]

Investigating Article 3 ECHR violations

The obligation to establish an 'effective investigation' further arises wherever there is an 'arguable claim' that a violation of Article 3 ECHR (right to freedom from torture or inhuman or degrading treatment or punishment) has occurred.[83] Similarly, the UN Convention Against Torture (UNCAT) states explicitly in Article 12 that state authorities 'shall...proceed to a

prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction.' Article 16 of the UNCAT confirms that the investigative obligation under Article 12 also applies to other forms of cruel, inhuman or degrading treatment or punishment. The ECtHR routinely refers to the content of the UNCAT and its interpretation by the CAT in order to elucidate the requirements of Article 3 ECHR.

States are obliged to investigate alleged torture or ill-treatment by private individuals or bodies as well as alleged violations of the rule against torture and ill-treatment that are attributable to the state.

Under the UNCAT, state responsibility for torture or ill-treatment arises where such harm is 'inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity'.[84] The concept of 'acquiescence' has been interpreted by the CAT to place direct responsibility on the state where state actors 'know or have reasonable grounds to believe' that non-state actors are perpetrating torture or ill-treatment and the state actors 'fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors'.[85] The CAT contends that '[s]ince the failure of the State to exercise due diligence to intervene...enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission'.[86] Importantly, as set out in General Comment No 2:

> Additionally, if a person is to be transferred or sent to the custody or control of an individual or institution known to have engaged in torture or ill-treatment, or has not implemented adequate safeguards, the State is responsible, and its officials subject to punishment for ordering, permitting or participating in this transfer contrary to the State's obligation to take effective measures to prevent torture in accordance with article 2, paragraph 1. The Committee has expressed its concern when States parties send persons to such places without due process of law as required by articles 2 and 3.[87]

More broadly, Article 2 UNCAT also requires states to 'take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction' (and the CAT has stated that this same obligation applies to ill-treatment).[88] Where a state fails to comply with the Article 2 obligation, according to the CAT, it will be considered the 'author' of the resulting torture or ill-treatment.[89] The HRC's General Comment on Article 7 ICCPR, similarly, clarifies that 'States Parties have to take positive measures to ensure that private persons or entities do not inflict torture or cruel, inhuman or degrading treatment or punishment on others within their power'.[90]

The ECtHR also finds states responsible for violating Article 3 ECHR where they have failed to exercise 'due diligence' in relation to the behaviour of non-state actors. In *97 Members of the Gldani Congregation of Jehovah's Witnesses and 4 Others v Georgia*,[91] the ECtHR reiterated that:

> the obligation on the High Contracting Parties under Article 1 of the Convention to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention, taken in conjunction with Article 3, requires States to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman and degrading treatment or punishment, including such treatment administered by private individuals ... This protection calls for reasonable and effective measures, including with regard to children and other vulnerable individuals, in order to prevent ill-treatment of which the authorities were or ought to have been aware.[92]

Whether a particular form of abuse will meet the minimum threshold of severity to amount to torture or another form of cruel, inhuman or degrading treatment 'depends on all the circumstances of the case, such as the nature and context of the treatment, the manner and method of its execution, its duration, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.'[93]

Physical pain or suffering is not essential for a finding of torture or ill-treatment: psychological pain or suffering is sufficient.[94] For example, the HRC has found violations of Article 7 ICCPR where family members have suffered mental anguish following their relative's disappearance and the authorities' refusal to provide information,[95] and the ECtHR has found violations of Article 3 ECHR in similar circumstances.[96] In *Aydin v Turkey*, the ECtHR held that the rape of a 17-year-old girl in detention by a state official amounted to torture, not just because of the circumstances of the rape and the 'acute physical pain of forced penetration' but also because 'rape leaves deep psychological scars on the victim which do not respond to the passage of time as quickly as other forms of physical and mental violence'.[97]

Torture has been defined by the ECtHR as 'deliberate inhuman treatment causing very serious and cruel suffering'.[98] The definition of torture under the UNCAT requires that severe pain or suffering has been intentionally inflicted for the purpose of punishing a person, intimidating or coercing her, or for any reason based on discrimination of any kind.[99] The question of intent and purpose in Article 1 is not subjective, but objective.[100] According to the CAT, 'the discriminatory use of mental or physical violence or abuse is an important factor in determining whether an act constitutes torture.'[101] The Special Rapporteur on Torture has stated that intent 'can be effectively implied where a person has been discriminated against'.[102]

Cruel or inhuman treatment or punishment arises in situations of very serious physical or mental suffering, and does not require the evidence of intent or discrimination that torture involves. The ECtHR's decision in *Fedotov v Russia* provides an example of inhuman treatment: there, the applicant was unlawfully detained for 22 hours in a cell unfit for an overnight stay, without food or drink or unrestricted access to a toilet.[103] Harris et al draw from this case that the 'anguish caused to an individual by being detained illegally by the state may contribute to a finding that the conditions of their detention are inhuman treatment'.[104] Often the ECtHR and other human rights treaty bodies do not explicitly state what particular type of ill-treatment has occurred—i.e. whether cruel, inhuman or degrading treatment has occurred:

instead, they find a violation of the prohibition of such ill-treatment overall. Harris et al contend from a review of the ECtHR's case law that inhuman treatment may arise, for example, from the suffering caused to relatives by the disappearance of their loved one,[105] or from child abuse.[106]

Indeed, in *VK v Russia*[107] the ECtHR found that a young child had suffered inhuman treatment where at his nursery school:

> on several occasions he had been locked into the dark in the toilets and told that he would be eaten by rats, had been forced to stand in the lobby in his underwear and with his arms up for prolonged periods of time and on one occasion had had his mouth and hands taped with sellotape. He had been told that if he complained to his parents he would be subjected to further punishment, which must have exacerbated his feelings of fear and vulnerability. The teachers had moreover used physical force (which had resulted in a bruise on his face) to administer eye drops to the applicant without his parents' consent and without any medical prescription having first been obtained or indeed any medical necessity having first been established by a medical professional...The Court...takes not of the fact that the applicant was subjected to such treatment for at least several weeks and that many years afterwards he continues to suffer from its consequences, in particular in the form of a post-traumatic neurological disorder. Moreover, the above acts were perpetrated by teachers in a position of authority and control over the applicant and some of them were aimed at educating him by humiliating and debasing him.[108]

Degrading treatment or punishment has a particular connection with humiliation. The ECtHR commonly finds degrading treatment or punishment to have occurred where behaviour towards a person 'was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance, or when it was such as to drive the victim to act against his will or conscience'.[109]

Evidence of malicious intent is not necessary for a finding of degrading treatment (just as it is not necessary for inhuman treatment, either). The ECtHR has held that in considering whether treatment is degrading, 'one of the factors which the Court will take into account is the question whether its object was to humiliate and debase the person concerned, although the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3'.[110] In *Price v United Kingdom* the ECtHR found inadequate prison conditions to amount to degrading treatment despite there being 'no evidence...of any positive intention to humiliate or debase the applicant'.[111]

Degrading treatment is also understood to be closely connected to the notion of dignity violations involving a person being treated as having lesser moral worth than others. In the 1973 case of *East African Asians v United Kingdom*, the European Commission of Human Rights (a precursor to today's ECtHR) found that racial discrimination in the UK's immigration law amounted to degrading treatment.[112] The 'requirement of respect for human freedom and

dignity, one of the fundamental principles on which the Convention is based', also means that non-consensual medical treatment which is not necessary by reason of emergency, as a general rule, amounts to ill-treatment.[113]

Violence against women has frequently been held to constitute degrading treatment, at least, if not also inhuman treatment or torture. In *Yazgul Yilmaz v Turkey*[114] the ECtHR found degrading treatment to have occurred where a 16-year-old girl in police custody complained of being sexually harrassed and was subjected to a gynaecological examination in response, without her or her legal representative's consent and while she was unaccompanied. Medical reports later concluded that she was suffering from post-traumatic stress and depression as a result of her ordeal. The fact that the girl had been under the total control of those subjecting her to the non-consensual procedure by virtue of her detention in custody was an important factor in the Court's decision. Similarly, in *Aydin v Turkey*, mentioned above, the ECtHR's finding of torture arising from the rape of a 17-year-old in police custody was influenced by the Court's recognition that such actions 'must be considered to be an especially grave and aborrent form of ill-treatment given the ease with which the offender can exploit the vulnerability and weakened resistance of his victim'.[115]

A further instance of ill-treatment of a young woman in a position of vulnerability occurred in *VC v Slovakia.*[116] Here, doctors in a public hospital sterilised a 20-year-old Roma woman immediately after she had given birth to her second child via Caesarean section. The ECtHR found that the procedure was not consensual because: 'she was asked to sign the typed words "Patient requests sterilisation" while she was in a supine position and in pain resulting from several hours' labour. She was prompted to sign the document after being told by medical staff that she or her baby would die in the event of a further pregnancy.'[117] The Court noted that 'it does not appear from the documents submitted that the applicant was fully informed about her health status, the proposed procedure and the alternatives to it', and that 'asking the applicant to consent to such an intervention while she was in labour and shortly before performing a Caesarean section clearly did not permit her to take a decision of her own free will, after consideration of all the relevant issues and, as she may have wished, after having reflected on the implications and discussed the matter with her partner.'[118] The Court concluded: 'The way in which the hospital staff acted was paternalistic, since, in practice, the applicant was not offered any option but to agree to the procedure which the doctors considered appropriate...'.[119] In reaching its finding of ill-treatment in breach of Article 3 ECHR the Court recognised that the young woman's treatment 'was liable to arouse in her feelings of fear, anguish and inferiority and to entail lasting suffering'; indeed, the Court noted that 'the applicant experienced difficulties in her relationship with her partner and, later, husband as a result of her infertility', that 'the applicant suffered serious medical and psychological after-effects from the sterilisation procedure, which included the symptoms of a false pregnancy and required treatment by a psychiatrist', and that '[o]wing to her inability to have more children the applicant has been ostracised by the Roma community'.[120] Finding that such invasion of the woman's autonomy was 'incompatible with the requirement of respect for human freedom and dignity' the ECtHR acknowledged that sterilisation '[a]s it concerns one of the essential bodily functions of human beings...bears on manifold aspects of the individual's personal

integrity including his or her physical and mental well-being and emotional, spiritual and family life.'[121]

In *N v Sweden*[122] the ECtHR recognised that widespread societal discrimination against girls and women in Afghanistan created a climate of ill-treatment such that Sweden could not lawfully return an asylum seeker who was in an extramarital relationship to the country. The Court relied on UN High Commissioner for Refugees reporting that 'Afghan women, who have adopted a less culturally conservative lifestyle...continue to be perceived as transgressing entrenched social and religious norms and may, as a result, be subjected to domestic violence and other forms of punishment' including if 'accused of bringing shame to their families, communities or tribes'.[123] The ECtHR further acknowledged US State Department Human Rights reporting that 'local officials occasionally imprisoned women at the request of family members for opposing the family's choice of a marriage partner or being charged with adultery or bigamy...Local officials imprisoned women in place of a family member who had committed a crime but could not be located. Some women resided in detention facilities because they had run away from home due to domestic violence or the prospect of forced marriage.'[124] In conclusion, the Court held, 'there are substantial grounds for believing that if deported to Afghanistan, the applicant faces various cumulative risks of reprisals which fall under Article 3 of the Convention from her husband X, his family, her own family and from the Afghan society.'[125]

According to the human rights treaty bodies, states have heightened positive obligations to protect girls and women from gender-based violence of which they know or ought to know. As the CAT's General Comment No 2 states, '[t]he protection of certain minority or marginalized individuals or populations especially at risk of torture is a part of the obligation to prevent torture or ill-treatment'.[126] In *Opuz v Turkey*, the ECtHR acknowledged the 'vulnerability' of the applicant as a woman who had suffered violence in the past and lived in a part of Turkey where violence against women was tolerated.[127] The Court found that the State's positive obligation to protect against gender-based violence included a specific obligation to ensure that the domestic legislative framework allowed for the prosecution of serious acts of violence even where the victim had withdrawn her complaints.[128]

Children are also recognised by the human rights treaty bodies to be more vulnerable to torture and ill-treatment due to their dependence on others for care, their powerlessness to remove themselves from abusive situations and the psychological impact of abuse suffered while at a formative stage of life.[129] The ECtHR scrutinises intensely the measures which states take (or fail to take) to protect from torture and ill-treatment, including at the hands of private individuals, where the individuals concerned are considered 'vulnerable'.[130] For example, in *O'Keeffe v Ireland*, on the basis that young children under the exclusive control of school authorities are 'especially vulnerable',[131] the ECtHR held that the general 'positive obligation to protect' from torture or ill-treatment includes a specific obligation to establish 'useful detection and reporting mechanisms' to guard against child sexual abuse at school.[132]

Individuals who are deprived of their liberty are also understood by the human rights treaty bodies to be particularly 'vulnerable' to suffering torture or ill-treatment because of the control that others exercise over them.[133] The international community's recognition of detainees' vulnerability is why Article 10 ICCPR states explicitly that '[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'.[134]

The ECtHR has held that 'in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3'.[135] According to the ECtHR, where this occurs it is not necessary to show that the use of force caused injury.[136] Importantly, forced labour can be considered 'violence' as defined by the Istanbul Convention on Preventing and Combating Violence Against Women and Domestic Violence:

> ..."violence against women" is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.[137]

The treaty bodies' jurisprudence makes clear that states' omissions to provide basic resources to individuals in detention may amount directly to acts of ill-treatment.[138] States must ensure adequate sanitary facilities, clothing and food; minimum floor space, air and natural light; a separate bed; and opportunity for recreation and contact with the outside world.[139] States must also provide healthcare tailored to individual needs and provide for the needs of persons with disabilities.[140] Where children are detained, the positive obligation to ensure humane treatment requires states to provide them with resources tailored to their needs, including education.[141]

Deprivation of liberty, in and of itself, has been recognised as amounting to ill-treatment in certain circumstances. The Special Rapporteur on Torture has highlighted that torture or ill-treatment may occur in care settings in the form of 'institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight'.[142] According to the Special Rapporteur, '[i]nappropriate or unnecessary non-consensual institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary'.[143] In *Mouisel v France*, the ECtHR held that the continued detention in prison of a 53-year-old man who was suffering from cancer amounted to inhuman and degrading treatment because it 'undermined his dignity and entailed particularly acute hardship that caused suffering beyond that inevitably associated with a prison sentence and treatment for cancer'.[144] In *C v Australia*, the HRC held that the arbitrary detention of an asylum seeker violated not only Article 9 ICCPR (the right to liberty) but also Article 7 ICCPR (the right to freedom from torture or ill-treatment) because of its psychological impact.[145]

Investigating Article 4 ECHR violations

The ECtHR has held that '[l]ike arts 2 and 3, art.4 also entails a procedural obligation to investigate'[146] where the state is aware or ought to be aware of 'circumstances giving rise to a credible suspicion'[147] of a violation of Article 4—whether the abuse has occurred at the hands of state or non-state actors. The case law under this Article of the Convention is sparse but to date this procedural obligation to investigate has been identified in cases involving human trafficking,[148] domestic servitude,[149] and forced prostitution.[150]

The detail of the investigative obligation—discussed below—is similar to that arising under Articles 2 and 3 because 'Article 4, together with Articles 2 and 3, enshrines one of the basic values of the democratic societies making up the Council of Europe'.[151] As noted above, the international treaties specifically concerning slavery, servitude and forced labour were some of the earliest human rights law treaties, along with the ECHR.

The UK had a legal duty from 1932, when the Forced Labour Convention 1930 came into force, to 'suppress the use of forced or compulsory labour in all its forms within the shortest possible period.' The 1930 Convention obliged the State not to 'impose or permit the imposition of forced or compulsory labour for the benefit of private individuals, companies or associations'[152] and specified that '[n]o concession granted to private individuals, companies or associations shall involve any form of forced or compulsory labour for the protduction or the collection of products which such private individuals, companies or associations utilise or in which they trade.'[153] In addition, the 1930 Convention required that '[t]he illegal exaction of forced or compulsory labour shall be punishable as a penal offence, and it shall be an obligation on any Member ratifying this Convention to ensure that the penalties imposed by law are really adequate and are strictly enforced.'[154]

The Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery 1956 required the UK to 'take all practicable and necessary legislative and other measures to bring about progressively and as soon as possible the complete abolition or abandonment of...[a]ny institution or practice whereby a child or young person under the age of 18 years, is delivered by either or both of his natural parents or by his guardian to another person, whether for reward or not, with a view to the exploitation of the child or young person or of his labour.'[155] The Abolition of Forced Labour Convention 1957, meanwhile, required the UK 'to suppress and not to make any use of any form of forced or compulsory labour...as a means of political coercion or education or as a punishment for holding or expressing political views or views ideologically opposed to the established political, social or economic system' or 'as a means of racial, social, national or religious discrimination'.[156]

Article 4 ECHR contains an absolute prohibition of slavery, servitude and forced or compulsory labour. The ECtHR's case law clarifies that not only must the state refrain from engaging in such acts but it must also take positive steps to put in place, among other things, a 'legal and administrative framework' to prohibit and punish violations of Article 4[157] as well as 'adequate measures regulating businesses often used as a cover for human trafficking'.[158]

In several cases the ECtHR has relied upon the 1930 Forced Labour Convention definition of 'forced or compulsory labour', which is: 'all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily'.[159] The Irish Human Rights Commission (IHRC), finding in 2013 that girls and women in Magdalene Laundries in ROI appear to have been subjected to forced or compulsory labour,[160] observed that: 'it was made clear during the consideration of the draft 1930 Convention that the penalty in question need not be in the form of penal sanctions, but might take the form also of a loss of rights or privileges.'[161]

In *Siliadin v France*[162] the ECtHR asserted that the concept of 'forced or compulsory' labour 'brings to mind the idea of physical or mental constraint'.[163] The Court noted that in this case—which involved a 15-year-old who was kept as a housemaid, working seven days a week for no pay—there was in fact no legal penalty which threatened the girl. However, the Court held:

> although the applicant was not threatened by a "penalty", the fact remains that she was in an equivalent situation in terms of the perceived seriousness of the threat. She was an adolescent girl in a foreign land, unlawfully present on French territory and in fear of arrest by the police. Indeed, Mr and Mrs B. nurtured that fear and led her to believe that her status would be regularised. Accordingly, the Court considers that the first criterion was met, especially since the applicant was a minor at the relevant time, a point which the Court emphasises.[164]

As to whether the girl performed the work of her own free will (which is the second aspect of the test for forced or compulsory labour under the 1930 Convention), the ECtHR in *Siliadin* found that 'it is evident that she was not given any choice'.[165] Ms Siliadin had been sent to France by her father who had an arrangement with another person, and upon arrival in France her passport was taken from her, her immigration status was not regularised, and she was 'lent' to a family who paid her no money for the constant work they forced her to do and did not send her to school.

The ECtHR found that servitude had also taken place in *Siliadin*. Recalling the previous case law of the Commission, the Court held: 'With regard to the concept of "servitude", what is prohibited is a "particularly serious form of denial of freedom" which 'includes, "in addition to the obligation to perform certain services for others...the obligation for the 'serf' to live on another person's property and the impossibility of altering his condition"'.[166] The Court further concluded that 'for Convention purposes "servitude" means an obligation to provide one's services that is imposed by the use of coercion'.[167] This test was met where Ms Siliadin 'was required to perform forced labour [which] lasted almost fifteen hours a day, seven days a week', had been 'brought to France by a relative of her father's, and had not chosen to work for Mr and Mrs B', as a minor 'had no resources and was vulnerable and isolated, and had no means of living elsewhere than in the home of Mr and Mrs B., where she shared the children's bedroom as no other accommodation had been offered' and 'was entirely at Mr and Mrs B.'s mercy, since her papers had been confiscated'.[168] The Court continued: 'In addition, the applicant, who was afraid of being arrested by the police, was not in any event permitted to

leave the house, except to take the children to their classes and various activities. Thus, she had no freedom of movement and no free time. As she had not been sent to school, despite the promises made to her father, the applicant could not hope that her situation would improve and was completely dependent on Mr and Mrs B.'[169]

Investigating Article 5 and Article 8 ECHR violations

The ECtHR has held that an 'effective investigation' must also be carried out where there is an 'arguable claim' that a person has 'disappeared' in violation of Article 5 (right to liberty and security)[170] or Article 8 (right to respect for private and family life),[171] or where another very serious violation of Article 8 has occurred.[172]

Arbitrary detention: a violation of Article 5 ECHR

Not all deprivations of liberty are unlawful (in other words, 'arbitrary'). Article 5 ECHR permits detention for a list of specified purposes including lawful arrest, the 'detention of a minor by lawful order for the purpose of educational supervision', and the 'lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants'.

If a detention happens for a reason other than one of those permitted under Article 5 ECHR, it will be arbitrary. Even where a deprivation of liberty occurs for a legitimate reason, in order to be lawful under the ECHR it must *still* have a 'clear and precise legal basis in domestic law' at all times during the detention,[173] the grounds and conditions for depriving people of their liberty under that domestic law must be clearly defined, and the law must be foreseeable in its application.[174] Furthermore, in order for detention to be lawful, the decision to detain a person must not be arbitrary, meaning for example that there must be no 'bad faith' element to the decision to detain, and domestic legislation allowing detention for a particular purpose must not be used as a smokescreen for detention serving another purpose.[175] Detention of a child purportedly for educational purposes will be unlawful if it does not actually involve their education,[176] and detention of a person 'of unsound mind' may only follow a finding based on 'objective medical expertise'[177] that such confinement is actually 'necessary in the circumstances'[178] for the whole period of confinement.[179] Where a person is arrested, their detention will also breach Article 5 ECHR if they are not informed promptly of the reasons for their detention,[180] and if they do not have access to a judge or other officer authorised by law to exercise judicial power.[181] All persons who are detained, for any reason, are entitled under Article 5(4) ECHR to 'take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.' Where people are detained indefinitely or for a long period in health or social care settings, this means that they must be enabled 'to take proceedings "at reasonable intervals" before a court' to challenge the lawfulness of their detention.[182]

Under Article 5 ECHR the State is obliged not only to refrain from perpetrating arbitrary detention but also to protect from such abuse in private settings.[183] In *Storck v Germany*, where the applicant was detained without any official authorisation in a private psychiatric clinic, the ECtHR held that the State is 'obliged to take measures providing effective protection of

vulnerable persons, including reasonable steps to prevent a deprivation of liberty, of which the authorities have or ought to have knowledge'.[184] Without such a positive obligation, the Court contended, there would be 'a sizeable gap in the protection from arbitrary detention, which would be inconsistent with the importance of personal liberty in a democratic society'.[185]

A preliminary question that must be answered before determining whether a person has been subjected to an arbitrary or unlawful deprivation of liberty is whether they have been deprived of their liberty at all.

State custody in the form of arrest or detention by police or military or prison authorities is the most commonly recognised form of deprivation of liberty; however, the definition of deprivation of liberty under human rights instruments is broad and does not in principle exclude any particular setting. As the ECtHR has repeatedly found, 'the difference between deprivation of liberty and restrictions of liberty of movement...is merely one of degree or intensity, and not one of nature or substance...In order to determine whether someone has been deprived of his liberty, the starting-point must be his specific situation and account must be taken of a whole range of factors such as the type, duration, effects and manner of implementation of the measure in question.'[186] In social care contexts, the ECtHR has found a deprivation of liberty to exist where a person is 'under continuous supervision and control and not free to leave',[187] and they have 'not validly consented to the confinement in question'.[188] Having entered a place voluntarily does not mean that deprivation of liberty cannot then arise. The ECtHR has stated repeatedly that 'the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention'.[189]

The ECtHR has found deprivations of liberty to exist in the social care context even where premises are unlocked[190] and where a person has previously gone on outings or visits away from the institution.[191] Individuals have been found to be 'not free to leave' where permission to leave the premises is required,[192] where a person's guardian is required to consent to the person leaving,[193] where there are restrictions as to the length of time and destination to which a person may go,[194] where an institution restricts access to a person's identity documents or finances, which would enable them to travel,[195] where a person is returned—for example, by the police—when they leave,[196] or where it is clear that a person would be prevented from leaving if they tried or returned to the institution if they did.[197]

The IHRC noted of the experiences of girls and women in Magdalene Laundries in ROI that: 'While there were accounts of the women working outside one particular Laundry, and going on outings, such accounts would not necessarily refute the possibility that the girls and women were nonetheless under constant supervision and control while residing in the Laundries. Otherwise put, such outings could be regarded as a form of temporary release if the girls and women concerned were subject to recall to the Laundries.'[198] The IHRC continued:

> there were certainly instances where Magdalen Laundries were providing an alternative to the prison system, and in this regard it was clearly understood that the girls and

> women were to be maintained in conditions of detention...the direct testimony of the women who spoke to the IDC suggests a very restrictive regime, more in line with incarceration... these statements would at a minimum suggest that the women concerned understood they were not free to leave the Laundry at will. In addition with respect to the placements of girls and women in Magdalen Laundries by State agencies, the IDC Report notes a significant number of instances where girls and women had little, if any, knowledge about the reasons for which they were in Magdalen Laundries, and whether they were required to remain there.[199]

The IHRC concluded: 'While these are all clearly subjective accounts of the experiences of girls and women in the Laundries, when combined with the objective evidence in the IDC Report regarding the use of the Laundries for the purpose of detaining women and girls on behalf of the State, it is hard not to come to the conclusion that many, although certainly not all, of the women who entered the Laundries were deprived of their liberty. The question then becomes one of whether that deprivation of liberty was lawful.'[200]

The IHRC found arbitrary detention on account of the following:

- Where a Magdalen Laundry was operating as an informal remand facility, not being designated by legislation or regulation, this put the custody of the girls and women outside the effective regulation of the State;[201]
- It is also clear that questions arise as to whether Magdalen Laundry residents were promptly released once the lawful basis for their detention ended or whether they over-stayed in conditions of *de-facto* detention;[202]
- There is no evidence in the IDC Report that the placement of minors in Magdalen Laundries that came through the route of industrial schools or health and social services was for the purpose of educational supervision or that they in fact received any form of education;[203] and
- there was no legal basis for coercing a woman to enter a Magdalen Laundry under thret of withholding public assistance to her. However, the records show that in relaity this may not have been the practice. Therefore, if a woman was under the apprehension that she did not have a choice as regards entering and remaining in a Laundry, then there may be instances where there was a breach of the constitutional right to liberty and its counterpart right under the ECHR.[204]

A very serious breach of Article 8 ECHR

As explained above, in *Jovanovic v Serbia* the ECtHR found a 'disappearance' to have occurred where a state-run hospital had taken a woman's new-born son from her and still 33 years later she had not been informed of whether or how her son had died and where if at all he was buried.[205] The state authorities' 'continuing failure to provide her with credible information as to the fate of her son'—in other words, the state's failure to investigate—gave rise to a violation of Article 8 ECHR.[206]

In *Mentes and Others v Turkey*[207] Kurdish villagers had suffered the destruction of their homes and expulsion from their village by state security forces.[208] The ECtHR held that 'the nature and gravity of the interference complained of under Article 8 of the Convention in the instant case' gave rise to 'an obligation on the respondent State to carry out a thorough and effective investigation of allegations brought to its attention of deliberate destruction by its agents of the homes and possessions of individuals.'[209]

Arguably, the unlawful separation of parent and child, and the unlawful denial of basic information about one's own identity, are also Article 8 ECHR violations of sufficient seriousness to give rise to a similar investigative obligation. As the ECtHR has held: 'There is no doubt that divesting a parent of his or her parental rights and putting a child up for adoption are both very restrictive measures, the latter of which results in the complete disruption of the relationship between a parent and child'[210] and 'the fact that the decisions may well prove to be irreversible as in a case where a child has been taken away from his parents and freed for adoption [means that] [t]his is accordingly a domain in which there is an even greater call than usual for protection against arbitrary interferences.'[211]

The ECtHR has held that Article 8 ECHR protects the right to know and be cared for by one's parents.[212] This is not an absolute right; however, as per Article 8 ECHR, the state may only interfere with the right in a manner that is in accordance with the law, and is necessary in a democratic society and proportionate to achieving a legitimate aim.[213]

The ECtHR's case law demonstrates that Article 8 will be violated where the state separates a parent and child without parental consent in anything other than exceptional circumstances, where objective evidence shows it to be necessary in order to protect the best interests of the child and the separation is in accordance with the law.[214] (Similarly, as the ECtHR frequently notes, Article 9 UNCRC states that 'a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child'.) The ECtHR has held that 'where the existence of a family tie with a child has been established, the State must act in a manner calculated to enable that tie to be developed and legal safeguards must be created that render possible as from the moment of birth the child's integration in his family'.[215] This includes where a child has been taken into care; a 'guiding principle' under Article 8 ECHR 'is that a care order should be regarded as a temporary measure, to be discontinued as soon as circumstances permit, and that any measures implementing temporary care should be consistent with the ultimate aim of reuniting the natural parents and child'.[216] Total deprivation of parental responsibilities and authorisation of adoption against the parents' wishes may only occur if 'motivated by an overriding requirement pertaining to the child's best interests'.[217]

Article 8 will also be violated where parents are not sufficiently involved in the decision making process as to whether or not a child should be separated from them.[218] The 1994 case of *Keegan v Ireland*[219] demonstrates this; the Court found a violation of Article 8 because Irish legislation allowed for the adoption of a child without the knowledge or consent of the natural

father. In *AK and L v Croatia*,[220] Article 8 was violated because the state authorities did not ensure that the mother's interests were adequately protected in child care proceedings which divested her of her parental rights following which her son was put up for adoption. The Court found that she was not legally represented, that '[t]he national authorities established that she had a mild mental disability and that despite the need for ongoing psychiatric treatment she was not receiving any such treatment', and that she 'could not properly understand the full legal effect of such proceedings and adequately argue her case'.[221]

The question of what amounts to valid consent to adoption has not been explained by the ECtHR. It is perhaps useful to consider the cases where the Court has examined the question of consent to medical interventions—for example in *VC v Slovakia*, referred to above, and in *Juhnke v Turkey*, discussed directly below.

In *Juhnke v Turkey*[222] a woman arrested by Turkish soldiers was subjected to a medically unnecessary gynaecological examination by a doctor while in custody.[223] The ECtHR found that the examination was non-consensual and thus in breach of Article 8 of the Convention. The Court recognised as evidence of the woman's non-consent 'that the applicant had resisted a gynaecological examination until persuaded to agree to it [and] that, in certain circumstances, a person in detention cannot be expected to continue to resist submitting to a gynaecological examination, given her vulnerability at the hands of the authorities, who exercise complete control over her throughout her detention.'[224] Further, the Court noted, 'the applicant was detained *incommunicado* for at least nine days prior to the impugned medical intervention and that at the time of the examination, she appeared to be in a particularly vulnerable mental state'.[225] The Court added: 'It is unclear from the material before the Court whether the applicant was adequately informed of the nature and the reasons for this examination. Moreover...the Court considers that the applicant might have been misled into believing that the examination was compulsory.'[226]

Notably, in Irish law, the leading authority on the meaning of valid consent to adoption is the 1980 Supreme Court judgment in *G v An Bord Uchtála*,[227] in which Walsh J stated:

> the consent, if given, must be such as to amount to a fully-informed, free and willing surrender or an abandonment of these rights. However, I am also of opinion that such a surrender or abandonment may be established by her conduct when it is such as to warrant the clear and unambiguous inference that such was her fully informed, free and willing intention. In my view, a consent motivated by fear, stress or anxiety, or a consent or conduct which is dictated by poverty or other deprivations does not constitute a valid consent.

In *DG v An Bord Uchtála*,[228] in 1996, Laffoy J held that:

> it is not sufficient merely to consider whether the relevant information was conveyed to the mother. It is necessary to consider also the ability of the mother to receive the information and to intellectually process it in such a way as to lead to an understanding

of the effect of an adoption order and the consequences of each step in the process leading to an option order.[229]

Other serious Article 8 violations arguably meeting the threshold of requiring an investigation, particularly where accompanied by any of the above-discussed human rights violations, include:

- Non-consensual gyanecological examination;[230]
- Failure to return the remains of deceased family members to their relatives;[231]
- The performance of medical procedures on children without parental consent;[232]
- Circumstances such as in *Marić v Croatia*, where Article 8 was violated because the parents of a stillborn child had not given their consent for their child's remains to be treated as clinical waste (which, through cremation, also deprived them of the ability to know the resting place);[233]
- Circumstances such as in *Petrova v Latvia*, where Article 8 was violated due to the absence of proper procedures to ensure parental consent prior to a hospital's removal of a deceased child's organs;[234] and
- Failure to to ensure the identification of graves: in its 2010 *Assessment of the Human Rights Issues Arising in relation to the 'Magdalen Laundries'*[235] in ROI the IHRC contended that Article 8 ECHR was engaged by the State's failure to ensure the identification of the bodies of women who were buried in a communal grave and thereafter exhumed and cremated.[236] The IHRC noted that 'respect for private and family life under Article 8 of the ECHR includes and encompasses the concept of personal integrity and that nothing can be more private, personal and integral to a human being than a person's identity including their name.'[237]

4. The elements of an 'effective investigation'

The ECtHR's case law contains a well-established list of elements that must be present in the state's investigative effort in order for it be 'effective'—while noting that 'what form of investigation will achieve those purposes may vary in different circumstances.'[238] These requirements are discussed below, alongside further investigative principles and standards set out in international human rights law documents concerning accountability and reparation for serious human rights violations and international crimes.

Where human rights violations are widespread and systematic, and where they involve the actions and culpable inaction of state authorities, one form of investigation alone is unlikely to be sufficient to meet human rights law requirements. In the cases of *O'Keeffe v Ireland*[239] and *Keenan v United Kingdom*,[240] for example, the ECtHR held that it was essential to provide victims of torture or ill-treatment and relatives of the deceased with access to accountability mechanisms that explicitly addressed the liability of the state for its human rights violations and not just the liability of individuals for criminal or civil law wrongs. The UN Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[241] state that in cases of an 'apparent existence of a pattern

of abuse', the authorities shall 'ensure that investigations are undertaken through an independent commission of inquiry or similar procedure'.[242]

The mechanism of a truth commission or commission of inquiry is connected to the idea of the 'right to truth'—a concept utilised in the human rights field to emphasise the extra characteristics of the investigation, access to justice and other reparation measures that are required in contexts where human rights violations are particularly serious and/or systematic. In *El Masri v Macedonia*,[243] which involved extraordinary rendition and inhuman and degrading treatment, three ECtHR judges in a concurring opinion contended that 'the "right to the truth", that is, the right to an accurate account of the suffering endured and the role of those responsible for that ordeal'[244] is both 'broadly implicit' in the investigative obligation and also, in itself, a requirement of the right to an 'effective remedy' where human rights violations are gross and systematic. The judges contended that the right to the truth includes 'a right of access to the relevant information about alleged violations, both for the persons concerned *and for the general public*'[245] (emphasis added). In this case, the right to the truth with its requirement of public information disclosure arose because of '[t]he scale and seriousness of the human rights violations in issue, committed in the context of the secret detentions and renditions system, together with the widespread impunity observed in multiple jurisdictions in respect of such practices'.[246]

The United Nations Updated Set of principles for the protection and promotion of human rights through action to combat impunity (Orentlicher Principles) explain that the right to know can be facilitated by mechanisms that are additional to—and, importantly, that enhance the functioning of—the ordinary existing justice mechanisms of the state. Crucially, specialised truth-telling mechanisms are not a substitute for existing justice mechanisms, which must also operate in response to the state's knowledge of gross human rights abuse. The Orentlicher Principles state that:

> Appropriate measures to ensure this right [to truth] may include non-judicial processes that complement the role of the judiciary. Societies that have experienced heinous crimes perpetrated on a massive or systematic basis may benefit in particular from the creation of a truth commission or other commission of inquiry to establish the facts surrounding those violations so that the truth may be ascertained and to prevent the disappearance of evidence. Regardless of whether a State establishes such a body, it must ensure the preservation of, and access to, archives concerning violations of human rights and humanitarian law.[247]

The CAT's General Comment No 3 on the right to redress for torture or ill-treatment, similarly, lists truth-telling mechanisms that may be required in addition to the ordinary civil and criminal investigation and justice proceedures in the state. The investigative requirements discussed below may need to be met by a combination of existing civil and criminal justice mechanisms and a specialised truth-telling process.

Promptness

The ECtHR has repeatedly held that where an investigation is required, it should be undertaken in a prompt and timely fashion in order to maintain public confidence.[248] The UN Principles on the Effective Investigation of Torture state, similarly, that: 'States shall ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation shall be undertaken if there are other indications that torture or ill-treatment might have occurred.'[249] The Minnesota Protocol notes, however, that 'The failure of the State promptly to investigate does not relieve it of its duty to investigate at a later time: the duty does not cease even with the passing of significant time.'[250]

ECtHR case law clearly establishes that the state authorities must undertake an investigation as soon as they know or ought to know of information indicating a serious human rights violation of the nature discussed above. The ECtHR has repeatedly held that the obligation to investigate 'is not dependent upon the lodging of a formal complaint' by the victim or next-of-kin 'or their suggesting a particular line or inquiry or investigative procedure'.[251]

Purposes of the investigation

Truth: As per the Orentlicher Principles, '[i]n recognition of the dignity of victims and their families, investigations undertaken by truth commissions should be conducted with the object in particular of securing recognition of such parts of the truth as were formerly denied.'[252] The ECtHR commonly states that in order to be 'effective', an investigation 'must be capable of leading to the establishment of the facts'.[253] Regarding the thoroughness of the investigation, the ECtHR has held that the authorities must always make a serious attempt to find out what happened and should not rely on hasty or ill-founded conclusions to close their investigation or to use as the basis of their decisions.[254] They must take all reasonable steps available to them to secure the evidence concerning the incident, including, inter alia, eyewitness testimony and forensic evidence.[255] Any deficiency in the investigation which undermines its ability to establish the cause of injuries or the identity of the persons responsible will risk falling foul of this standard.[256]

Investigation of human rights violations: The Orentlicher Principles state that commissions of inquiry 'should focus as a matter of priority on violations constituting serious crimes under international law, including in particular violations of the fundamental rights of women and of other vulnerable groups'.[257] State responsibility as well as individual responsibility must be addressed. The UN Principles on the Effective Investigation of Torture provide that 'the purposes of an investigation must include clarification of the facts and establishment and acknowledgement of individual and State responsibility for the victims and their families.'[258] According to the Minnesota Protocol concerning potentially unlawful deaths: 'The investigation must determine whether or not there was a breach of the right to life. Investigations must seek to identify not only direct perpetrators but also all others who were responsible for the death, including, for example, officials in the chain of command who were complicit in the death. The investigation should seek to identify any failure to take reasonable

measures which could have had a real prosepct of preventing the death. It should also seek to identify policies and systemic failures that may have contributed to a death, and identify patterns where they exist.'[259]

Individualised investigation: The Minnesota Protocol concerning potentially unlawful deaths requires that 'investigations must: at a minimum, take all reasonable steps to: (a) Identify the victim(s); (b) Recover and preserve all material probative of the cause of death, the identity of the perpetrator(s) and the circumstances surrounding the death; (c) Identify possible witnesses and obtain their evidence in relation to the death and the circumstances surrounding the death; (d) Determine the cause, manner, place and time of death, and all of the surrounding circumstances; and (e) Determine who was involved in the death and their individual responsibility for the death...In the case of an enforced disappearance, an investigation must seek to determine the fate of the disappeared and, if applicable, the location of their remains'.[260] The ECtHR has held in the Article 2 context that 'Any deficiency in the investigation which undermines its ability to establish the cause of death or the person responsible will risk falling foul' of the Convention standard.[261]

Archival access and preservation: The Orentlicher Principles state that 'The terms of reference of commissions of inquiry should highlight the importance of preserving the commission's archives. At the outset of their work, commissions should clarify the conditions that will govern access to their documents, including conditions aimed at preventing disclosure of confidential information while facilitating public access to their archives.'[262] The Principles state further that: 'Access to archives shall be facilitated in order to enable victims and their relatives to claim their rights. Access shall be facilitated, as necessary, for persons implicated, who request it for their defence. Access to archives should also be facilitated in the interest of historical research, subject to reasonable restrictions aimed at safeguarding the privacy and security of victims and other individuals. Formal requirements governing access may not be used for the purposes of censorship.'[263] The Special Rapporteur on truth, justice, reparation and guarantees of non-recurrence has published a Set of General Recommendations for Truth Commissions and Archives; they state that truth commissions 'are encouraged to' make recommendations to the State 'on archives and the establishment of national archival policies that concern records containing information on gross human rights violations and serious violations of international humanitarian law' including recommendations that:

(a) Encourage the establishment of modern, accessible, and reliable archives which are essential for the long-term preservation and use of records containing information on gross human rights violations and serious violations of international humanitarian law;

(b) Recommend the creation of archival laws, freedom of information legislation, data protection legislation and transparency requirements within other laws, which take into account the right to information, the right to know the truth, and the specificity of the records dealing with human rights violations and violations of international humanitarian law; and

(c) Promote the establishment of comprehensive National Archival systems, including non-governmental records, especially those that are relevant to gross human rights violations and serious violations of international humanitarian law.[264]

Contribution to other justice and redress mechanisms: The ECtHR has frequently held that an 'effective' investigation is one which is capable of leading to the establishment of the facts, of determining whether the elements of unlawful behaviour are present, and of identifying and – if appropriate—punishing those responsible.[265] Failing to securing a punishment where one is not possible does not vitiate the investigation's effectiveness; the ECtHR holds that the investigative obligation is 'not an obligation of result, but of means'.[266] According to the Orentlicher Principles, 'Commissions of inquiry shall endeavour to safeguard evidence for later use in the administration of justice.'[267] The Orentlicher Principles state that the relevant archives must be available to all justice mechanisms: 'Courts and non-judicial commissions of inquiry, as well as investigators reporting to them, must have access to relevant archives'—a principle that 'must be implemented in a manner that respects applicable privacy concerns, including in particular assurances of confidentiality provided to victims and other witnesses as a precondition of their testimony.'[268] As the UN Principles on the Effective Investigation of Torture state, the purposes of an investigation must include 'facilitation of prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation'.[269]

Recommendations for reforms to prevent future abuse: According to the UN Principles on the Effective Investigation of Torture, a key purpose of an effective investigation is the 'identification of measures needed to prevent recurrence'.[270] The Orentlicher Principles provide that a commission's 'terms of reference should include provisions calling for it to include in its final report recommendations concerning legislative and other action to combat impunity...When establishing a commission of inquiry, the Government should undertake to give due consideration to the commission's recommendations.'[271]

Characteristics and powers of the investigators

Independence and competence: The ECtHR has frequently stated that the investigation must be carried out by a body with both institutional and practical independence from those implicated in the events.[272] The UN Principles on the Effective Investigation of Torture state that the investigators 'must be not just independent but also competent and impartial, and they must have access to impartial medical or other experts'.[273] According to the Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol), commission of investivation members 'should be chosen for their recognised impartiality, competence and independence as individuals as defined as follows:

(a) Impartiality. Commission members should not be closely associated with any individual, State entity, political party or other organization potentially implicated in the torture. They should not be too closely connected to an organization or group of which the victim is a member, as this may damage the commission's credibility. This should not, however, be an excuse for blanket exclusions from the commission, for instance, of members of large organizations of which the victim is also a member or of persons associated with organizations dedicated to the treatment and rehabilitation of torture victims;
(b) Competence. Commission members must be capable of evaluating and weighing evidence and exercising sound judgement. If possible, commissions of inquiry should include individuals with expertise in law, medicine and other appropriate specialized fields;
(c) Independence. Members of the commission should have a reputation in their community for honesty and fairness.[274]

The Istanbul Protocol adds that '[a] single commissioner should in general not conduct investigations into torture' and that '[t]he objectivity of the investigation and the commission's findings may, among other things, depend on whether it has three or more members rather than one or two.'[275] The Protocol continues: 'The investigation will often require expert advisers. Technical expertise should be available to the commission in areas such as pathology, forensic science, psychiatry, psychology, gynaecology and paediatrics. To conduct a completely impartial and thorough investigation, the commission would almost always need its own investigators to pursue leads and develop evidence.'[276]

Gender balance: The UN Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence contends that:

> It is essential to achieve gender parity or balance among commission members. This: (a) brings greater visibility to the political decision to include a gender perspective in commission work, (b) ensures the presence of women at the highest decision-making levels of commissions; and (c) brings commissions closer to women victims. All commission staff should have sufficient knowledge of gender issues and receive ongoing training to raise awareness ...This training process is especially necessary for teams that collect statements because they are the first (and sometimes only) point of contact with victims...Interviewers should be trained in techniques to safely, confidentially and sensitively identify and record the experience of both male and female victims or survivors of sexual violence, or those who have been subjected to violence because of their actual or perceived sexual orientation or gender identity, and be trained to deal with reluctance, considering the therapeutic value of the interview.[277]

Powers to secure and compel the production of evidence: The ECtHR has held that the investigation should not be reliant solely on evidence or information from the source being investigated.[278] It should have full investigatory powers to compel witnesses and it should be capable of securing evidence.[279] In the Article 2 context, the ECtHR has held that 'The authorities must take whatever reasonable steps they can to secure the evidence concerning the

incident, including, *inter alia*, eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of the clinic findings, including the cause of death.'[280] The UN Principles on the Effective Investigation of Torture state the requirement thus: 'The investigation must have all necessary budgetary and technical resources for effective investigation and the authority to summons witnesses and demand the production of evidence'.[281] The Istanbul Protocol states that a commission of investigation 'specifically needs the following:

> (a) Authority to obtain all information necessary to the inquiry including the authority to compel testimony under legal sanction, to order the production of documents including State and medical records, and to protect witnesses, families of the victim and other sources;
>
> (b) Authority to issue a public report;
>
> (c) Authority to conduct on-site visits, including at the location where the torture is suspected to have occurred;
>
> (d) Authority to receive evidence from witnesses and organizations located outside the country.'[282]

The Istanbul Protocol notes that 'Practically, this authority may involve the power to impose fines or sentences if government officials or other individuals refuse to comply.'[283] Regarding the securing of archives, the Orentlicher Principles state that 'Technical measures and penalties should be applied to prevent any removal, destruction, concealment or falsification of archives, especially for the purpose of ensuring the impunity of perpetrators of violations of human rights and/or humanitarian law.'[284]

Adequate resources: The Orentlicher Principles state that a commission 'shall be provided with (a) Transparent funding to ensure that its independence is never in doubt; (b) Sufficient material and human resources to ensure that its credibility is never in doubt.'[285]

Responsiveness to those affected

Involvement of those affected: The Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences, on reparations to women who have been subjected to violence, contends that: 'Women-centred processes of reparations [including investigations] require participation of women in the process of shaping, implementing, monitoring and evaluating reparations programmes'.[286]

Gender-sensitivity: The Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, on the gender perspective in transitional justice processes[287] states that the mandate of a truth commission 'should comprehensively address the impact of gender, including sexual and other gender-based violence suffered by all persons, and consider the dimension of sexual orientation and gender identity.'[288] The Special Rapporteur's report adds that '[i]t is key to take into account, in all cases, an intersectional perspective'.[289] The Report of the Special Rapporteur on Violence Against Women, its Causes

and Consequences, on reparations to women who have been subjected to violence, argues that a 'women-centred' process of investigating human rights violations must make sure 'that those violations that target women and girls have been duly included' and that determination of harms must include 'those which are gender-specific or have a differential impact on women'.[290] The Special Rapporteur continues by stating that recognition of wrongdoing 'has to be underpinned by the notion that the same violations may entail different harms for men and women, but also for women and girls from cultural minorities.' She explains: 'For instance, harms emanating from sexual violence—including...undesired pregnancies...loss of reproductive capacity...vaginal injuries, and multiple psychological disorders—are always compounded with social stigmatization and ostracism by the family and/or community, subsequent emotional distress, loss of status and the possibility to marry...'.[291]

Flexibility: The Istanbul Protocol states that a commission of inquiry's terms of reference must 'provide flexibility in the scope of the inquiry to ensure that thorough investigation by the commission is not hampered by overly restrictive or overly broad terms of reference. The necessary flexibility may be accomplished, for example, by permitting the commission to amend its terms of reference.'[292]

Procedural fairness

Involvement of the victim and access to evidence: The ECtHR has held that 'the victim must be involved to the extent necessary to safeguard their legitimate interests'.[293] The UN Principles on the Effective Investigation of Torture specify that: 'Alleged victims of torture or ill-treatment and their legal representatives must be informed of and have access to any hearing, have access to all information relevant to the investigation, and be entitled to present other evidence.'[294] The Istanbul Protocol states, similarly, that: 'Those alleging that they have been tortured and their legal representatives should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings reflects the especially important role his/her interests play in the conduct of the investigation...Parties to the inquiry should be allowed to submit written questions to the commission.'[295]

In the case of *Edwards v United Kingdom*,[296] the ECtHR found that the parents of a man killed in prison were denied their right to an effective investigation notwithstanding that an inquiry, chaired by independent experts and assisted by lawyers, was commissioned by the Prison Service, Essex County Council and North Essex Health Authority and sat for 10 months and heard from about 150 witnesses. The parents were not 'involved to the extent necessary to safeguard their interests' on the grounds that the inquiry was held in private and:

> The applicants, parents of the deceased, were only able to attend three days of the inquiry when they themselves were giving evidence. They were not represented and were unable to put any questions to witnesses, whether through their own counsel or, for example, through the Inquiry Panel. They had to wait until the publication of the

final version of the Inquiry Report to discover the substance of the evidence about what had occurred.[297]

Access to personal information: According to the Orentlicher Principles: 'All persons shall be entitled to know whether their name appears in State archives and, if it does, by virtue of their right of access, to challenge the validity of the information concerning them by exercising a right of reply. The challenged document should include a cross-reference to the document challenging its validity and both must be made available together whenever the former is requested. Access to the files of commissions of inquiry must be balanced against the legitimate expectations of confidentiality of victims and other witnesses testifying on their behalf'.[298]

Access to information about a deceased or disappeared family member: The Minnesota Protocol, which concerns potentially unlawful death, states that: 'Family members have the right to seek and obtain information on the causes of a killing and to learn the truth about the circumstances, events and causes that led to it. In cases of potentially unlawful death, families have the right, at a minimum, to information about the circumstances, location and condition of the remains and, insofar as it has been determined, the cause and manner of death.'[299]

Archival access rules and procedures more generally: The Set of General Recommendations for Truth Commissions and Archives published by the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence contends that truth commissions should, through their operations:

(d) Build provision for the eventual disposition of their records, guaranteeing both their safety and accessibility;

(e) Plan to deposit their archives, preferably in existing national archives, duly taking into account considerations of the security, integrity and accessibility of the archives;

(f) Stipulate that the access policy of truth commission archives should maximise public accessibility, while respecting applicable privacy concerns, including in particular assurances of confidentiality provided to victims and other witnesses as a precondition of their testimony;

(g) Note that maximising future accessibility has an impact on many operations of a commission throughout its lifetime, including, for example, on the process of taking statements and other contact with victims and witnesses who should be advised that their contributions to the commissions may be accessible in the future under specified conditions; and

(h) Establish guidelines for access to truth commission records, which shall take into account (among other things) general access rules, such as:

  (i) What was previously public should remain public;

  (ii) victims, families, investigative and prosecutorial authorities, as well as legal defence teams, should have unhindered access to information on their specific case;

  (iii) there should be a presumption of public access to all State information with only limited exceptions;

(iv) a procedure to make effective the right of access should be established; and

(v) whatever access rules are determined for various categories of potential users (for example, victims, legal representatives, journalists, academics, and members of the general public) should apply to all members of the given category without discrimination.

Rights of alleged wrongdoers: According to the Istanbul Protocol, all 'interested parties' should have an opportunity to be heard by a commission of investigation. It continues: 'All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves. There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.'[300] The Orentlicher Principles provide that '[b]efore a commission identifies perpetrators in its report, the individuals concerned shall be entitled to the following guarantees: (a) The commission must try to corroborate information implicating individuals before they are named publicly; (b) The individuals implicated shall be afforded an opportunity to provide a statement setting forth their version of the facts either at a hearing by the commission while conducting its investigation or through submission of a document equivalent to a right of rely for inclusion in the commission's file.'[301]

Framing of terms of reference: The Istanbul Protocol states that a commission of inquiry's terms of reference must be 'neutrally framed so that they do not suggest a predetermined outcome' and that '[t]o be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture'.[302]

Evaluation of evidence: The Istanbul Protocol provides that: 'The commission must assess all information and evidence it receives to determine reliability and probity. The commission should evaluate oral testimony, taking into account the demeanour and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanour. Corroboration of evidence from several sources will increase the probative value of such evidence and the reliability of hearsay evidence. The reliability of hearsay evidence must be considered carefully before the commission accepts it as fact. Testimony not tested by cross-examination must also be viewed with caution. In-camera testimony preserved in a closed record or not recorded at all is often not subject to cross-examination and, therefore, may be given less weight.'[303] The ECtHR has held that: 'the investigation's conclusions must be based on thorough, objective and impartial analysis of all relevant elements. Failing to follow an obvious line of inquiry undermines to a decisive extent the investigation's ability to establish the circumstances of the case and the identity of those responsible. Nevertheless, the nature and degree of scrutiny which satisfy the minimum threshold of the investigation's effectiveness depend on the circumstances of the particular case. The nature and degree of scrutiny must be assessed on the basis of all relevant facts and with regard to the practical relaities of investigation work.'[304]

Protection of the rights of those affected: further requirements

Written statements: The Istanbul Protocol states that: 'Commissions of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors are afraid to testify, cannot travel to proceedings or are otherwise unavailable. Commissions of inquiry should review other proceedings that could provide relevant information.'[305]

Public v private proceedings: The Istanbul Protocol acknowledges that while the proceedings of a commission of inquiry should generally be conducted in public, 'in-camera proceedings' may be necessary 'to protect the safety of a witness.'[306] The Protocol continues: 'In-camera proceedings should be recorded and the sealed, unpublished record kept in a known location. Occasionally, complete secrecy may be required to encourage testimony, and the commission may want to hear witnesses privately, informally or without recording testimony.'[307] The Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence on the gender perspective in transitional justice processes contends in relation to the design of truth commission hearings that: 'The risks of revictimization are high and must be taken into account when designing hearings. The informed consent of those who testify is essential.'[308] The Special Rapporteur adds that there must be 'protection and security measures in place to prevent the social exposure of victims and avoid inflicting further damage on them once they return to their communities.'[309] The Orentlicher Principles state, meanwhile, that '[e]ffective measures shall be taken to ensure the security, physical and psychological well-being and, where requested, the privacy of victims and witneses who provide information' to a commission.[310]The Orentlicher Principles specify that 'Victims and witnesses testifying on their behalf may be called upon to testify before the commission only on a strictly voluntary basis' and that: 'Information that might identify a witness who provided testimony pursuant to a promise of confidentiality must be protected from disclosure. Victims providing testimony and other witnesses should in any event be informed of rules that will govern disclosure of information provided by them to the commission. Requests to provide information to the commission anonymously should be given serious consideration, especially in cases of sexual assault, and the commission should establish procedures to guarantee anonymity in appropriate cases, while allowing corroboration of the information provided, as necessary.'[311]

Support to victims who testify: The Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence on the gender perspective in transitional justice processes states: ' Psychosocial support must be guaranteed before, during and after the hearing. Those who testify must be in a decent and safe environment, have support to prepare their testimonies and anticipate questions'.[312] The Orentlicher Principles specify that 'Social workers and/or mental health-care practitioners should be authorized to assist victims, preferably in their own language, both during and after their testimony, especially in cases of sexual assault' and that 'All expenses incurred by those giving testimony shall be borne by the State'.[313]

Medical examinations: The UN Principles state that 'Medical examinations conducted for investigative purposes must conform to established standards of medical practice and result in an accurate written report, communicated confidentially to the person affected.'[314]

Public scrutiny

Transparency: According to the ECtHR, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.[315] Transparency also assists victims' involvement as well as holding the investigation to account more broadly. As the Minnesota Protocol states:

> The right to know the truth extends to society as a whole, given the public interest in the prevention of, and accountability for, international law violations. Family members and society as a whole both have a right to information held in a state's records that pertains to serious violations, even if those records are held by security agencies or military or police units.
>
> Investigative processes and outcomes must be transparent, including through openness to the scrutiny of the general public and of victims' families. Transparency promotes the rule of law and public accountability, and enables the efficacy of investigations to be monitored externally. It also enables the victims, defined broadly, to take part in the investigation ... Any limitations on transparency must be strictly necessary for a legitimate purpose, such as protecting the privacy and safety of affected individuals, ensuring the integrity of ongoing investigations, or securing sensitive information about intelligence sources or military or police operations. In no circumstances may a state restrict transparency in a way that would conceal the fate or whereabouts of any victim of an enforced disappearance or unlawful killing, or would result in impunity for those responsible.[316]

Advertising, communication and partnerships: The Istanbul Protocol states that: 'Wide notice of the establishment of a commission and the subject of the inquiry should be given. The notice should include an invitation to submit relevant information and written statements to the commission and instructions to persons willing to testify. Notice can be disseminated through newspapers, magazines, radio, television, leaflets and posters.'[317] Highlighting the importance of proactively encouraging those affected—particularly women—to participate in the investigation, the UN Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence contends that:

> In cases of women victims of human rights violations in general, and sexual violence in particular, the problem of their self-identification as victims arises. Many women do not perceive the crimes committed against them as violations of their human rights or they diminish them by prioritizing the telling of the experiences of others, which entails making their own suffering invisible. In particular, in the case of sexual violence, silence prevails, not only because of feelings of guilt, shame or fear of being stigmatized

> or ostracized by the community, but also because of the conviction that any complaint would be futile owing to the lack of institutional protection, which highlights the extent of sexist cultural patterns...In the face of this and the risk of a possible distortion of the historical record, a proactive strategy of support and confidence-building is required to motivate women, lesbian, gay, bisexual and transgender persons and victims of sexual violence in general to provide statements.[318]

Cooperation of third countries

The Orentlicher Principles state that 'Third countries shall be expected to cooperate with a view to communicating or restituting archives for the purpose of establishing the truth.'[319] The ECtHR has held, similarly, in the Article 2 ECHR context, at least, that '[w]here there are cross-border elements to an incident of unlawful violence leading to loss of life...the authorities of the State...in which evidence of the offence could be located may be required by Article 2 to take effective measures in that regard, if necessary of their own motion.'[320]

5. The right to a remedy for Convention violations

The 2005 United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (Basic Principles) provide a framework that reflects and is reflected by Transitional Justice approaches and the position of the CAT regarding states' multi-layered obligations where gross and/or systematic abuses appear to have occurred. The Basic Principles state that they are based on the:

> right to a remedy for victims of violations of international human rights law found in numerous international instruments, in particular article 8 of the Universal Declaration of Human Rights, article 2 of the International Covenant on Civil and Political Rights, article 6 of the International Convention on the Elimination of All Forms of Racial Discrimination, article 14 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and article 39 of the Convention on the Rights of the Child.[321]

The right to an 'effective remedy' for breaches of ECHR rights is protected explicitly by Article 13 of the Convention.

According to the Basic Principles, in addition to meeting their investigative obligation states must provide the following remedies to victims of gross violations of international human rights law: (a) equal and effective access to justice; (b) adequate, effective and prompt reparation for harm suffered; and (c) access to relevant information concerning violations and reparation mechanisms.

Access to justice

States must ensure that victims of gross human rights violations have access to judicial remedies as well as administrative and other bodies that can provide a remedy to them. Accessibility requires: dissemination of 'information about all available remedies'; measures 'to minimize the inconvenience to victims and their representatives, protect against unlawful interference with their privacy as appropriate and ensure their safety from intimidation and retaliation'; the provision of 'proper assistance to victims seeking access to justice'; and procedures where possible 'to allow groups of victims to present claims for reparation and to receive reparation, as appropriate'.[322]

Reparation

The Basic Principles state that reparation 'should be proportional to the gravity of the violations and the harm suffered',[323] and furthermore: 'States should endeavour to establish national programmes for reparation and other assistance to victims in the event that the parties liable for the harm suffered are unable or unwilling to meet their obligations.'[324] Reparation for gross human rights violations has five elements, according to the Basic Principles: restitution, compensation, rehabilitation, satisfaction and guarantees of non-recurrence.

Restitution includes, 'as appropriate: restoration of liberty, enjoyment of human rights, identity, family life and citizenship, return to one's place of residence, restoration of employment and return of property.'[325]

Compensation should be provided, as appropriate and proportional to the gravity of the violation and the circumstances of each case, for any assessable damage including 'physical or mental harm; lost opportunities, including employment, education and social benefits; material damages and loss of earnings, including loss of earning potential; moral damage; and costs required for legal or expert assistance, medicine and medical services, and psychological and social services.'[326]

Rehabilitation 'should include medical and psychological care as well as legal and social services'.[327]

Satisfaction should include, where applicable:

> (*a*) Effective measures aimed at the cessation of continuing violations;
>
> (*b*) Verification of the facts and full and public disclosure of the truth to the extent that such disclosure does not cause further harm or threaten the safety and interests of the victim, the victim's relatives, witnesses, or persons who have intervened to assist the victim or prevent the occurrence of further violations;
>
> (*c*) The search for the whereabouts of the disappeared, for the identities of the children abducted, and for the bodies of those killed, and assistance in the recovery,

identification and reburial of the bodies in accordance with the expressed or presumed wish of the victims, or the cultural practices of the families and communities;

(*d*) An official declaration or a judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connected with the victim;

(*e*) Public apology, including acknowledgement of the facts and acceptance of responsibility;

(*f*) Judicial and administrative sanctions against persons liable for the violations;

(*g*) Commemorations and tributes to the victims;

(*h*) Inclusion of an accurate account of the violations that occurred in international human rights law and international humanitarian law training and in educational material at all levels.[328]

Guarantees of non-repetition should include, where applicable, any or all of the following measures, which will also contribute to prevention:

(*a*) Ensuring effective civilian control of military and security forces;

(*b*) Ensuring that all civilian and military proceedings abide by international standards of due process, fairness and impartiality;

(*c*) Strengthening the independence of the judiciary;

(*d*) Protecting persons in the legal, medical and health-care professions, the media and other related professions, and human rights defenders;

(*e*) Providing, on a priority and continued basis, human rights and international humanitarian law education to all sectors of society and training for law enforcement officials as well as military and security forces;

(*f*) Promoting the observance of codes of conduct and ethical norms, in particular international standards, by public servants, including law enforcement, correctional, media, medical, psychological, social service and military personnel, as well as by economic enterprises;

(*g*) Promoting mechanisms for preventing and monitoring social conflicts and their resolution;

(*h*) Reviewing and reforming laws contributing to or allowing gross violations of international human rights law and serious violations of international humanitarian law.[329]

Notably, archives are considered an important measure that can assist in meeting the requirements of satisfaction and guarantees of non-recurrence. In 2015, the UN Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence stated that:

> Archives containing records of mass violations can contribute to prevention. Access to well-preserved and protected archives is an educational tool against denial and revisionism, ensuring that future generations have access to primary sources, which is of direct relevance to history teaching. One notable example in this regard are the Stasi files opened up by Germany after 1989. Opening files contributes directly to the process of societal reform.[330]

> ...archives are relevant and can make significant contributions to each of the pillars of transitional justice, not merely truth and justice...Beyond the fact that transitional justice measures generate records themselves, truth commissions, trials, reparations programs and other transitional justice initiatives can contribute to improving archival practice both by the way they implement relevant standards with respect to their own documents, and because some of them, particularly truth commissions, are in a good position to make comments and recommendations about archival reform in general.[331]

In 2020, the UN Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence issued a report highlighting the obligation on states to protect and provide access to archives in order to ensure memorialisation of atrocities. The Special Rapporteur noted:

> Memorialization is linked to the ability to obtain access to archives. The most obvious risk is that some warring groups might deliberately seek to destroy documents that may be compromising or be used as evidence of serious violations of human rights and international humanitarian law. This desire to hide is not new: more than a century ago, King Leopold II of Belgium ordered the destruction of archives documenting the terrible violence committed under his authority in the Congo Free State. Since then, many Governments have tried to eradicate the traces of their crimes. The Special Rapporteur considers the protection of archives to be essential for enabling societies to learn the truth and regain ownership of their history.
>
> It is not enough to protect archives. All too often, State bodies linked to security structures refuse to cooperate fully with transitional justice mechanisms or to make their archives available. This has occurred in Morocco, where the Equity and Reconciliation Commission was denied access to certain archives belonging to the security services. In some countries, such as El Salvador, it is still practically impossible to obtain access

to military archives related to specific crimes, over 30 years after they occurred, owing to the lack of cooperation by the authorities who hold them. This contrasts with the exemplary attitude of the German authorities, who have opened the archives of the Stasi (the Ministry of State Security of the former German Democratic Republic).[332]

On the basis of international human rights law documents, the International Council on Archives' Human Rights Working Group has published Principles on the Role of Archivists and Records Managers in Support of Human Rights: A working document of the International Council on Archives.[333] The Principles recognise that:

> the enforcement of human rights and fundamental freedoms to which all persons are entitled under the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and its two Optional Protocols, the International Covenant of Economic, Social and Cultural Rights and other international treaties and legal instruments is strengthened by the preservation of archives and the ability of individuals to gain access to them;
>
> ...governments have the responsibility to promote and protect the right to seek and receive information as a fundamental prerequisite to ensuring public participation in governance;
>
> ...adequate protection of the human rights and fundamental freedom to which all persons are entitled, be they economic, social and cultural, or civil and political, requires that all persons have effective access to archival services provided by independent archival professionals; and
>
> ...professional associations of archivists and records managers have a vital role to play in upholding professional standards and ethics, providing archival services to all in need of them, and cooperating with governmental and other institutions in furthering the ends of justice and the public interest.[334]

Among the particular obligations established by the Principles are the following:

- Institutions, archivists and records managers should ensure that the management of archives documenting human rights violations preserves the integrity of the archives and their value as evidence. This means that archive management systems need to ensure that the archives can be proven to be genuine, are accurate and can be trusted, are complete and unaltered, secure from unauthorised access, alteration and deletion, can be found when needed, and are related to other relevant archives;[335]

- Governments and private institutions should ensure the provision of sufficient funding and other resources for the professional management of human rights archives;[336]

- Archivists should describe archival holdings in ways that enable users to understand whether the archives might contain information that would be useful in exercising a human rights claim, with particular regard to information concerning gross human rights violations, information that would help resolve the fate of missing persons, or information that may enable individuals to seek compensation for past violations;[337]

- Archivists and records managers should advocate for and support the right of access to government archives and encourage non-governmental institutions to provide similar access to their archives;[338]

- Institutions, archivists and records managers should ensure that safeguards are in place to protect personal information from unauthorised access, in order to ensure respect for rights, fundamental freedoms and the dignity of persons to whom the information relates;[339]

- Archivists should provide services without discrimination; all persons are entitled to call upon the assistance of an archivist to help them locate and retrieve archives that may enable them to establish their rights;[340]

- Archivists or records managers who, in the course of their professional activity, discover archives that they in good faith and on reasonable grounds believe contain evidence of gross violations of internationally recognized human rights that (a) are ongoing or (b) for which victims might seek compensation, should inform pertinent authorities about the existence of such archives;[341] and

- Where there exist groups or communities whose needs for archival services are not met, particularly where such groups have been the victims of discrimination, governments, professional associations of archivists and records managers, archival and educational institutions and individual professionals should take special measures to provide opportunities for persons from these groups to enter the archival profession and should ensure that they receive training appropriate to the needs of their groups.[342]

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[1] International Labour Organization (ILO), *Forced Labour Convention, C29*, 28 June 1930 (entered into force 1 May 1932).
[2] Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11, 14 and 15*, 4 November 1950, ETS 5 (entered into force 3 September 1953).
[3] ILO, *Convention Concerning the Abolition of Forced Labour*, 25 June 1959 (entered into force 17 January 1959).
[4] UN Economic and Social Council (ECOSOC), *Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery*, 7 September 1956 (entered into force 30 April 1957).
[5] UN General Assembly (UNGA), *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13 (entered into force 3 September 1981).
[6] UNGA, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85 (entered into force 26 June 1987).

[7] UNGA, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3 (entered into force 2 September 1990).
[8] UNGA, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106 (entered into force 3 May 2008)
[9] *Kotov v Russia* App no 54522/00 (ECtHR, 3 April 2012) para 92, citing *Costello-Roberts v United Kingdom* App no 13134/87 (ECtHR 25 March 1993) para 27.
[10] International Law Commission Articles on Responsibility of States for Internationally Wrongful Acts, annex to General Assembly resolution 56/83 of 12 December 2001, and corrected by document A/56/49(Vol. I)/Corr.4, Chapter II).
[11] In *O'Keeffe v Ireland* (2014) 59 EHRR 15 the ECtHR noted that 'this Court's case-law confirmed, as early as its fifth judgment, that the Convention could impose positive obligations on States' (para 147).
[12] UN Human Rights Committee (HRC), *Jegatheeswara Sarma v Sri Lanka* , Communication No. 950/2000 (16 July 2003), UN Doc. CCPR/C/78/D/950/2000 para 9.4.
[13] *Jovanowiec and Others v Russia*, Apps nos 55508/07 and 29520/08 (ECtHR, 21 October 2013) paras 146-147; see also *Silih v Slovenia* App no 71463/01 (ECtHR, 9 April 2009) para 163.
[14] UN Committee Against Torture (CAT), General comment no. 3, 2012: Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment : implementation of article 14 by States parties, 13 December 2012 para 40.
[15] The CAT's multiple Concluding Observations directed at the UK and Ireland in relation to the Magdalene and Mother and Baby institutions, and its admissibility decision in *Elizabeth Coppin v Ireland* (UN Doc CAT/C/68/D/879/2018, 14 January 2020), demonstrate that as of the date of the UNCAT's coming into force, those who have suffered in the past are included in the obligations under articles 12, 13 and 14.
[16] CAT, General comment no. 3, 2012 : Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment : implementation of article 14 by States parties, 13 December 2012 para 3.
[17] *Mocanu v Romania* (2015) 60 EHRR 19 para 261.
[18] *O'Keeffe v Ireland* (2014) 59 EHRR 15; *Mocanu v Romania* (2015) 60 EHRR 19.
[19] *Mocanu v Romania* (2015) 60 EHRR 19 para 265.
[20] *In the matter of an application by Brigid McCaughey and another for Judicial Review (Northern Ireland)* (2011) UKSC 20, Phillips LJ paras 50-51, 59, 62.
[21] United Nations Declaration on the Protection of All Persons from Enforced Disappearances, UNGA Res 47/133 (1 December 1992) UN Doc A/RES/47/133.
[22] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013) para 47.
[23] Ibid para 71 (references within the paragraph to earlier paragraphs in the judgment which establish these facts are omitted).
[24] United Nations Declaration on the Protection of All Persons from Enforced Disappearances, UNGA Res 47/133 (1 December 1992) UN Doc A/RES/47/133, Article 17(1).
[25] *Varnava and others v Turkey* App nos 16064/90, 16065/90, 16066/90, 16068/90, 16069/90, 16070/90, 16071/90, 16072/90 and 16073/90 (ECtHR, 18 September 2009) [GC] para 148.
[26] *Janowiec v Russia* (2014) 58 EHRR 30 para 178.
[27] *Varnava and others v Turkey* App nos 16064/90, 16065/90, 16066/90, 16068/90, 16069/90, 16070/90, 16071/90, 16072/90 and 16073/90 (ECtHR, 18 September 2009) para 200.
[28] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013) para 70. Note that the unmarried mother's constitutional right to the custody of her child has been recognised by the Irish courts as an unenumerated right: *G v An Bord Uachtala* [1980] IR 32. See also *I.O'T v. B* [1998] 2 IR 321. The ECtHR has also held that Article 8 protects the right to know and be cared for by one's parents: *B v United Kingdom* (1987) 10 EHRR. 87.
[29] *Custafa and Armagan Akin v Turkey* App no 4694/03 (ECtHR, 6 July 2010), para 19; *Boughanemi v France* App no 22070/93 (ECtHR, 24 April 1996) para 35.
[30] *Butt v Norway* App no 47017/09 (ECtHR, 4 March 2013) paras 4, 76; *Jucius and Juciuviene v Lithuania* App no 14414/03 (ECtHR, 25 February 2009) para 27.
[31] However the ECtHR frequently notes that 'the existence or non-existence of "family life" is essentially a question of fact depending upon the real existence in practice of close personal ties': deriving from *K and T v Finland* App no 25702/94 (ECtHR, 12 July 2001) para 150.
[32] Council of Europe: Commissioner for Human Rights, *Missing persons and victims of enforced disappearance in Europe*, March 2016, 17-18: 'Enforced disappearance is a crime under international law and a violation of multiple human rights, including the right to personal liberty and security, the right to recognition as a person before the law, the right not to be subjected to torture or other cruel, inhumane or degrading treatment or punishment, the right to a fair trial, and the right to life. Enforced disappearance also violates the economic, social and cultural rights of the disappeared person and his or her family.' See also Working Group on Enforced

or Involuntary Disappearances (WGEID), 'Study on enforced or involuntary disappearances and economic, social and cultural rights', UN Doc A/HRC/30/38/Add.5 (9 July 2015).
[33] *Kurt v Turkey* (1999) 27 EHRR 373; *Bazorkina v Russia* (2008) 46 EHRR 15; HRC, *María del Carmen Almeida de Quinteros et al v Uruguay*, Communication No 107/1981 (21 July 1983) UN Doc CCPR/C/OP/2.
[34] *Gasin v UK* (1989) 12 EHRR 36; *Odievre v. France* App No 42326/98 (ECtHR, 13th February 2003) and *Godelli v Italy* App No 33783/09 (ECtHR, 25 September 2012); Irish Human Rights Commission, *Assessment of the Human Rights Issues Arising in relation to the "Magdalen Laundries"* November 2010.
[35] *SH v Austria* (2011) 52 EHRR 6 para 83.
[36] *Gaskin v United Kingdom* (1990) 12 EHRR 36.
[37] Ibid para 36.
[38] *Barthold v Germany* A 90 (1985); 7 EHRR 383 para 46.
[39] *Sunday Times v United Kingdom (No 1)* A 30 (1979); 2 EHRR 245 para 49.
[40] *Silver and Others v UK* A 61 (1983); 5 EHRR 347 paras 87-88.
[41] *Sunday Times v United Kingdom (No 1)* A 30 (1979); 2 EHRR 245 para 49.
[42] *Silver and Others v United Kingdom* A 61 (1983); 5 EHRR 347 para 80.
[43] *Al-Nashif v Bulgaria* Hudoc (2002); 36 EHRR 655 paras 119-123.
[44] *Handyside v UK* A 24 (1976) para 49; 1 EHRR 737.
[45] *Hirst v United Kingdom (No 2)* App no 74025/01 (ECtHR, 6 October 2005) para 79.
[46] *Mouvement Raelien Suisse v Switzerland* App no 16354/06 (ECtHR, 13 July 2012) para 75.
[47] *Soering v United Kingdom* (1989) 11 EHRR 439 para 89; *N v United Kingdom* (2008) 47 EHRR 39.
[4848] *Marckx v Belgium* (1980) 2 EHRR 330.
[49] *Gaskin v United Kingdom* (1990) 12 EHRR 36.
[50] *Mikulic v Croatia* App no 53176/99 (ECtHR, 7 February 2002).
[51] Ibid para 65.
[52] *Jäggi v. Switzerland* App no. 58757/00 (ECtHR, 13th October 2006).
[53] Ibid para 38.
[54] Ibid para 40.
[55] Ibid para 38.
[56] Ibid para 41.
[57] Ibid para 42.
[58] *Mahelet Getye Habte v Minister for Justice and Equality* [2020] IECA 22 (Power J) para 31.
[59] *Pannullo and Forte v France* App no 37794/97 (ECtHR, 30 October 2001), *Girard v France* App no 22590/04 (ECtHR, 30 June 2011). See for discussion of these cases, Geoffrey Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (Department of Children, Equality, Disability, Integration and Youth, 2018) 32-33. See also the discussion in 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* (Justice For Magdalenes Research, Adoption Rights Alliance, Hogan Lovells, 15 October 2018) 114 of the following cases: *Hadri-Vionnet v Switzerland*, App No 55525/20 (ECtHR, 14 February 2008); *Sabanchiyeva and Others v. Russia* App no 38450/05 (ECtHR, 6 June 2013); *Maskhadova and Others v Russia* App no 18071 (ECtHR, 6 June 2013).
[60] *Hadri-Vionnet v Switzerland* App no 55525/00 (ECtHR, 14 February 2008).
[61] *Znamenskaya v. Russia* App no. 77785/01 (ECtHR, 2nd June 2005).
[62] Ibid para 29.
[63] Ibid para 30.
[64] *Fatullayev v. Azerbaijan* App No 40984/07 (ECtHR, 22 April 2010) para 87; *Monnat v Switzerland* App No 73604/01 (ECtHR, 21 September 2006) para 57.
[65] *Kenedi v Hungary* App no 31475/05 (ECtHR, 26 August 2009).
[66] Ibid apara 43.
[67] *Dink v Turkey* Apps Nos 2668/07, 6102/08, 30079/08, 7072/09 and 7124/09 (ECtHR, 14 September 2010) para 137, translated and summarised in Council of Europe/European Court of Human Rights, Research Report: Positive obligations on member States under Article 10 to protect journalists and prevent impunity, December 2011, 5.
[68] *Mazurek v France* (2006) 42 EHRR 9; *Marckx v Belgium,* Series A, No. 31 (1979) 2 EHRR 330.
[69] *Johnston v Ireland* (1986) 9 EHRR 203.
[70] *Quinn's Supermarket v. Attorney General* [1972] IR 1 p13.
[71] Council of Europe, *Guide to good practice in respect of domestic remedies (adopted by the Committee of Ministers on 18 September 2013)* (2013) 31.
[72] *Nuri Kurt v Turkey* (2007) 44 EHRR 36, para 117.

[73] HRC, General Comment No. 36: Article 6 (Right to Life), UN Doc CCPR/C/GC/35 (3 September 2019) paras 21, 17.
[74] *Fernandes v Portugal* App No 43098/09 (ECtHR, 15 December 2015) para 70. See also *Tunç v Turkey* App no 24014/05, (ECtHR, 25 June 2013) para 171; *McCaughey v United Kingdom* App No 43098/09 (ECtHR, 15 December 2015).
[75] *Salman v Turkey* (2002) 34 EHRR 425 para 99.
[76] *Musayeva v Russia* (2008) 47 EHRR 25 para 77.
[77] *Oneryildiz v Turkey* (2005) 41 EHRR 20 para 93
[78] 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, p1.
[79] *Anguelova v Bulgaria* App no 38361/97 (ECtHR, 13 June 2002) para 137.
[80] *Makaratzis v Greece* (2005) 41 EHRR 49 para 57 .
[81] See for example *Oneryildiz v Turkey* (2005) 41 EHRR 20; *Osman v United Kingdom* (2000) 29 EHRR 245; *Opuz v Turkey* (2010) 50 EHRR 28.
[82] *Nencheva and Others v Bulgaria* App no 48609/06 (ECtHR, 18 June 2013).
[83] *Aksoy v Turkey* (1997) 23 EHRR 553 para 98; *Assenov and Others v Bulgaria* (1999) 28 EHRR 652 para 98; *Kaya v Turkey* (1999) 28 EHRR 1 para 107.
[84] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entered into force 26 June 1987) 1465 UNTS 85 (UNCAT), Article 1.
[85] CAT, General Comment no 2. *Implementation of Article 2 by State Parties,* UN Doc CAT/C/GC/2, 24 January 2008, para 18.
[86] Ibid.
[87] Ibid para 19.
[88] Ibid para 3.
[89] Ibid para 18.
[90] HRC, General Comment No 31, *'The Nature of the General Legal Obligation Imposed on States Parties to the Covenant'* UN Doc CCPR/C/21/Rev.1/Add.13 (29 March 2004) para 8.
[91] *97 Members of the Gldani Congregation of Jehovah's Witnesses and 4 Others v Georgia* (2008) 46 EHRR 30.
[92] Ibid para 96, citing *Pretty v United Kingdom* (2002) 35 EHRR 1 paras 50–51; *Okkalı v Turkey* App no 52067/99 (ECtHR, 17 October 2006) para 70; *Mubilanzila Mayeka and Kaniki Mitunga v Belgium* (2008) 46 EHRR 23 para 53.
[93] *Kudla v Poland* (2002) 35 EHRR 11 para 9.
[94] See, for example, HRC General Comment No 20, *'Article 7 (Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment)'* UN Doc HRI/GEN/1/Rev 9 (Vol I) (10 March 1992) paras 2, 5. See also David Harris and others, *Law of the European Convention on Human Rights* (3rd edn, Oxford University Press 2014) 238, citing *Ireland v United Kingdom* [1978] 2 EHRR 25 para 167; *Tyrer v United Kingdom* (1979–80) 2 EHRR 1; *Campbell and Cosans v United Kingdom* (1982) 4 EHRR 293; *Soering v United Kingdom* (1989) 11 EHRR 439.
[95] See, for example, HRC, *Sarma, Jegatheeswara v Sri Lanka,* Communication No 950/2000 (16 July 2003) UN Doc CCPR/C/78/D/950/2000 para 9.5; HRC, *Natalia Schedko v Belarus*, Communication No 886/1999 (3 April 2004) UN Doc CCPR/C/77/D/886/1999; HRC, *Mariam Sankara et al v Burkina Faso*, Communication No 1159/2003 (28 March 2006) UN Doc CCPR/C/86/D/1159/2003.
[96] See, for example, *Kurt v Turkey* (1999) 27 EHRR 373; *Gongadze v Ukraine* (2006) 43 EHRR 967; *Bazorkina v Russia* (2008) 46 EHRR 15; *Yandiyev and others v Russia* App nos 34541/06, 43811/06 and 1578/07 (ECtHR, 10 October 2013). In *Çakici v Turkey* (2001) 31 EHRR 5, however, the ECtHR held (at para 98) that an Article 3 violation in respect of a relative of a 'disappeared' person 'will depend on the existence of special factors which gives the suffering of the applicant a dimension and character distinct from the emotional distress which may be regarded as inevitably caused to relatives of a victim of a serious human rights violation.'
[97] *Aydin v Turkey* (1998) 25 EHRR 251 para 83.
[98] *Aksoy v Turkey*, App No 21987/93 (ECtHR, 18 December 1996) para 63.
[99] UNCAT Article 1; see also CAT, *General Comment No 2, Implementation of article 2 by State parties*, UN Doc CAT/C/GC/2 (24 January 2008) para 10.
[100] CAT, *General Comment No. 2*, ibid para 9.
[101] Ibid para 20.
[102] UNHRC, *'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Méndez'* (1 February 2013) UN Doc A/HRC/22/53 para 20.
[103] Fedotov v Russia (2007) 44 EHRR 26.
[104] David Harris and others, *Law of the European Convention on Human Rights* (4th edn, Oxford University Press 2018) 244.
[105] Harris and others, ibid 256-7.

[106] Ibid 257.
[107] *VK v Russia* App no 68059/13 (ECtHR, 7 March 2017).
[108] Ibid para 172. See also *Z and Others v United Kingdom*, (2002) 34 EHRR 3: *M and M v Croatia*, App no. 10161/13 (ECtHR, 3 September 2015) paras 131-135.
[109] *Jalloh v Germany* (2007) 44 EHRR 32 para 68.
[110] *Price v United Kingdom* (2002) 34 EHRR 53 para 24; *Peers v Greece* (2001) 33 EHRR 51 paras 67, 68, 74.
[111] *Price v United Kingdom* (2002) 34 EHRR 53 para 30.
[112] *East African Asians v United Kingdom* (1973) 3 EHRR 76. See also *Abdulaziz, Cabales and Balkandali v UK* (1985) 7 EHRR 471.
[113] *VC v Slovakia* Application no. 18968/07 (ECtHR, 8 November 2011) para 106-7.
[114] *Yazgul Yilmaz v Turkey* App no 36369/06 (ECtHR 1 February 2011); see ECtHR's Information Note on the Court's case-law No. 138 February 2011.
[115] *Aydin v Turkey* App No 23178/94 (ECtHR, 25th September 1997) para 83.
[116] *VC v Slovakia* (2014) 59 EHRR 29.
[117] Ibid para 117.
[118] Ibid para 112.
[119] Ibid para 114.
[120] Ibid para 118
[121] Ibid para 106.
[122] *N v Sweden* App no 23505/09 (ECtHR, 20 July 2010).
[123] Ibid para 55.
[124] Ibid para 59.
[125] Ibid para 62.
[126] CAT, *General Comment No. 2: Implementation of Article 2 by State Parties,* UN Doc CAT/C/GC/2 (24 January 2008) para 21.
[127] *Opuz v Turkey* (2010) 50 EHRR 28 para 160.
[128] Ibid para 168.
[129] See for example *O'Keeffe v Ireland* (2014) 59 EHRR 15; *Z and Others v United Kingdom* (2002) 34 EHRR 3; *Tarakhel v Switzerland* (2015) 60 EHRR 28 para 119; IACtHR, '*Juvenile Reeducation Institute' v Paraguay*, Judgment of 2 September 2004 (Preliminary Objections, Merits, Reparations and Costs) Series C No 112 paras 163, 212; *Aydin v Turkey* (1998) 25 EHRR 251 para 84; *Rahimi v Greece*, App no 8687/08 (ECtHR, 5 July 2011).
[130] In *O'Keeffe v Ireland (2014)* 59 EHRR 15 the ECtHR explained at para 144: 'This positive obligation to protect is to be interpreted in such a way as not to impose an excessive burden on the authorities, bearing in mind, in particular, the unpredictability of human conduct and operational choices which must be made in terms of priorities and resources. Accordingly, not every risk of ill-treatment could entail for the authorities a Convention requirement to take measures to prevent that risk from materialising. However, the required measures should, at least, provide effective protection in particular of children and other vulnerable persons and should include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.' See also *Opuz v Turkey* (2010) 50 EHRR 28 para 159 and *A v United Kingdom* (1999) 27 EHRR 611 para 22.
[131] *O'Keeffe v Ireland* (2014) 59 EHRR 15 para 145.
[132] *O'Keeffe v Ireland* (2014) 59 EHRR 15 paras 144–148, 168–169.
[133] See,for example, HRC General Comment No 21, *'Article 10 (Humane treatment of persons deprived of their liberty)'* UN Doc HRI/GEN/1/Rev 9 (Vol 1) (10 April 1992) para 3; *MS v United Kingdom* (2012) 55 EHRR 23; *Bouyid v Belgium* (2016) 62 EHRR 32 para 107; IACtHR, *'Street Children' (Villagran Morales et al) v Guatemala*, Judgment of 19 November 1999 (Merits) Series C No 63 para 166; IACtHR, *Laoyza Tamayo v Peru* para 57.
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[135] *Ribitsch v Austria,* App no 18896/91(ECtHR, 4 December 1995) para 38.
[136] *Bures v Czech Republic,* App no 37679/08 (ECtHR, 18 October 2012) paras 78, 80.
[137] *Council of Europe Convention on preventing and combating violence against women and domestic violence*, Istanbul 11.V. 2011, Article 3.
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[139] See, for example, *Nevmerzhitsky v Ukraine* App no 54825/00 (ECtHR, 5th April 2005) paras 86–87; APT and CEJIL, *Association for the Prevention of Torture and Center for Justice and International Law, 'Torture in International Law: A Guide to Jurisprudence' (2008)* 185; HRC, *Womah Mukong v Cameroon*, Communication No 458/1991 (21 July 1994) UN Doc CCPR/C/51/D/458/1991 para 9.

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[141] *Mubilanzila Mayeka and Kaniki Mitunga v Belgium* App no 13178/03 (ECtHR, 12 October 2006) paras 50–59.
[142] UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc A/HRC/22/53 (1 February 2013) para 70.
[143] UN Human Rights Council, *Report of the Special Rapporteur on torture*, ibid para 70, citing *Mouisel v France,* App no. 67263/01 (ECtHR 14 November 2002), and Nell Monroe, *'Define acceptable: how can we ensure that treatment for mental disorder in detention is consistent with the UN Convention on the Rights of Persons with Disabilities?'* (2012) 16(6) The International Journal of Human Rights 902.
[144] *Mouisel v France,* App no. 67263/01 (ECtHR 14 November 2002), para 48.
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[166] Ibid para 123 citing *Van Droogenbroeck v Belgium*, Commission's report of 9 July 1980, Series B no. 44, p. 30, paras 78-80.
[167] *Siliadin v France* App no 73316/01 (ECtHR, 26 July 2005) para 124.
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[169] Ibid paras 126-127.
[170] *Kurt v Turkey* (1999) 27 EHRR 373 para 104.
[171] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013).
[172] *Mentes and Others v Turkey* (1998) 26 EHRR 595 para 89.
[173] See for example *Quinn v France* App No 18580/91 (ECtHR, 22 March 1995); *Labita v Italy* App No 26772/95 (ECtHR, 6 April 2000); Irish Human Rights Commission, *Follow-Up Report on State Involvement with Magdalen Laundries* (June 2013), Chapter 3.
[174] See for example, *Creanga v Romania* App No 29226/03 (ECtHR, 23 February 2012); *Medvedyev and Others v France* App No 3394/03 (ECtHR, 29 March 2010).
[175] *Saadi v United Kingdom* (2008) 47 EHRR 17 paras 67-74; *Khodorkovskiy v Russia* (2011) 53 EHRR 1103 para 142.
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[177] *Wassink v Netherlands* App no 12535/86 (ECtHR, 27 September 1990) paras 33 and 34.
[178] *Varbanov v Bulgaria* App no 31365/96 (ECtHR, 5 October 2000) paras 46-49.
[179] *Mihailovs v Latvia* App no 35939/10 (ECtHR, 22 January 2013) paras 149-150.
[180] ECHR Article 5(2). Those reasons must clarify for the person concerned the legal and factual grounds for the deprivation of liberty, so that the person can apply to a court to challenge the lawfulness of the arrest or detention. See *Fox, Campbell and Hartley v United Kingdom* App Nos 12244/86; 12245/86; 12383/86 (ECtHR, 30 August 1990); see also IHRC *Follow-Up Report on Magdalen Laundries* Chapter 3; see also *M v Ukraine* App no 2452/04 (ECtHR, 19 April 2012) paras 55-67.
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[182] *Stanev v Bulgaria* App no 36760/06 (ECtHR, 17 January 2012) para 171.
[183] Ibid para 120.
[184] *Storck v Germany* (2005) 43 EHRR 96 para 102.
[185] Ibid.
[186] *Stanev v Bulgaria* (2012) 55 EHRR 22 para 115.
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[190] *HL v United Kingdom* (2005) 40 EHRR 32 para 92, citing *Ashingdane v the United Kingdom* (1985) 7 EHRR 528 para 41.
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[193] *Kedzior v Poland*, App no 45026/07 (ECtHR, 16 October 2012) para 57. The Court referred also to *Stanev v Bulgaria* (2012) 55 EHRR 22 para 128.
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[195] Ibid para 125–26.
[196] Ibid para 127; *DD v Lithuania* App no 13469/06 (ECtHR, 14 February 2012) para 146.
[197] *HL v United Kingdom* (2005) 40 EHRR 32.
[198] Irish Human Rights Commission, *Follow Up Report on State Involvement with Magdalen Laundries* (June 2013) 46.
[199] Ibid 46-47.
[200] Ibid 47.
[201] Ibid 51.
[202] Ibid 51.
[203] Ibid 60.
[204] Ibid 66.
[205] *Zorica Jovanovic v Serbia* App no 21794/08 (ECtHR, 26 March 2013) para 71 (references within the paragraph to earlier paragraphs in the judgment which establish these facts are omitted).
[206] Ibid para 74.
[207] *Mentes and Others v Turkey* App no 23186/94 (ECtHR, 28 November 1997).
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[212] *B v United Kingdom* (1987) 10 EHRR 87.
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[215] *Keegan v Ireland* App no 16969/90 (ECtHR, 26 May 1994) para 50.
[216] *Strand Lobben and Others v Norway* App no 37283/13 (ECtHR, 10 September 2019).
[217] Ibid para 209.
[218] *W v United Kingdom* (1987) 10 EHRR 313.
[219] *Keegan v Ireland*, App No 16969/90 (ECtHR, 26 May 1994).
[220] *AK and L v Croatia* App no 37956/11 (ECtHR, 8 January 2013).
[221] Ibid para 72.
[222] *Juhnke v Turkey* App no 52515/99 (ECtHR, 13 May 2008).
[223] Ibid para 77.
[224] Ibid para 76.
[225] Ibid para 77.
[226] Ibid.
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[228] *DG v An Bord Uchtála* [1996] ILFR 263. Subsequently affirmed in an *ex tempore* SC judgment delivered on 11th July 1996.
[229] *DG v An Bord Uchtála* [1996] ILFR 263.
[230] *Juhnke v Turkey* App no 52515/99 (ECtHR, 13 May 2008).
[231] See for example *Hadri-Vionnet v Switzerland*, App No 55525/20 (ECtHR, 14 February 2008); *Girard v France*, App No 22590/04 (ECtHR, 20 June 2011); *Pannullo and Forte v France*, App no 37794/97 (ECtHR, 30 October 2001); *Sabanchiyeva and Others v. Russia* App no 38450/05, (ECtHR, 6 June 2013); *Maskhadova and Others v. Russia* no. 18071, (ECtHR, 6 June 2013).

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[233] *Maric v Croatia* App no 50132/12 (ECtHR, 12 June 2014).
[234] *Petrova v Latvia* App no 4605/05 (ECtHR, 24 June 2014). Discussed in Geoffrey Shannon, *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway* (Department of Children, Equality, Disability, Integration and Youth, Shannon, 2018) 39.
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[254] *El Masri v Macedonia* (2013) 57 EHRR 25, paras 183-185; See also *Assenov v Bulgaria* (1999) 28 EHRR 652 para 103 ; and ***Batı v Turkey*** (2006) 42 EHRR37 para 136 (extracts).
[255] See ***Tanrıkulu v Turkey*** (2000) 30 EHRR950 para 104; and *Gül v Turkey* (2002) 34 EHRR28 para 89.
[256] See *Boicenco v Moldova* App no 41088/05 (ECtHR, 11 July 2006) para 123.
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[284] UN Commission on Human Rights, Updated Set of principles for the protection and promotion of human rights through action to combat impunity, UN Doc E/CN.4/2005/102/Add.1 (8 February 2005), Principle 14.
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MOTHER AND BABY HOMES COMMISSION OF INVESTIGATION

FIFTH INTERIM REPORT

15TH MARCH 2019

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Appendix A:	Report on the Findings from the Geophysical Surveys of the Memorial Garden, Tuam ,13th November 2015
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Introduction

1. One of the major factors in the decision to establish this Commission of Investigation was the controversy about the burial practices at the Tuam Children's Home. As is now very well known, Catherine Corless established that the deaths of almost 800 children in the Tuam Home had been registered but there was no register of the burials of these children. She concluded that they were probably buried in the grounds of the former Home. The location and the manner of these burials became a major controversy.

2. The Terms of Reference of the Commission include, among other things,
"To investigate post-mortem practices and procedures in respect of children or mothers who died while resident in these institutions, including the reporting of deaths, burial arrangements and transfer of remains to educational institutions for the purpose of anatomical examination;"

3. This report is concerned with the burial arrangements in the main institutions under investigation and with the transfer of remains to educational institutions for the purpose of anatomical examination. It is limited to burials and does not include any analysis of the causes of deaths or the registration of deaths. These issues will be dealt with in the final report.

Other institutions being investigated

4. The other institutions being investigated by the Commission are not covered in this report for a variety of reasons. Some of the other institutions do not have significant issues relating to burials either because they did not have any, or any significant number of, deaths or because the deaths did not occur in the institutions and the responsibility for burial did not lie with the institutions (for example, Dunboyne, the Castle). There is very little information available about deaths in some institutions (for example, Kilrush). The Commission's investigation of Regina Coeli is not yet sufficiently advanced. The deaths in all the institutions will be analysed in the Commission's final report and any further information on burials will also be included.

Terminology

5. The Commission is acutely conscious of the hurt that is often caused to former residents and their families when they come across words and terms that are no

longer acceptable. The Commission is writing a historical document so it is not possible to completely avoid using such terms.

"Illegitimate"

6. The term "illegitimate" is not acceptable and should never have been applied to any child. However, the fact is that it was used on official documentation until 1988 when the *Status of Children Act 1987* came into effect. The descriptions "legitimate" and "illegitimate" are used in very many of the documents being analysed by the Commission. In many cases, it is the description "illegitimate" which allows the Commission to correctly identify the children covered by its Terms of Reference.

"Home"

7. Former residents often object to the use of the word "Home" to describe the institutions. The Commission understands this and recognises that these were institutions and not "homes" in the normal meaning of the word. However, the Commission uses the historically correct title, for example, the Tuam "Children's Home". Pelletstown was the original name of St Patrick's, Navan Road. The Commission uses Pelletstown in order to avoid confusion with all the other institutions such as industrial schools and hospitals which are also called St Patrick's.

Burial ground

8. "Burial ground", "graveyard" and "cemetery" are usually regarded as synonyms nowadays. In the past, the words cemetery and graveyard applied to a designated burial area. A cemetery was generally a large burial ground especially one not in a churchyard. A graveyard generally adjoined a church. The governing legislation uses the more general term "burial ground" and this is the term used by the Commission.

Context

9. The Commission is conscious that this report is not placed in the social and economic context of the times as the final report will be. Some background information is given on the institutions in order to clarify their particular roles and who was responsible for burials. Neither Pelletstown nor Tuam was exclusively a home for unmarried mothers and their babies. Pelletstown was used to house orphans, abandoned children (who may have been "legitimate" or "illegitimate") and very sick children. Tuam was used to house homeless families and children of married parents who were unable to care for them. "Legitimate" children who were resident

in an institution with a parent are not within the Commission's Terms of Reference but those who were resident without a parent are. Bessborough, Castlepollard, Sean Ross and Bethany were almost exclusively mother and baby homes. Pelletstown and Tuam were local authority institutions while the others were private institutions.

Burials of children in non-institutional settings

10. The Commission has tried to establish what were the general practices in relation to the burial of children who died in the community in the first half of the 20th century but has had difficulty in finding solid evidence on the subject. There is anecdotal evidence that sometimes children who died were placed in a coffin with an adult. Similarly, there is anecdotal evidence that very small children were not buried in standard coffins but were either shrouded or placed in a small box. It is possible that children who were born at home and died very soon after birth had neither their births nor their deaths registered and were buried privately by their families.

Stillbirths

11. It is well established that stillborn children and unbaptised children were not generally buried in consecrated grounds but in cillíní. Sometimes the cillín was just outside the walls of a recognised burial ground. (Cillíní may also have been used for people who were not considered to be entitled to a Christian burial in a consecrated burial ground, for example, people who died by suicide.) It is very likely that all children who were born in mother and baby homes were baptised. There were stillbirths in the institutions being investigated. Stillbirths from Bethany were buried in Mount Jerome but it is not clear where stillbirths from the other institutions were buried. It seems unlikely that they were buried in the same place as baptised children.

12. It was standard practice in Dublin maternity hospitals for the hospital to arrange the burial of a stillborn child (regardless of status) without reference to the parent(s). This practice lasted at least until the 1950s.

13. It was not possible to register stillbirths until 1995.[1] Maternity homes were obliged to report the numbers of stillbirths to the Department of Local Government and Public Health (later the Department of Health).

[1] The *Stillbirth Registration Act 1994* came into effect on 1 January 1995.

Numbers of deaths

14. In analysing the information available about mothers and children who were resident in the various institutions, the Commission has paid particular attention to the deaths, the numbers involved, whether or not they were reported to other authorities when that was a requirement (for example, to the Department of Local Government and Public Health (later the Department of Health), the local health authority or the Coroner) and to the Registrar of Deaths. This involves very detailed examination of information from a number of sources, for example, the General Register Office (GRO) and returns made to the Department of Local Government and Public Health and then matching that information with the information compiled within the institutions. This exercise is complex for many reasons not least the sometimes different names and/or variations on spelling recorded in the different documents. These differences arise in some cases from the deliberate use of different names in order to maintain privacy or secrecy. More often, they arise because of different versions of the same name or simple errors such as mistakes in dates. The difficulties presented by the use of different names are described in Chapter 16 of the *Report of the Inter-Departmental Committee to establish the facts of State involvement with the Magdalen Laundries.*[2]

15. Children who were boarded out often took the surname of their foster parents. This was not illegal. Until the *Registration of Births Act 1996* came into effect, children were not given a registered surname. The child's forename was recorded as were the forename and surname of the parent(s) but there was no requirement that the child use a parent's surname. If a child who was born in an institution, and subsequently boarded out, was returned to the institution and died there, the name used may not match the original name in the institution.

16. The Commission considers that children who were sent to hospitals from the various institutions and who died soon afterwards in the hospitals should be included in the number of deaths in the institution. The GRO death registers record the information given by the informant. In some of these cases, they record the institution as the last known residence and in other cases the hospital or sometimes another location such as the home address of the mother is shown as the last known residence. This,

[2] Generally known as the McAleese Report: http://www.justice.ie/en/JELR/2013Magdalen-P%20III%20Chapter%2016%20Death%20(PDF%20-%20384KB).pdf/Files/2013Magdalen-P%20III%20Chapter%2016%20Death%20(PDF%20-%20384KB).pdf

obviously, makes it difficult to accurately identify the number of deaths. The Commission is not including children who had been in the institutions and who died after they were placed at nurse or boarded out.[3]

17. The Commission considers it important to try to trace all children who died and so it has devoted considerable time and resources to this particular exercise. There are extensive records in some cases and very sparse records in others. At this stage (March 2019) the Commission is close to finalising the detailed numbers and these will be included in the final report. In this report, the Commission gives information about the now known numbers involved. After further checking, some of these may change slightly but they can be taken as reasonably accurate.

18. All records from the various sources are not yet fully reconciled and, indeed, may never be. There are a small number of instances where, for example, the register of deaths records the last residence of a child as Bessborough or Tuam but there is no mention of this child in the records compiled in Bessborough or Tuam.

19. There are instances of deaths noted in the Tuam Children's Home records which are not on the register of deaths. The number of such discrepancies is very small and may yet be resolved. In the Commission's view, there is very little basis for the theory that the children concerned did not die but were "sold" to America. Children from Tuam were adopted to America (as were children from nearly all the institutions under investigation). These adoptions are generally recorded in the Tuam records. It is not obvious why subterfuges would be required to arrange such adoptions.

Presence of mothers

20. In the institutions other than Dublin Union/Pelletstown, the majority of child deaths occurred while the mother was also resident there. There is no information available about the involvement of mothers in decisions about the burial of the child. It seems likely that the mothers would have asked about the burial arrangements. It is not known if they were told or if they were involved in any way.

[3] Children "at nurse" were children who were placed by the mother or a voluntary agency in a private home or institution and a payment was made by the mother or agency for the child's upkeep. The *Children Act 1908*, as amended, required people taking nurse children to be registered – this issue will be dealt with in more detail in the Commission's final report. "Boarded out" children were children placed with families by the health authorities and the families were paid an allowance.

Finding out about burials

21. Within weeks of its establishment, the Commission wrote to the relevant religious orders asking for any information about the institutions they owned or ran. Specific information on burials was requested. The replies from the Sisters of Bon Secours (Tuam) and the Congregation of the Sacred Hearts of Jesus and Mary stated that the relevant information was no longer available to them because their records were all held by the Child and Family Agency (TUSLA). It took considerable time for the Commission to electronically copy these records and then analyse them. There is no information about burials in these records. Information about Tuam burials was also sought from Galway County Council. It did not have any documentary information on the subject.

Obligation to record burials

22. There was a legal obligation on local authorities to keep a register of burials in public burial grounds. It is the Commission's view that this obligation applied to Galway County Council in relation to the Tuam burial ground but there is no burial register. Carr's Hill in Cork was a public burial ground for which the health authorities were responsible. It seems that a burial register was compiled there but, unfortunately, the Commission has failed to find it; the HSE, which owns Carr's Hill, does not know if it ever held such a burial register.

23. There was no obligation on private burial grounds to keep a register of burials. However, three private burial grounds relevant to this report, Glasnevin, Mount Jerome and St Joseph's Cemetery, Cork, did keep proper records. There is no evidence that any record of burials was kept by the Congregation of the Sacred Hearts of Jesus and Mary in respect of burials in Castlepollard and Sean Ross. There was a canon law requirement to keep a record of burials.

Further information

24. The Commission is of the view that there must be many people who know more about the burials which are described in this report and who have not come forward with relevant information. The Commission would welcome any such new information.

Summary of findings

1. The major issues about burials arise in the cases of Bessborough and Tuam. It is not known where the vast majority of the children who died in Bessborough are buried. There is a small burial ground in the grounds of Bessborough. This was opened in 1956 for members of the congregation. It seems to have been assumed by former residents and advocacy groups that this is also where the children who died in Bessborough are buried as there are occasional meetings and commemoration ceremonies held there. The vast majority of children who died in Bessborough are not buried there; it seems that only one child is buried there. More than 900 children died in Bessborough or in hospital after being transferred from Bessborough. Despite very extensive inquiries and searches, the Commission has been able to establish the burial place of only 64 children. The Congregation of the Sacred Hearts of Jesus and Mary who owned and ran Bessborough do not know where the other children are buried.

Sacred Heart Homes

2. The burials of children who died in the three Sacred Heart Homes (Bessborough, Castlepollard and Sean Ross) are not recorded at all. More importantly, there is no certainty about where they are buried.

3. The Congregation of the Sacred Hearts of Jesus and Mary who owned and ran these institutions provided the Commission with an affidavit about burials generally and specifically about the Castlepollard and Sean Ross child burials but very little evidence was provided to support the statements in it. The affidavit was, in many respects, speculative, inaccurate and misleading.

4. The children who died in Castlepollard are likely to be buried in the burial ground there. However, there is no documentary evidence to confirm this.

Bessborough

5. As already stated, the Congregation of the Sacred Hearts of Jesus and Mary do not know where the children who died in Bessborough are buried. The Commission finds this very difficult to comprehend as Bessborough was a mother and baby home for the duration of the period covered by the Commission (1922 – 1998) and the congregation was involved with it for all of this time. The Commission finds it very difficult to understand that no member of the congregation was able to say where the children who died in Bessborough are buried.

6. The Commission tried to establish where the Bessborough children were buried. Cartographic and landscape assessment was undertaken of possible unrecorded burial arrangements in the Bessborough grounds. A site survey was also conducted. It is clear that there are a number of locations within the grounds where burials could have taken place. However, there is no significant surface evidence of systematic burial anywhere except for the congregation burial ground.

7. The Commission considers that it is likely that some of the children are buried in the grounds but has been unable to find any physical or documentary evidence of this. In particular, during the 1940s (when many of the deaths occurred) and when petrol was scarce, it would have been very expensive to arrange off-site burials. However, as no physical evidence of possible locations was found, the Commission did not consider it feasible to excavate 60 acres not to mention the rest of the former 200 acre estate.

Cork County Home

8. The Commission has established that, between 1922 and 1998, 552 "illegitimate" children died in Cork County Home/St Finbarr's Hospital. So far, no burial records have been found for these children. It is likely that they are buried in Carr's Hill Cemetery but there is no documentary evidence available.

Tuam

9. In the light of a great deal of inaccurate commentary about the Tuam site, the Commission considers it important to emphasise what it has established and what it has not established.

- The memorial garden site contains human remains which date from the period of the operation of the Tuam Children's Home so it is likely that a large number of the children who died in the Tuam Home are buried there.
- The human remains found by the Commission are not in a sewage tank but in a second structure with 20 chambers which was built within the decommissioned large sewage tank.
- The precise purpose of the chamber structure has not been established but it is likely to be related to the treatment/containment of sewage and/or waste water. It has not been established if it was ever used for this purpose although soil analysis illustrates that it is likely it was so used for an unspecified duration. The Commission does not consider that any of its features suggest that it was

deliberately formed as a crypt or formal burial chamber. If that were the case, an entirely different type of structure would have been expected that would allow for easy human access.

- It has not been established that all the children who died in the Tuam Children's Home are buried in this chamber structure. There is some evidence that there may be burials in other parts of what were the grounds of the Home.

10. It seems clear that relatively extensive work and construction was conducted in and around the site of the Children's Home in Tuam, particularly during the July – December 1937 period. The Commission thinks it possible that the reworking of the old sewage tank and the construction of the second structure described above may have occurred at this time. If this is so, then the human remains found in the chambers are likely to date from after 1937. This raises the question of where the children who died before then are buried.

11. The more difficult question to answer is why the children were "buried" in such an inappropriate manner.

12. All the residents of the Tuam Home were the responsibility of the Galway and Mayo County Councils. It seems to the Commission that responsibility for the burials of deceased children rested with the local authorities and Galway County Council had a particular responsibility as the owner of the institution.

13. The Sisters of Bon Secours who ran the Tuam Home were unable to provide any information about the burials there.

14. The Commission is surprised by the lack of knowledge about the burials on the part of Galway County Council and the Sisters of Bon Secours. Galway County Council members and staff must have known something about the manner of burial when the Home was in operation. The Board of Health and its sub-committees sometimes held their meetings in the Home. Employees of Galway County Council must have known about the burials. County Council employees would have been in the grounds of the Home quite frequently as they carried out repairs to the building and possibly also maintained the grounds. It seems very likely that Galway County Council must have been aware of the existence of burials when they were planning the Athenry Road housing scheme in 1969.

15. The Sisters of Bon Secours continued to live and run a private hospital in the town of Tuam until 2001. They must have been aware of the building works which were carried out on the Children's Home site in the 1970s.

16. The Commission considers that there must be people in Tuam and the surrounding area who know more about the burial arrangements and who did not come forward with the information.

Dublin Union/Pelletstown

17. The burials of children who died in the Dublin Union institutions including Pelletstown are properly recorded in Glasnevin Cemetery.

Bethany

18. The burials of children from Bethany are properly recorded in Mount Jerome cemetery.

Anatomical subjects

19. There can be little doubt that most people will find the arrangements made for anatomical studies prior to the 1970s distasteful at a minimum. However, the burials of the anatomical subjects used by the Dublin Medical Schools are properly recorded in Glasnevin Cemetery. It has not been possible to establish anything about the burials of the child anatomical subjects used in the Galway Medical School as their names are not known.

Chapter 1: The law on burials

Summary

1.1 For the period covered by the Commission, the law on burials was set out in the *Public Health (Ireland) Act 1878 (Part 111)* and in the *Rules and Regulations for the Regulation of Burial Grounds 1888.*

1.2 In summary, the law provided that:

- Public burial grounds were run by local burial boards (local authorities) and were subject to statutory regulation and central government oversight (initially the Local Government Board for Ireland and after 1924, the Minister for Local Government and Public Health and the successors in title).[4]
- Private burial grounds, including those owned and operated by churches and religious institutions, were not subject to statutory regulation unless they applied to be licensed by the Minister or to be taken over by the burial board; in effect the 1878 Act and the 1888 regulations did not apply to private burial grounds. However, after 1948 any new such burial ground was not allowed to be operated without ministerial consent or approval, or planning permission.
- In public burial grounds, bodies were required to be buried in coffins. This did not apply to private burial grounds, including those owned by religious institutions.
- Burials in public burial grounds were required to be recorded in a register book provided by the local burial board. There was no registration requirement for burial in private burial grounds except in very specific circumstances relating to the registration of the death.[5]

Public burial grounds

1.3 The 1878 Act provided that, in general, the sanitary authority in each sanitary district was designated the "burial board" for the district, under the control and direction of the Local Government Board for Ireland. Following the establishment of the Irish Free State, the Local Government Board's functions were transferred to the Minister for Local Government and Public Health in 1924 and subsequently to the Minister's successors in title.[6] So, for almost all of the period covered by the Commission, the central government authority was the relevant Minister. In practice, the sanitary authorities and consequently the burial boards were the local authorities.

[4] The successors in title during the period covered by the Commission were the Minister for Local Government from 1947; the Minister for the Environment from 1977; and the Minister for the Environment and Local Government from 1997. At present, the relevant Minister is the Minister for Rural and Community Development.
[5] This will be dealt with in the Commission's final report.
[6] See Footnote 1

1.4 The 1878 Act also provided that publicly owned burial grounds were transferred into the ownership of the burial boards which were given responsibility for their management and protection.

1.5 The 1878 Act gave the Minister the power to order that no new burial ground could be opened in any district without his or her approval, or to order that burials would be discontinued (wholly or subject to exception or qualification) in a particular district or burial ground. The Minister was also given the power to direct an inquiry into any matter in relation to a burial ground and to make an appropriate order arising from such an inquiry.

1.6 Any person who knowingly and wilfully buried a body, or acted or assisted in any burial, in violation of an order of the Minister under the 1878 Act was guilty of an offence.

1.7 The 1878 Act gave the Minister the power

> "...to make such rules and regulations in relation to the burial grounds and places of reception of bodies previous to interment under this Act as may seem proper for the protection of the public health and the maintenance of public decency".

The burial boards were obliged to comply with such rules and regulations.

1.8 The 1888 regulations required burial in "a coffin of wood or other sufficiently strong material".[7]

1.9 The *Open Spaces Act 1906*[8] gave local authorities the power to make bye-laws for the regulation of any open space or burial ground which they controlled.

Private burial grounds

1.10 The 1878 Act was mainly concerned with public burial grounds. It does have some provisions which are relevant to private burial grounds. It provided for the licensing of existing burial grounds on church/chapel premises. A licence could be granted "on application" to the Local Government Board and subsequently the Minister but there was no requirement to get a licence and, if a licence was granted, there was no penalty for breaching its terms. The Act also dealt with the right to interment, or absence of such a right, in private burial grounds but this is not relevant to the Commission's Terms of Reference.

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[7] This remained the law until 2013; the Burial Ground (Amendment) Regulations 2013 (SI/ 144/ 2013), allows for "uncoffined burials" in certain circumstances.

[8] http://www.irishstatutebook.ie/eli/1906/act/25/enacted/en/html

1.11 Aside from these provisions, it is clear that the 1878 Act did not apply to non-public burial grounds. Section 199 provided that:

> "The provisions of this part of this Act shall not apply to any private and exclusive family mausoleum or burial place not being within the limits of any public burial ground."

The term "public burial ground" was not defined, but it seems clear that it was meant to refer to burial grounds provided by the burial boards. In effect, this means that private burial grounds, for example, those attached to churches or religious institutions were not regulated.

1.12 The 1878 Act did provide for the placing of any burial ground under the management of the burial board, in which case the Act would apply to it. The *Public Health (Ireland) Act 1896* [9] clarified that this included "any burial ground attached or contiguous to a Roman Catholic place of worship" where "the ownership...is not vested in any person or persons, corporation or limited company". However, unless this option was availed of, the 1878 Act did not regulate non-public burial grounds, other than in the very limited manner outlined above.

Glasnevin Cemetery

1.13 Glasnevin Cemetery is a private cemetery. Prior to 1970 it was governed by the *Dublin Cemeteries Act 1846* and the bye-laws made under that Act (see Chapter 7). Since 1970, it has been governed by the *Dublin Cemeteries Committee Act 1970.*[10] These are private Acts and they are applicable only to Glasnevin and a small number of other cemeteries in the Dublin area. Neither the local authorities nor the Minister with responsibility for oversight of public burial grounds has a role.

Mount Jerome

1.14 Mount Jerome is also a private cemetery. It is governed by Dublin General Cemetery Company's Acts 1933[11] which incorporated Acts from 1834 and 1874. Again, these are private Acts and apply only to Mount Jerome cemetery. Neither the local authorities nor the Minister with responsibility for oversight of public burial grounds has a role.

[9] http://www.irishstatutebook.ie/eli/1896/act/54/enacted/en/print.html
[10] http://www.irishstatutebook.ie/eli/1970/prv/1/enacted/en/html
[11] http://www.irishstatutebook.ie/eli/1933/prv/2/enacted/en/html

Where a body may be buried

1.15 The *Local Government (Sanitary Services) Act 1948*[12] limits the places in which a body may be buried. Section 44 provides:

> "(1) ...a person shall not, without the consent of the Minister, bury the body of a deceased person in a place which is not a burial ground for the purposes of this section.
>
> (2) The following (and no other) places shall be burial grounds for the purposes of this section—
>
> (a) a place which is in lawful use as a burial ground and which was, immediately before the commencement of this section, in lawful use as a burial ground,
>
> (b) a place as respects which the Minister has, after the commencement of this section, given his approval to its being used as a burial ground,
>
> (c) a burial ground provided by a burial board under the Acts."[13]

1.16 The phrase "lawful use as a burial ground" was not defined. However, as burial grounds not operated by burial boards were not unlawful, any such grounds operating before 1948 seem to have effectively been given statutory recognition under the 1948 Act. This statutory recognition did not mean that they were subject to the requirements of the 1878 Act. Any new private burial grounds opened after 1948 needed the approval of the Minister but, again, they were not made subject to the requirements of the 1878 Act.

Register of burials

1.17 The 1878 Act provided for the keeping of a register of burials. The power to make rules and regulations under the 1878 Act in relation to burial grounds expressly included rules and regulations "for the proper registry of interments".

1.18 Section 191 of the 1878 Act provided that:

> "All burials within any burial ground provided under this Act shall be registered in a register book to be provided by the burial board providing such ground, and kept for that purpose; and such register book shall be so kept by some officer appointed by the said board to do that duty; and in such register book shall be distinguished in what parts of the burial ground the several bodies (the burials of which are entered in

[12] http://www.irishstatutebook.ie/eli/1948/act/3/enacted/en/html

[13] This provision was amended by the *Local Government Act 1994*. The Minister's consenting role under s. 44(1) was transferred to the burial boards and a new s. 44(2A) was added, clarifying that burial grounds granted permission under the planning legislation, and those provided by local authorities, were also to be considered burial grounds for the purposes of s. 44(2).

such register book) are buried; and such register book, or copies or extracts thereof, or any document purporting to be a copy or extract thereof, shall be received in all courts as evidence of the burials entered therein. The clerk or secretary, or registrar to every burial board and cemetery company, or other authority having charge of any burial ground, shall make or cause to be made, at such times and in such manner as the Local Government Board may direct, a return of the names, addresses, dates of death and causes of death, so far as ascertained by him, of the persons whose bodies have been interred in such burial ground to the registrar of the district in which such persons resided at the dates of their deaths respectively, and such clerk, secretary, or registrar of each such cemetery company shall be paid therefor by the sanitary authority during the period he is required to perform such duty such sum as the Local Government Board may direct, not being more than threepence for each separate entry of death."

1.19 The *Public Health (Ireland) Amendment Act 1879* clarified that returns under this section were to be sent to the registrar of births and deaths of the district or the Registrar General of Births and Deaths in Ireland. The functions of the Minister under this provision were transferred to the Minister for Health in 1947.[14]

1.20 It is clear that the registration requirement extended only to burial grounds operated by the burial boards and therefore did not cover burials in religious premises or in other private places of burial.

Stillborn children

1.21 The *Births and Deaths Registration Act (Ireland) 1880 Act* made it an offence to "wilfully bury or procure to be buried the body of any deceased child as if it were still-born". It also made it an offence for "[a] person who has control over or ordinarily buries bodies in any burial ground" to "permit to be buried in such burial ground the body of any deceased child as if it were still-born". In the case of stillborn burials, such persons were required to have delivered to them, before burial, a certificate from a medical practitioner confirming the stillbirth, a declaration to that effect from a relative or an order from the coroner. These provisions were obviously aimed at stopping people from bypassing registration requirements in relation to infant deaths by passing them off as stillbirths.

[14] Health (Transfer of Departmental Administration and Ministerial Functions) Order 1947 (SI/58/1947).

More than one body in a coffin

1.22 There was also a provision in the 1880 Act, aimed at preventing the burial of persons whose death was not registered, by means of placing the body in a coffin with another body.

Chapter 2: Dublin Union/St Patrick's, Navan Road (Pelletstown) 1922 - 1985

Background

2.1 "St Patrick's, Navan Road, Dublin 7, originally known as Pelletstown and subsequent transfer to Eglinton House, Eglinton Rd, Dublin 4" is one of the institutions which the Commission is specifically mandated by its Terms of Reference to investigate. In accordance with its terms of reference and the criteria set out there, the Commission chose the Dublin Union[15] as one of the county homes to be investigated. In practice, Pelletstown and the Dublin Union were really one institution with separate premises. Pelletstown was frequently referred to as the "Pelletstown Auxiliary" as it was an auxiliary building to the South Dublin Union. Both sets of premises were owned and financed initially by the Dublin Board of Guardians and subsequently by its successors in title (for example, the Dublin Board of Assistance, the Dublin Health Authority from 1960 – 1970 and the Eastern Health Board from 1971 onwards).[16]

2.2 The South Dublin Union premises were in James's Street on the site of what is now St James's Hospital. The North Dublin Union and the South Dublin Union were amalgamated in 1918 as part of the changes to the Poor Law and the South Dublin Union premises then became the Dublin Union premises.[17]

2.3 Pelletstown[18] was run by the Company of Daughters of Charity of St Vincent de Paul.[19] The sisters and other staff who worked in Pelletstown were local government employees and paid as such.

2.4 From 1910 to 1919/20, Pelletstown was a National School and orphanage for the South Dublin Union. The Daughters of Charity became involved in Pelletstown in 1910; they were already involved in running a number of workhouses in Ireland. The Daughters of

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[15] Changes to the Poor Law were made in the period just before and just after 1922. In most counties, the workhouses which were to be retained in use were renamed county homes. The Dublin workhouse was never given this name. Like all other former workhouses, it started to be called by a saint's name at some stage – St Kevin's. Locally, it was generally called simply "the Union".

[16] The Commission's final report will include details of the various changes in health authority structures.

[17] At some point, it began to be called St Kevin's Institution; there was also a St Kevin's Hospital on the site; it amalgamated with a number of other Dublin hospitals in the early 1970s and then became known as St James's Hospital.

[18] The Commission has decided to use the name Pelletstown in order to avoid any confusion with the many other institutions such as industrial schools, children's homes and hospitals which are or were also called St Patrick's.

[19] They were, and sometimes still are, known as the Sisters of Charity of St Vincent de Paul. As a result they are sometimes confused with the Irish Sisters of Charity. The Commission intends to use "Daughters of Charity" in order to minimise any such confusion.

Charity in Pelletstown were initially asked to provide "care instruction and industrial training of the children of the Poor". They were expected to cater for boys from age 3 to 14 and girls from age 3 to 15; they were then expected to "place the children in situations suited to their capacity". The specific role of Pelletstown was changed in May 1919. From 1919, Pelletstown was expected to cater for all mothers and infants; motherless children; all healthy children under age 5; and all sick children such as the Medical Officers considered would be suitably treated there.[20]

2.5 So, like Tuam, Pelletstown was not exclusively a mother and baby home. In later years, while it was mainly a mother and baby home, it continued to house very sick children, abandoned children and children who were considered not suitable for adoption. Occasionally, it also housed children who were awaiting a place in an industrial school.

Deaths in Dublin Union/Pelletstown

2.6 A full analysis of the deaths that occurred in the Dublin Union, including Pelletstown, will be included in the Commission's final report. This analysis is complex for many reasons not least that many of the children were sent there because they were very ill.

2.7 The births and deaths which occurred in Pelletstown were registered at the Castleknock Dispensary.[21]

2.8 The deaths which occurred in the Dublin Union, and its associated institutions including Pelletstown, were recorded in the Dublin Union Register of Deaths. These registers are held by the National Archives of Ireland. There are eight volumes (BG79/2/1-8), each covering a 4-6 year period between 1908 and 1951. For each entry, the deceased's date of admission to the Union, register number, name, religion, previous residence prior to admission to the Union, occupation, condition (single, married, widowed), the department of the Union in which the person was resident, date of death, cause of death and the medical officer who "disposed of"[22] the deceased were all recorded. Where relevant, children are identified in the register as "illegitimate", "deserted", "abandoned" or "at nurse". The parents of the child, if known, are usually identified in their record. If the child was "illegitimate", the mother and her occupation are noted. If the child was deserted, it was

[20] Correspondence between the Daughters of Charity and Dublin Union; provided to the Commission by the Daughters of Charity.
[21] NAI, Dublin Union Minute Books: BG 79/A/121, 5 January 1938 – 29 June 1938: Minutes of Board of Guardians Meeting, 19 January 1938: Report of Resident Medical Superintendent, Copy of Report by Mr James Cahill, re the Women and Children in Pelletstown Auxiliary, pp. 55-6.
[22] "How disposed of" is the heading used in the register.

noted where and by whom the child was found. If the child was a "nurse child", the name of the foster mother and her address were noted. However, in the majority of cases, these registers do not record the cause of death.

2.9 The Commission has examined these registers and extracted the details about all children who are registered. These details have then been matched with the information about deaths which is contained in the records which were compiled in Pelletstown (and now held by the Child and Family Agency (Tusla) and made available to the Commission). This exercise is almost, but not quite fully, complete but it is clear that there is a very close match between the various registers. It can reasonably be said that deaths were appropriately recorded.

Burials

2.10 Children who died in the Dublin Union premises – St Kevin's – and in Pelletstown were generally buried in Glasnevin Cemetery where detailed records are maintained. A very small number were buried in Mount Jerome. The Commission is continuing to check the burial places of a number of other children. Some of these were "legitimate" and it is possible that they were taken home by their families for burial.

2.11 In the majority of cases the children were buried in the "Poor Ground" burial plots, later renamed the "Angels' Plot"[23] in Glasnevin. They were buried there at the expense of the Dublin Union and its successors.

2.12 Appropriate records of the burials are maintained at Glasnevin in a Register of Poor Ground Burials. Volumes 27 – 37 of this register cover the burials between August 1919 and July 2002. The Commission has inspected this register and cross checked it with the names of the children known to have died in the Dublin Union, including Pelletstown.

2.13 The Register of Poor Ground Burials records the child's name, age, sex, religious persuasion, the date of death, cause of death, date of interment in the grave and the date of the issuing of the interment order. In contrast to the Dublin Union Register of Deaths, the cause of death for each child was always recorded in the Glasnevin burial register. The register also records the address the child came from, which in the case of these children was described as either the Dublin Union, St Patrick's, Navan Road or Pelletstown. It also records who made the burial arrangements, which for children from the Dublin Union, was a

[23] This term seems to have been used from the 1960s

named official employed by the Dublin Union and its successors in title. Where relevant, the child is described as "abandoned", "deserted" and/or "illegitimate". In the case of the latter, the mother's name and her occupation are noted.

2.14 The Glasnevin Burial Registry records the name and location of each burial plot. The Poor Ground sections of the cemetery are divided into multiple squares, each representing a single burial plot. A series of horizontal and vertical lines divide the Poor Ground section, allowing for each specific burial plot to be located on a map of the section. The horizontal lines are designated by specific letters, and the vertical lines are represented by a number. The letters run from A-Z, through to Aa - Za, Ab – Zb and Ac to Zc. The numbers run from 1 to over 150, depending on the size of each Poor Ground section.

2.15 Again, the Commission has cross referenced the names of the children who died in the Dublin Union, including Pelletstown, with the names of those who are recorded in the Pelletstown records, the names on the Dublin Union Register of Deaths and the names in the Glasnevin Burial Registry. While some further checking needs to be completed, it is clear that the majority of the children are buried in Glasnevin and their names are recorded in the burial registers there.

Chapter 3: The Sacred Heart Homes

Background

3.1 The Mother and Baby Homes in Bessborough[24], Castlepollard and Sean Ross[25] were owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. Unlike Pelletstown and Tuam, they were not local authority owned. They are sometimes described as "extern institutions" which means that they were not owned by the local health authorities but the local authorities could send people who were eligible for services to them. The local health authorities who sent mothers to these homes paid a capitation rate in respect of each resident. (The Commission's final report will look in detail at the financial arrangements.) These homes were entitled to take private patients.

Sources of Information

3.2 The records of admissions, births, discharges and deaths which were compiled in each of these institutions were handed over to the HSE in September 2011 and subsequently to the Child and Family Agency (TUSLA) in 2013.

3.3 The Congregation of the Sacred Hearts of Jesus and Mary told the Commission that they did not know where the children who died in Bessborough are buried. The Commission finds this difficult to comprehend as the congregation was still providing services to mothers and children right up to the end of the period covered by this investigation[26], that is, 1998, long after the other congregation institutions closed.

3.4 The congregation was unable to explain why there were designated child burial grounds in Castlepollard and Sean Ross but not in Bessborough. The congregation provided the Commission with an affidavit about burials generally and specifically about the Castlepollard and Sean Ross child burials but very little evidence was provided to support the statements in it. The affidavit was, in many respects, speculative, inaccurate and misleading.

3.5 In its affidavit, the congregation said that the child burial grounds in Castlepollard and Sean Ross were "created within existing by-laws and with the approval of the local Bishops".

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[24] This is sometimes spelled Bessboro.

[25] This is sometimes spelled Shan Ross. It seems that Shan is an anglicisation of the Irish word "sean" meaning old and is not the male name Seán; the correct pronunciation would seem to be Shan Ross but the correct spelling is Sean Ross.

[26] The congregation told the Commission that the Mother and Baby Home closed in 1986. The Maternity Hospital closed in 1986 and it then became a "hostel" for unmarried pregnant women and for unmarried mothers and their babies. The congregation consider that it would be "misleading" to describe Bessborough as a mother and baby home after 1986. The Commission recognises that the character of the home changed as was the case with the other mother and baby homes which existed in the 1980s but it was still a mother and baby home.

The Commission is not aware of any bye-laws which would have applied to these burial grounds as they were not subject to specific legislation; any bye-laws made by local authorities would have applied only to local authority burial grounds. The congregation was unable to provide any information about such bye-laws and, in response to the initial draft of this report, acknowledged that there were no specific bye-laws which applied to religious burial grounds.

3.6 The Commission has not seen documentary evidence but it has no reason to doubt that the local bishops were aware of the existence of burial grounds in Castlepollard and Sean Ross and did approve. The involvement of local bishops and priests in the institutions will be documented in the Commission's final report.

3.7 The affidavit states that all of the children buried in the burial grounds of these two institutions were accorded the rites of the Catholic Church and the congregation "did not bury infants in unapproved cemeteries". These assertions may well be true but the congregation provided no evidence to support them. The congregation was unable to elaborate on what the rites of the Catholic Church in relation to child burials were. As the congregation accepts that it does not know where most of the Bessborough children are buried, it cannot definitively state that they were not buried in unapproved burial places.

3.8 The congregation also said that the infants buried at Sean Ross and Castlepollard "were laid to rest without any cost accruing to the coffers of the local or central government". This is not true in respect of some, if not all, of the burials. The Commission has seen evidence of bills for burials having been sent to a local health authority by Bessborough and a bill for coffins was sent by Sean Ross to a local health authority.[27] There is quite likely to be further evidence of such bills in the archives of other local authorities. The Commission recognises that it was reasonable for the congregation to bill the local authorities for the costs involved.

3.9 There was no legal requirement (see Chapter 1) to keep a register of burials in such burial grounds and no such registers seem to exist. Accordingly, there is no documentary evidence of these burials.

3.10 A Canon Lawyer has told the Commission that the 1917 Code of Canon Law requires the completion of a register of deaths after a funeral with details of the name and age of the

[27] Kilkenny County Archive, Kilkenny County Council Manager's Orders-Public Assistance Section: MO/PA/5/2 April 1947-31 March 1948

deceased, name of parents or spouse at time of death, what sacraments had been received and the place and date of the burial.

Chapter 3A: Sean Ross 1931 - 1969

3A.1 Analysis of the records compiled in Sean Ross and information on deaths provided by the General Registrar Office shows that over 1,000 children died in Sean Ross or in the District Hospital, Roscrea to which they were sent when they became very ill. Twenty nine mothers died; the majority of these deaths were related to the pregnancy/childbirth.

3A.2 There is a designated child burial ground in the grounds of the institution. The Commission was made aware of concerns about this burial ground and decided to undertake a geophysical study and subsequently a test excavation of the site. The results of this excavation are currently being examined.

Chapter 4: Bessborough 1922 – 1998

Background

4.1 Bessborough Mother and Baby Home was opened in 1922. It was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. The congregation had been invited to set up a mother and baby home in Cork by a senior official of the Cork Board of Guardians as it was already running a number of mother and baby homes in England and Scotland. The Board of Guardians official identified the Bessborough Estate, which was a Georgian house on 150 acres[28], as a suitable property. The congregation bought the property with financial assistance from the Archbishop of Westminster.

4.2 The objective of the Board of Guardians was to implement the policy of removing unmarried mothers and their children from workhouses and making provision for them in dedicated facilities or "special homes" as they were sometimes called. The first mothers and children who took up residence in Bessborough came from the Poor Law Union workhouses in Cork. Over the years, the Bessborough home accepted unmarried expectant mothers and unmarried mothers who had recently given birth who were admitted there and paid for on a capitation basis by the health authorities in all parts of the country. Bessborough also accepted private fee paying expectant mothers.

4.3 In the early years, expectant mothers who were resident in Bessborough did not give birth there. They usually gave birth in Cork District Hospital (see below). In 1930, a maternity ward was created within the home and, in 1935, the Sacred Heart Maternity Hospital was built alongside the Bessborough Home. From 1930 to the 1980s, most expectant mothers resident in Bessborough gave birth in the maternity ward/hospital. The Commission uses the term "Bessborough" to cover both the Home and the hospital except where the context shows otherwise.

Sources of information

4.4 The records of admissions, births, discharges and deaths which were compiled in Bessborough by the congregation were transferred to the HSE in 2011 and subsequently to the Child and Family Agency (TUSLA) in 2013. The Commission has made digital copies of these records and their analysis is near completion. These documents record the deaths of children, and the causes of death in many cases, but do not include any information about burials.

[28] The congregation told the Commission that a portion of land adjoining the estate was bought in 1930; this brought the total acreage to about 200 acres. About 100 acres were sold in 1973 for the building of the N25 and for social housing. The Commission understands that there are about 60 acres of ground around the building now.

Deaths in Bessborough

4.5 The Commission is aware that over 900 children who were born in, or admitted to Bessborough died in infancy or early childhood. Most died either in the Sacred Heart Maternity Hospital soon after birth or in the Bessborough Home itself to which infants were transferred some weeks after birth (many more died in the Home than in the Maternity Hospital). The Bessborough Home and the Sacred Heart Maternity Hospital kept separate death registers.[29] Deaths that occurred in the Home and deaths which occurred in the hospital were separately recorded and notified. This has led some commentators to suggest that the Bessborough authorities overstated deaths which occurred in the institution when reporting to the Department of Local Government and Public Health. The number of deaths reported to the department was the combined deaths in the two facilities as opposed to deaths which occurred in the Home only.

Cork County Home and Cork District Hospital/St Finbarr's

4.6 In the reorganisation of poor law institutions which occurred in the early 1920s, the Cork City Poor Law Union Workhouse became two separate but co-located institutions - the Cork County Home and Cork District Hospital. The Cork County Home is one of the county homes chosen by the Commission for investigation. The Commission is not investigating the Cork District Hospital but it does have a role in the story of both Bessborough Mother and Baby Home and the Cork County Home. Both the Cork County Home and the Cork District Hospital were renamed St Finbarr's in the 1950s. The Cork District Hospital/St Finbarr's had a maternity unit until 2007 when the Cork University Maternity Hospital opened.

4.7 A significant number of children born in or admitted to Bessborough (113) subsequently died in Cork District Hospital/St Finbarr's Hospital. Expectant mothers living in Bessborough, who required extra medical attention, were routinely transferred to St Finbarr's Hospital to give birth. A number of children born to Bessborough residents in Cork District Hospital/St Finbarr's Hospital died in that institution. The medical and administrative staff of Bessborough and Cork District Hospital/St Finbarr's Hospital assumed separate responsibility for registering deaths which occurred in their respective institutions.

4.8 The Commission has examined the records of deaths in the Bessborough Home itself and in the Sacred Heart Maternity Hospital and cross referenced them with information on Bessborough deaths (including those in Cork District Hospital/St Finbarr's) provided by

[29] The *Registration of Maternity Homes Act* 1934 made it obligatory for the administrators of all registered maternity homes to keep records relating to the reception and discharge of patients as well as a record of all births and deaths.

the General Register Office (GRO). There are some discrepancies between the death records maintained by the Bessborough authorities and those held by the GRO but they are small in number and the Commission is continuing to try to reconcile them.

Who was responsible for burials

4.9 While it was reasonably straightforward to reconcile institutional death records with those held by the GRO, the identification of the burial places of the children has proven to be very challenging. One complicating factor is that the administrators of Bessborough and Cork District Hospital/St Finbarr's appear to have taken separate responsibility for the burial of unclaimed remains in their respective institutions. The children who died included children of mothers who were being maintained by the local health authorities (public patients) and children of mothers who were paying privately (private patients). When the child of a public patient died in Bessborough or Cork District Hospital/St Finbarr's the mother had two options: to make private arrangements for the burial of the child or to let the administrators of the institution where the death occurred make burial arrangements on her behalf. While a small number of women made private arrangements,[30] most single women had neither the means, nor the familial support, to do so. In the majority of cases, the burial of a child of a public patient was arranged by the administrators of Bessborough or Cork District Hospital/St Finbarr's, most likely in conjunction with the health authorities who were paying for the mother and child.[31]

4.10 A number of the children who died in Bessborough were the children of private fee-paying residents. If the child of a private patient died while the mother was resident in Bessborough, the mother alone was legally responsible for the burial. However, private patients routinely discharged themselves from Bessborough, leaving children in the institution unaccompanied, in most cases awaiting informal adoption through the Catholic Women's Aid Society (CWAS).[32] This practice ceased in 1946 when Bessborough administrators were no longer willing to accommodate unaccompanied children born to private patients. CWAS records are held by the Child and Family Agency (TUSLA) and were made available to the Commission for inspection. These records show that the CWAS assumed responsibility for the cost of burial of children in their care. Burial arrangements for children born in Bessborough, who subsequently died while in foster care, were generally

[30] St Finbarr's Cemetery burial registers record some Bessborough child burials in separate non-perpetuity burial plots – see below.

[31] Kilkenny Board of Assistance Records contain an invoice from the Bessborough Home seeking to recoup the cost of an infant burial. A former administrator of St Finbarr's Hospital confirmed that the Board of Assistance/Southern Health Board arranged for the burial of unclaimed infants who died in Cork District Hospital/St Finbarr's Hospital.

[32] The Catholic Women's Aid Society was a privately run agency set up in 1919 to facilitate single women who sought to make private permanent fostering arrangements for their children.

arranged by foster parents who were then reimbursed by the CWAS. On rare occasions, foster parents handed the remains of a deceased child back to the society for burial.[33] It is reasonable to assume that the CWAS reimbursed the Bessborough authorities for the costs associated with the burial of unaccompanied infants maintained by the society in Bessborough. CWAS records do not record where children who died in its care were buried.

4.11 Work undertaken by the Child and Family Agency (TUSLA) has shown that St Anne's Adoption Society took responsibility for the burial of infants who died in Bessborough while under the auspices of St Anne's. St Anne's Adoption Society was registered with the Adoption Board in November 1954. The society facilitated the adoption of children born to single Irish women returning from the United Kingdom. Expectant single women, whose repatriation from the UK was facilitated by the society, were admitted to the Sacred Heart Maternity Hospital, Bessborough. Although these women were public patients, maintained in Bessborough by local authorities, St Anne's' Adoption Society appears to have taken responsibility for the burial of infants born to these women who died in Bessborough, Cork District Hospital/St Finbarr's Hospital or in foster care.[34]

4.12 The majority of recorded child deaths in Bessborough (in both the Bessborough Home and the Sacred Heart Maternity Hospital) occurred while the children were accompanied by their mothers. There is no information available about the involvement of mothers in the burial arrangements. In theory at least, the mothers were legally responsible for the burial of deceased infants but it seems unlikely that they had much involvement in making burial arrangements.

Where are the children buried

4.13 There is a small burial ground in the grounds of Bessborough. Some members of the congregation are buried there and their graves are marked in the normal way. It seems to have been assumed by former residents and advocacy groups that this is also where the children who died in Bessborough are buried as there are occasional meetings and commemoration ceremonies held there. There is a plaque there commemorating the children who died in Bessborough.

4.14 At an early stage, the Commission thought it unlikely that all the children who died in Bessborough were buried in this burial ground as it was not nearly large enough for the

[33] Records of the Catholic Women's Aid Society held by the Child and Family Agency (TUSLA).
[34] Child and Family Agency (TUSLA). St Anne's Adoption Society Registers. Also, Cork Diocesan Archives: Records of St Anne's Adoption Society and the History and Development of St Anne's Adoption Society.

number of children involved and, in any event, it would be unlikely that children would be buried in the same burial ground as members of the congregation.

Congregation knowledge of burials

4.15 Shortly after its establishment in 2015, the Commission asked the Congregation of the Sacred Hearts of Jesus and Mary for information about many aspects of Bessborough, including the burial arrangements. The congregation said it had very little information as the records compiled in the institution were held by the Child and Family Agency (TUSLA) and it did not have access to these records. As already stated, there is no information about burials in these records.

4.16 A number of members of the congregation provided affidavits and/or oral evidence to the Commission. They were able to provide remarkably little evidence about burial arrangements.

4.17 The congregation told the Commission that the burial ground in Bessborough was opened in 1956 for deceased members of the congregation and the congregation does not know where the vast majority of the children who died in Bessborough are buried. The Commission has not seen any evidence that the approval of the Minister for Local Government for the opening of this burial ground was sought or granted as required by the *Local Government (Sanitary Services) Act 1948* (see Chapter 1).

4.18 A member of the congregation who was in Bessborough for most of the period 1948-1998 told the Commission that she did not remember any child deaths during her time there but she implied that the children who did die there were buried in the congregation burial ground. In the years 1950-1960 (inclusive), 31 children died in Bessborough so it is rather surprising that she does not remember any deaths.

4.19 Another congregation member who was in Bessborough from 1978-1985 told the Commission that one baby died during her time there. She said that the manager of the maternity hospital (who was also a member of the congregation) "took over the arrangements for the burial". She "vaguely remembered" that the mother wanted the baby buried in St Michael's Cemetery but she did not know where the baby was actually buried. The Commission has established that there is no record of this baby in St Michael's burial

records. She did not remember if the mother's family was involved in the burial arrangements but she was clear that the congregation had bought the coffin for the baby.[35]

4.20 In evidence to the Commission, a member of the congregation who was there in the 1980s said that there were two children buried in the burial ground during her time there and a third was disinterred elsewhere and reinterred in this ground. Another member of the congregation who was in Bessborough for a period in 1971 and again between 1975 and 1981 swore an affidavit in which she said that she remembered one child who died and was buried in the congregation's plot in the grounds. The recollections of these two congregation members seem to be incorrect. In fact, it would appear that there is only one child buried in the congregation's burial ground and that burial took place in 1994. The burial ground has some individual memorials to other children who died in Bessborough but it is unlikely that they are buried in this plot.

Investigation of possible burial sites in grounds of Bessborough

4.21 It is possible that children who died in Bessborough were buried within the grounds. However, to date, the Commission has found no physical or documentary evidence which indicates that this occurred.

4.22 The Commission engaged forensic archaeologists to carry out a cartographic and landscape assessment of possible unrecorded burial arrangements in the Bessborough grounds. As already stated, the grounds measure approximately 60 acres. It is also possible that burials took place in the grounds that no longer form part of the Bessborough estate, that is, a total area of 200 acres.

4.23 The forensic archaeologists and the Commission's researchers reviewed all available cartographic sources and aerial images in order to identify possible burials within the grounds of Bessborough. A site survey was also conducted. It is clear that there are a number of locations within the grounds where burials could have taken place. However, there is no significant surface evidence of systematic burial anywhere except for the congregation burial ground.

4.24 The third edition Ordnance Survey Map for the Bessborough area was produced in 1949/50. This identifies a southeast portion of the site as a "Children's Burial Ground". Such a label is not uncommon on this edition of maps and usually denotes a cillín (see

[35] This baby's remains were sent to St Finbarr's for a post-mortem examination. St Finbarr's almost certainly arranged the burial.

Introduction). It is possible that, in this case, the label may refer to the area north-west of the Keep folly, a small rectangular enclosure to the north-east or the wider field in which the label is located.

4.25 In the intervening years, groundwork has left this area in a highly disturbed state and there is nothing physical to mark it as a former burial ground. The Commission interviewed a landscaper who undertook extensive groundwork on the Bessborough Estate over a period of almost thirty years. The witness stated that he had personally undertaken excavations in the area marked "Children's Burial Ground". He said that it was necessary for him to dig six to eight feet deep across this site and that he found no evidence of human remains or any evidence to suggest that the site was formerly used as a burial ground.

4.26 The Commission examined vertical aerial photography taken by the Irish Air Corps in 1951. This series includes high resolution aerial photography of the Bessborough Estate.[36] The majority of child deaths at Bessborough occurred before 1951 (over 700) and it would be reasonable to expect that, if there were burials there, an aerial photograph taken in February 1951 would show up some ground disturbance, or anomaly on the landscape. If over 700 children were buried on the Bessborough Estate before 1951 the aerial photograph would be expected to give some indication of where the remains are located. The aerial photographs of the Bessborough site were examined by forensic archaeologists who determined that no visible features on the Bessborough landscape were indicative of any obvious site hosting the remains of such a large number of children.

4.27 Early in 2018, the Commission issued a national public appeal seeking information from individuals who may have personal knowledge, documentation, or any other information concerning the burial arrangements and/or burial places of children who died in Bessborough. Members of the public contacted the Commission, with mostly second-hand information, suggesting that children were buried in different parts of the estate. All of this information was followed up and the locations identified as possible burial sites by members of the public were assessed by forensic archaeologists. Some of these locations have been built on. To date, no physical or documentary evidence has been produced which suggests that any of the sites identified by members of the public contain human remains. An individual who gave a media interview claiming knowledge of child burials in Bessborough did not respond to the Commission's appeal and declined a request to assist the Commission.

[36] Military Archives, Vertical Aerial Photography, V190 #72; Cork-Douglas/Blackrock, 13 February, 1951.

4.28 The Commission considers that it is highly likely that burials did take place in the grounds of Bessborough. In particular, during the 1940s (when many of the deaths occurred) and when petrol was scarce it would have been very expensive to arrange off-site burials. However, as no physical evidence of possible locations was found, the Commission did not consider it feasible to excavate 60 acres not to mention the rest of the former 200 acre estate.

Other possible burial grounds

4.29 As stated, the Commission has not ruled out the possibility that former Bessborough residents were buried onsite. However, the Commission has also actively investigated the possibility that former residents may have been buried in other locations.

4.30 During the period under review, 1922-1998, eight burial grounds were in operation in Cork city and surrounding hinterland. These were:

- St Joseph's Cemetery, Tory Top Road, Cork.
- St Finbarr's Cemetery, Glasheen Road, Cork.
- St Michael's Cemetery, Mahon, Cork.
- Douglas Municipal Cemetery, Douglas, Cork.
- St Mary's Cemetery, Curraghkippane, Cork.
- St Catherine's Cemetery, Kilcully, Cork
- Rathcooney Cemetery, Glanmire, Cork.
- Cork District Cemetery (All Saints), Carr's Hill, Cork.

4.31 The Commission located and examined the burial records of seven of the eight burial grounds listed above. So far, the Commission has been unable to locate the burial records for Cork District Cemetery, Carr's Hill.

4.32 The burial records of four burial grounds - Douglas Municipal Cemetery; St Mary's Cemetery, Curraghkippane; St Catherine's Cemetery, Kilcully and Rathcooney Cemetery, Glanmire, contain no record of deceased Bessborough residents.

St Joseph's Cemetery, Tory Top Road, Cork

4.33 Prior to its handover to Cork Corporation in 1947, St Joseph's was a privately owned burial ground administered by the Society of African Missions (SMA).[37] Burial records for the

[37] Society of African Missions, Provincial Archive, Blackrock, Cork.

period prior to 1947 are held by Cork City and County Archives.[38] Burial records for the post 1947 period are maintained by Cork City Council.

4.34 The Commission has established that, in the period between the opening of the Bessborough Home in 1922 and March 1929, 54 children who died in Bessborough were buried in St Joseph's Cemetery. Of these, 50 were buried in the "Poor Ground" section at St Joseph's and burial expenses were paid by the Congregation of the Sacred Hearts of Jesus and Mary. Burials in the Poor Ground ceased in June 1928 except for one further burial in March 1929.

4.35 In November 1927, the congregation bought three adjacent burial plots in St Joseph's and a further four children were buried there.[39] No child burials are recorded in the congregation's burial plot after June 1928. It appears that, at this point, some alternative burial arrangements were made for deceased Bessborough children.

4.36 In the period 1922 to June 1928, a total of 63 child deaths are recorded in the Bessborough registers and the St Joseph's Burial records combined. Of these, 53 are buried in St Joseph's Cemetery. St Finbarr's Cemetery burial registers record that two Bessborough children, both of whom died in 1923, were buried in separate non-perpetuity graves there.[40] It is likely that these burials were arranged by relatives of the deceased children. The GRO records show that five of the remaining eight Bessborough children died after being transferred to Cork District Hospital. The South Cork Board of Public Assistance was responsible for arranging the burial of the unclaimed remains of patients who died in Cork District Hospital, including the unclaimed remains of deceased children. If the Board did arrange these five burials, it is likely that they are buried at Cork District Cemetery, Carr's Hill; however, the Commission has no documentary evidence of this. One of the children was the child of a private patient so it is possible that the mother made private arrangements for the burial. The Commission found no evidence about the burial of the remaining two children.

4.37 The identification of Bessborough children in St Joseph's burial records for this period is interesting for a number of reasons. First, it demonstrates that, from the inception of the Bessborough Home in 1922, the Congregation of the Sacred Hearts of Jesus and Mary assumed responsibility for the burial of children who died in Bessborough. Secondly, it

[38] Cork City & County Archives. St Joseph's Cemetery Collection; CP/CY/SJ/2/29-31 (1921-1947).
[39] Cork City & County Archives. St Joseph's Cemetery Collection; Register Book of Burial Plots and Burial Rights Therein; CP/CY/SJ/3. (Closed for Public Access).
[40] Cork City Council, St Finbarr's Cemetery Burial Records, 1947-98.

demonstrates that those infants were not buried in the grounds of Bessborough but were buried in a number of different locations.

4.38 The Congregation of the Sacred Hearts of Jesus and Mary paid the Society of African Missions ten shillings for the burial of each child in the "Poor Ground" section of St Joseph's Cemetery.[41] As these children were maintained in Bessborough by the various health authorities, the Congregation recouped the cost of the burials from the health authority responsible for each child's maintenance.[42] The abrupt cessation of child burials at St Joseph's in June 1928 may have had something to do with costs. If these deaths had occurred in Cork County Home, or Cork District Hospital, the South Cork Board would have arranged burials in its burial ground, the Cork District Cemetery at Carr's Hill, at no additional cost to the local authority. Considering that the next identifiable burial place of a Bessborough child is at this burial ground, in 1960, it seems plausible to suggest that the remains of unclaimed Bessborough children who died between June 1928 and 1960 may have been buried by the South Cork Board in Cork District Cemetery, Carr's Hill. However, the Commission has been unable to find any direct evidence of this.

St Michael's Cemetery, Blackrock, Cork

4.39 St Michael's Cemetery, Blackrock, Cork was opened in 1957 and is owned and operated by Cork City Council. St Michael's does not have a designated "Poor Ground" area. The South Cork Board of Public Assistance and its successors, Southern Health Board and HSE South, opened burial plots for their own use as required. The Commission identified two former Bessborough residents, both infants, who are recorded as being buried at St Michael's. One infant was born in Bessborough in 1958 and died aged ten days at St Finbarr's Hospital, Cork (formerly called the Cork District Hospital). The record shows that this infant was buried in a South Cork Board of Public Assistance burial plot along with five adults. The plot is unmarked. The second infant was born in St Finbarr's Hospital in 1986. Mother and child were transferred to Bessborough when the infant was aged 27 days. The infant subsequently died in Cork Regional Hospital aged 4 months. This infant is recorded as having been buried in a Southern Health Board plot along with a number of adults. The plot is unmarked by a headstone but a small plaque, placed by family members, marks the burial place.

[41] Cork City & County Archives; St Joseph's Cemetery Collection; CP/CY/SJ/2/29-31 (1921-1947).
[42] Kilkenny County Archive, Kilkenny County Council Manager's Orders-Public Assistance Section: MO/PA/5/2 April 1947-31 March 1948.

Cork District Cemetery (All Saints) Carr's Hill, Cork

4.40 The Commission identified documentary evidence which indicates that the unclaimed remains of at least one Bessborough child, who died in St Finbarr's Hospital, was buried in Cork District Cemetery, Carr's Hill. This three acre former famine burial ground had been administered by the Cork Board of Guardians, and subsequently by the South Cork Board of Public Assistance, since 1844. Land Registry records show that the South Cork Board of Public Assistance took full ownership of the burial ground in November 1944 and the site remains in the ownership of the South Cork Board's successors, the HSE.[43] The HSE has informed the Commission that it has been unable to confirm whether it ever held the Burial Register for this burial ground.

4.41 In 1994, a former Bessborough resident contacted the Congregation of the Sacred Hearts of Jesus and Mary requesting documentation about her time in the institution and making a formal inquiry about the burial place of her child. The child was resident in Bessborough with his mother in 1960 and subsequently died in St Finbarr's Hospital later that year. Bessborough records show that the congregation contacted the chaplaincy at St Finbarr's Hospital for information on the child. In response to a query from the chaplaincy, the administrator of St Finbarr's Hospital provided a full overview of the child's stay in St Finbarr's including the cause of death and the place of burial. The Board of Public Assistance had made arrangements for the child's burial in Cork District Cemetery, Carr's Hill, in December 1960.[44] In 1994, a member of the congregation told the mother of this infant that her child was buried in the congregation burial ground at Bessborough. However, records held by the administrator of St Finbarr's Hospital at that time recorded the child's place of burial as Cork District Cemetery, Carr's Hill.

4.42 As already stated, during the period under review, 1922-1998, a significant number of Bessborough children died in Cork District Hospital/St Finbarr's Hospital. The majority of these children were maintained in Bessborough by the South Cork Board of Public Assistance, who also administered Cork District Hospital/St Finbarr's and Cork District Cemetery (Carr's Hill). A former administrator of St Finbarr's Hospital, who had access to hospital mortuary records, confirmed to the Commission that the South Cork Board of Assistance assumed responsibility for the burial of Bessborough children who died in Cork District Hospital/St Finbarr's and that many of these children were buried in Cork District Cemetery, Carr's Hill.

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[43] Land Registry, County Cork; Folio 53L.

[44] Southern Health Board, Administration Department, St Finbarr's Hospital, Letter dated 12 December 1994.

4.43 It should be noted that, during the period under review, several hundred neo-natal deaths were recorded among "legitimate" children born in, or admitted to, Cork District Hospital/St Finbarr's. The Commission identified hundreds of burial records relating to "legitimate" children who died there. For the most part, these children were buried in private and municipal burial plots in St Joseph's Cemetery and St Finbarr's Cemetery. Of the 552 "illegitimate" children who died in Cork District Hospital/St Finbarr's, (including 113 transferred from Bessborough), the Commission has identified the burial place of only five.

4.44 As already stated, the only Cork burial ground records which the Commission has not located are those associated with Cork District Cemetery, Carr's Hill. With the assistance of HSE staff, the Commission engaged with five former hospital administrators of St Finbarr's Hospital in a bid to locate the "Burial Books" maintained by the South Cork Board of Assistance relating to Cork District Hospital/St Finbarr's Hospital. The existence of these records was flagged in the 1994 correspondence between the then hospital administrator and the chaplaincy at St Finbarr's Hospital (referred to above). The Commission interviewed a former hospital administrator, and author of the 1994 correspondence, who stated that the records in question were mortuary records and were onsite at St Finbarr's Hospital at the time of his retirement in 2001. HSE staff undertook a thorough search of the medical records room at St Finbarr's Hospital and forwarded a detailed inventory of records held there to the Commission. However, the mortuary records, which are of considerable interest to the Commission, were not found. The Commission examined archival St Finbarr's Hospital records onsite, and in their off-site storage facility, but did not locate the mortuary records.

4.45 The Commission has recently discovered that a "Burial Book" relating to St Finbarr's Hospital was transferred to Cork University Hospital (CUH) in 2001. The Commission has issued a discovery order in respect of these records held by CUH and continues to work with the HSE in regard to this matter.

4.46 The Commission has also recently discovered that maternity records relating to St Finbarr's Hospital were transferred to Cork University Maternity Hospital (CUMH) when it opened in 2007. The Commission has requested access to the records held at CUMH and continues to work with the HSE in regard to this matter.

4.47 In a bid to locate the Burial Register associated with Carr's Hill Cemetery the Commission engaged with HSE South, Cork County Council, Cork City Council and the Cork City and County Archives. However, the Burial Register was not located. A former employee of St Finbarr's Hospital wrote to inform the Commission that he had visited Carr's Hill

cemetery in the 1990s and was informed by a local resident that the Burial Register was maintained by a caretaker living nearby and that the site had been used by the South Cork Board of Assistance to bury infants and children up to at least 1962. Aerial photography, provided by the Military Archives, shows that Carr's Hill cemetery was still in use in 1951[45] and Southern Health Board correspondence confirms that the South Cork Board were using the site for infant burials in 1960. In a bid to locate the Burial Register and/or caretaker, the Commission undertook house-to-house inquiries at Carr's Hill. However, to date, this has also proved unsuccessful.

St Finbarr's Cemetery, Cork

4.48 In March 2017, the Child and Family Agency (TUSLA) discovered a deed in respect of a burial plot in the name of St Anne's Adoption Society in St Finbarr's Cemetery, Cork. The supervisor at St Finbarr's Cemetery confirmed that the plot was purchased by St Anne's Adoption Society in March 1978 and that four infants who died while in the care of the Society were buried there.[46] This burial plot is unmarked. The Cemetery Supervisor also flagged a burial plot originally registered to St Patrick's Orphanage, precursor of St Joseph's Industrial School, Greenmount. The burial plot was bequeathed to St Anne's Adoption Society when Greenmount closed in the 1950s. St Finbarr's Cemetery burial registers confirmed that 16 children who died in the care of St Anne's Adoption Society are buried in this plot.[47] This plot is marked by a headstone inscribed "Suffer Little Children". Four of the 20 children buried in St Anne's Adoption Society plots at St Finbarr's Cemetery had an association with Bessborough. One of these infants was born in Bessborough and subsequently died in St Finbarr's Hospital, following an extended stay there. A second infant was born to a Bessborough resident at St Finbarr's Hospital. This infant subsequently died in foster care. The remaining two infants were both born at St Finbarr's Hospital and were subsequently admitted to Bessborough unaccompanied. Both infants subsequently died in Bessborough while receiving palliative care. St Anne's Adoption Society took responsibility for their burials.

Adult burials

4.49 The Commission has established that, between November 1927 and January 1985, 12 adult women, all former residents of the Bessborough Home, were buried in a Congregation of the Sacred Hearts of Jesus and Mary owned burial plot at St Joseph's

[45] Military Archives Ireland. Vertical Aerial Photography, V190 #137; Cork-Carr's Hill, February 1951.
[46] St Finbarr's Cemetery: Section I, Row 18, Plot No.55.
[47] St Finbarr's Cemetery: Section K, Row 6, Plot No.44.

Cemetery.[48] This plot is marked by a headstone. However, the headstone lies in three broken pieces and the inscription is unreadable. It is unlikely that the headstone bears the names of women buried in this plot. The women buried here remained in Bessborough for extended periods working as domestic servants; their deaths were not childbirth related. One woman entered Bessborough in 1922, aged 20 years, and remained there until her death in 1984 - a period of 62 years. Another entered Bessborough in 1924, aged 21 years, and remained there until her death in 1985 - a period of 60 years.

4.50 The Commission has established that there were an additional 14 deaths of mothers who were Bessborough residents. Nine of these seem to be pregnancy of childbirth related.[49] The Commission has not been able to establish the burial place of these 14 women. Six were private patients. Eight mothers were public patients; two of these died in Bessborough, five in Cork District Hospital/St Finbarr's and one in Dungarvan County Home.

[48] St Joseph's Cemetery, Border St Dominick, Plot 191-93. The Congregation bought this plot from the Society of African Missions in December 1927. Cork City & County Archives. St Joseph's Cemetery Collection; Register Book of Burial Plots and Burial Rights Therein; CP/CY/SJ/3.

[49] The Commission is consulting medical experts on the issues here and will report further.

Chapter 4A Cork County Home

4A.1 The close interconnectedness of Cork County Home, Cork District Hospital/St Finbarr's Hospital and Bessborough, and the nature of their relationship with the South Cork Board of Public Assistance, makes it necessary to consider institutional deaths and burials of "illegitimate" children in Cork institutions under the Commission's remit. The Commission has established that, between 1922 and 1998, a combined total of 1,343 "illegitimate" children died; 771 died in Bessborough;[50] 552 died in St Finbarr's Hospital and 20 subsequently died elsewhere.[51] To date, as outlined above, the Commission has identified the burial places of just 64 children. Despite having undertaken an intensive investigation the burial locations of 1,279 of these children remain unknown. A common factor which links the majority of the yet unlocated children is that almost 92% were born to public patients maintained in Bessborough and Cork County Home by Boards of Public Assistance. Responsibility for the burial of the unclaimed remains of children fell to the South Cork Board of Public Assistance. Despite the absence of any documentary evidence, it is possible that these children were buried in Carr's Hill cemetery; in particular, it seems likely that the children who died in St Finbarr's are buried there.

[50] Child and Family Agency (TUSLA), Records of the Sacred Heart Home and Hospital Bessborough, 1922-98.
[51] Cork City & County Archives, Cork County Home Indoor Registers 1922-60.

Chapter 5: Castlepollard 1935 - 1971

Background

5.1 Castlepollard Mother and Baby Home opened in 1935 with the same arrangements as Bessborough. It was owned and run by the Congregation of the Sacred Hearts of Jesus and Mary. The original building was an old manor house. In 1941 a maternity home was built and became known as St Peter's Hospital. Castlepollard ceased to be a mother and baby home in 1971; the Midland Health Board bought the entire premises and started to use it as an institution for people with intellectual disabilities.

Sources of information

5.2 The records of admissions, births, discharges and deaths which were compiled in Castlepollard were left with the Midland Health Board when the mother and baby home closed. It is not entirely clear what happened to them after that. In September 2015, a member of the congregation said that some of the Castlepollard records "made their way" to Bessborough over the next number of years. Some were stored in Mullingar Hospital; it is not known why or for how long. A historian working in Bessborough in the early 2000s told the Commission that the Castlepollard records which were then in Bessborough were incomplete. The Castlepollard records which were held in Bessborough and those held in Mullingar were handed over to the HSE in 2011 along with the records from Bessborough and Sean Ross and are now in the possession of the Chiid and Family Agency (TUSLA). The Commission has made digital copies of these records and is in the process of analysing them. In 2018, the Department of Health gave the Commission copies of a series of registration of births books from Castlepollard covering the period 1948 – 1971. It is not known how or why these ended up in the Department of Health.

Deaths

5.3 From the records compiled in Castlepollard and the records provided by the GRO, the Commission has established that over 220 children died in Castlepollard (or in hospitals to which they were sent) and there were eight mothers who died from complications of pregnancy/childbirth.

Burials

5.4 In its affidavit, the congregation told the Commission that the Castlepollard burial ground is located within the 18th century walled garden complex.

> "The infants are buried at the rear-ground of the garden/cemetery where the marble memorial cross is located. There was an original 18th century pathway midway

across this garden. When one of the sisters [...] died, in 1939[52], she was buried alongside this wall in the foreground of the garden/cemetery. This wall effectively became the marker point between the infant garden/cemetery and the burial place for the sisters of the congregation. Sometime after the congregation left Castlepollard the wall was demolished, and [a mother's] grave[53] became the marker point."

In the same affidavit the congregation said there were three members of the congregation and three mothers buried in this burial ground. Subsequently, the congregation said that there were two congregation members and one mother buried there.

Archaeological assessment

5.5 The HSE (which currently owns the buildings and surrounding land including the burial ground) provided the Commission with a copy of an archaeological assessment of the Castlepollard burial ground. This was carried out in 2017 by Eachtra Archaeological Projects Ltd on behalf of the HSE.

5.6 The archaeological report states that the burial ground is located in a rectangular area immediately south of the walled garden. It is bordered by a high stone wall to the north and a low stone wall to the south. Access is via a pedestrian iron gate decorated with a cross. This gate was erected in the late 1980s or 1990s and the remains of an earlier gate hinge are visible in the wall.

5.7 The archaeologists interviewed three people with "strong local links to Castlepollard and to the Mother and Baby Home". The archaeologists were told (in 2017) that:

- The graveyard was reorganised and cleaned up about 20 years earlier under the direction of a visiting nun. It had been arranged in two separate sections with a central dividing wall. The nuns were buried at the eastern end and the mothers and babies at the western end. In the reorganisation/clean-up, the dividing wall was removed, vegetation undergrowth was removed and the ground surface was levelled off between the two sections. Mounds or soil humps marking babies' graves were levelled off in the process. Soil was brought in during the levelling process. No bones were noted when the work took place. A white marble cross which had been located against a wall at the centre of the site was removed to the far western end following the removal of the central dividing wall.

[52] This particular Sister's grave does not seem to be marked in the burial ground and the death does not seem to have been registered.

[53] This mother's grave is marked in the burial ground and her death is registered.

- There was a caretaker who was responsible for burials; he was considered to have had a strong devotion to the nuns.
- The caretaker had explained that the burial ground was blessed by a priest and that both sections were consecrated.
- The burials were conducted with care and attention.
- The babies were buried wrapped in cloth and each baby was buried in its own single grave.

5.8 Apart from the information about the clean-up that occurred in the 1990s, all of the information provided by the local people is second hand. The Commission has no reason to doubt its general accuracy but it is not possible to prove any of it.

5.9 The archaeologists who carried out the 2017 assessments logged all the memorials[54] in the burial ground. These include headstones for a member of the congregation who died in 1964, another member who died in 1957 and a mother who died in 1939. There is a cross commemorating the members of the congregation and a plaque commemorating the babies who are buried there. There are 38 cobble stones; six of these have names painted on but none of these names appears in the register of deaths.

5.10 The wall on the northern side of the burial ground has a large number of iron nails embedded in the mortar. It had been suggested by some former residents that these were informal grave markers for child burials either as locational markers or markers of the fact of a burial. The archaeologists who examined the burial ground concluded that, while this is possible, they are more likely to have been installed as training nails for wall vegetation and pre-date its use as a burial ground. The congregation told the Commission that it believes the nails predate the mother and baby home by about 200 years and so could not possibly be grave markers; the congregation did not cite any evidence for this.

5.11 The archaeological assessment concluded that there was sufficient space in the burial ground for the number of children who died there.

Congregation evidence

5.12 Two members of the congregation who had worked in Castlepollard told the Commission that the workmen made coffins for the deceased children; one said the coffins were white.

[54] Memorials include permanent structures such as headstones as well as other markers such as crosses.

Commission conclusion

5.13 There was no legal requirement (see Chapter 1) to keep a register of burials in such burial grounds and no such registers seem to exist. Accordingly, there is no documentary evidence of these burials. However, the Commission has no reason to doubt that the majority of the children who died in Castlepollard are buried in this burial ground.

Chapter 6: Bethany Home 1922 – 1972

Background

6.1 Bethany Home was located in Blackhall Place, Dublin between the years 1922 and 1934 and in Orwell Road, Rathgar after that. The records of admissions, births, discharges and deaths which were maintained in the Home have been digitally copied by the Commission and are in the process of being analysed.

Sources of Information

6.2 The deaths of children born in, or admitted to, the Bethany Home were recorded in the Bethany Baby Book Register, which was kept and updated by the Home's authorities between the years 1922 and 1970. In two columns in that register, marked "where gone" and "later news", the death of each particular child was noted, along with the date of death and the location, in cases where the child did not die in the Bethany Home itself.

6.3 Details about the burial of children who died in the Bethany Home were published in 2010 after thorough research by Niall Meehan.[55]

6.4 Mount Jerome Cemetery in Harold's Cross, Dublin, was the main burial site for the children who died in the Bethany Home. The names from the Bethany Home records, including the Baby Book Register were checked against the burial register in Mount Jerome. The cemetery's burial registers show that 240 children who were born in, or at one time admitted to, Bethany Home, died between September 1922 and October 1964. This figure constitutes the majority of known deaths of Bethany Home children from the records made available to the Commission. The burial register also records the burial of 18 stillborn children from Bethany. There are at least 20 other children who died and are not recorded in the Mount Jerome burial register.

6.5 Of that 240, 213 were recorded as coming directly from the Bethany Home. The remaining 27 children were listed in the Mount Jerome burial records as coming from other addresses, with 24 of those being various hospitals around Dublin. The oldest age at death recorded was 36 months; the others were all aged 19 months or under.

6.6 The children who are buried in Mount Jerome are buried in a series of unmarked graves. In most cases, the costs of burial were met by the Bethany Home authorities. The

[55] See Niall Meehan, Supplement to *History Ireland*, Vol 18. No 5, September-October 2010 https://www.academia.edu/320793/Church_and_State_and_The_Bethany_Home

Mount Jerome records show that all were buried in graves located in sections 218 – 618 of the cemetery; all but five are located between sections 253 and 404. A monument to commemorate them, erected in 2014, is located in section 274 - roughly central to most of these sections of the graveyard.
http://www.mountjerome.ie/?map=mount-jerome-cemetery-map

6.7 The Bethany children were buried in ordinary public graves and grave plots in the cemetery, often in, or next to, those used for other private/public adult or child interments. They were not placed in a specific and separate "Poor Ground" section. Once a particular grave reached full capacity, it was simply closed and the next available grave with spare capacity was used.

6.8 Mount Jerome Cemetery has kept very good records of all burials. The Mount Jerome Cemetery Register of Burials, Volumes 24 - 46, covers all burials in the cemetery between March 1919 and January 1967. In the case of the Bethany Home children buried there, the Register of Burials records the child's name, age, the cause of death, the date of death, the date of burial and the burial number it represented for the year. The Register also recorded the address the child came from which, for most, was Bethany Home, 23 Blackhall Place prior to October 1934 and Bethany Home, Orwell Road, for all burials subsequent to that. The Register also noted the grave number and section of the graveyard the child was buried in and the future capacity of the grave. In relation to the latter, all were marked "full" by the time the burial records were completed.

6.9 In all but 19 cases, the Mount Jerome Burial Register recorded the causes of death for each Bethany child who was buried there between 1922 and 1964.

6.10 The Burial Register had a column marked: "Address and Relationship of Attestant". This column was completed up to May 1929 but is blank after that. For most, the Matron of Bethany or her assistant was the attestant. However, in some cases the child's mother and her address (either Bethany if she was still resident there, or else her home address) were inserted.

Anatomical studies

6.11 The burial records show that the children were usually buried within two to three days of death. Therefore, unlike children who died in the Dublin Union and associated institutions (see Chapter 7), there is no evidence of any child from Bethany being used as an anatomical subject before being interred in Mount Jerome.

Chapter 7: Burial of Anatomical Subjects

Background

7.1 The sending of the bodies of unclaimed deceased residents (of all ages) from institutions such as workhouses/county homes and psychiatric hospitals to medical schools for the purposes of dissection and anatomical study was common practice across the UK and Ireland until the mid-1960s. The *Anatomy Act 1832*[56] gave legal backing to this practice. An *Irish Times* article on the subject in 1907 described the processes involved.[57]

7.2 A campaign to encourage voluntary donation was undertaken in the 1960s by the Professors of Anatomy in the various Irish medical schools.[58] This seems to have resulted in the ending of the practice of using unclaimed bodies; however, it remained legal to use them. An Inspector of Anatomy said that donated bodies had "almost replaced" unclaimed bodies in the Dublin medical schools at the time of his appointment in 1967. An internal Department of Health memorandum, dated 1984, states that the practice of using unclaimed bodies in anatomical studies had ceased.[59] This seems to have occurred because there was a sufficient supply of donated bodies.

Anatomy Act

7.3 The *Anatomy Act 1832* provided that it was lawful for any executor or other party who had lawful possession of the body of any deceased person (apart from an undertaker who had possession of the body for the purposes of burial) to allow the body to undergo anatomical examination unless the deceased person had expressly stated that this was not to happen. This had to be expressed in writing or orally in the presence of at least two witnesses; in effect, people had to specifically opt out. The husband, wife or any known relative of the deceased could also prevent such an examination. Bodies could not be sent to medical schools until at least 48 hours after death: this was to enable family members to claim the body and/or object to the body being sent for anatomical studies.

7.4 This meant that the body of any resident who died in an institution such as a workhouse, county home or psychiatric hospital could be supplied to medical schools if no relative claimed it within 48 hours of the death. In the case of deserted or abandoned children who died in these institutions, there was no one with the legal capacity to object to

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[56] It was introduced in order to regulate the practice of anatomical studies and to try to prevent illegal trafficking in corpses (including grave-snatching). The text is available at: http://www.irishstatutebook.ie/eli/1832/act/75/enacted/en/html

[57] Jerry Cassidy, "Food for the dissecting knife: How the anatomical schools are supplied with dead bodies", *Irish Times*, 13 April 1907.

[58] Statement by the Anatomical Committee of the Irish Medical Schools 2011.

[59] Department of Health file CBP-NF-0-49129.

the bodies being sent for anatomical studies. The bodies of "illegitimate" children that were unclaimed by the mother or any other relative, could similarly be used for anatomical studies. It is not known, but it seems unlikely, that the mothers concerned were made aware of the existence or requirements of the *Anatomy Act* at any stage during their stay in any of the institutions being investigated.

7.5 The *Anatomy Act* required that all bodies being removed for anatomical examination be placed in a "decent Coffin or Shell" before removal. The medical schools which received the bodies were obliged to ensure that the bodies, after the anatomical examination, were "decently interred in consecrated Ground" or in some public burial ground in use for people of the same religion as the deceased. The Act required that a certificate of interment be provided to the Inspector of the district[60] within six weeks of the receipt of the body but this was amended in 1871 to provide that this time period could be varied.[61] The 48 hour rule and the six week time limit applied to all bodies being sent for anatomical studies and not just to unclaimed bodies. The medical schools were required to maintain registers of bodies received for anatomical studies.

Compliance with the Act

7.6 It seems that the provisions of the *Anatomy Act* were not always strictly observed; in particular, the time limits seem to have been rarely observed. An internal Department of Health memorandum, compiled in 1983, notes that there were complaints in the 1960s from relatives of deceased former residents of a county home and a public nursing home. The memorandum does not give details of the nature of the complaints but it does note that the author held a file on one of the complaints.[62]

7.7 This memorandum makes it clear that the 48 hour rule and the six week limit were not implemented in practice; it noted that it was commonplace for the body to be removed for anatomical study on the day of the death and the bodies were "rarely" buried within the specified time.

7.8 A witness told the Commission that he had discovered his mother had given birth to a son in Pelletstown in 1947. The child died in St Clare's Hospital[63] a few weeks later. His body was removed to UCD the day after he died. The child's mother was resident in

[60] The Act provided for the appointment of Inspectors of Schools of Anatomy.
[61] It does not seem to have been varied but, as is clear in the text, it was not strictly adhered to.
[62] Department of Health File CBP-NF-0-49129.
[63] St Clare's Hospital was in Glasnevin. It was also part of the Dublin Union and specialised in dealing with gastroenteritis; many children from Pelletstown were sent there for treatment.

Pelletstown at the time of his death. It is theoretically possible that his mother consented to his body being sent for anatomical study but the 48 hour rule should have applied anyway. The child was buried in Glasnevin in 1949.

7.9 The Commission has since established that a number of children were transferred for anatomical studies from Dublin Union institutions before the 48 hour period for claiming the body was over. In general, burial took place two to three years after the death.

Separate burial spaces

7.10 The rules about burials (see Chapter 1) applied to the burial of bodies used for anatomical studies in the same way as all other burials. There is some evidence that those responsible for burials did not consider that the burials of bodies used for anatomical studies should be treated in the same way as other burials. In January 1961, the Galway County Chief Medical Officer wrote to the Department of Health to complain about the rules in relation to burials and to suggest that they were not being kept by medical schools:

> "A problem has arisen regarding the interment of such remains of bodies following their use for anatomical dissection.
>
> According to the Rules applicable to burial grounds for every person over 12 years of age a burial space of 9ft. x 4 ft. must be provided. This would mean that if the remnants of ten cadavers were to be interred, ten graves should be provided, ten graves which would prove very costly and indeed wasteful of graveyard space. The remains of a cadaver after dissection consists of dismembered bones, perhaps some entrails and muscles which could be easily accommodated in a coffin 3' x 12" x 9 ", and if placed vertically in the grave four such coffins could be accommodated in the space above prescribed. Markers, of course, would be placed over each coffin. There would be no intermixing of corpses. I understand that this procedure is adopted for other anatomical schools.
>
> I request a direction if the procedure suggested above would be allowed and approved of by your Department."

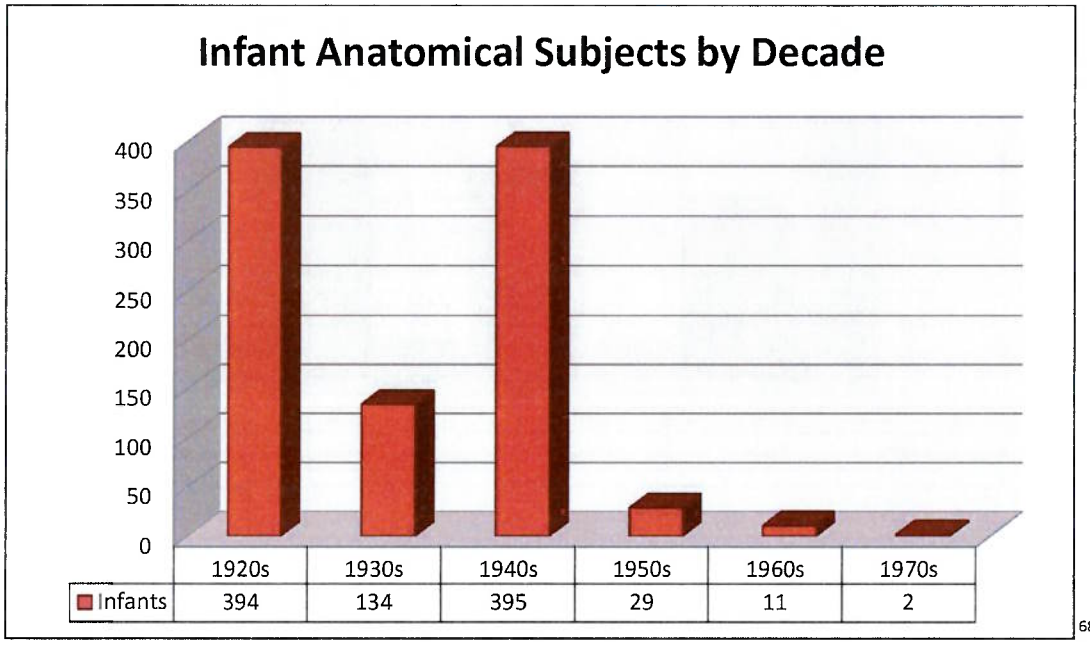
7.11 The Department's Inspector of Anatomy did not agree with the suggestion but a civil servant's note on the file states that "... it might be said that these Rules are not always (or even usually) strictly observed throughout the country".[64] The Galway County Medical

[64] Department of Health file SND-INA-0-516193.

Officer called to the department's offices to pursue his point but was met with the same response.[65]

Dublin Medical Schools

7.12 The Combined Anatomical Register of the Dublin Medical Schools shows that, between January 1920 and October 1977, the bodies of more than 950 children[66] who died in the Dublin Union and associated institutions, including Pelletstown, were sent to the medical schools at University College Dublin, Trinity College Dublin and the Royal College of Surgeons in Ireland for the purpose of anatomical studies.[67]



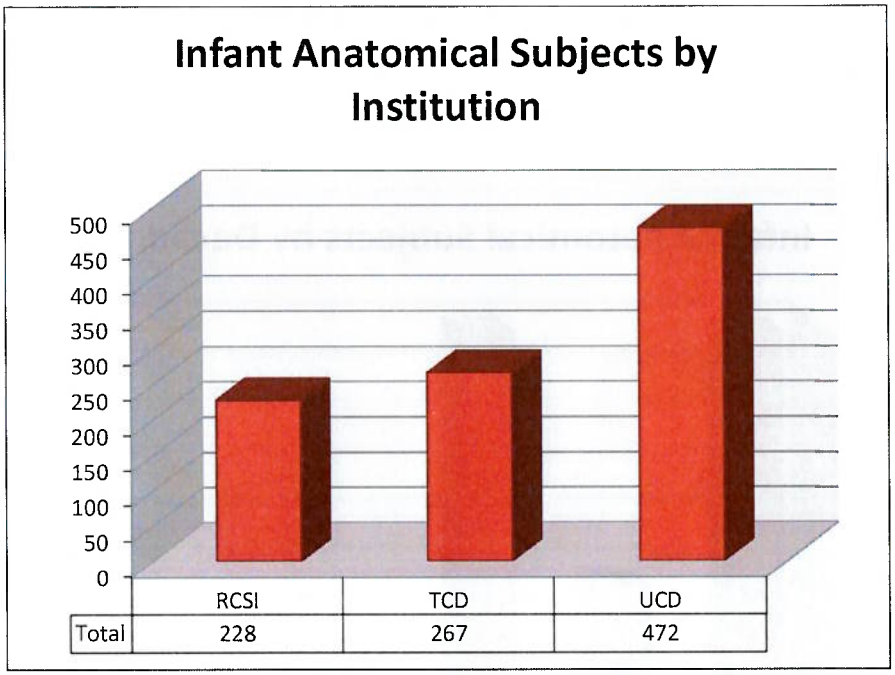
[68]

7.13 The Combined Anatomical Register of the Dublin Medical Schools records that all but 18 of the children received as anatomical subjects were "illegitimate" children. Children used as anatomical subjects in the Dublin Medical Schools were aged between 10 minutes and 15 years at the time of death. In addition, the register records that 27 stillborn infants were received as anatomical subjects. Many of the stillborn infants had a note reading "not to be

[65] *ibid*
[66] The Commission is checking the exact number involved; this represents 29% of all bodies received by the Dublin medical schools in this period.
[67] The Commission examined this register in UCD.
[68] These figures are based on the date of receipt of infants as anatomical subjects. In two cases it was not possible to establish a date of receipt.

interred" on their record.[69] It may be that stillborn infants were preserved as "wet specimens" for display purposes in medical schools.[70]

7.14 Not all deserted or abandoned children who died in Dublin Union institutions were sent for anatomical studies. There is no information available about the criteria (if any) used to choose which children's bodies were sent.



Burial in Glasnevin

7.15 The children from Dublin Union institutions whose bodies were used for anatomical studies were subsequently transferred from the three Dublin medical schools for burial in the Poor Ground section of Glasnevin Cemetery. They were clearly identified in the Glasnevin Poor Ground Burial Registry by the designation "AS" (anatomical subject). The time lag between when these children died, were received by the medical institution for anatomical study and were subsequently sent to Glasnevin Cemetery for burial varied considerably. Usually it was over a year between a child's death and the eventual interment of the remains in Glasnevin.

7.16 They were buried in different sections of the Poor Ground in Glasnevin: from 1919 to 1928 in St Paul's Poor Ground; from 1934, in St Patrick's Poor Ground; and from December

[69] Combined Anatomical Register of the Dublin Medical Schools pre 1972, University College Dublin, Special Collections.
[70] Stillborn infants received by the Dublin medical schools do not appear in the Glasnevin Cemetery Burial Records.

1945, anatomical study burials were placed in the newer South Poor Ground section of the cemetery.

7.17 Anatomical subject remains were not buried in a distinct section of the Poor Ground. They were buried in individual burial plots that were located next to those used for ordinary child and adult burials. The usual practice in Glasnevin Cemetery was for the remains of a number of anatomical subjects to be collectively buried in the same plot on the same day. For example, the Glasnevin Poor Ground Burial Register shows that on 20 May 1921, 33 anatomical study remains, all former residents of the Dublin Union, were buried in grave plots Sb 76-76.5, of the St Paul's Poor Ground. Eighteen of these were adults aged between 28 and 109. Fifteen were children; 14 were described as either "illegitimate" and/or deserted. Ten days later, 41 anatomical study remains, all originally from the Dublin Union, were buried in graves Rb 76-76.5, of the St Paul's Poor Ground. Ten were adult anatomical studies aged between 51 and 83. Thirty-one were children, described as either "illegitimate", deserted and/or nurse children. One child buried on this date is not recorded as an anatomical study in the Glasnevin Burial Register but he is recorded as one in the Anatomical Register of children from the Dublin Medical Schools.

7.18 This practice of adult and children remains being buried together on the same day within the same grave plots continued down through the years. On 21 July 1922, thirteen adult and nine children (all but one described as "illegitimate" and/or deserted) were buried in plots Wb 82-82.5 of the St Paul's Poor Ground. On 9 July 1924, 30 anatomical study remains, 15 adults and 15 children (all but one described as "illegitimate" and/or deserted) were buried in plots Tb 91-91.5 of the St Paul's Poor Ground.

7.19 On 7 July 1926, 16 anatomical study remains, seven adults and nine children (all described as "illegitimate" and/or deserted) were buried in plots Jb 69-69.5 of the St Paul's Poor Ground. On 30 April 1935, nine anatomical study remains, five adults and four children (two "illegitimate", one legitimate and one nurse child) were buried in plots Go 157-157 of the St Patrick's Poor Ground. Eight anatomical study remains, four adults and four children, were buried on each of three dates in January 1943. Of the twelve children, one was described as a nurse child, the others were recorded as being "illegitimate". All were buried in plots Bo 168.5-169 of the St Patrick's Poor Ground.

7.20 On 13 July 1946, 23 anatomical study remains, three adults and 20 children (all but one described as "illegitimate") were buried in plots Na 113-113.5 of the South section of the Poor Ground. On 11 July 1950, 21 anatomical study remains, eight adults and 13 children (all described as "illegitimate") were buried in plots Va 116-116.5 of the South section of the

Poor Ground. On 9 June 1960, 12 anatomical study remains, six adults and six children (all described as "illegitimate") were buried in plots Ia 104-104.5 of the South section of the Poor Ground.

Separate coffins

7.21 It is unknown if the remains of individual bodies used for anatomical studies were placed in separate coffins for burial in Glasnevin. A meeting of the Dublin Board of Guardians in 1907 heard accusations that in the medical schools, coffins were not being used for one body alone, but that the practice was simply to fill up a coffin with various body parts from various individuals who had been dissected.[71]

7.22 Glasnevin Cemetery is a private cemetery. At the relevant time, it was governed by the *Dublin Cemeteries Act 1846* and the bye-laws made under that Act.[72] The bye-laws (made in 1901) set out procedures to be followed if there was more than one body in a coffin:

> "In every case of an application being made for an order for burial of more than one body in a coffin, a notice or certificate in writing in the prescribed form shall be delivered or furnished to Head Office, duly signed by the applicant, containing to the applicant's best knowledge and belief, all the particulars indicated by such form respecting each of the bodies of the deceased persons contained in said coffin."

7.23 This clearly envisages the possibility of more than one body being in a coffin. The Dublin Cemeteries Committee (generally known as the Glasnevin Trust) which runs the Glasnevin Cemetery told the Commission that each of the anatomical subject burials was given an individual sexton's number indicating that for each register entry there was an individual coffin. "There are no annotations within the burial registers showing that permission was granted ... to allow more than one set of remains per coffin."

7.24 A further bye-law provided that:

> "No coffin containing a body or portion of a body (save in the case where the person whose body is being buried had not been identified previous to burial) shall be admitted into the Cemeteries unless and except the name or names of the person or persons whose body or bodies etc. are contained in said coffin shall have been legibly inscribed on the lid of the coffin. In the case of stillborns the surname or

[71] North Dublin Union: Paupers' bodies for medical schools, *Irish Times*, 28 March 1907.
[72] The 1846 Act was replaced by the *Dublin Cemeteries Committee Act 1970* which is currently in force.

surnames of the body or bodies contained in the coffin shall be inscribed on the lid of the coffin."

7.25 A member of the cemetery staff was required to see that the names on the docket and the names on the coffin corresponded. The Glasnevin Trust told the Commission that, while each burial was required to be witnessed by a designated member of staff, the staff did not inspect coffins internally.

Galway Medical School

7.26 The Galway Medical School Anatomical Register[73] records details of approximately 690 deceased adults whose remains were transferred to the School of Anatomy, Galway Medical School,[74] during the years 1909-1997, for the purposes of anatomical study. The register includes all the required details about the deceased adults. It records human remains as they were received in chronological order and there is no break in the numerical assignation associated with each individual. There is no obvious gap or omission in the register.

7.27 During the period 1909-1920, the adult human remains were received almost exclusively from the South Dublin Union. From 1920 to 1950, human remains were received almost exclusively from the Ballinasloe Mental Asylum; the Castlebar Mental Hospital after 1950; and Ennis Mental Hospital after 1958. A small number of bodies were received from Galway Central Hospital/ Galway Regional Hospital[75] over the period 1909-1970, but again these were all adult remains.

7.28 The Galway anatomical register does not include any children. However, evidence exists that children's bodies were sent to the medical school.

7.29 The Department of Children and Youth Affairs *Report of the Inter-Departmental Group on Mother and Baby Homes* states that the Anatomy Department at University College Galway received the remains of 35 children from the Central Hospital/Regional Hospital, Galway in the years 1940-1964. It also states that the Galway Medical School received the remains of 27 children between 1960 and 1964; however, the Galway Anatomical Register records just 24 bodies in total during the same period and they are all adult remains.

[73] This is held by the Medical Council.
[74] Originally Queen's University Galway, then University College Galway, now NUI Galway.
[75] The old Galway workhouse became the Galway Central Hospital in the period 1922 - 1924. It was subsequently rebuilt and renamed the Regional Hospital. It is now the Galway University Hospital.

7.30 The Commission asked the current head of the anatomy department at NUI Galway for further information about this. He invited the Commission to see some extant historical documents from the department. One of the items examined was a "Receipt Book for the Removal of a Dead Body" issued to the department by a then Inspector of Anatomy. Details relating to 15 adult anatomical subjects were recorded as having been received on dates between October 1920 and March 1922; 11 remains were received from Ballinasloe Asylum and the remainder came from the Galway Workhouse/Union/Central Hospital.

7.31 A Department of Anatomy Mortuary Book recorded the reception of adult anatomical subjects from January 1878. The last entry seen by the Commission was made on 6 November 2017. All entries relate to adult anatomical subjects and correspond with the Galway Anatomical Register.

7.32 The third item was labelled "Day Book". This records single line handwritten entries relating to the anatomy department, including the purchase of materials and supplies. Although the Day Book covers the period 1920 to the 1970s, a large portion of the book covering the period 1931 to 1947 is missing. It has not been possible to determine when these pages were removed, or the reason why they were removed.

7.33 In what remains of the Day Book, it is possible to identify the reception of infant remains for use as anatomical subjects. In every instance, the body or bodies were supplied by a porter at the Central Hospital/Regional Hospital Galway. In every instance the infant remains were received by the head of the School of Medicine and Anatomy Department, University College Galway. He paid the porter 10/- for every infant body received. It appears that between April 1949 and November 1964, he received and paid for 35 infant anatomical subjects. None of these infants is recorded in the Galway Anatomical Register. Unfortunately, no records survive which name the children whose bodies were sold. It is possible that some of the bodies were stillbirths which, at the time, could not have been registered.[76]

7.34 Children resident in the Tuam Children's Home were routinely sent to Galway Central Hospital for treatment. The Commission has established that 86 children from the Tuam Home died there (see Chapter 8). The Commission has found burial records for 50 of these children in Bohermore Cemetery Burial Records. The records show that these children were generally buried within a few days of death so it seems unlikely that they were used for

[76] The *Stillbirth Registration Act 1994* came into effect on 1 January 1995. Prior to that, it was not possible to register stillbirths.

anatomical studies. The Commission has asked the HSE if any relevant records from the Galway Central Hospital can be located.

7.35 The current head of the Galway Anatomy Department told the Commission that, when he took up this post in 1995, there were many "wet" infant anatomical subjects preserved in the department. These unidentifiable infant remains were buried together in Rahoon Cemetery, Galway in 1995 with full funeral rites and with the permission of the Coroner.

Cork Medical School

7.36 The Commission has found no evidence that children were used for anatomical studies in the Cork Medical School.

Chapter 8: Tuam Children's Home 1925 - 1961

Background

8.1 The Commission's Terms of Reference describe the Tuam Children's Home as "Bon Secours Mother and Baby Home". This does not seem to have ever been the name of the Home.

8.2 The Tuam building was originally a Poor Law Union workhouse and was used as such until the early 1920s when a number of workhouses were closed and other changes were made to the Poor Law institutional arrangements in Galway.[77] It was occupied briefly by the Free State army after it ceased to be a workhouse and before it became the Children's Home. As part of the Poor Law reorganisation, another former workhouse, Glenamaddy, was designated as a Children's Home for children and unmarried mothers and was used as such in the period 1922 – 1925. It was run by the Sisters of Bon Secours and owned by Galway County Council. It was in very poor condition so the decision was made to use the former Tuam workhouse as the Children's Home. Children were moved from Glenamaddy in 1925. The Commission regards the Glenamaddy Children's Home and the Tuam Children's Home as one institution.

8.3 The title "Children's Home" was used by its owner, Galway County Council, for virtually all of its existence (it closed in 1961); the first record the Commission has seen of Galway County Council's use of "St Mary's Home" dates from 1960. Locally, it was known simply as "the Home". The Sisters of Bon Secours used the title "St Mary's Children's Home" but the Commission has not been able to establish when it first used this title.[78] The Archbishop of Tuam gave the Sisters approval to set up St Mary's Home as a separate foundation in 1956.

8.4 The Tuam Children's Home was owned by Galway County Council[79] and operated by the Sisters of Bon Secours[80]. The Commission has seen references to the existence of a

[77] Changes were made in nearly all other counties as well; further information about the re-organisation of Poor Law institutions will be included in the Commission's final report.

[78] Former workhouses which became county homes in the 1920s were generally known by their location. Gradually, they were given saints' names and these names became officially used from the 1950s onwards; locally, they continued to be known by their location.

[79] The grounds were owned at different times by different State bodies but the institution was the responsibility of Galway County Council for all of the period during which it was the Tuam Children's Home.

[80] The Sisters opened a hospital/nursing home called The Grove in Vicar Street, Tuam in 1945; it was sometimes called St Anne's. This was a private institution and had no official connection with the Tuam Children's Home. Between 1945 and 1953, the Sister who was the Superior in the Children's Home was also the Superior in The Grove. The Grove closed in 2001 and the premises are now owned by the HSE.

formal agreement between Galway County Council and the Sisters but, so far, has not been able to locate this. Galway County Council made the decisions on who entered the Home; it paid directly for external repairs to the building, rates, water rent and insurance. It also paid the salaries of the chaplain (who was allocated by the Archdiocese of Tuam) and the medical officer and it paid for the services of the maternity nurse. It paid a capitation rate to the Sisters for the upkeep of the residents. It did not pay salaries to the Sisters who worked there. Tuam Children's Home differed in this respect from St Patrick's, Navan Road/Pelletstown (see Chapter 2) which was owned and financed by the Dublin health authorities[81] and operated by the Daughters of Charity of St Vincent de Paul. The Daughters of Charity were paid as public servants to operate the institution and all costs were met by the Dublin health authorities.[82]

8.5 In 1931, Mayo County Council entered into an agreement with Galway County Council to send women and children from Mayo to the Tuam Children's Home. Mayo County Council paid capitation rates in the same way as Galway but was not involved in decision making about the Home.

8.6 The Tuam Children's Home was designated as a home for children and unmarried mothers. It was not used exclusively as a home for unmarried mothers or as a mother and baby home. It did house unmarried mothers and their children but it also housed children of married parents who were unable to care for them and it housed homeless families.[83]

8.7 Between 1925 and 1942, many of the decisions in relation to the Tuam Children's Home were made by the Galway Board of Health which was composed of members of Galway County Council.[84] The County Home and Home Assistance Committee, which was a sub-committee of the Board of Health but also included non-council members, was also involved in making decisions. The Board of Health and the County Home and Home Assistance Committee held a number of their meetings in the Tuam Children's Home. In 1942, the Board of Health ceased to exist and its functions were transferred to the County Manager when the *Public Assistance Act 1939* and the *County Management Act 1940* came into effect. From 1942, many of the decisions were made by the County Manager by way of Managers' Orders. National government also had a role in the decisions made. Many of the

[81] The different arrangements and titles of bodies for the delivery of health and public assistance services will be fully explained in the Commission's final report.
[82] The post 1922 structures for health authorities differed somewhat in Dublin.
[83] A small number of children who died in the Home were resident there with their families. "Legitimate" children accompanied by a parent or parents are outside the Commission's Terms of Reference.
[84] The *County Scheme Order, Galway No 1, 1923* provided for the establishment of the Board of Health and for it to establish sub-committees: http://www.irishstatutebook.ie/eli/1923/sro/920/made/en/print

decisions, for example, in relation to capitation rates, were subject to the approval of the Department of Local Government and Public Health between 1922 and 1947 and the separate Department of Health after that. Decisions on water and sewerage expenditure were subject to the approval of the Department of Local Government and Public Health between 1922 and 1947 and the separate Department of Local Government after that. Such expenditure frequently involved taking out loans from the Local Loans Fund. The Board of Public Works had a role in approving the use of these funds.

Deaths in the Tuam Children's Home

8.8 The Commission has established that a total of 973 children from the Children's Home died either in Glenamaddy, in the Tuam Home itself or in a hospital or institution soon after they were transferred there from Tuam. Of these, 79 children died in Glenamaddy. The Glenamaddy workhouse had its own burial ground so it is likely that the children who died there are buried in that burial ground. However, there is no burial register available for the period in question so this cannot be verified. The vast majority, 802, died in the Tuam Home itself. This number includes a significant number of "legitimate" children who are within the Commission's Terms of Reference because they were not accompanied by a parent and a small number of "legitimate" children who are outside the Commission's Terms of Reference because they were accompanied by a parent. (The children who were accompanied by a parent are less likely to be buried in the Tuam burial ground and are more likely to have been buried by their parents.) The details of the deaths of the children were established by the Commission from the records compiled in the Home (see below) and from a list provided by the General Register Office (GRO) and already in the public domain. There are six children whose deaths are recorded in the records compiled within the Home and who are not on the GRO list. The Commission has been unable to find any mention in the Tuam Home records of six children who are included in the GRO list.

8.9 When analysing the records, the Commission noted that a significant number of children who were resident in the Tuam Children's Home were transferred to the Central Hospital, Galway[85] when they became seriously ill. The Commission checked the Register of Deaths and found that 86 children who had been transferred there died soon after the transfer. Six other children died soon after leaving the Tuam Home: two children died in the County Home, Castlebar; one died in Crumlin Children's Hospital; one in St Bridgid's Industrial School for Girls, Loughrea; one in Clifden District Hospital and one died at home.

[85] The old Galway workhouse became the Galway Central Hospital in the period 1922 - 1924. It was subsequently rebuilt and renamed the Regional Hospital. It is now the Galway University Hospital.

The Commission has found burial records for 50 of the children who died in the Central Hospital, Galway -- they are recorded as being buried in Bohermore Cemetery.

8.10 Twelve mothers who were resident in the Tuam Home died, the majority from complications of childbirth; some died in the Home itself and some in the Central Hospital, Galway. It is not known who took responsibility for the burial of these mothers. If the Central Hospital took responsibility for the burials it would be expected that they would be recorded in Bohermore cemetery but the Commission did not find any record of these burials there.

Sources of information on burials

8.11 There is remarkably little official documentation available about many aspects of the Tuam Children's Home and there is virtually no information about burials in the documentation that has been seen by the Commission. There are references in various documents provided to the Commission by Galway County Council and the Department of Health to inspections of the Home. However, until very recently, the Commission has seen only one report of an inspection; this is the inspection carried out in 1947 by the Department of Health. This report does not mention burials. In December 2018, the Commission received a number of files from the Department of Health which contain some inspection reports on the maternity wing of the Home and some other reports about the condition of the Home immediately before it was closed. Again, none of these reports contain any references to burials.

Records compiled in the Tuam Children's Home

8.12 The records of admissions, births, discharges and deaths which were compiled in the Tuam Home by the operators of the Home were left with Galway County Council when the Home was closed in 1961. (The County Council was probably the owner of the records anyway.) These then became the property of the Western Health Board when it was established in 1970. Subsequently they became the property of the HSE in 2005 and then the Child and Family Agency (TUSLA) in 2013. The Commission has made digital copies of these records and has almost completed analysing them. These records include details about the deaths of children and the causes of death in many cases but do not include any information about burials.

8.13 In the years since the Home closed, these records have been used mainly for tracing purposes. The Commission is concerned that some records may have been lost or destroyed over the years. It is impossible to establish if the records currently held by the

Child and Family Agency (and made available to the Commission) constitute all of the records left behind when the Tuam Home closed in 1961.

Galway County Council records

8.14 The extant minutes of the Galway Board of Health are held by Galway County Council. There is almost a complete set for the period 1922 – 1941 but there are some gaps and there are no surviving minutes for the year 1937. The Commission has examined these records in detail. There is no specific mention of burials in these minutes but there are a number of references to issuing tenders for coffins. The tenders were for coffins of various sizes. There is no mention of coffins actually being bought.

8.15 These minutes do contain extensive references to the water supply problems faced by the Tuam Home and to the various attempts to improve it and to connect the Home to the Tuam sewerage system – see below.

8.16 The meetings of Galway County Council, the Board of Health and its subcommittees were held in public and received extensive coverage in the local newspapers. The Commission has searched these newspapers for any references to the Tuam Children's Home.

8.17 Managers' Orders were not discussed publicly. The Commission has examined the Managers' Orders for the period 1942 – 1961 in order to find any references to the Tuam Children's Home. Again, there are references to the water supply and sewerage problems and to tenders for coffins but no specific reference to burials. The coffin tenders are for various sizes of coffins and seem to have been issued at six month intervals. The cost of the large coffins was questioned a number of times. However, there is no record of any coffin being bought in this period either.

8.18 Galway County Council told the Commission that it was unable to find any records which showed that the Council had any role in the administration or regulation of a burial ground in the grounds of the Children's Home. In oral evidence to the Commission, representatives of Galway County Council said that there are 233 burial grounds in County Galway listed on the Galway County Council register of burial grounds. There are two listed in Tuam. One is the very old burial ground in Templejarlath which is in High Street and the other is the burial ground on the Athenry Road across the road from the Children's Home and which is still in use. There are registers of burials for both of these burial grounds. The burial ground in the Tuam Children's Home is not on the register. The Tuam workhouse had

a burial plot in the burial ground across the road from the building (for which there is a register of burials). There is no evidence that this plot was used for the burials of children or adults who died in the Tuam Children's Home.

8.19 The Tuam Children's Home was owned by a local authority and not by a religious order. The Commission considers that the general rules in relation to local authority burial grounds should have applied – see Chapter 1. Among other things, this meant there was a legal requirement to keep a register of burials. There is no evidence that such a register was compiled.

8.20 The first documentary evidence of Galway County Council's awareness of the possible existence of a burial ground in the grounds of the Tuam Children's Home dates from the 1970s (see below). The issue came to light during the building of the Dublin Road Housing Estate. This was a Galway County Council development which was built in four phases starting in 1972 and concluding in 1978. Galway County Council has documentation relating to the last two phases but not to the first two.[86] Documentation in relation to the first phase was sent to the Department of Local Government in 1969/70. The Department is currently searching its archives to see if this is available. The National Archives of Ireland does not have this documentation.

8.21 There is a document on a Department of Health file[87] which suggests that there may have been some rumours about the Tuam site in 1969. This is a handwritten note on a file dealing with the possible closure of some mother and baby homes. The note states "Surely the story about the Waterworks is not true? Do M[88] get police reports on abandoned dead babies?" The Commission interviewed a retired senior official of the Department of Health about this. He was able to give an indication of who the author was but that person is dead. He was not able to cast any further light on the matter. The Commission recognises that this note may be completely unconnected to Tuam but its creation in 1969 does coincide with the making of plans for the development of the Dublin Road Housing Estate. In the absence of any other related documents, the Commission is unable to draw any conclusions about this.

[86] At the time, local authorities did not need planning permission for their own developments so there would not have been any planning documents created. It is highly likely that there were detailed plans, including water and sewerage plans, bills of quantities and other construction documentation created at the time but Galway County Council has been unable to provide such documentation.
[87] Department of Health file INACT-INA-0-426512
[88] M was a section of the Department of Health at the time.

The Sisters of Bon Secours

8.22 Soon after its establishment in 2015, the Commission asked the Sisters of Bon Secours for any information or documentation they held on the Tuam Children's Home. In 2015, the Sisters provided a small number of documents which were largely concerned with the plans to close the Home in the period 1959 – 1961. They stated that they had left all relevant documents in Tuam when the Children's Home closed in 1961 and they believed that these documents were now in the possession of the Child and Family Agency. In March 2016, they provided some further documentation but this was largely concerned with correspondence after the closure of the Home. None of the documentation had any reference to burials.

8.23 The Sisters told the Commission that there is only one Sister alive who actually served in the Home. She served for only a few months and is now unable to assist.

8.24 The Country Leader of the Sisters of Bon Secours in Ireland provided an affidavit to the Commission in February 2018. This dealt with a range of issues including burial arrangements. She told the Commission that she does not know what the actual burial arrangements were. She said that the present Sisters are "shocked and devastated by what has come to light to date in relation to burials in the subsurface structure".

8.25 The Country Leader said that she understood that mother and baby homes "commonly had burial areas within their confines commonly referred to as "Angels' Plots"" and she would not have been surprised to learn there was such a burial situation in Tuam. She also said that she understood that it was common practice for such burial areas not to be publicly marked. The Commission is aware that the plot in Glasnevin Cemetery has been known as the Angels' Plot since the 1960s. It is not aware that any other similar plot was so named. There is no evidence that the burial plots in Castlepollard and Sean Ross were ever known as "Angels Plots".

8.26 The Country Leader apologised for the failure to provide a proper burial: "It is the view of the Sisters that the children who died at St Mary's deserved a proper burial and this did not happen. For this we express our deep sorrow and apologise unreservedly."

The burial ground/memorial garden

8.27 A walled off area, previously part of the grounds of the Tuam Home, has been maintained by local people as a "memorial garden" since the late 1970s. This garden was maintained with considerable care mainly by a local couple who, with a number of other local

residents, formed a "Graveyard Committee" to maintain the area. The Graveyard Committee created a grotto at the south east corner of the garden in memory of the children who died at the Home; this was installed around 1990.

8.28 This area had been entirely enclosed by walls for some time. Two of the walls are higher and older than the others. Two more recently constructed walls on the western and northern boundaries of the garden had been built to fully enclose the garden with gated access. On the western side of the garden, one of the lower walls separates the garden from the back garden of a house in the Dublin Road Housing estate. On the northern side, a wall separates the garden from a children's playground which was created in the 1980s also on part of the grounds of the former Tuam Children's Home. Part of the eastern boundary is a much higher wall and was evidently, in part at least, a continuation of the long stone boundary wall that bounded the eastern perimeter of the Home and remains in situ. The southern boundary is of similar height and this forms a boundary with a number of other residential properties. Two gates allow access to the memorial garden; one in the north that leads to the children's playground and the other to the west that leads to a gravelled road that provides access to the rear of a number of houses on the Athenry Road (R347) which are part of the Dublin Road Housing estate.

8.29 In October 2015, the Commission arranged for a geophysical survey to be conducted on the site. This was a non-invasive survey which was conducted over the surface of the ground inside the current boundaries of the memorial garden/burial ground. The sub surface of the site was not disturbed. The purpose of the survey was to detect the presence of possible sub surface anomalies. Ground Penetrating Radar, Magnetometry and Electrical Resistivity remote sensing methods were used. The report of this survey is at Appendix A.

8.30 This survey identified a particular area of interest and identified a number of sub surface anomalies that were considered worthy of further investigation. These were further investigated by a test excavation in November/December 2016 and in January/February 2017. In March 2017, the Commission issued a short statement setting out the most significant findings of the excavation.

> "Test trenches were dug revealing two large structures. One structure appears to be a large sewage containment system or septic tank that had been decommissioned and filled with rubble and debris and then covered with top soil. The second structure is a long structure which is divided into 20 chambers. The Commission has not yet determined what the purpose of this structure was but it appears to be related to the

treatment/containment of sewage and/or waste water. The Commission has also not yet determined if it was ever used for this purpose. In this second structure, significant quantities of human remains have been discovered in at least 17 of the 20 underground chambers which were examined. A small number of remains were recovered for the purpose of analysis. These remains involved a number of individuals with age-at-death ranges from approximately 35 foetal weeks to 2-3 years. Radiocarbon dating of the samples recovered suggest that the remains date from the timeframe relevant to the operation of the Mother and Baby Home (the Mother and Baby Home operated from 1925 to 1961; a number of the samples are likely to date from the 1950s). Further scientific tests are being conducted."

8.31 The detailed reports of this excavation and the further tests are at Appendix B and Appendix C.

8.32 The Commission's Terms of Reference require an investigation into burial arrangements. They do not give the Commission the responsibility to deal with inappropriate burial arrangements. For example, the Commission does not have the power to arrange for the exhumation of the bodies. Accordingly, the Commission reported its findings to the Minister for Children and Youth Affairs. Subsequently, the government decided that it would take responsibility for dealing with the matter even though it is arguable that, in this case, the onus of dealing with the inappropriate burial arrangements lies with Galway County Council as the owners of the site and of the Home.

8.33 In June 2017, the government established an Expert Technical Group to advise on options and appropriate courses of action available to the government at the Tuam site. Its report was published in December 2017.[89] In October 2018, the government announced its intention to conduct a forensic excavation of the available site.[90]

The Commission's investigation of the burial ground

8.34 The Commission appointed a forensic archaeologist to carry out preliminary investigations into the area described as the children's burial ground and ultimately instructed her to carry out limited excavations. She and her team of specialist archaeologists compiled the detailed reports.

[89] https://www.dcya.gov.ie/viewdoc.asp?DocID=4515; the Commission had no involvement with this report. The members of the Expert Technical Group did not have access to the Commission's reports.
[90] https://www.dcya.gov.ie/docs/EN/Press-Releases-copy-dcya-gov-ie-2018/81/4983.htm

8.35 The Commission interviewed a number of people who had knowledge of the area. The Commission has not heard any evidence from individuals with **direct** knowledge of the burial arrangements. A local woman (who moved into the area in the 1970s) told the Commission that she was told by a former worker in the Home that the dead babies, including babies who were stillborn, were swaddled and buried. She did not ask where or how; she assumed that they were buried in what is now the memorial garden. This woman told the Commission that her husband had found bones in their back garden when he was sowing it; she believed that they were animal bones.

8.36 The Commission heard evidence from the two men who, as young boys in the 1970s, found evidence of bones at the site. They described how they had descended the southern wall leading into what later became the memorial garden. One of them remembers jumping off the wall and the ground giving way beneath him when he landed. When he and his friend explored what was underneath their feet, they saw bones at the bottom of a tank which also contained water. He remembers telling his parents about this and the ground was filled in shortly after that after being blessed by a priest. The other person has largely the same memory of the discovery except that he thought the tank was dry. He too had the same view that a priest came some days later and blessed the area which was filled in. A third person who gave evidence to the Commission remembers, as an adult in the 1970s, seeing a child running around a portion of the grounds of the Children's Home with a skull on top of a stick. She challenged the child and took the skull and when she went to investigate where it came from and return it she fell into a structure which she said was full of the swaddled bodies of children.

8.37 A local woman told the Commission that she remembered the construction of the Dublin Road housing estate. She said that mounds of earth were created during the construction and bones were visible in those mounds. She said the bones were collected in or near the playground area.

8.38 In 2014, An Garda Síochána conducted an investigation. The documentation collected and the analysis done were provided to the Commission. The Gardaí had met a number of people with knowledge of the Home and the burial ground including representatives of the Sisters of the Bon Secours and the two men who had found bones at the site in the 1970s. The Gardaí concluded from their analysis of maps and from inspection of the site that the burial ground was about three times larger than the area which is now maintained as a burial ground. They concluded that the back gardens of some of the properties on the Athenry Road were part of the burial ground.

Maps and aerial photographs

8.39 The archaeological team and the Commission's researchers examined, among other material, archival records held by Galway County Council and historic Ordnance Survey records, and accessed some aerial photography from the Military Archives. The area representing the memorial garden in part at least corresponded with a delineated area of ground that appeared on a six inch map dating from 1838. This area was an adjunct to the grounds of what was then a workhouse and was described as a "gravel pit". An Ordnance Survey map of 1892 showed for the first time the outline of a formal structure roughly in the same place; however, this structure was not expressly described. An Ordnance Survey map from 1927 labelled the area as "Sewage Tank".

8.40 A drawing for the Dublin Road Housing Estate from Galway County Council archives, apparently created prior to 1975, identified an area of ground which included the area of interest as a "burial ground". An additional plot of ground within the portion marked "burial ground" on this map lying outside of the memorial garden represents an access road that leads up to the current memorial garden. A later drawing of the Dublin Road Housing Estate dated 1978 identifies the "burial ground" in the same location; however, the insertion of this description on the drawing is located more proximately to the area where the memorial garden now stands.

8.41 A third drawing from Galway County Council which outlined plans for further development of the Dublin Road Housing Estate was produced around 1978. An area was marked delineating a "burial ground" but the writing signifying burial ground has moved somewhat closer to what is now the memorial garden. A further map obtained from Galway County Council contains a drawing with annotation "as constructed layout of County Council Estate Dublin Road Tuam"; on this particular edition of the map, the area previously identified as a burial ground has not been marked or labelled.

8.42 Conveyancing documents from Galway County Council in the 1980s describe the area in question as "indicated with the words sewage tank".[91]

8.43 An aerial photograph taken in 1974 obtained from Ordnance Survey Ireland demonstrates that an area overgrown with vegetation largely corresponds with the area from the housing estate drawings as a burial ground. A second aerial photograph from 1977 from

[91] Letter from the Council's solicitor to the Western Health Board's solicitor dated 2 June 1982

the Military Archives shows the same area as still overgrown.[92] A more recent aerial photograph obtained from Ordnance Survey Ireland which is dated circa 2015 shows both the memorial garden, walled off, with the remaining part of ground included in the area described as a burial ground now devoid of any of the overgrowth previously seen. This area to the west is currently used as an access way to the rear of a number of the houses on the Dublin Road Estate and for access to the memorial garden.

Galway County Council awareness of burial ground

8.44 There is evidence from the County Council archives that the Council was aware of the existence of a children's burial ground on the Tuam site in the early 1970s. The Council told the Commission that it was not aware that burials of the nature discovered by the Commission's investigation had taken place there. Some of the maps and aerial photography described above were available to the Council. The aerial photography illustrates that the walled off area identified locally as the memorial garden was an area that was walled off on all sides at some stage after 1977. Council records suggest that this occurred in the early 1980s and was possibly altered by raising the level of one of the walls in the early 1990s. The wall separating the memorial garden from what became the children's playground and also separating the area later utilised for the purposes of an access road was apparently built in the 1970s presumably during or proximate to construction of a phase of the Dublin Road Estate and before 1977. The most recent aerial photograph dating from 2015 when compared with the earlier aerial photos demonstrates the changes that took place between 1977 and 2015.

8.45 The minutes of a Galway County Council meeting of 17 December 1979 record a motion proposed by a Council member for development of a playground "...having regard to the existence of a memorial site, a children's Burial Ground, and another Burial Ground adjoining." The reference to the memorial site is to a civil war memorial for six men executed in Tuam in 1923. An estimate of costs involved was prepared which came to a total of £10,700. Two items on the costing are of note:

"6. Level rake and shed border areas and burial ground 1,100.00

7. Provide playing equipment on children's burial ground 2,000.00"

Approval was given in May 1981 for expenditure of £10,700.00 for the development of the open space and what was described as the "old children's burial ground".

[92] Military Archives Ireland. Vertical Aerial Photography, V456#23; Tuam, Co Galway, October 1977.

8.46 On 1 February 1991 a local priest wrote to the secretary of Galway County Council as follows:

> "I have been asked by the Sec of Athenry Rd Tobberjarlath Rd Residents Association to write to you concerning the condition of the children's burial ground in the former Home in Tuam. It is in poor condition with bones being exposed quite often as a result of children and animals digging. The residents are quite upset by this sight and are doing everything possible to protect the burial ground and to ensure that it is treated as a hallowed place.
>
> If you could use your office to have it concreted, we would be very grateful."

8.47 A Council engineer was directed to investigate and, after visiting the site, responded

> "The area in question is as indicated on the attached map. The area is grassed and on my inspection following numerous previous letters it was in a satisfactory condition. I have no evidence of bones being exposed. Indeed parents should be advising children that it was a formal burial ground and the parents themselves should thus control their children. I have no evidence of digging in the area during my inspection. The area is bounded by concrete walls and a small gate and I do not recommend any further action to be taken".

8.48 This reply suggests that there were other complaints – "numerous previous letters" - about the site but these have not been made available to the Commission.

8.49 A further letter from the Council to the priest on 5 March 1991 confirms that the Council was in the process of arranging to raise the wall adjacent to the playground and to padlock the entrance gate to this burial ground. The Commission notes that the wall bordering the playground is now higher than the wall which bears the entrance gate, so this addition to the wall may have taken place as indicated.

8.50 The Commission heard evidence from both the priest and the engineer. The priest said he had had no further dealings with the Council on the issue. The engineer said he did not remember anything about the site and he was unable to cast any light on the "numerous previous letters".

Results of the Excavation

8.51 The areas of interest identified in the geophysical survey were investigated by test excavations in November/December 2016 and in January/February 2017. The full reports of these excavations are at Appendix B and Appendix C. The following is a brief summary.

8.52 As the excavation was very likely to reveal human skeletal remains, steps were taken to ensure that anything that might be found within the test area was treated with utmost dignity and respect. Forensic protocols and archaeological standards conforming to the best practice guidelines were maintained throughout the excavation. A number of measures were also put in place to protect the integrity of the site and ensure the privacy of the work. The area known as the memorial garden was surrounded by plywood hoarding to inhibit line of sight and to assist in maintaining the security of the location. An Garda Síochána provided a 24 hour security presence at the site. Once excavation was underway, a scene tent was used to cover the trench areas.

8.53 Two structures were discovered. The location of the first structure discovered corresponds with the location of what is described as the "Sewage Tank" on the older Ordnance Survey and title maps. This structure had at some point been deliberately filled with a large deposit of stones, almost to the upper edges. Within the filled material, a glass double ended baby bottle with a made in Germany stamp was found. The Commission understands that pyrex and plastic replaced glass in this type of bottle to a large extent over the 1950s and 1960s, though production of this type of item likely stemmed from the 1920s through to the 1940s. A number of small enamel tin cups were also found at this location. One type of cup, in particular, had a children's nursery rhyme imprinted on it and enquiries confirmed that this cup was of Swedish design and produced between 1920 and 1940.

8.54 The second structure discovered proved to be of greater significance. It is a long structure built within the boundaries of the old sewage tank. It is divided into 20 chambers. Initially, a structure with two lids was discovered. One of the lids was completely intact and the other was partly broken. These lids were carefully removed and were found to have covered a chamber with a small division between two sections of the chamber. Human skeletal remains were immediately visible. Further excavations revealed more lids and, when they were removed, more human skeletal remains were found in the chambers underneath.

8.55 Samples of the remains were retrieved from within the chambers using customised telescopic equipment from the surface openings. The Commission did not consider physically entering the individual chambers because the size of the surface access points was very confined, there was a danger that any attempt at physical entry would have compromised the many skeletal remains and entry was, in any event, not considered to be safe.

8.56 The remains were first visually identified as human, and were subsequently confirmed as such by the Human Osteoarchaeologist who was part of the team. The remains which were recovered were carefully catalogued and detailed records were made of the location and context in which they were found.

Purpose of the structures

8.57 An archaeologist on the team appointed by the Commission considers that the logical intended use of the first structure discovered (described in the reports as "cesspool" or "sewage tank") was to receive sewage from the culverts and pipes found coming from the direction of the former Home. This was most likely used at one time as the primary filtration sewage tank for the workhouse/Home. This hypothesis is supported by the descriptions on maps. It is also supported by a reference from 1935 in documentation discovered in connection with a tender concerning the Home which reported that "the existing sewerage at the Home is defective, being merely drains **without pipes** leading to a septic tank outside the grounds" (emphasis added).[93]

8.58 The archaeologist thinks that it is possible that some of the chambers in the second structure (where the human remains were found) were designed to act as cesspools or tanks into which the waste would be deposited and were designed to allow liquid percolate from them into the surrounding soil area.

8.59 The Commission consulted a chartered consulting engineer with considerable experience in sewerage installations. His view was that the likely purpose of the chambers was the collection and holding of sewage but did not consider that the extent of the structures visible in photographs produced to him indicated use as a septic tank.[94]

8.60 Whatever the precise design the structure was built to serve, the Commission does not consider that any of its features suggest that it was deliberately formed as a crypt or formal burial chamber. If that were the case, an entirely different type of structure would have been expected that would allow for easy human access. Access to the chambers is only possible though the narrow openings with relatively fragile pre-cast concrete lids

[93] Minute G5/16 29 November 1935.

[94] A septic tank operates by introducing the waste into the tank by pipe into a chamber where, solid material sinks to the bottom of the tank and forms a sludge as the waste is broken down. The fluid covers it over. Anaerobic activity then occurs where the solid material breaks down naturally while fluid that builds up is allowed to spill over into a second chamber. The same process occurs again allowing the smaller solid particles to fall to the bottom, where they break down. The water is then allowed to filter out of the tank into a filtration area.

permitting access. The openings were largely uniform in size and while large enough to permit a small adult to pass through with difficulty, were clearly not designed with human access in mind nor for access with a ladder. The depth of the chambers was 2.7 metres from the current ground surface to the top of sediment at the base. Entry by an adult would require considerable dexterity and exit would require even greater dexterity.

8.61 Without a full excavation it is not possible to conclusively say what was the exact engineering purpose of the structures but the Commission considers that it is very likely that it was sewerage related. This view is corroborated by some of the scientific testing carried out at the request of the Commission and described below.

Bon Secours response

8.62 The Commission provided Galway County Council and the Sisters of Bon Secours with the detailed technical reports in June/July 2017 and asked for their responses. Galway County Council did not respond. The Commission provided Galway County Council and the Sisters of Bon Secours with the first draft of this report in November 2018. Again, Galway County Council did not respond. The Sisters of Bon Secours commissioned an archaeologist to review the reports.

8.63 This review suggested that the archaeological reports did not adequately consider the possibility that the structure in which the human remains were found was designed as a burial vault and then used as such. The reports did consider such a possibility and the Commission also considered this. However, the Commission notes that there are a number of features that suggest the structure was constructed for the storage of cess/waste materials:

- There are eight basal openings along the northern walls of the eight easternmost chambers, that is, connected to the larger sewage tank; other breaches in the north wall suggest hydraulic flow between the large sewage tank at north and the enclosed chambers.
- The size of these basal openings at the north end are as small as 0.3m in width by a similar height, therefore too small for usable access; they would not allow for the placement of remains inside the chamber.
- The top openings are all approximately 0.84m in length by 0.29m, again restrictively small considering the size of the internal space (generally 1.6m x 0.95 and c. 2m in depth). In all, the openings are limited in size, and not designed to be accessed by

people (adults) and certainly not large enough to be accessed by a person and a ladder.

- The fluctuation of the water-table within the chambers was evidenced throughout the structure, an aspect which is acceptable for cesspool percolation but not burial.
- The top openings of the chambers were closed by relatively thin pre-cast concrete lids. These were light enough to be opened regularly but were not of a size or durability that one might expect from a ground vault slab. This is evidenced by the fact that 16 of the 21 lids were broken.
- It would be a very unusual decision to construct a burial vault within an operational, or recently operational, sewage tank that had, as yet, not been totally back-filled/disused.

8.64 The limited excavations conducted by the Commission have not revealed the existence of a sewage delivery pipe/culvert; however, soil analysis illustrates that it is likely that the chambers were used for an unspecified duration as sewage tanks. If, after full excavation, no sewage inlet into the chambered structure is found, the likelihood is that the chambers were either never used for sanitary waste, or that waste was delivered into the chambers from the top.

8.65 The Sisters of Bon Secours archaeological review also suggested that the Commission's archaeological reports did not identify comparable sites. The Commission's archaeologists did try to establish if comparable sites existed but did not find any. The review put forward seven different sites as possible comparators but none of these had features which are comparable to the Tuam site.

Water and sewage system at the Tuam Children's Home

8.66 The Commission attempted to establish the intended purpose of the structures uncovered in the excavation from any available records and sought out any historic commentary concerning the sewerage system in the Home and prior workhouse.

8.67 The town of Tuam had an inadequate water supply and sewerage system prior to and for the entire period of the existence of the Tuam Children's Home. The authorities recognised its inadequacy while it was a workhouse.

Pre 1922

8.68 The minute books of the Poor Law Board of Guardians[95] contain numerous references to problems with the sewerage system and sanitation in the Tuam Workhouse.

8.69 At a meeting of the Board of Guardians in June 1911 the Tuam District Council Engineer recommended that the Board should buy a field on the west side of the country road and south of the St Jarlath's College farm. The field, an acre in size, would be utilised for a new workhouse sewerage scheme which would cost £140. Sewerage from the institution would be carried through the field by pipes over a distance of 50 yards until it discharged into an open drain. A new septic tank, 6 feet long and 25 feet wide, would be constructed and the public road would now be 35 yards from the tank.[96] In August, the Local Government Board[97] contacted the Board of Guardians in relation to this scheme which was now estimated to cost £185. They were concerned that the plans made no provision to either cover the existing tank or the new one which would be constructed. There was also no provision made for any overflow from the new tank. They noted that such overflow should be provided for and the advisability of deciding on some arrangement to prevent sewage from accumulating in the old tank should be considered by the engineer. In response, the engineer stated that there was no provision to cover the new tank as the old one was there fifty years and had never been covered. He was of the opinion that it would be a waste of money. He stated that the purchase of a portion of land would deal with the passage of the overflow as the accumulation of any overflow from the tank would form as a cesspool there.[98]

8.70 By 1917 the Board of Guardians had become concerned that sewage was leaking into a neighbour's field. The report from the Board meeting published in the *Tuam Herald*[99] recorded that

> "Immediate relief could be effected by the constructions of a drain under the public road to intercept and drain the effluent and discharge it into the old quarry. It is found, as it is inspected, that the liquid will pass away through the fissures in the quarry, the Guardians should then proceed with the most urgent work of the construction of a suitable covered tank or tanks to take the place of the present dangerous open tank. It will be noted that the site of the present tank is not the property of the Guardians, but is rented at £3 per annum".

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[95] The Board of Guardians ceased to exist when the changes were made to Poor Law arrangements in the early 1920s.
[96] *Tuam Herald (hereafter TH)*, 3 June 1911.
[97] The Local Government Board had overall responsibility for the implementation of the Poor Law at this time.
[98] *TH*, 12 August 1911.
[99] *TH*, 22 September 1917

8.71 At a meeting of the Board of Guardians in May 1917, the question of adopting the proposed 1911 scheme for the improvement of the workhouse sewerage system was again considered. A concern was raised that if the sewage was deposited in an open field, as appeared from the plan, the people of the town would object because the road on one side of it was the most frequented walk in the town. One member stated that the people of the town had suffered enough from the present state of the sewerage system and it was only a waste of time and money if it was to be exposed on the other side. The engineer suggested an alternative plan of running the sewage up by the Railway Bridge and allowing it to discharge about 100 yards in a specific field, if the owner could be persuaded to sell part of the land.[100] Later the engineer reported back that the owner had little interest in selling.[101]

8.72 That September, the sewerage system was again addressed at a meeting of the Board of Guardians. The Local Government Board forwarded a report from its inspector, which stated that he had made an inspection of the septic tank and outfall sewer from the workhouse and considered the best method of dealing with the sewage was to abate the existing nuisance and prevent further nuisance. All the sewage was collected in an open tank on the south end of the workhouse and only 40 yards from the building. This tank, in such close proximity, was a menace to the health of the inhabitants and caused frequent expense. The overflow from it was conveyed in pipes and discharged on the surface of the land adjoining the pattern fence of the public road. In 1912, a scheme by a firm of Dublin engineers was considered and the inspector thought it desirable to put it into operation with certain modifications. This scheme had suggested roofing the septic tank and discharging the effluent into a field owned by the College at the southern side of the road. The plan was to acquire two acres of that field in which there was an old quarry which would admit all liquid to percolate away. The College stated that it would be willing to sell the two acres but it would also be willing to sell the half acre which just contained the quarry. The Board of Guardians decided to take steps to purchase the quarry and to request the Tuam District Council engineer to proceed with the work when permission to enter the land had been granted by the College. The engineer's estimate for his scheme was about £150.[102]

8.73 In May 1918, the Local Government Board sanctioned the scheme devised by the Tuam District Council engineer for the disposal of the workhouse sewage.[103] In July, the

[100] *TH*, 12 May 1917.
[101] *TH*, 26 May 1917.
[102] *TH*, 22 September 1917.
[103] *TH*, 25 May 1918.

Board of Guardians was informed that the work was currently being carried out.[104] It seems clear this work was carried out between June and September 1918. It is not entirely clear what exact plan was approved by the Local Government Board and put into operation by the Board of Guardians in the summer of 1918. It seems that the scheme which was implemented was a modification of the plan submitted by the engineer in June 1911. This means that it is likely that a new septic tank, 6 feet long and 25 feet wide was constructed. The original scheme was modified so that the sewage would be taken by pipes and emptied into an old quarry located in a portion of a field owned by St Jarlath's College, which the Guardians purchased. It is clear that, whatever scheme was implemented, it did not fully address the problems.

1922 - 1930

8.74 The Free State army occupied the building for some time prior to 1925. In March 1925, the Quartermaster General's Department of the army asked for sanction from the Army Finance Officer to spend £35 10s on cleaning out and putting the sewage disposal works in order.[105] The work was considered necessary because "The sewage disposal plant having been a number of years without cleaning or overhaul, the whole plant is in need of thorough cleaning in order to put it in a satisfactory and sanitary state." The work to be done involved "Cleaning out cess-pool and sludge chamber and carting away all sewage matter. Open and trim sides of drains on sewage farm."

8.75 Within a few weeks, the army decided to evacuate the barracks and, as a result, the work was not needed.

8.76 Galway County Council decided to use the Tuam workhouse as the Children's Home in 1925. The problems with the water and sewerage system continued to be discussed. There are numerous references in the minutes of the Board of Health and in the local papers to problems including inadequate water supply, inadequate pressure, water being cut off intermittently, no water and sewerage connections for new houses and blockage/overflowing of sewers; here we concentrate on the references to the impact on the Tuam Children's Home.

8.77 In January 1928, a meeting of the Tuam Town Commissioners[106] discussed a Galway Board of Health proposal to initiate a new sewerage scheme in the town at a cost of

[104] *TH*, 13 July 1918.
[105] Military Archive, File 20/Buildings/282.
[106] The Tuam Town Commissioners had no direct involvement with the running of the Home.

£7,000. Although a scheme was badly needed, this expenditure would only cover the cost of a partial scheme. The Tuam Commissioners objected to the likely possibility that the rate payers of the town[107] would have to foot the bill.[108] Following this a deputation, appointed by the Commissioners, met the Galway Board of Health. The deputation offered to agree to the scheme if a rate of ¼ pence in the pound on the county was approved, with the rate payers in Tuam agreeing to pay the balance. They considered that they were justified in asking rate payers in the county as a whole to contribute as the Children's Home was a "County charge" and that it should be included in any new sewerage work being undertaken. However, the Board of Health would not agree to their suggestion.[109]

8.78 The water supply, and especially the issue of having adequate water pressure, was a constant concern for households on the outskirts of the town, in particular in the Dublin Road area where the Children's Home was located. This issue was discussed at the first meeting of the newly appointed Tuam Waterworks Committee in August 1928. The Chairman of the committee expressed his concerns about the fact that the town reservoir seldom had more than five feet of water in it at any time.[110] In November 1929, the same committee passed a resolution calling the immediate attention of the Board of Health to the Tuam water supply problem. It was stated that the town's waterworks were now unable to guarantee a continuous supply to the people of the town and in particular to the institutions on the Dublin Road. It seems that the water supply was intermittently cut off and this was regarded as a great source of danger to public health. It was believed the six inch water pipes in the system were choked up and were no longer able to meet the water demand for the town. The Committee called on the Board of Health and the Minister for Local Government and Public Health to sanction a loan of £6,000, repayable in forty years, from the Local Loans Fund for the purpose of laying down a nine inch pipe and improving the Tuam water supply.[111] The Board of Health meeting was told in December 1929 that any loan from the Local Loans Fund for the improvement of the Tuam Waterworks would have to be repaid in 25 years.[112]

8.79 The superintendent of the waterworks, in reply to a letter from the Department of Local Government and Public Health reported that the Tuam Children's Home got a supply of water only at night as the pressure during the day was inadequate. The superintendent

[107] "Rates" was local authority taxation payable by all property owners.
[108] *TH*, 21 January 1928
[109] Minute GC5/6 February 1928; *TH*, 10 March 1928.
[110] *TH*, 11 August 1928.
[111] *TH*, 2 November 1929.
[112] Minute GC5/8 December 1929

had visited the Home early in December and noted that there would have been a water shortage at the time only for the rainwater going into the tanks.[113]

8.80 Because of the requirement to pay back a loan within 25 years, the Waterworks Committee decided to scrap the improvement scheme and instead concentrate on cleaning the existing pipes and installing a new water engine, storage tank and pump for which they asked the Board of Health for a £2,000 loan in February 1930.[114]

8.81 A town public meeting in March 1930 called on the Waterworks Committee to stop the practice of cutting off the water supply at night. However, the Committee decided that this would not be possible as it would mean that no water at all would be available to the houses and the Children's Home on the Dublin Road, due to the lack of water pressure. The Committee decided that in order to give residents on the Dublin Road a chance to get water, the water supply would have to be cut off from the rest of the town and let up the Dublin Road on Sunday, Tuesday and Thursday nights.[115]

8.82 That September, a letter from the Department of Local Government was read out at the latest meeting of the Tuam Waterworks Committee. The Minister outlined the findings of a report by his engineering inspector who recently inspected the site of the waterworks. The inspector believed that the scheme outlined was the most economical method of improving the poor water supply. He added that in the near future it would be necessary to lay a second main from the reservoir to the town or else to supply a high level service tank at the fair green.[116]

8.83 The Board of Health noted that an amount of £2,400 would actually be required.[117] The Minister for Local Government and Public Health agreed that a loan of £2,000 could be made available from the Local Loans Fund; this was increased to £2,400 in November 1930. Tenders were invited in early 1931. At the same time an application was made for a subsidy out of the Unemployment Relief Grant towards the cost of the scheme. This was refused because employment would be generated by the works anyway. It seems that this caused the Board of Health to not proceed with the scheme.[118]

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[113] *ibid*
[114] *TH*, 1 February 1930.
[115] *TH*, 29 March 1930.
[116] *TH*, 27 September 1930.
[117] Minute GC5/10
[118] At the time, the Board of Health had been temporarily replaced by a Commissioner.

8.84 In December 1930, a deputation from Tuam looked to proceed with a partial sewerage scheme costing an estimated £7,000. It was pointed out that almost 100 new houses had been recently built in the town and none had access to any sewerage facility. Following this, the Galway Board of Health approved a £7,500 loan for work on this partial sewerage scheme.[119] At a subsequent meeting of the Tuam Commissioners, it was reported that a delay in beginning the new sewerage scheme was likely because land for way-leaves and septic tanks would need to be secured first and it was probable the owners of such land would not give their consent.[120]

1931 - 1936

8.85 Progress on obtaining a new water and sewerage scheme for Tuam stalled as a dispute arose between the Town Commissioners, the Board of Health and the Department of Local Government and Public Health over obtaining grants to help fund the project. In October 1932, the Town Commissioners stated that plans and proposals for further housing schemes in the town were now being held up for want of a proper and adequate sewerage system.[121] At two separate monthly meetings of the Tuam Commissioners in 1933, resolutions were passed calling on the Board of Health to conduct a proper survey of the town for the purpose of getting a comprehensive sewerage scheme designed and then put into operation. It was stated that the question of securing a sewerage scheme for Tuam had now been ongoing for twenty-five years. In December, it was reported that the Board of Health engineers had now prepared a full sewerage scheme and that this was awaiting the sanction of the Board and the Department of Local Government and Public Health to be put into operation.[122]

8.86 In February 1934, a meeting of the Galway County Council agreed to make the cost of undertaking the Tuam sewerage scheme a county charge (on account of the Children's Home) and the overall estimated cost was put at £21,200. The Department agreed to contribute £7,000 with the balance being paid for by the Galway County and Tuam urban rate payers. It was specifically stated at this meeting that the Children's Home had yet to be provided with or connected to a sewerage scheme. The Council agreed that if there was anything like an outbreak of fever in the institution, which was a real possibility at any time, it might prove much more costly to the public services than this proposed sewerage scheme.[123] That October, Galway County Council agreed to the raising of a £15,000 loan to

[119] *TH*, 27 December 1930.
[120] *TH*, 1 February 1931.
[121] *TH*, 1 October 1932.
[122] *TH*, 8 July; 23 December 1933.
[123] *TH*, 24 February 1934.

cover the cost of the sewerage scheme. It was reported that the only issue left to be resolved was the drawing up of an agreement between the Council and the Board of Health, whereby the Council would guarantee the repayment of half the instalment of the principal and the interest.[124]

8.87 In October 1934, tenders were invited for the construction of a maternity hospital at the Children's Home.[125] Despite this, no work on the new sewerage scheme was undertaken over the next fourteen months.

8.88 It is clear that mains sewerage had not been extended as far as the Home by 1935. "The Secretary of the Homes and Home Assistance Committee wrote enquiring if the **new sewerage scheme** will extend as far as the Children's Home, as the existing sewerage at the Home is defective, being merely drains without pipes leading to a septic tank outside the grounds..." (emphasis added)

8.89 Although it was reported that the Department of Local Government and Public Health had sanctioned a new housing scheme involving the construction of seventy houses on the Dublin Road in July, in December the editor of the *Tuam Herald* was complaining that there was still some inexplicable hold up in beginning the sewerage work. The latest setback was due to a dispute between the contractor and the local branch of the Irish Transport and General Workers Union (ITGWU) over the proposed wages for the workmen. The paper bemoaned: "The Sewerage Scheme has been the subject of spasmodic agitation for the last ten or fifteen years and it is about time now that it was finished with."[126]

8.90 The dispute between the contractor and the ITGWU dragged on until April 1936. Finally, a settlement was reached and on 24 April work on the long awaited sewerage scheme commenced, although the press reported the scheme would only be a partial one. Work began near where the new housing scheme had been completed. It was reported that there was an initial workforce of twenty which would increase to around 100 men over the next few weeks. An unemployment relief grant of £5,700 had been made in 1935/6 for the sewerage scheme and the provision of water supplies to specific areas.[127] The Department of Local Government and Public Health had also supplied a £4,000 grant towards the cost of

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[124] *TH*, 27 October 1934.
[125] *Connacht Tribune*, 27 October 1934; it seems that a separate maternity hospital was not built but a maternity unit was provided within the existing building. In October 1936, a grant of £550 towards the cost of this was made by the Hospitals Trust – DLGPH Annual Report 1936/7
[126] *TH*, 27 July; 14 December 1935.
[127] DLGPH Annual Report 1935/6, Appendix IX

the scheme (a reduction from the £7,000 they were reported to have agreed to in 1934).[128] Discussing the progress of the work a week later, the *Tuam Herald* noted that a new pipe had been laid from the new housing scheme to Vicar St and from Vicar St to the part of the Galway Road known as 'The Claureen'.[129]

8.91 That August, the sewerage scheme contractors agreed to link up the sewerage with the new houses on the Dublin road, following a request to do so at the latest meeting of the Tuam Town Commissioners.[130]

8.92 It is unknown if this work also connected the Children's Home to this new sewerage system. There is no reportage of any such work by the papers. However in October, the *Tuam Herald* reported that a deputation of tenants in the new houses on the Dublin road had met the Tuam Town Commissioners to complain about the "offensive and unhealthy stench from the sewerage outlet from the Children's Home". The Clerk was asked to write to the Board of Health about the issue.[131] There is no newspaper record of this issue being raised at any meeting of the Galway Board of Health from then until the end of the year.

1937 - 1939

8.93 Nevertheless, in January 1937, the *Connacht Tribune* reported on a meeting of the Galway County Home and Home Assistance Committee where a petition, signed by a number of residents at Tubberjarlath, Tuam, was read out. The residents were calling for the removal of the cesspool at the back of the Children's Home which was now in close proximity to a large number of houses occupied by the tenants of the Town Commissioners' houses. The petition stated that the smell from the cesspool was "intolerable and highly dangerous to the health of a large number of residents and their families in the locality". It added that if something was not done to remove the cesspool, they would have to take more serious action in the matter.[132] In response, the Committee's Secretary stated that on 17 November 1936 the County Home and Home Assistance Committee "had sent plans etc. for a new system of drainage and sewerage from the Children's Home **to connect with the new sewerage system** in Tuam but no reply had yet been received from the Department". (emphasis added) An order was made again asking the Local Government Department to expedite the matter and to send a copy of the petition to them.[133]

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[128] *TH*, 18/25 April 1936.
[129] *TH*, 30 May, 1936.
[130] *TH*, 29 August 1936.
[131] *TH*, 10 October 1936.
[132] *Connacht Tribune*, 23 January 1937.
[133] *Connacht Tribune*, 23 January 1937.

8.94 This would suggest that, as of January 1937, the Children's Home had not been connected to the new town sewerage plan.

8.95 In May 1937, the Homes and Home Assistance Committee invited tenders for the construction of drainage works at the Home.[134] In May 1937, the *Tuam Herald* reported that a meeting of the Galway County Homes and Home Assistance Committee had accepted a tender from Galway contractors for drainage work to be carried out at the Children's Home Tuam at a cost of £791 5s 5d.[135] Two months later, the Committee reported that the contract for the above drainage work had been signed and that the contractor was ready to begin the work.[136]

8.96 A proposal to start construction of a new "drainage scheme" at the Children's Home was evidenced by a note for tender in the *Irish Independent* in 1937. No documentation has been found which supplies any detail as to what was proposed in this scheme.

8.97 That September, a letter from the County Engineer was submitted to the Committee outlining improvements that were required for the lavatory system at the Children's Home. The engineer stated that the existing lavatory system was very unsatisfactory and not suitable for the new drainage scheme as the type of cisterns installed for the flushing were inadequate. He strongly recommended the erection of new lavatories with special "Epic Flushing" cisterns which

> "...will give an almost continuous flushing system, which is desirable for an institution of this kind. The buildings where the lavatories are contained require to be taken down and reconstructed as they are all in a very dilapidated condition and without light or ventilation. I recommend the erection of new buildings with tiled floors and tiled walls to a height of 4 feet and with proper ventilation and light. During construction of the new sewer, I discovered that most of the new sewer was not conveyed to the septic tank, but deposited in the old trenches and in a well which I found in the ground. This is due to the fact the flushing system is bad. It is desirable that this work should be done before the present contract is complete. As the present floor level of the lavatories requires to be raised it would be cheaper to have it done by the present contractors so as to make the necessary construction, otherwise it will mean excavation later which will cost more money".

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[134] *TH*, 22 April 1937
[135] *TH*, 22 May 1937.
[136] *TH*, 17 July, 1937.

The committee decided to carry out the engineer's recommendations, subject to departmental approval.[137]

8.98 In the July meeting of the County Homes and Home Assistance Committee, plans had been submitted to erect a new laundry at the Children's Home and these were sent on to the Department of Local Government and Public Health for approval.[138] Yet over a year later the Committee was still discussing the proposal to erect a new laundry and also a disinfecting chamber at the Children's Home. The department had so far refused to sanction the work because it believed the local Galway engineer selected to oversee the project did not have the necessary or sufficient experience. The committee was read a letter from the matron of the Children's Home asking if anything could be done to speed up the erection of the new laundry, as the present one was in a very bad state. The committee decided to send another letter to the department asking it to either sanction the proposal to allow a local engineer to oversee the works or else to recommend another engineer whom they could appoint.[139]

8.99 The problem of securing an adequate water supply for the Dublin Road area also continued to persist. The November 1937 meeting of the County Homes and Home Assistance Committee was addressed by the Medical Officer for the Children's Home. He explained that there were frequent shortages in the water supply to the Home and that the issue had become especially serious since those houses built under the housing scheme near the Home had been occupied. He noted that the area where the Children's Home was located was always the last part of the town which got water from the town reservoir and the demand from the new houses was also now impacting on their supply. His concerns were referred to the Board of Health.[140]

8.100 In January 1937, the Tuam Town Commissioners had discussed an offer from the Galway Board of Health to transfer a triangular plot of ground, near the Children's Home, to the County Homes and Home Assistance Committee in exchange for the land required to widen the Dublin road at this point. It was noted that the piece of land was valuable and that about six houses could be built on it. However the Commissioners decided to leave the matter in abeyance.[141] Eventually in July 1940, it was reported that a meeting of the Tuam

[137] *TH*, 18 September 1937.
[138] *TH*, 17 July 1937.
[139] *TH*, 22 October 1938.
[140] *Connacht Sentinel*, 16 November 1937.
[141] *TH*, 9 January 1937.

Town Commissioners had agreed to transfer this plot of land to the Board of Health.[142] That November, tenders were invited for work to knock part of the existing boundary wall, including gates and piers on the Athenry-Tuam road at the Children's Home, and to build a new boundary wall to enclose an additional plot near the road as well as a new wall to replace an old fence.[143]

8.101 Meanwhile, the Tuam sewerage scheme had been approved by the Department of Local Government and Public Health with the intention that the work would be carried out in two separate portions. By July 1937, the first portion of the Tuam sewerage scheme had been completed and put into operation.[144] This portion of the scheme was described (in 1941) by the Secretary of the Galway Board of Health as containing "a septic tank and filter beds".[145] No work was commenced on the second portion of the scheme for several months. Only in November did the Galway County Council sanction the raising of a £12,000 loan by the Board of Health for the provision of the second section of the new sewerage scheme for Tuam.[146] Sometime in 1938/9, a Local Loans Fund loan of £5,400 was approved for the Tuam Sewerage Scheme.[147]

8.102 In September 1938, the Galway Board of Health invited tenders for the extension of the sewerage system in the town of Tuam. The works included the provision and laying of nine inch and 250 lineal yards of twelve inch sewer pipes, the construction of a syphon and manholes, the making of house connections and other incidental works.[148]

8.103 Work on the second portion of the Tuam sewerage scheme began at some point after and continued through the spring of 1939 in areas such as the Galway Road. Meanwhile in July, tenders were invited for the supply and installation of electrical laundry equipment and structural alterations to the laundry premises at the Children's Home. A month later a tender for this work was accepted by the County Homes and Home Assistance Committee.[149]

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[142] *TH*, 6 July, 1940.
[143] *TH*, 23 November 1940.
[144] *TH* 24 April 1937
[145] *TH* 12 April 1941; the secretary is reported as saying that the first section had been completed in 1939 but all the evidence suggests it was completed in 1937.
[146] *TH*, 20 November 1937.
[147] DLGPH Annual Report 1938/9, Appendix II
[148] *TH*, 17 September 1938.
[149] *TH*, 22 July; 19 August 1939.

1940 onwards

8.104 Work on the second portion of the Tuam water scheme continued until its completion in March 1941. In January 1940, a deputation appeared before a meeting of the Galway Board of Health to discuss ways to expedite the extension of Tuam's waterworks system. A report outlined the necessary works which were needed which included sourcing additional water as well as constructing an elevated reservoir near the Dublin Road. The report recommended that a new eight inch diameter main was necessary and should be laid from the reservoir to the town square and then from the square onto the Children's Home with other smaller extensions. The Chairman of the Tuam Waterworks and Sewerage Advisory Committee was part of the deputation that addressed the Board. He explained that between 300 and 400 new houses had been built in the town and all of these were connected to the water supply. The result was that people in the centre of the town were not now getting an adequate supply, even in the middle of the day. In response, the Board agreed to expedite the new water scheme.[150] In July, the Consulting Engineer for the Galway County Home and Home Assistance Committee wrote stressing the fact that the water supply to the laundry in the Children's Home was not reliable and that the water was very hard. To solve the issue he suggested the construction of an underground storage tank which would collect rain water from the roof of the institution. This was rejected as the Committee declared that work on the Tuam water system would soon ensure a plentiful supply of water.[151] That same month the County Home Committee, on account of war in Europe, decided to prepare a tunnel at the Children's Home for use as an air raid shelter by the occupants. The committee also decided to have red crosses painted on the roof of the Home.[152] The Commission has seen no evidence to show that the air raid shelter was ever built or that the crosses were painted on the roof.

8.105 By June 1941, the Board of Health Engineer told the Board that the Children's Home was dealing with the constant issue of low water pressure because the main leading to it was not able to carry enough water.[153] Due to the World War, it appears that no new water scheme was actually begun in Tuam. A report from the Galway County Council in May 1946 stated that the extension of the Tuam water supply had been held up for several years. It noted that the existing waterworks provided a supply for a town of about half the population now resident in the borough area. The result was that in the new housing schemes and in the higher parts of the town only a very poor water supply was available. The *Tuam Herald* noted that as far back as 18 November 1944, the County Council had approved the raising

[150] *TH*, 13 January 1940.
[151] *TH*, 13 July 1940.
[152] *TH*, 20 July, 1940.
[153] *TH*, 14 June 1941.

of a loan of £16,000 for this work.[154] However, in June 1947 the Tuam Town Commissioners were informed that the continued delay in beginning the water scheme was due to the fact that the acquisition of the additional water rights required had not yet been completed.[155] This issue was finally resolved and in November the Galway County Council was reported as agreeing to raise a loan of £25,600 to cover the cost of the Tuam water supply extension scheme. The original estimate had been £15,800.[156]

8.106 Yet it was reported at a meeting of the Tuam Town Commissioners in March 1948 that the town's water supply "was never as bad in terms of quality and quantity". The chairman stated that cases of scarlet fever were now being reported in the town, caused by the insufficient and impure water supply. He stated that two years earlier a water extension scheme had been decided on at that time when the water supply problem was critical. Two years had also passed since certain water rights were secured. Though the County Manager had given assurances that work would finally begin in January, nothing had happened and now some parts of the town had no supply at all; sanitary accommodation was rendered useless and in parts of the town the water was simply too dirty for drinking purposes. After discussion, it was decided to send protests to the Ministers for Health and Local Government about the delay in the water extension scheme.[157] Work on the water scheme seems to have finally begun in early August. At a meeting of the Tuam Town Commissioner in September, the County Manager stated that work had begun on the construction of the new water storage tank. Yet the meeting still had to deal with complaints from residents about the frequent practice of turning off the water supply at night to parts of the town, to ensure other parts and the likes of the Children's Home had an adequate supply. The Commissioners bemoaned that nothing could be done to remedy this until the water extension works were completed and the town given a proper supply to meet the demand.[158]

8.107 In October 1949, the County Manager addressed a meeting of the Tuam Town Commissioners and informed them that there should be a marked improvement in the Tuam water supply within days. A new eight inch main pipe from the reservoir to the town had been laid and would reach upper Bishop St, resulting in a "big" improvement in the water pressure throughout the town.[159] Work on the water scheme seems to have finished sometime after. At a meeting of the Commissioners in 1954, it was reported that around

[154] *TH*, 11 May 1946.
[155] *TH*, 7 June 1947.
[156] *TH*, 22 November 1947.
[157] *TH*, 27 March 1947.
[158] *TH*, 11 September 1948.
[159] *TH*, 8 October 1949.

£90,000 had been spent on the water extension. Despite this, a lack of water supply was still being reported in parts of the town on occasion.[160]

8.108 During 1951 and 1952 the Galway County Council also made several applications to the Department of Health for an extensive extension of the Children's Home. The work was estimated to cost £82,000 and the Council got an agreement from the Hospitals Trust to cover half of the sum. However, the Department replied that this amount of money could not be given from the Hospitals Trust funds.[161] By September 1952, the Council was still waiting on the Department to sanction the improvements scheme.[162] Nothing more was reported in the press and it is assumed the scheme simply fell through because of a lack of support from the department.

When the chambered structure was built

8.109 It seems clear that relatively extensive work and construction was conducted in and around the site of the Children's Home in Tuam, particularly during the July – December 1937 period. The Commission thinks it possible that the reworking of the old sewage tank and the construction of the second structure described above may have occurred at this time. If this is so, then the human remains found in the chambers are likely to date from after 1937. This raises the question of where the children who died before then are buried.

Scientific testing

8.110 As already described, the excavation had established that there were human remains at the site. The Commission decided to have tests carried out on a sample of those remains and on the surrounding soil.

Bone Analysis

8.111 Eighteen of the 20 chambers contained visible examples of human remains of infants or juveniles. While no remains are immediately visible in the two remaining chambers, they are likely to contain human remains as scientific sampling of the soil from these chambers had indicators of bone decomposition. No adult bone (18 years or over) was visually identified or collected, and all identifiable skeletal remains within the chambers appear to be from either infants of less than one year or young children between one and six years. It was not always possible to correctly identify the precise age group and many bones were

[160] *TH*, 8 May 1954.
[161] *TH*, 8 September; 6 October 1951.
[162] *TH*, 13 September 1952.

simply classified as "juvenile" which specifically refers to individuals aged six years or less at the time of death.

Articulation

8.112 In archaeological terms, if bones are found in an order and proximity that is to be expected if the body decomposed in situ, they are referred to as being in an "articulated" state. The Osteoarchaeologist on the team undertook a detailed study of photographs of the visible deposits within each chamber in order to determine if there was any evidence of articulation. There was some evidence of articulation from this visual inspection. This evidence is limited to the particular instances described here.

8.113 A significant quantity of bones was visible in one chamber. In particular, cranial remains from either an infant or young juvenile were visible at the northern end. Along the eastern side of the chamber, at least two separate concentrations of ribs, which appear to be in an articulated state, were visible along with bones of a possible left arm (left humerus and ulna). Two shin (tibiae) bones also appear close together in this area along with a concentration of possible infant vertebrae. All of these may represent the, at least partially, articulated remains of an individual or individuals.

8.114 At the southern end of this chamber there was also a significant concentration of skeletal remains. Two further individual sets of possibly articulated infant ribs were identified. Two mandibles were identified which are probably from infants of less than one year old. The Osteoarchaeologist was of the view that it was probable that the articulation of the ribs in particular demonstrated that they have remained there since the body of the child had decomposed.

8.115 Significant quantities of skeletal remains were also present in another chamber. In one concentration of bone, a possible ischium was identified under the right ilium (both are parts of the hip) with possible articulated vertebrae identified. These were seen adjacent to a set of right ribs and another set of possibly articulated bones that could not be identified. A right humerus probably from an infant of less than one year old was identified beside a radius and another long bone which may well be an ulna. These are the bones that form the arm. The Commission has been advised that the occurrence of these three bones being found together is unlikely to be coincidental and there is provisional evidence of articulation here. It is possible that the arm bones along with the set of the right rib bones, the possible scapula and the articulated vertebrae and the pelvis are all approximately in situ as they would be in the approximate correct position for an infant lying on its left side.

8.116 Near the southwest corner of this same chamber three further concentrations of apparently articulated ribs were evident suggesting possibly two individuals. A right scapula was observed adjacent to one of those set of ribs which may suggest some degree of articulation.

8.117 In the same chamber cranial remains were identified which appear to represent the relatively intact cranium of an infant or young juvenile. The left frontal and temporal bones are in the correct position for an articulated infant/juvenile cranium. A larger cranial fragment underlies the two and that larger fragment may be a parietal or the squama from the occipital.

8.118 Within another chamber, a small collection of bones is visible in the south west corner. Left ribs and a possible scapula (shoulder blade) were suggestive of the articulated remains of a young juvenile as well as a number of ribs, vertebrae and an ulna. Based on the length of this ulna, the age-at-death of the individual is approximately 4.5 years.

8.119 The fusion of bones within the vertebral body fuse at different times as a child develops. The cervical (neck) vertebrae the body and neural arch are fused by the age of four. The thoracic vertebrae (torso) which articulate with the ribs fuse by the age of six. The lumber vertebrae (lower back) fuse by the age of five. In another chamber, the Commission has been told that some fusion of vertebrae suggest the presence of an individual in this chamber aged between four and six years at the time of death. A concentration of cranial bones can be seen nearby. Within the same chamber a left maxilla, of a probable young juvenile, is visible in the south east corner of the tank. It is probable that the first left upper deciduous molar had erupted at the time of death. In another chamber, there is a concentration of cranial bones. Both sides of the skull can be seen along with the back of the skull and some parts of the cervical vertebrae which appear to be largely intact also evidence some degree of articulation.

8.120 The chambers contain a mixture of infants and young juvenile bones. A cranium present in one chamber is potentially from an individual aged between 1.5 and 2.5 years, maybe even slightly older. What is unusual about the identification of this skull is that it is complete and sits above the sediment. This suggests that it was introduced to the chamber at a later date, that is, it was deposited possibly from another location. A humerus lying near this cranium shows post mortem erosion. This type of erosion was not evident in most of the visible remains observed which appeared largely to be in exceptional states of preservation.

This suggests that this long bone may also have been redeposited having suffered differential erosion elsewhere.

8.121 The assessment by the Osteoarchaeologist was that it is probable that complete bodies were deposited in the chambers. If bones had been dug up elsewhere and redeposited in the tanks, it would be expected that there would be much more fragmentation and damage. It would be very unlikely that bones as small as juvenile cranial would survive the transfer. Furthermore, it would be expected that redeposited earth would also be visible within the chambers. The sediment visible within the tanks appeared from visual examination to have been placed there as a part of the normal fluctuations of water levels within the chambers rather than from soil thrown in from above.

Water influx

8.122 When the chambers were opened and inspected, the sediment was relatively dry with no visible water present. There was however evidence that waters levels in the chambers had fluctuated. If complete bodies had been deposited within the tanks and were not covered by earth, then fluctuations in the water table would have allowed these bodies and later body parts and bones to float and disperse. There were obvious bone concentrations found in the south side of the chambers which reflect the normal drainage of the site with the higher ground to the north. Further evidence of water fluctuation can be found in a chamber where a single infant/ young juvenile probable hand phalanx (finger bone) was attached to the south facing wall. The hand phalanx was located above the current sediment level suggesting that there was at some point water present.

Soil Sampling

8.123 Soil samples taken from the chambers were forensically recovered and sent to a soil scientist who specialises in volatile organic chemistry. The soil scientist carried out what is termed volatile organic compound analysis on thirty two soil samples.

8.124 The Commission sought to determine from the soil recovered within the chambers whether they had ever been utilised for the containment or filtration of sewage and whether or not it was possible to establish if the bodies of the children in question decomposed in situ or elsewhere.

The science of soil testing

8.125 Soil is a mixture of inorganic and organic material. The organic material reflects the planted animal material that is deposited or decomposed within the soil and also human

organic inputs to the soil. A process of gas chromatography spectrometry is used to characterise and identify organic compounds in order to ascertain what the inputs to the soil actually were. A comparison of the distribution of the actual volatile compounds found in samples can then be compared to published data from other soil sampling. The Commission was interested specifically in the origin of the material surrounding the remains discovered including the possibility of human decomposition and the presence of human sewage.

8.126 During the decomposition of animal (including human) bodies large quantities of cholesterol are released. Substances known as coprostanol and epicoprostanol have also been found in association with body decomposition. These biomarkers are also found in sewage but the relative concentration patterns differ greatly between samples from faecal sewage and material that was deposited as a result of body decomposition. In faecal matter and sewage, the cholesterol concentrations are much lower than those of coprostanol and epicoprostanol. On the other hand, cholesterol concentrations in material associated with human decomposition are considerably higher than the stanol concentrations found in faecal or sewage material (coprostanol and epicoprostanol). Faecal bile acids may also be indicative of the presence of sewage.

Analysis of samples

8.127 In general, the quantities of solid organic compounds were very low, lower than would have been expected from sewage. The volatile organic compounds were indicative both of elements of sewage and decomposition of human remains. The solid organic compounds isolated indicated that the primary component in those samples was human decomposition rather than sewage. Samples were not taken from the very bottom of the chambers due to the potential destruction this would have caused.

8.128 There were some exceptions from the general findings. The ratio between the stanols and cholesterol found in one particular sample suggested that this sample originated from predominantly sewage. Lower ratios observed in the other samples from the remaining chambers suggest mixed origins from sewage and from body decomposition. Some samples also yielded the presence of faecal bile acids, indicative that sewage had been present in those chambers. Control soil samples were also taken from soil just outside of the chambered structure. These analysed samples had generally lower biomarker concentrations than the samples that were collected within the chambers.

8.129 The scientific evidence suggests that at least some of the chambers in which human remains were found were at some stage used to receive sewage. There is evidence of water ingress and fluctuations and it is possible that the sewage filtered into the chambers by virtue of this process. Relatively low concentrations of biomarkers in many cases meant that actual sewage was not present in the samples and they were considered to contain material other than sewage. There remains the possibility that quantities of sewage had been removed from the chambers before the deposition of the human remains. A second possibility is that some soil may have been added at the time when the bodies were introduced or soil may have seeped in through the lids to some of the chambers and possibly through the openings at the base of some of the tanks. All of the bones observed were considered to be of human origin. In areas where there was a high concentration of bones accumulated, there were hot spots for compounds characteristic of bone decomposition which is what would be expected, given that the chambers have been covered over for many years and contained such large numbers of bones.

8.130 The soil scientist confirmed that the findings of the Osteoarchaeologist in relation to articulation corroborated the findings that human remains decomposed in situ. The Commission does not consider that there is any real doubt that a considerable number of the children in the tanks decomposed in this way.

Radiocarbon Dating

8.131 The Commission sought to establish approximately when the infants and juveniles whose bones were discovered had died. The Commission provided six infant bone samples to a Radiocarbon Dating Laboratory in Scotland. All six samples had been found inside the chambers. These samples have since been recovered by the Commission and are securely held by the State Pathologist on behalf of the Commission.

The science of radiocarbon dating

8.132 The process of radiocarbon dating is used to date, among other things, bone, cloth, wood and plant fibres that were created in the relatively recent past. The method of radiocarbon dating is made possible by isolating a radioactive isotope called Carbon-14. Carbon has other isotopes which are usually not radioactive (such as Carbon-12) which makes a relative comparison possible. Cosmic rays create Carbon-14 atoms that when combined with oxygen form carbon dioxide which find their way into plant fibres. Animals and people in turn eat the plants and as a consequence take in the Carbon-14. At a certain point in time, the human body has a certain percentage of Carbon-14 and at the same time all living plants and animals have the same percentage of Carbon-14. Once a living

organism dies, it stops taking in the new carbon and the Carbon-14 begins to decay and is not replaced. Other carbon isotopes such as Carbon-12 do not decay and remain constant in the sample. By looking at, for example, the ratio of Carbon-12 to Carbon-14 in the subject sample and then comparing it to the ratio of Carbon-12 to Carbon-14 in a living organism, it is possible to determine the age of a formerly living thing relatively accurately using a mathematical formula.

8.133 Decay of Carbon-14 occurs at a constant rate. Between 1955 and 1963 atomic bomb testing doubled the amount of Carbon-14 in our atmosphere. Any bones containing the higher levels of Carbon-14 must have been born in the nuclear era which, from atmospheric records maintained, is considered to be after 1955. Following an international nuclear test ban treaty, the atmospheric concentration of Carbon-14 has gradually reduced starting around 1963/64.

8.134 Any short lived sample that has a ratio of Carbon-12 to Carbon-14 of a value greater than 1 must have been alive after 1955. In human bone, the datable portion where the levels of carbon can be measured within the bone is in a protein within the bone called collagen. In new born or close to new born babies, because bone collagen in infants is formed from the mother's dietary intake, the dated sample must be projected forward by one to two years to ascertain the actual age at death of the child. All of the samples analysed were from children of less than one year of age.

Results of radiocarbon dating

8.135 All of the samples produced calibrated age ranges within the period within which the Tuam Children's Home was operational. Two of the bones sampled put the years of death within the nuclear era 1956-1957. If the time lag of one to two years as described is applied to those figures this would put the actual years of death of those two individuals at around 1957-1959. The remaining four samples were in the pre nuclear era (pre 1955). The calibrated range using the radiocarbon dating for the other four samples was

1. 1800-1940
2. 1935-1955
3. 1925-1955
4. 1930-1955

8.136 The carbon fraction available for measurement in the pre nuclear era is much smaller because of the much lower levels of Carbon-14. It is less than one. As a consequence of this, these samples have multiple possible calibrated age ranges and produced calendar

ages in the pre modern 1650-1950AD range. However, all the samples produced age ranges within the period of operation of the Children's Home. The two samples that existed during the nuclear age enabled much more precise dating (both samples being dated between 1957 and 1959) which is why the calibrated range is so small in those two cases.

Artefacts of interest

8.137 A plastic bottle lay directly on the surface of the sediment within one of the chambers. This was recovered at the request of the Commission. This was a bottle which was marked '*Castrol GTX*' which was printed directly onto the plastic bottle which was empty. The text on the label read '*Castrol GTX high performance raw oil contents 500ml* Castrol (Ireland) Limited. Enquiries made by the archaeologist confirmed that this product was released into the UK market for the first time on 18 April 1968. Therefore, the product would have been available on the Irish market on or after that date. This information proves that this particular chamber at least was accessible either temporarily or for an extended period of time post 1968.

8.138 In another chamber, a piece of timber which was visible has an unusual angle and is reminiscent of the angles often seen on coffins. Other pieces of wood were found within the chambers but they appeared more crude and of the type that would be expected to be used in forming the chambers by way of shuttering. In another chamber there is possible wickerwork identified.

Commission conclusions

8.139 It seems clear that many of the children who died in the Tuam Home are buried in the chambers described. It is unlikely that the children who died prior to 1937 are buried there as it would appear that the structure was put in place around this time. There is evidence that the burial grounds may extend beyond the area of the current Memorial Garden.

8.140 This was not a recognised burial ground or purpose built burial chamber. It did not provide for the dignified interment of human remains.

8.141 It is not clear if it was a blessed/consecrated Catholic burial ground either. In June 2014, the Archbishop of Tuam issued a statement in which he said, among other things, that "It will be a priority for me, in cooperation with the families of the deceased to seek to obtain a dignified re-interment of the remains of the children in consecrated ground in Tuam". This seemed to the Commission to imply that the current burial ground was not consecrated

ground. The Archbishop told the Commission that, in his view, it is more likely than not that this ground would have been blessed in the past even if there is no record of this.

8.142 The more difficult question to answer is why the children were "buried" in such an inappropriate manner. It has not been possible to establish who actually physically conducted the burials. It seems likely that the burials were conducted on the instructions of the Sisters. As is described above, the burial process required lifting a concrete lid. It is highly unlikely that the Sisters actually conducted the burials themselves.

8.143 All the residents of the Tuam Home were the responsibility of the Galway and Mayo County Councils. It seems to the Commission that responsibility for the burials of deceased children rested with the local authorities. In particular, Galway County Council had a legal responsibility to keep a record of burials.

8.144 Galway County Council members and staff must have known something about the manner of burial when the Home was in operation. As outlined above the Board of Health and its sub-committees sometimes held their meetings in the Home.

8.145 Employees of Galway County Council must have known about the burials. County Council employees would have been in the grounds of the Home quite frequently as they carried out repairs to the building and possibly also maintained the grounds. It is known that there was a caretaker while the Home was in operation but it is not clear if he was employed by the Sisters or by the County Council.

8.146 The Sisters of Bon Secours continued to live and work in Tuam until 2001. They must have been aware of the building works which were carried out on the Children's Home site in the 1970s.

8.147 The Commission considers that there must be people in Tuam and the surrounding area who know more about the burial arrangements and who did not come forward with the information. It is, of course, still possible for them to come forward.

Mandates of the Working Group on Enforced or Involuntary Disappearances; the Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material; the Special Rapporteur on contemporary forms of slavery, including its causes and consequences; the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; the Special Rapporteur on trafficking in persons, especially women and children; the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence; the Special Rapporteur on violence against women, its causes and consequences and the Working Group on discrimination against women and girls

REFERENCE:
OL IRL 2/2021

5 November 2021

Excellency,

We have the honour to address you in our capacities as Working Group on Enforced or Involuntary Disappearances; Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material; Special Rapporteur on contemporary forms of slavery, including its causes and consequences; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; Special Rapporteur on trafficking in persons, especially women and children; Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence; Special Rapporteur on violence against women, its causes and consequences and Working Group on discrimination against women and girls, pursuant to Human Rights Council resolutions 45/3, 43/22, 42/10, 43/20, 44/4, 45/10, 41/17 and 41/6.

In this connection, we would like to bring to the attention of your Excellency's Government concerns in relation to the possible impact of the **General Scheme of the Birth Information and Tracing Bill, the General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill and the proposed Restorative Recognition Scheme for former residents of Mother and Baby Homes and County Homes (Restorative Recognition Scheme), on the rights of victims and survivors. These legislative proposals raise serious concerns in relation to the State's compliance with its international legal obligations, and raise concerns in relation to appropriate responses to the human rights issues raised in relation to the terms of reference, and methodology of the Mother and Baby Homes Commission of Investigation (hereafer the Commission), and other related redress schemes and reports on institutional and historic abuses.**

General Scheme of the Birth Information and Tracing Bill

In follow up to the recommendations of the Commission regarding the access of victims to information on their birth, on 11 May 2021, the Government published the General Scheme of the Birth Information and Tracing Bill. This is an important step forward, noting that in her report, the Special Rapporteur on the sale and sexual exploitation of children recommended to your Excellency's Government, to enact legislation that would facilitate transparent adoption processes and guarantee adopted people's right to an identity, including access to their birth certificates and health records (A/HRC/40/51/Add.2 para 77.d).

We acknowledge the Bill's objective, namely to ensure compliance with the State's obligations under the UN Convention on the Rights of the Child (CRC) ratified by your Excellency's Government on 21 December 1992, in particular articles 7 and 8, on the name and nationality and preservation of identity, which includes, "the right to know and cared for by his or her parents". The right to know one's parents has been interpreted by the UN Committee on the Rights' of the Child in conjunction with article 3 on the child's best interests as an obligation by each State party:

"to take all necessary measures to allow all children, irrespective of the circumstances of their birth, and adopted children to obtain information on the identity of their parents, to the extent possible" (CRC/C/15/Add 188 para 32).

However, we are concerned that the Bill in its current draft, fails to ensure and effectively vindicate rights of access to records and personal data.

Specifically, we are concerned that:

1. the definition of the 'care information' which an adopted person will be entitled to receive excludes information about 'care provided by (a) a birth parent or guardian of the child, or (b) a relative of the child who is providing care other than as part of a nursed out, boarded out or foster care arrangements, or (c) a person who is, or becomes, the adoptive parent of the child';

2. The draft legislation does not provide a right for mothers to receive their full records; and

3. There is no provision in the draft legislation to ensure the right of relatives of those who died in institutional custody to obtain full records about their disappeared relative.

General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill

We have been informed of the publication of the *General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill of 2021*. The aim of the Bill is:

"[...] to provide the statutory basis and framework under which the Government may decide to authorise interventions at certain sites where manifestly inappropriate burials have taken place".

However, we are concerned that this proposed new legislation would, if adopted, in practice, negatively impact upon the rights to truth and justice of affected individuals, whose relatives may be buried in these sites.

We are concerned that this Bill may create additional obstacles to undertaking effective investigations into the deaths that occurred in the Mother and Baby homes and analogous institutions. The Bill proposes the establishment of an Agency for each burial site, which, if created, will have the power to undertake excavations and exhumations. However, the ad hoc Agency will only be established by a Government

Minister if a list of specified conditions are met.[1]

We are concerned that these conditions may not effectively facilitate victims and relatives' access to information about the circumstances of their relatives' burials. The discretionary power eventually granted to Government officials in this matter is a source of concern and would fail to ensure an impartial, effective and transparent system and process of investigation.

Under the Coroners Act 1962, the Attorney General is authorised to direct any coroner to hold an inquest, where it is considered that the holding of an inquest is considered 'proper'. (s.18) The Coroner is under a statutory obligation to hold an inquest in the event of an unexplained or unnatural death (s.17). However, the new proportionality test proposed in this Bill would effectively prevent an investigation based on an economic impact, or the impact of such excavation on residents, "whose dwelling adjoins the site". (Head 3 of the Bill). The views of the relatives of the deceased are only one of the reasons to be considered in applying the proportionality test. These limitations raise concerns as to how the State will discharge its obligations under Article 2 of the European Convention on Human Rights (ECHR), ratified by your Excellency's Government in 1953. It also raises concerns regarding the compliance with articles 2 and 6 of the International Covenant on Civil and Political Rights (ICCPR), ratified by Excellency's Government in 1989.

In addition, Head 6 of the Bill proposes to restrict the establishment of the Agency if there was informed consent by the family to the burial, or if the lapse of time since the last known burial exceeds 70 years. It is unclear from the current wording of the proposed legislation how informed family consent will be established or how such a limitation ensures compliances with the State's procedural obligations arising under Article 2 ECHR, on the right to life, and Articles 2, 3 and 6 ICCPR. Of concern also is the imposition of a statutory limitation of 70 years, potentially excluding burial sites established prior to 1950. This is inconsistent with the timeline given to the Commission to investigate cases from 1922 to 1998. We are concerned that the proposed legislation allows for the possibility that an investigation does not take place if Government has formed the view that a memorialisation of the site without further investigation is more appropriate (Head 6(10)). We are also concerned about the lack of clarity regarding rights of appeal for victims and relatives against decisions taken not to establish an Agency or to continue an investigation.

The concerns in relation to the proposed legislation do not preclude our opinion that a revision of and full implementation of the Coroners Acts 1962 could meet the State's international and regional human rights obligations, in particular articles 2.3 and 6 of ICCPR and Articles 2 and 13 ECHR, by for example, regulating access to information, establishing clear rules of procedure, an accessible appeals mechanism, and meeting the State's obligations to ensure effective investigations in relation to alleged human rights violations, and effective remedies. Given the

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[1] Where the current legislation clearly established the circumstances under which the Coroner must initiate the investigation, under the new Bill, the order to investigate, excavate and exhume, will only be made if:

(1) a Minister is satisfied that manifestly inappropriate burials have taken place at a site associated with an institution;
(2) if such excavation is necessary for safeguarding important objectives of general interest (according to the said Ministry's ponderation of the situation);
(3) If the action is proportionated with its intended objective;
(4) If it also passes the test of the criteria for interventions outlined in the Bill and;
(5) if none of the restrictions set forth in the same legislation apply.

conclusions in the Commission's report concerning the higher mortality rates in the Mother and Baby Homes, it is critical to ensure that provisions are made for the holding of inquests to investigate the deaths that occurred and that the Bill does not impede the holding of such inquests.

Restorative Recognition scheme: Right to Truth, Reparations and Guarantees of non-recurrence

As a response to the recommendations of the Commission, the Government has stated that a Restorative Recognition scheme would be established. However, little information has been provided to date as to the nature of this Scheme, and its scope appears to be limited only to certain institutions. In view of the experiences of two previously established restorative mechanisms, namely the Residential Institutions Redress Scheme and the Magdalen Restorative Justice Ex-Gratia Scheme, we recommend to your Excellency's Government that any new restorative scheme encompasses measures to provide full reparation to victims that extend beyond financial compensation to include the five forms of reparation owed to victims (restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition), and are undertaken jointly with measures to ensure truth, justice, memory and non-recurrence.[2] In this regard, we would recommend that redress schemes should ensure:

1. A clear and transparent procedure for unconditional access to information and archives, which can enable victims and relatives to establish their identity, as well as the fate of disappeared relatives;

2. A review of the methods of investigation of the Mother and Baby Homes Commission of Investigation, in procedures followed and in institutional sites reviewed, and in its analysis of human rights violations, in light of Ireland's obligations under international law to ensure the right to truth, justice and reparations;

3. Ensure accountability for violations of human rights, through investigation, and prosecution of perpetrators, and imposition of effective, proportionate and dissuasive sanctions;

4. Provide compensation commensurate with the gravity of the offences and other measures of rehabilitation if victims wish to avail of such measures (and without prejudice to the right to seek further remedies for human rights violations experienced);

5. A State apology that fully recognises the gravity and range of human rights violations that occurred in the Mother and Baby homes and analogous institutions;

6. Establish and support processes of memorialisation designed and led by victims and survivors.

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[2] On the analysis of memorialisation processes in the context of serious violations of human rights and international humanitarian law as the fifth pillar of transitional justice, please see report by the Special Rapporteur on the promotion of truth, justice reparations and guarantees of non-recurrence, to the Human Rights Council in 2020, A/HRC/45/45

As the proposed Scheme and the above mentioned draft legislative measures are responses, in part, to the Commission's report, we would like to recall the observations made by UN human rights mechanisms. For example, the Special Rapporteur on the sale and sexual exploitation of children following her visit to Ireland in 2018, specifically warned about the limited scope of the Commission's work, noting that its investigation was not broad enough, "to uncover the full scale of illegal adoption, which still affects Irish citizens today." (A/HRC/40/51/Add.2 para 14)[3]. The UN Committee against Torture in its Concluding Observations to Ireland in 2017 expressed its concerns about the Terms of Reference of the Commission (CAT/C/IRL/CO/2, para 27) and recommended an independent, thorough and effective investigation into any allegations of ill-treatment, including cases of forced adoption, amounting to violations of the Convention, at all of the Mother and Baby Homes and analogous institutions (CAT/C/IRL/CO/2, para 28). We urge that the proposed legislation and the proposed Restorative Recognition Scheme ensure compliance with your Government's international obligations to ensure effective remedies, and undertake effective investigations in relation to the full range of human rights violations raised to date in relation to the Mother and Baby homes and analogous institutions.

These obligations are recalled below:

Regarding standards related to **sale of children and illegal adoptions**, the report of the Special Rapporteur on the sale and sexual exploitation of children on her visit to Ireland in 2018, specifically warned that: "[…] the limited scope of the Commission's work – as with that of other commissions examining abuses in institutions before it – will mean that its investigation is not broad enough to uncover the full scale of illegal adoption, which still affects Irish citizens today." (A/HRC/40/51/Add.2 para 14). Illegal adoption may come within the international legal definition of trafficking; the purpose may be exploitative – of both the natural parent(s), and the adopted child, given the failure to ensure the best interests of the child and the rights of the child. We note that while the current international legal definition of trafficking stems from the Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, and the Council of Europe Convention on Action against Trafficking in Human Beings (both ratified by Your Excellency's government in 2010), trafficking in persons comes within the scope of the international legal prohibition of slavery, servitude and forced labour – a peremptory norm of international law.[4] In respect of children, it is important to note that the act and purpose of exploitation are sufficient to bring the impugned conduct within the scope of the international law prohibition of trafficking in persons.[5] As such, it is critical to ensure that the proposed Restorative Recognition Scheme establishes a process for effective investigations and ensures access to effective remedies to all victims, without exception.

Concerning standards related to **forced labour and servitude**, it is important to ensure that the proposed Restorative Recognition scheme includes forced labour

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[3] Similar concerns had already been raised, for example by the Human Rights Committee in their Concluding Observations to Ireland in 2014, see para. 10, CCPR/C/IRL/CO/4.

[4] *Rantsev v. Cyprus and Russia App no 25965/04 (Judgment of 7 January 2010)* para 281

[5] *See* Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery art. 1(d), Sept. 7, 1956, 18 U.S.T. 3201, 266 U.N.T.S. 3: [Child Trafficking is defined as] any institution or practice whereby a child or young person under the age of 18 years is delivered by either or both of his natural parents or by his guardian to another person, whether for reward or not, with a view to the exploitation of the child or young person or of his labour.

and servitude within its scope. We note that gendered human rights abuses, are frequently neglected in restorative justice and reparations schemes, and particular attention is required to ensure a gender-lens is applied to the design and implementation of the Scheme, informed by survivors and victims. In her report on Ireland, the Special Rapporteur on sale and sexual exploitation of children found that: "[...] girls who were transferred to the Magdalene laundries were made to work against their will and with little to no compensation, in arrangements that could amount to the sale of children." (A/HRC/40/51/Add.2, para 16) It has been reported that women and children in the Mother and Baby homes and when 'hired out', were forced to work without remuneration under threat of abuse and in abusive circumstances.[6] The Commission's executive summary of the report states: "The women worked but they were generally doing the sort of work that they would have done at home; women in the county homes did arduous work for which they should have been paid and there are a few other examples where this is also the case."[7] The Working Group on Discrimination against Women and girls in its report on the causes of deprivation of liberty of women stated that forced confinement of women should be understood as a form of gender-based violence as many lack resources, choice and opportunities. These conditions push women into the realm of human trafficking, contemporary forms of slavery (A/HRC/41/33). In addressing the scope and status of Article 4 ECHR, the European Court of Human Rights in *Siliadin v. France* emphasised at para.112: *"The Court reiterates that Article 4 enshrines one of the fundamental values of democratic societies."*[8] We note that the Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery, (ratified by your Excellency's Government on 18 Sep 1961) requires States Parties to take all practicable and necessary legislative and other measures to bring about the complete abolition or abandonment of the following institutions and practices:

"(d) Any institution or practice whereby a child or young person under the age of 18 years, is delivered by either or both of his natural parents or by his guardian to another person, whether for reward or not, with a view to the exploitation of the child or young person or of his labour." (cited in *Siliadin v France*, at para 125).

In the case of *Rantsev v. Cyprus and Russia*, the European Court of Human Rights, recalling the previous interpretation of *Siliadin v. France*, further stated, regarding the obligation to investigate and the positive obligations stemming from article 4 ECHR, that: "Like Articles 2 and 3, Article 4 also entails a procedural obligation to investigate situations of potential trafficking." [9] In its General Recommendation no.38 on trafficking in women and girls in the context of global migration (2020),[10] the UN Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) states at para 15:

"Obligations flowing to non-State actors to respect the prohibition of trafficking also arise from the peremptory norm (jus cogens) prohibiting slavery, the

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6 Report of the Confidential Committee to the Commission of Investigation into Mother and Baby Homes October 2020, see pp 115, 118

7 Executive summary of the Final Report of the Commission of Investigation into Mother and Baby Homes, Department of Children, Equality, Disability, Integration and Youth, 2021, p 5

8 *Siliadin v. France*, Application no 73316/01 (Judgment of 26 October 2005), para 112.

9 *Rantsev v. Cyprus and Russia*, Application no. 25965/04 (Judgment of 7 January 2010), para. 288. See: *S.M. v. Croatia*, Application no. 60561/14 (Judgment of 25 June 2020) para 316

10 Committee on the Elimination of Discrimination against Women, 'General recommendation No. 38 (2020) on trafficking in women and girls in the context of global migration' (20 November 2020) UN Doc CEDAW/C/GC/38.

slave trade and torture, noting that in certain cases trafficking in women and girls may amount to such rights violations." (CEDAW/C/GC/38 para 15).

Further the CEDAW Committee states in General Recommendation no.38 (2020) that victims: "[...] must be ensured access to justice on the basis of equality and non-discrimination, including the prosecution of their perpetrators and the provision of remedies" (CEDAW/C/GC/38 para. 42). States parties to the Convention on the Elimination of All Forms of Discrimination against Women (ratified by your Excellency's government on 23 December 1985) must: "provide appropriate and effective remedies, including restitution, recovery, compensation, satisfaction and guarantees of non-repetition, to women whose rights under the Convention have been violated." (CEDAW/C/GC/38 para. 43). In this regard, the CEDAW Committee recommends that States: "Ensure facilitated access to inclusive, age-sensitive and gender-sensitive complaint mechanisms and justice mechanisms, including through the provision of procedural and age-appropriate accommodations, for all women and girls who are victims of trafficking, including non-citizens". (CEDAW/C/GC/38 para 100-101). As such, we bring to your Excellency's Government's attention, the positive obligations on the State, of due diligence, of protection and of effective investigation and access to effective remedies, which should be fulfilled in the proposed Restorative Recognition Scheme and any related measures.

Concerning standards on **torture, inhuman and degrading treatment and gender-based violence against women and girls**, we note that the European Court of Human Rights has held that States are obliged under Article 3 ECHR to: "provide effective protection in particular of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge." [11] This obligation was restated in O'Keeffe v Ireland.[12] The UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment has noted: "[...] whenever States fail to exercise due diligence to protect trafficking victims from the actions of private actors, punish perpetrators or provide remedies, they are acquiescent or complicit in torture or ill- treatment". (A/HRC/26/18, para 41). The Committee against Torture has also highlighted the positive obligations of States regarding access to remedy for victim of an act of torture. In General Comment n°3 regarding States' obligations under article 14 of the Convention - the obligation to "ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible"- the Committee stressed that:

[11] For example, *Z and Others v United Kingdom*, Application no. 29392/95 (Judgment 10 May 2001) para 73; *O'Keeffe v Ireland, Application no. 35810/09* (Judgment 28 January 2014), para 144; *X and Y v The Netherlands*, Application no. 8978/80, (Judgment 26 March 1985) paras 35–36.

[12] O'Keeffe v Ireland, Application no. 35810/09 (Judgment 28 January 2014), para 93

"The obligations of States parties to provide redress under article 14 are two-fold: procedural and substantive. To satisfy their procedural obligations, States parties shall enact legislation and establish complaints mechanisms, investigation bodies and institutions, including independent judicial bodies, capable of determining the right to and awarding redress for a victim of torture and ill-treatment, and ensure that such mechanisms and bodies are effective and accessible to all victims. At the substantive level, States parties shall ensure that victims of torture or ill-treatment obtain full and effective redress and reparation, including compensation and the means for as full rehabilitation as possible" (CAT/C/GC/3, para. 5)

The due diligence obligation of States to prevent gender-based violence against women is well established. (Article 4 (c & d) of the United Nations Declaration on the Elimination of Violence against Women) In addition, General Recommendation No. 35 (2017) of the Committee on the Elimination of Discrimination against Women, updating General Recommendation No. 19 (1992), clarifies that States parties are under an obligation to act with due diligence to investigate all crimes of violence perpetrated against women and girls, to punish perpetrators and to provide adequate compensation without delay. The Working Group on Discrimination against Women and girls stated that failure to protect women's rights to health and safety may amount to cruel, inhuman or degrading treatment or punishment or torture, or even a violation of their right to life. (A/HRC/32/44). We note the importance of ensuring that the Restorative Recognition Scheme addresses the obligations of the State arising from reports of the conduct of vaccine and infant milk-trials in Mother and Baby homes, and the legal responsibility of the State, and third parties, in relation to the conduct of non-consensual experimental medical treatment.

Regarding standards on **arbitrary detention** (deprivation of liberty and security of the person), the proposed Restorative Recognition Scheme should also address concerns that have been raised in relation arbitrary detention in Mother and Baby Homes and analogous institutions, again ensuring that a gender equality lens is applied in the design and implementation of the Scheme and that the rights of women and girls are ensured.[13]

Concerning standards on **enforced disappearances**, in its General Comment on children and enforced disappearances, the Working Group on enforced disappearances states:

"States need to develop truth-seeking mechanisms that are child-sensitive and that assess how children were affected by enforced disappearances. The mandate of those mechanisms should make clear references to child victims of enforced disappearances. There should be proper allocation of resources to secure the proper expertise, methodology and structure." (A/HRC/WGEID/98/1, para. 24).

We would like to recall the Working Group's General Comment on women affected by enforced disappearances (A/HRC/WGEID/98/2), which stresses, inter alia, the differentiated effects of enforced disappearances in women and girls. In particular, States must acknowledge disappeared women and girls, and recognize the particular types of harm they suffer based on their gender, including instances of sexual violence and forced impregnation, and the resulting psychological damage and

[13] Report of the Confidential Committee to the Commission of Investigation into Mother and Baby Homes October 2020.

social stigma as well as the disruption of family structures. Reference is also made to the Working Group's General Comment on the right to truth (A/HRC/16/48), which states that the right of the relatives to know the truth of the fate and whereabouts of the disappeared persons is an absolute right, not subject to any limitation or derogation. No legitimate aim, or exceptional circumstances, may be invoked by the State to restrict this right. The right to know the truth about the fate and the whereabouts also applies to the cases of children who were born during their mothers' enforced disappearances, and who were thereafter illegally adopted. Article 20 of the Declaration provides that such acts of abduction, as well as the act of altering or suppressing documents attesting to their true identity, shall constitute an extremely serious offence, which shall be punished as such". The same provision also provides that States "shall devote their efforts to the search for and identification of such children and to the restitution of the children to their families of origin". That is to say that the falsity of the adoption should be uncovered. Both the families of the disappeared and the child have an absolute right to know the truth about the child's whereabouts. However, paragraph 2 of the same article tries to ensure a balance when it comes to the issue of whether the adoption should be revisited. This balance, taking into consideration the best interest of the child, does not prejudice the right to know the truth of the family of origin or the child's whereabouts.

The State's positive obligations in relation to enforced disappearances are stated in international human rights treaties, and customary international law, and raise questions also in relation to the State's responsibility under the ECHR, specifically Articles 2 (right to life), Article 3 (prohibition of torture), Article 5 (right to liberty and security), Article 8 (right to respect for private and family life) and Article 13 (right to an effective remedy). Reference is also made to Articles 6, 7, 9, 10, 16 of the ICCPR, read alone and in conjunction with Article 2.3 and, where minors are involved, also Article 24.1. In addition, we would like to recall the obligation of the State under Article 20 of the Declaration on the Protection of All Persons from Enforced Disappearance, which requires that measures be taken to prevent and suppress the abduction of children of parents subjected to enforced disappearance and of children born during their mother's enforced disappearance. It also requires that the State devote their efforts to the search for and identification of such children and return them to their families of origin. Further, Articles 13 and 19 of the Declaration respectively require States to conduct prompt, thorough and impartial investigations into allegations of enforced disappearance and to provide victims and their family with adequate redress for the harm suffered. Article 17 of the Declaration clarifies that enforced disappearances shall be considered a continuing offence as long as the perpetrators continue to conceal the fate and the whereabouts of persons who have disappeared and these facts remain unclarified.

Regarding standards relating to **non-discrimination and equal protection of the law**, the proposed Restorative Recognition Scheme must ensure that the principle of non-discrimination is respected, and that equal protection of the law is ensured, including for victims from minority ethnic groups, including the Travelling Community, and for persons with disabilities. It is essential to ensure that multiple and intersecting forms of discrimination, affecting the equal enjoyment of human rights, are addressed in the design and implementation of the Scheme. Specifically, in relation to the Mother and baby homes, the UN Committee on the Elimination of Racial Discrimination, in its Concluding Observations on Ireland stated:

"The Committee is concerned about reports of abuses based on race in mother and baby homes, including racial discrimination in the adoption process and physical, emotional and sexual abuse experienced by those children who self-identify as mixed-race Irish in these institutions." (CERD/C/IRL/CO/5-9, para 17).

Concerning standards on **the right to life**, the proposed Restorative Recognition Scheme must also address and ensure that within its scope, all measures necessary are taken to fulfil the State's procedural and substantive obligations concerning the right to life.

Finally, regarding **standards on the right to effective remedy**, access to records and information is a key component of an effective investigation and to access to effective remedies. The right to an effective remedy encompasses both a substantive right to reparations and procedural rights necessary to access reparations, including accessing information. The *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law* provide that reparation may include the following forms: restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition. The *Updated set of principles for the protection and promotion of human rights through action to combat impunity* establishes the right to truth as:

"[…] the inalienable right to know the truth about past events concerning the perpetration of heinous crimes and about the circumstances and reasons that led, through massive or systematic violations, to the perpetration of those crimes. Full and effective exercise of the right to the truth provides a vital safeguard against the recurrence of violations" (E/CN.4/2005/102/Add.1).

In her report on reparations to women who have been subjected to violence (A/HRC/14/22), the Special Rapporteur on violence against women noted that women have historically been neglected in discussions of reparations, despite the recognition of the right to a remedy in international human rights instruments. She stressed that reparations for women cannot be just about returning them to the situation in which they were found before the individual instance of violence, but instead should strive to have a transformative potential. This implies that reparations should aspire, to the extent possible, to subvert instead of reinforce pre-existing patterns of crosscutting structural subordination, gender hierarchies, systemic marginalization and structural inequalities that may be at the root cause of the violence that women experience before, during and after the conflict. Complex schemes of reparations, such as those that provide a variety of types of benefits, can better address the needs of female beneficiaries in terms of transformative potential, both on a practical material level and in terms of their self-confidence and esteem. Measures of symbolic recognition can also be crucial. They can simultaneously address both the recognition of victims and the dismantling of patriarchal understandings that give meaning to the violations. The Working Group on Discrimination against women and girls in its report on health and safety stated that redress and remedies are part of the States 'international human rights obligations, especially, when it comes to survivors/victims of gender-based violence and rectification of the past wrong doings (A/HRC/32/44). The Human Rights Committee, in its General Comment no.31 on *The Nature of the General Legal Obligation Imposed on States Parties to the Covenant* (CCPR/C/21/Rev.1/Add. 13) specifically stated that:

"There may be circumstances in which a failure to ensure Covenant rights as required by article 2 would give rise to violations by States Parties of those rights, as a result of States Parties' permitting or failing to take appropriate measures or to exercise due diligence to prevent, punish, investigate or redress the harm caused by such acts by private persons or entities. States are reminded of the interrelationship between the positive obligations imposed under article 2 and the need to provide effective remedies in the event of breach under article 2, paragraph 3. (para.8)."

"A failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant." (para.15).

"Article 2, paragraph 3, requires that States Parties make reparation to individuals whose Covenant rights have been violated. Without reparation to individuals whose Covenant rights have been violated, the obligation to provide an effective remedy, which is central to the efficacy of article 2, paragraph 3, is not discharged." (para.16).

In relation to the relevant international law, we draw your Excellency's attention to the international legal instruments, in force at the time of the events occurring, and relevant peremptory norms of international law (*jus cogens* norms), that also form part of customary international law and were binding upon the State. Specifically, these include, and are not limited to: Right to life, right to be free from torture, inhuman and degrading treatment, the prohibition of forced labour and servitude, the prohibition of racial discrimination, the prohibition of enforced disappearance, and the right to liberty and security of the person, including the right to be free from arbitrary detention. We also note that the procedural duty to carry out an effective investigation under Article 2 ECHR has evolved into a separate and autonomous duty and may bind the State even when the death took place before the critical date of ratification. [14]

As it is our responsibility, under the mandates provided to us by the Human Rights Council, to seek to clarify all cases brought to our attention, we would be grateful for your observations on the following matters:

1. Please advise what steps are being taken to ensure that the Birth Information and Tracing Bill will comply with the State's obligations under international law, including its obligations to ensure effective remedies for human rights violations, and to effectively protect rights to information, and to truth, justice and reparation.

2. Regarding the General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill, please explain why the proposed legislation on institutional burials dis-apply the Coroner's powers, once a specialised Agency is established to undertake exhumations, identification and re-interment of remains at institutional sites. Please explain what legal protections and judicial oversight will be in place to ensure transparency in the process, and what further steps will be taken to ensure that the legislation complies with the State's obligations under international law.

3. Given that the Attorney General is currently empowered under the existing Coroners Acts, 1962, to direct the holding of inquests, and in light of the Commission Report's findings, please provide information on whether the Government will order inquests into the deaths and burials identified in this report.

[14] See also: Silih v Slovenia, Application No 71463/01, (Judgment of 9 April 2009). We note that in *Varnava and Others v Turkey*, the European Court of Human Rights observed that interpretation of the Convention obligations cannot be equated to a retroactive imposition of liability and concluded that its case-law is a means of clarifying pre-existing texts to which the principle of non-retroactivity does not apply in the same manner as to legislative enactments.*Varnava and Others v Turkey* Applications Nos 16,064/90 (Judgment of 18 September 2009), para. 140

4. Please provide further information on the proposed "Restorative Recognition Scheme." Please clarify what steps are being taken to ensure that the scheme fulfils the State's obligations under international human rights law, to ensure effective access to remedies, and to ensure compliance with the rights of victims to truth, justice, reparations, guarantees of non-recurrence and memory, without discrimination and without further delay.

5. Recognizing that, "without memory, the rights to truth, justice and full reparation cannot be fully realized, and there can be no guarantees of non-recurrence" (A/HRC/45/45, para. 100), please provide information on what memorialisation measures are planned in the proposed "Restorative Recognition Scheme", and what role will be given to survivors in the design and implementation of such measures

6. Please provide information on what steps the Government will take to investigate and ensure accountability through the proposed Restorative Recognition Scheme, for the conduct of vaccine and infant milk-trials in Mother and Baby homes.

7. Please provide information on what steps the Government will take, through the proposed legislation and scheme, to ensure the rights to information and to effective remedies, including rights of access to personal data, the rights of natural mothers to access their full records and the rights of relatives of those who were in Mother and Baby Homes and analogous institutions, to obtain full records about relatives who died in Mother and Baby homes and analogous institutions.

This communication, as a comment on pending or recently adopted legislation, regulations or policies, and any response received from your Excellency's Government will be made public via the communications Reporting website after 48 hours. They will also subsequently be made available in the usual Report to be presented to the Human Rights Council.

Please accept, Excellency, the assurances of our highest consideration.

Luciano Hazan
Chair-Rapporteur of the Working Group on Enforced or Involuntary Disappearances

Mama Fatima Singhateh
Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material

Tomoya Obokata
Special Rapporteur on contemporary forms of slavery, including its causes and consequences

Nils Melzer
Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Siobhán Mullally
Special Rapporteur on trafficking in persons, especially women and children

Fabian Salvioli
Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence

Reem Alsalem
Special Rapporteur on violence against women, its causes and consequences

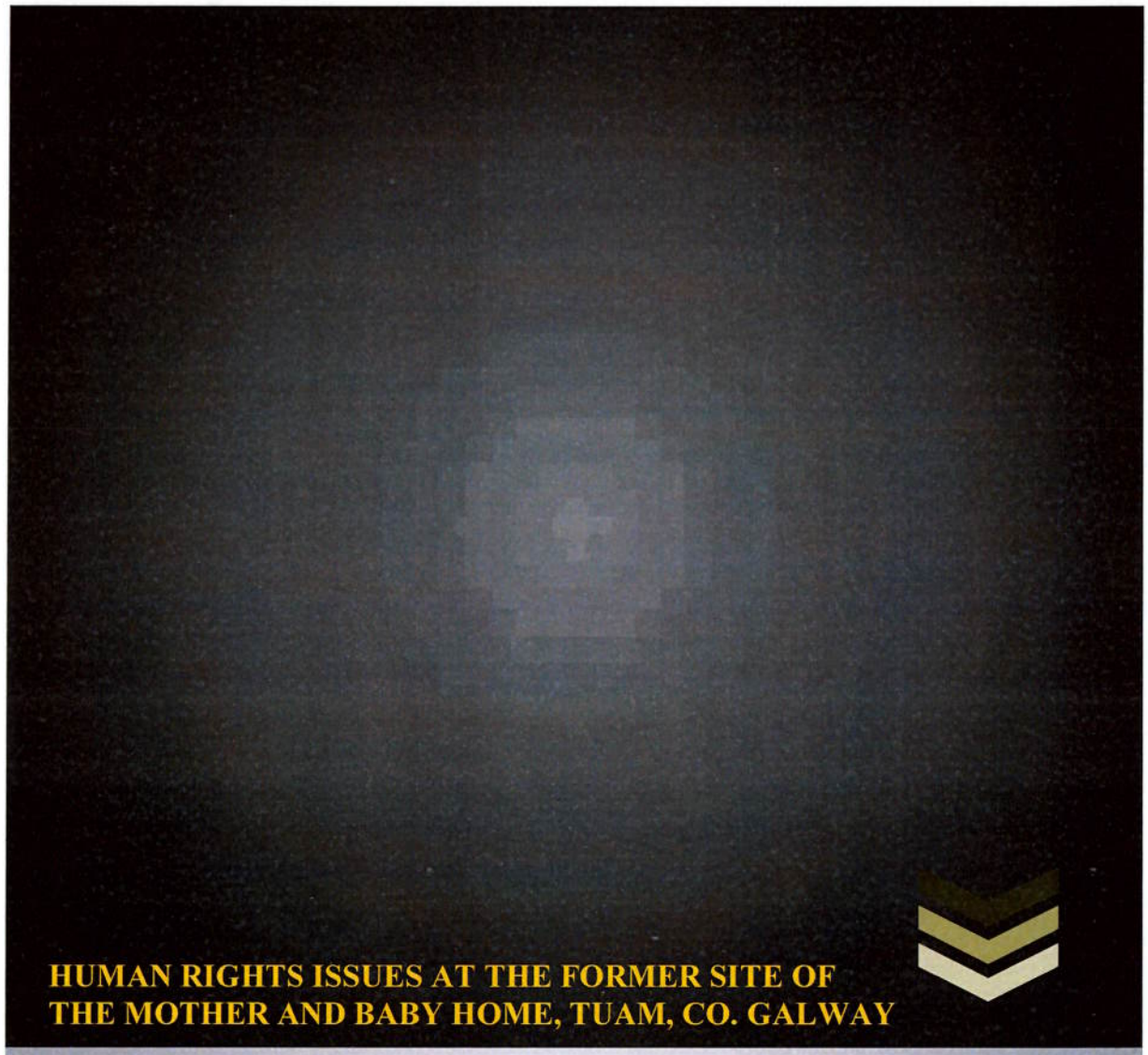
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HUMAN RIGHTS ISSUES AT THE FORMER SITE OF THE MOTHER AND BABY HOME, TUAM, CO. GALWAY

Dr. Geoffrey Shannon

12/4/2018

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ABBREVIATIONS AND ACRONYNS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CMC	Cuprija Medical Centre
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ETG	Expert Technical Group
GRO	General Register Office
IACmHR	Inter-American Commission on Human Rights
IACtHR	Inter-American Court of Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICJ	International Court of Justice
ICRC	International Committee of the Red Cross
ICTY	International Criminal Tribunal for the former Yugoslavia
MADEKKI	Inspectorate of Quality Control for Medical Care and Working Capability
PSNI	Police Service of Northern Ireland
UDHR	Universal Declaration of Human Rights
UNCAT	United Nations Convention against Torture
UNCRC	United Nations Convention on the Rights of the Child

PREFACE

This report has been prepared pursuant to a request from the Minister for Children, Dr. Katherine Zappone TD in a letter (dated 7 December 2017) to me in my capacity as Special Rapporteur on Child Protection. The request involves a general consideration of the human rights issues that appear to arise in the wake of the discovery of juvenile human remains at the site of the former Mother and Baby Home in Tuam, County Galway. In particular, I have been asked to examine the following matters:

(i) human rights issues relating to the right of an individual to a respectful and appropriate burial;

(ii) obligations, if any, under international human rights law, including under the European Convention on Human Rights, arising from the right to respect for family life. This is to include an examination of the entitlement of living family members to know the fate of their relatives;

(iii) any obligation on the State under human rights law to fully investigate the deaths so as to vindicate the right to life of those concerned;

(iv) on a more general level, the applicable domestic law and human rights law in place between the years 1920 to 1960, and how this might impact on the right to respect for family life, and/or the right to a respectful and appropriate burial.

In Section 1, I consider the absence of unified mass-grave protection guidelines for States to follow when they are faced with the discovery of sites, such as the burial site at the former Mother and Baby Home in Tuam. Section 2 addresses the human rights issues under the European Convention on Human Rights relating to the right of an individual to a respectful and appropriate burial and any entitlement of living family members to know the fate of their relatives.

In Section 3, I comprehensively set out the obligations under international human rights law relevant to the report. I outline in Section 4 any legal obligations based on customary international law.

In Section 5, I consider the provisions in the Irish Constitution relevant to the report. In Sections 6 and 7, I outline the statute law and common law in place between the years 1920 to 1960, and how this might impact on the right to respect for family life, and/or the right to a

respectful and appropriate burial. Finally, Section 8 considers the limitation periods which might apply to legal proceedings arising out of events which occurred at the site of the former Mother and Baby Home in Tuam.

It is hoped this report may assist in informing any determination that is to be made concerning the treatment of the remains buried at the Tuam site, guiding consideration of the five options proposed by the Expert Technical Group.

This report does not examine or make any determinations on the deaths of the infants at the former Mother and Baby Home in Tuam nor does it seek to make any determination on whether the burials were appropriate or inappropriate.

EXECUTIVE SUMMARY

It is worth noting at the outset that in international law, there are no unified mass-grave protection guidelines in place for States to follow when they are faced with the discovery of sites, such as the burial site at the former Mother and Baby Home in Tuam, despite the existence of guidelines to deal with situations of armed conflict and investigations of missing persons.[1] Calls have been made to work toward a more comprehensive set of legal guidelines for the protection of such graves at an international level. This would assist in achieving a number of desired aims, including ensuring that family members are informed of the fate of their relatives, allowing survivor populations be aware about what happened at the site in question and enabling proper investigations to take place - answering questions and finding those responsible where possible.[2] While the site at Tuam cannot be considered to be a mass grave in terms of what is typically associated with violence or conflict, physical investigation of the site has necessitated use of the skillset designed to forensically investigate mass graves and similar legal issues are thus raised.

EUROPEAN CONVENTION ON HUMAN RIGHTS

The Convention for the Protection of Human Rights and Fundamental Freedoms, better known as the European Convention on Human Rights (ECHR) came into force in 1953. It was the first instrument to give effect to certain of the rights stated in the Universal Declaration of Human Rights and make them binding. Its contracting states are obliged to secure to everyone within their jurisdiction the rights and freedoms set out in section 1 of the ECHR. The ECtHR is tasked with enforcing the provisions of the ECHR and its judgments, in some cases, have broadened the interpretation of the Convention. In Ireland, the European Convention of Human Rights Act 2003 was introduced to give further effect to the ECHR in Irish law. The Act did not incorporate the Convention into Irish law, but rather requires Irish courts to interpret legislation in line with the Convention insofar as it is possible to do so. It

[1] For instance, the Geneva Conventions and their Additional Protocols form the core of international humanitarian law, regulating the conduct of armed conflict and seeking to limit its effects. With regard to missing persons, the International Committee of the Red Cross (ICRC), "Guiding Principles/Model Law on the Missing" (2009) and the International Convention for the Protection of All Persons from Enforced Disappearance are of assistance.

[2] See Melanie Klinkner, "Towards mass-grave protection guidelines" *Human Remains and Violence,* Volume 3, No.1 (2017) 52-70. This article, however, concerns primarily the protection of mass-graves in post-conflict situations.

also requires that certain public bodies perform their functions in a manner compatible with the Convention, unless precluded by law.

Application of Article 8 principles

Article 8 of the ECHR may be of relevance in relation to the particular set of circumstances arising from the discovery of juvenile remains at Tuam. Article 8 has been broadly interpreted, providing family members of deceased persons with a substantial number of rights capable of assertion. While these rights are not absolute, and may be proportionately interfered with, their existence is of considerable importance and the State should be careful to ensure no illegitimate infringement of such rights. Family members may possess the right to have their loved one's body returned to them. Moreover, relatives may have a right to know the fate of their family members, including information surrounding the death and/or burial of their loved ones. A failure to provide relatives with definite and/or credible information may fall foul of the positive obligation under Article 8, even where the death occurred before the Convention came into force in the relevant county, where the failure to provide information continues following the coming into force of the ECHR. It is also of note, that where samples are sought to be taken from a corpse, the consent of the family member is a relevant concern and should be borne in mind in any approach taken in relation to the subject matter of this report. Irish authorities are required to carry out their functions in a manner compatible with the ECHR and Article 8 rights in particular must be positively vindicated. Regard should be given to the distress and anguish of family members seeking information surrounding the death and/or burial of their loved ones. Nonetheless, it should also be borne in mind that there may be limits to the information which can or must be provided for the purposes of complying with Article 8. The decisions of the ECtHR confirm that Article 8 rights include information concerning the fate and place of burial of the deceased but it may not necessarily extend to additional matters (although these may be covered by Articles 2 and 3 ECHR).

The Court's Article 8 case law has been concerned so far with negative interferences on the part of the State with the right of family members to the return or disposal of bodies, or to information about their disposal. The Court does not yet appear to have considered whether

Article 8 imposes a more extensive positive obligation on the part of State authorities to assist or ensure that a burial takes place in the particular manner desired by the family.

Furthermore, any Article 8 ECHR right should be considered having regard to the extreme delicacy of any exhumation and further investigation at the Tuam site, as determined by the Expert Technical Group. The report of the ETG states that: "There are a number of factors that make this situation unique: The forensic requirement of the site; The 'significant' quantities of juvenile remains; The commingled or intermixed state of the remains; The position of the remains within subsurface chambers, with limited access." The report[3] concludes that the comingled state of the remains renders identification "particularly challenging". Moreover, the ETG states there is a "risk of destruction to human remains" that raises ethical issues.

In terms of pursuing any claim for violation of Convention rights, it is the family members alone who are capable of asserting these rights. The deceased no longer possess human rights and they are not capable of asserting same. This approach is similarly demonstrated in the Council of Europe's Additional Protocol on Transplantation of Organs and Tissues of Human Origin.[4] Pursuant to Article 18, "Respect for the human body", it is provided that during removal of organs and/or tissues, the human body must be treated with respect and all reasonable measures must be taken to restore the appearance of the corpse. The Explanatory Comment to Article 18 states; "A dead body is not legally regarded as a person, but nonetheless should be treated with respect."

Therefore, it is the family members who assert their rights under the Convention. They are not asserting the rights of the deceased, but their own as relatives. It is even questionable whether the deceased possess any human rights, as realistically due to their death, they are not capable of asserting same. This issue was considered by Rosenblatt in relation to the investigation of mass graves in *International Forensic Investigations and the Human Rights of the Dead.*[5] He states:

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[3] Report of the Expert Technical Group, December 2017, (i).
[4] Adopted 24 January 2002, entered into force 1 May 2006; See Comment to Article 18, Additional Protocol on Transplantation of Organs and Tissues of Human Origin.
[5] *Human Rights Quarterly*, Volume 32, Number 4, November 2010, pp. 921-950 (Article) published by The Johns Hopkins University Press.

> ... [H]uman rights for the dead are philosophically unworkable and irreconcilable with the practical limitations of forensic work; therefore, we should not think of the dead as having human rights. However, this conclusion does not end discussion about what forensic investigators do for dead bodies. Rather, it makes room for a modest but rich sense of how exhumation can restore the identity, physical location, and care that have been denied to victims of atrocity.

Articles 2 and 3 ECHR

While much of the discussion above focuses on Article 8 ECHR rights and the right to respect private and family life, Articles 2 and 3 of the Convention also warrant consideration. Article 2 protects the right to life. The obligation of States to protect life is set out in the Convention, but is similarly recognised in other international human rights instruments, including the Universal Declaration of Human Rights (Article 3). As with Article 8, the ECtHR has interpreted Article 2 as placing a positive obligation on States. While, therefore, it requires States to refrain from the intentional and unlawful taking of life, they must positively take appropriate steps to safeguard the lives of those within their jurisdiction. Procedurally, there exists an obligation upon States to effectively investigate a killing or suspicious death within their territory. Article 3 prohibits torture, inhuman or degrading treatment or punishment. A similar obligation to investigate arises out of Article 3 ECHR. Where inhuman or degrading treatment is alleged, a State has a duty to investigate a complaint made.

The ECtHR case law concerning Article 2 in particular demonstrates that the procedural obligation upon a State to investigate effectively arises where the death occurs in suspicious circumstances or where an individual has gone missing in life-threatening circumstances. The purpose of such investigations is to ensure that domestic law in place to protect the right to life is implemented. The Last Rights Project, in its article *The Dead, the Missing and the Bereaved at Europe's International Borders – Proposal for a Statement of the International Legal Obligations of States* (May 2017), sets out the criteria which the ECtHR has required to be met for an investigation to satisfy international human rights standards as follows:

- State initiative – the State authorities must take the initiative to investigate once the matter has come to their attention and may not leave it to the next of kin to bring proceedings;
- Independence – those carrying out the investigation must be independent from those implicated in their death;

- Effectiveness – the investigation must be capable of leading to a determination of whether the action taken by State officials was justified in the circumstances and to a determination of the culpability of those responsible for the death. Steps must be taken to secure all relevant evidence in relation to the death;
- Promptness – the investigation must take place promptly and must proceed with reasonable expedition;
- Transparency - the investigation must be open to public scrutiny to a degree sufficient to provide accountability in the circumstances of the case.[6]

Duty to investigate incidents which took place before the ECHR came into force

The Convention duty to investigate incidents may include incidents that happened some time ago. It is, however, a more limited duty in relation to historical incidents which occurred before the State in question signed the Convention. Nevertheless, relatives of the deceased should be involved in the investigation to a sufficient degree to safeguard their legitimate interests.[7]

The ECtHR has stated that its temporal jurisdiction to review a State's compliance with its procedural obligation under Article 2 to carry out an effective investigation into alleged unlawful killing by State agents was not open-ended where the deaths had occurred before the date the Convention entered into force in respect of that State. In such cases, the Court has jurisdiction only in respect of procedural acts or omissions in the period subsequent to the Convention's entry into force, provided there was a "genuine connection" between the death as the triggering event and the entry into force. For a "genuine connection" to be established, the period between the death and the entry into force had to have been reasonably short, no more than 10 years, and a major part of the investigation had or ought to have been carried out after the date of entry into force. The emergence of new, credible information about such past events, however, may trigger the duty to investigate.

The unsettled position in the UK should be noted. In *Re McKerr*,[8] the UK Supreme Court held that an obligation to initiate an investigation under Article 2 only applies to deaths occurring after the Human Rights Act 1988 came into force in 2000. A similar approach was followed by the UK Supreme Court in *Keyu v Secretary of State for Foreign and*

[6] The Last Rights Project - *The Dead, the Missing and the Bereaved at Europe's International Borders – Proposal for a Statement of the International Legal Obligations of States* (May 2017) at p.11.
[7] *Edwards v UK* [2002] ECHR 303.
[8] [2004] 1 WLR 807.

Commonwealth Affairs, discussed in this report. This approach, however, was called into question in other decisions and the current position is unclear.[9]

The question arises whether relatives of those interred in Tuam could contend that their rights pursuant to Article 3 ECHR have been violated. Whether any such claim would be successful would depend on the specific set of facts prevailing in each individual case as a minimum level of severity must be achieved.

In order to ensure the effective vindication of the abovementioned ECHR rights, there appears to be an inferred duty on the Irish State to collect, as far as reasonably possible, the remains of those interred at Tuam. The Tuam site, according to the Expert Technical Report, will test the boundaries of forensic investigation in every regard. The Expert Technical Group, due to the varied nature of the complexities at the site in Tuam, notes the limitations of the forensic possibilities involved in excavation and examination on the site. It states that given that the site holds a group of collectively interred individuals, "it may only ever be possible to provide collective answers", and the potential to identify individuals interred there poses many challenges. These limitations therefore must be borne in mind and where the State fails to collect remains for these reasons, it is unlikely to fall foul of its duty where it takes all reasonable steps to investigate the possibility of retrieval and, if proportionate and justified, undertakes reasonable measures to retrieve the bodies in question.

INTERNATIONAL HUMAN RIGHTS LAW: THE UN FRAMEWORKS

International human rights law also warrants consideration. The Universal Declaration of Human Rights (UDHR) is crucial in this regard. Drafted by representatives with different

[9] See *In Re McCaughey* ([2011] UKSC 20) where Lord Phillips reflected on the *Silih* judgment [(2009) 49 EHHR 372] of the Grand Chamber:

> I believe that the most significant feature of the decision ... is that it makes it quite clear that the Article 2 procedural obligation is not an obligation that continues indefinitely ... [j]ust because there has been a historic failure to comply with the procedural obligation imposed by Article 2 it does not follow that there is an obligation to satisfy that obligation now. In so far as Article 2 imposes any obligation, this is a new free-standing obligation that arises by reason of current events. The relevant event in these appeals is the fact that the coroner is to hold an inquest into [the applicants'] deaths. *Silih* ... establishes that this event gives rise to a free standing obligation to ensure that the inquest satisfies the procedural requirements of Article 2.

However in that same judgment, Baroness Hale doubted whether the decision grounded any free-standing right to open a new investigation. See also *Re McGuigan* [2017] NIQB 96.

legal and cultural backgrounds from all regions of the world, the Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly resolution 217 A) as a common standard of achievements for all peoples and all nations. It sets out the fundamental human rights that are to be universally protected. These are enforced through supervision and reporting by expert bodies, some of which may also deal with individual complaints. The state has an obligation to respect, protect and fulfil the rights guaranteed in these instruments pursuant to section 1 and as a member of the United Nations since 1955, Ireland is expected to uphold its principles, and to protect the rights set out in international treaties through its laws, policies and practices.

CUSTOMARY INTERNATIONAL HUMANITARIAN LAW

The international human rights norms may not be directly relevant to this review, as Ireland has been quite slow to ratify the relevant instruments. The older humanitarian law is also not directly legally applicable, as they are legal norms that are active only when death occurred in, and as a result of, wartime atrocities, although the jurisprudence on dignity and State custom and practice may shed light on the requirement of the Irish constitution in this regard discussed later.

Much of the material included in this section is either human rights in times of war (customary international humanitarian rights), or instances of 'gross' or 'systemic' violations of human rights (under the various human rights frameworks of the United Nations). It is therefore subject to a number of qualifications.

Firstly, the UDHR is generally regarded as not legally binding.

The two International Covenants (the ICCPR and lCESCR) were not in existence until 1966, and Ireland did not ratify both until 1989. Ratification is key to legal effect in a particular jurisdiction. It is not clear therefore that there were any legally recognisable breaches of human rights in the 1920 to 1960 period. Moreover, it is not clear whether the right to know – which seems to be the legally strongest right – can be based on breaches of human rights before the state ratified the relevant instruments (as it cannot be stated at the time they were breaches).

In summary, if it was not a breach at the time, it is difficult to legally determine it so retrospectively. Therefore, there may be very limited grounds for the right to know which is parasitic upon the basic rights in the UN Charter (the conceptual instrument combining the UN Declaration and both Covenants together).

If inhuman or degrading treatment and violations of privacy can be characterised as continuing, it may constitute a violation of the UNCAT, ICCPR or CEDAW.

The most relevant jurisprudence on this matter relates to Enforced Disappearance. This is the most fruitful area of international human rights law to review, as it has an express right to truth/right of victims and their families to know. It is also closely tied to the ICCPR which, as stated above, Ireland ratified in 1989. It seems there may not be a requirement that the ICCPR was ratified by the member state when the 'disappearances' took place. There are interesting parallels between the experience in South America, where much of this law emerged, and the experience of the institutional abuse of women and children in settings such as the mother and baby homes. It should be noted, however, that Ireland has not ratified the International Convention for the Protection of All Persons from Enforced Disappearance, although it codifies what is already implied in many international human rights instruments to which Ireland is a party.

STATUS OF INTERNATIONAL OBLIGATIONS

It is important to bear in mind that the obligations imposed on the State by international agreements occur and are enforceable, if at all, under international law only. Article 29.6 of the Constitution provides that:

> No international agreement shall be part of the domestic law of the State save as may be determined by the Oireachtas.

The Supreme Court explained in *McD v L*[10] that this means that:

> The obligations undertaken by a government which has ratified the Convention arise under international law and not national law. Accordingly those obligations reside at international level and in principle the state is not answerable before the national

[10] [2010] 2 IR 199.

courts for a breach of an obligation under the Convention unless express provision is duly made in national legislation for such liability.[11]

This means that even if it could be factually established that a breach of obligations under these international agreements has occurred in Tuam, this would not provide a right of action under Irish law or before an Irish court in respect of that breach.

THE IRISH CONSTITUTION

Irish case law confirms the importance of dignity under the Constitution and, in particular, the importance attached to the circumstances associated with a person's death. Clearly, this is of potential significance in the Tuam context. It raises the question as to whether there was a failure to take account of considerations of the dignity of the deceased children in the circumstances of their burial; and whether, if so, this would give rise to a breach of the Constitution? Applying the reasoning in *PP v HSE,* there is an argument that constitutional considerations of dignity may have continued to be engaged after the deceased children had passed away. If that is the case, the questions then raised include how, to what acts and for what period of time, those considerations continued to apply. As the decision in *Fleming* indicates, there may also be a distinct question as to whether – assuming considerations of dignity did apply to the burial and may continue to apply thereafter – the circumstances give rise to an enforceable constitutional right or claim, whether on the part of the deceased or of other persons.

On this last question, Irish law recognises a cause of action for breach of constitutional rights, insofar as the right breached is not vindicated by other legal mechanisms.[12] Importantly, where a person is incapable of asserting a right on his/her own behalf, the Irish courts have recognised that the right can be asserted by another appropriate person.[13] As such, if this is a breach of constitutional rights and is not addressed by the law of torts (discussed below), a question arises as to whether there could potentially be an action in respect of a breach of constitutional rights, which would be actionable at the suit of the families of the deceased, or appropriate other parties, on behalf of the deceased.

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[11] At p. 247.

[12] ***Meskell v Córas Iompair Éireann*** [1973] IR 121, *Hanrahan v Merck Sharpe and Dohme (Ireland) Ltd.* [1988] ILRM 629.

[13] *SPUC v Coogan (No.1)* [1989] 1 IR 734. The Society for the Protection of Unborn Life was entitled to litigate to protect the right to life of the unborn.

While the decision of the Supreme Court in *Fleming* confirms that the values of autonomy and dignity are not absolute, the analysis in *Ward of Court* indicates that the right to life and the related constitutional commitment to dignity extend to the manner and process of dying. Moreover, the High Court decision in *PP v HSE* suggests that considerations of dignity may be capable of applying after the point of death.

The capacity of rights to be asserted on the part of the deceased could be a challenge in an Irish context. The recent Article 40.3.3° Supreme Court decision in *M* places considerable emphasis on the inability of the unborn to invoke constitutional rights because it has not been born and is therefore not a rights-holder. The corollary of the concept of rights-holder that emerges in that judgment (and that is consistent with some judicial decisions in recent cases about whether non-citizens are necessarily rights-holders) might be that deceased are not rights-holders for constitutional purposes. This would probably place the deceased in a position of being entitled to respect, but not to have specific rights under the Constitution invoked on their behalf.

The rights that could be invoked to challenge any prosecutions brought include the right to a trial within a reasonable time. The courts may be reluctant to require the State to take steps if those steps are unlikely to produce any practical benefit.

The report of the Expert Technical Group also raises significant practical concerns about the results that would be obtained from any exhumation or retrieval. The obligations imposed on the State by the Constitution are to defend and vindicate the personal rights of the citizen "as far as practicable". The decision in *PP v HSE* highlights the important point in this context that the Constitution does not require the taking of steps to promote or vindicate a constitutional value (in that case the right to life of the unborn) if those steps will not produce any practical benefit. This suggests that the views expressed in the expert report should be given weight in considering the steps to be taken in this matter.

It also should be stated that there may be a countervailing dignity interest in disturbing the burial site. That could also be a factor that a court would weigh in assessing the practical benefits of exhumation. If there are countervailing constitutional considerations which may incline against exhumation, the fact that exhumation may not produce any practical benefits may weaken any claim that it is constitutionally required.

Finally, there is a general judicial reluctance to litigate matters after several decades, even though attitudes may have changed to the practices in question. On a practical level, a major problem for a claimant in any litigation could be the apparent indication that these deaths were registered. This makes it much more difficult to argue that there was a lack of knowledge or concealment. There might be a separate issue about the circumstances of the burials although this might run into factual problems if the indication was that it was known in the local area about the burials.

STATUTE LAW

It may be the case that all deaths which took place at the Tuam Mother and Baby Home were duly notified to the registrar. There is no doubt, in any event, that a clear statutory duty existed in respect of such notification. Auditing the obligation to register a death should be considered in the context of Tuam. This might be undertaken by matching the death certificates to the number of juvenile human remains.

COMMON LAW

At common law, the body of law derived from judicial decisions rather than statute or constitutions, there has long since been recognition of the right to a decent burial, and of a range of rights and duties concerning dead bodies. The common law of England and Ireland was a unified body of law until 1922. After that, Irish common law diverged in various ways, although in certain respects the common law in each jurisdiction remained the same. Because of the nature of this topic, many of the key common law precedents date from before 1922, and thus the English cases can be taken as a strong indication of the common law in both England and Ireland. Precedents from other common law jurisdictions such as Australia, Canada and the United States, are also of assistance in stating what, precisely, the common law of Ireland is in this area, and what it was in the relevant period.

It seems that the operators of the Mother and Baby Home at Tuam may have been under a common law duty to bury those who died under their roof. This duty to bury incorporates a duty to bury decently and with dignity, in a Christian burial.[14]

A question that arises in the present review is whether the original actions of the operators of the Tuam Mother and Baby Home could have constituted prevention of a lawful and decent burial. Moreover, were the relevant authorities to refuse to exhume, sort and bury the remains, could this constitute a continuing offence of prevention of a lawful and decent burial? In contrast to the tortious claim considered below, this crime does not require there to be any identifiable family member who is affected by the failure to bury.

One option which may merit further consideration is whether there is an inherent jurisdiction on the part of the High Court to determine whether and how the remains should be dealt with. There is some (although limited) support from other jurisdictions for the proposition that the courts retain a common law power to determine disputes concerning the duty to dispose of the body of the deceased. In the New Zealand Supreme Court decision of *Takamore v Clarke*,[15] Elias CJ suggested that "where there is a dispute as to burial, either party (meaning personal representatives) has standing to bring the dispute to the High Court for resolution". The High Court of England and Wales reached a similar conclusion in *Oldham MBC v Makin*[16] where a dispute arose as to the manner and timing of the disposal of the remains of the Moors Murderer, Ian Stewart-Brady. While the Court decided the matter on other grounds, it observed that:

> In my judgment, the court does have an inherent jurisdiction to direct how the body of a deceased person should be disposed of. The court will normally, as I have said, be deciding between the competing wishes of different sets of relatives, and will only need to decide who should be responsible for disposal rather than what method of disposal should be employed. I cannot see, however, why the court's inherent jurisdiction over estates is not sufficiently extensive to allow it, in a proper case, to give directions as to the method by which a deceased's body should be disposed of.

[14] It is probably the case that the modern duty to bury is not solely one of Christian burial but rather about burial reasonably appropriate to the deceased person's known values and religious practices. At the relevant time, it seems that Christian burial would have been the appropriate entitlement.
[15] [2012] NZSC 116.
[16] [2017] EWHC 2543.

Perhaps most relevantly, the High Court of England and Wales held in *In re K* that it had an inherent jurisdiction to authorise arrangements to be made for the disposal of a child's body where the parents had neglected to make any arrangements.[17]

It should be emphasised that this does not necessarily mean that the Irish courts have such an inherent power, or that it would be engaged in the case of the Tuam deceased. Aside from the fact that these cases provide limited persuasive authority for the existence of such a power, the courts in those cases are dealing with situations where there is a dispute between personal representatives of an estate; and where the body remains to be dealt with. The legal context of any application here might be quite different. There is also the obvious factual difference that the question at Tuam would be one not of burial but of possible exhumation and re-burial. Nonetheless, the reasoning of the courts in these cases is based in part on the existence of a common law duty to dispose of remains. As discussed elsewhere in this Report it is arguable that duty is engaged and/or may have been breached in the situation in Tuam.

[17] [2017] 4 WLR 112.

CONCLUSIONS

European Convention on Human Rights

Application of Article 8 principles

1. Article 8 of the ECHR may be of relevance in relation to the particular set of circumstances arising from the discovery of juvenile remains at Tuam. Article 8 has been broadly interpreted, providing family members of deceased persons with a substantial number of rights capable of assertion. While these rights are not absolute, and may be proportionately interfered with, their existence is of considerable importance and the State should be careful to ensure no illegitimate infringement of such rights. Family members may possess the right to have their loved one's body returned to them. Moreover, relatives may have a right to know the fate of their family members, including information surrounding the death and/or burial of their loved ones. A failure to provide relatives with definite and/or credible information may fall foul of the positive obligation under Article 8, even where the death occurred before the Convention came into force in the relevant county, where the failure to provide information continues following the coming into force of the ECHR.

2. Irish authorities are required to carry out their functions in a manner compatible with the ECHR and Article 8 rights in particular must be positively vindicated. Regard should be given to the distress and anguish of family members seeking information surrounding the death and/or burial of their loved ones. Nonetheless, it should also be borne in mind that there may be limits to the information which can or must be provided for the purposes of complying with Article 8. The decisions of the ECtHR confirm that Article 8 rights include information concerning the fate and place of burial of the deceased but it may not necessarily extend to additional matters (although these may be covered by Articles 2 and 3 ECHR).

3. The Court's Article 8 case law has been concerned so far with negative interferences on the part of the State with the right of family members to the return or disposal of bodies, or to information about their disposal. The Court does not yet appear to have

considered whether Article 8 imposes a more extensive positive obligation on the part of State authorities to assist or ensure that a burial takes place in the particular manner desired by the family.

4. Any Article 8 ECHR right should be considered having regard to the extreme delicacy of any exhumation and further investigation at the Tuam site, as determined by the Expert Technical Group. The report of the ETG states that: "There are a number of factors that make this situation unique: The forensic requirement of the site; The 'significant' quantities of juvenile remains; The commingled or intermixed state of the remains; The position of the remains within subsurface chambers, with limited access." The report[18] concludes that the comingled state of the remains renders identification "particularly challenging". Moreover, the ETG states there is a "risk of destruction to human remains" that raises ethical issues.

5. In terms of pursuing any claim for violation of Convention rights, it is the family members alone who are capable of asserting these rights. The deceased no longer possess human rights and they are not capable of asserting same.

Articles 2 and 3 ECHR

6. As with Article 8, the ECtHR has interpreted Article 2 as placing a positive obligation on States. Procedurally, there exists an obligation upon States to effectively investigate a killing or suspicious death within their territory. Article 3 prohibits torture, inhuman or degrading treatment or punishment. A similar obligation to investigate arises out of Article 3 ECHR. Where inhuman or degrading treatment is alleged, a State has a duty to investigate a complaint made.

Duty to investigate incidents which took place before the ECHR came into force

7. The Convention duty to investigate incidents may include incidents that happened some time ago. It is, however, a more limited duty in relation to historical incidents which occurred before the State in question signed the Convention. Nevertheless,

[18] Report of the Expert Technical Group, December 2017, (i).

relatives of the deceased should be involved in the investigation to a sufficient degree to safeguard their legitimate interests.[19]

8. The ECtHR has stated that its temporal jurisdiction to review a State's compliance with its procedural obligation under Article 2 was not open-ended where the deaths had occurred before the date the Convention entered into force in respect of that State. In such cases, the Court has jurisdiction only in respect of procedural acts or omissions in the period subsequent to the Convention's entry into force, provided there was a "genuine connection" between the death as the triggering event and the entry into force. For a "genuine connection" to be established, the period between the death and the entry into force had to have been reasonably short, no more than 10 years, and a major part of the investigation had or ought to have been carried out after the date of entry into force. The emergence of new, credible information about such past events, however, may trigger the duty to investigate.

9. The question arises whether relatives of those interred in Tuam could contend that their rights pursuant to Article 3 ECHR have been violated. Whether any such claim would be successful would depend on the specific set of facts prevailing in each individual case as a minimum level of severity must be achieved.

10. In order to ensure the effective vindication of the abovementioned ECHR rights, there appears to be an inferred duty on the Irish State to collect, as far as reasonably possible, the remains of those interred at Tuam. The Tuam site, according to the Expert Technical Report, will test the boundaries of forensic investigation in every regard. The Expert Technical Group, due to the varied nature of the complexities at the site in Tuam, notes the limitations of the forensic possibilities involved in excavation and examination on the site. It states that given that the site holds a group of collectively interred individuals, "it may only ever be possible to provide collective answers", and the potential to identify individuals interred there poses many challenges. These limitations therefore must be borne in mind and where the State fails to collect remains for these reasons, it is unlikely to fall foul of its duty where it takes all reasonable steps to investigate the possibility of retrieval and, if

[19] *Edwards v UK* [2002] ECHR 303.

proportionate and justified, undertakes reasonable measures to retrieve the bodies in question.

International Human Rights Law

11. The international human rights norms may not be directly relevant to this review, as Ireland has been quite slow to ratify the relevant instruments. The older humanitarian law is also not directly legally applicable, as they are legal norms that are active only when death occurred in, and as a result of, wartime atrocities, although the jurisprudence on dignity and State custom and practice may shed light on the requirement of the Irish constitution in this regard discussed later.

12. Much of the material included in the customary international humanitarian section of the report is either human rights in times of war (customary international humanitarian rights), or instances of 'gross' or 'systemic' violations of human rights (under the various human rights frameworks of the United Nations). It is therefore subject to a number of qualifications. Firstly, the UDHR is generally regarded as not legally binding. Furthermore, the two International Covenants (the ICCPR and lCESCR) were not in existence until 1966, and Ireland did not ratify both until 1989. Ratification is key to legal effect in a particular jurisdiction. It is not clear therefore that there were any legally recognisable breaches of human rights in the 1920 to 1960 period. Moreover, it is not clear whether the right to know – which seems to be the legally strongest right – can be based on breaches of human rights before the state ratified the relevant instruments (as it cannot be stated at the time they were breaches). In summary, if it was not a breach at the time, it is difficult to legally determine it so retrospectively. Therefore, there may be very limited grounds for the right to know which is parasitic upon the basic rights in the UN Charter (the conceptual instrument combining the UN Declaration and both Covenants together).

13. If inhuman or degrading treatment and violations of privacy can be characterised as continuing, it may constitute a violation of the UNCAT, ICCPR or CEDAW.

14. The most relevant jurisprudence on this matter relates to Enforced Disappearance. This is the most fruitful area of international human rights law to review, as it has an express right to truth/right of victims and their families to know. It is also closely tied to the ICCPR which, as stated above, Ireland ratified in 1989. It seems there may not be a requirement that the ICCPR was ratified by the member state when the 'disappearances' took place. There are interesting parallels between the experience in South America, where much of this law emerged, and the experience of the institutional abuse of women and children in settings such as the mother and baby homes. It should be noted, however, that Ireland has not ratified the International Convention for the Protection of All Persons from Enforced Disappearance, although it codifies what is already implied in many international human rights instruments to which Ireland is a party.

Status of International Agreements

15. It is important to bear in mind that the obligations imposed on the State by international agreements occur and are enforceable, if at all, under international law only. Article 29.6 of the Constitution provides that:

> No international agreement shall be part of the domestic law of the State save as may be determined by the Oireachtas.

The Irish Constitution

16. Irish case law confirms the importance of dignity under the Constitution and, in particular, the importance attached to the circumstances associated with a person's death. Clearly, this is of potential significance in the Tuam context. It raises the question as to whether there was a failure to take account of considerations of the dignity of the deceased children in the circumstances of their burial; and whether, if so, this would give rise to a breach of the Constitution? There may also be a distinct question as to whether – assuming considerations of dignity did apply to the burial and may continue to apply thereafter – the circumstances give rise to an enforceable constitutional right or claim, whether on the part of the deceased or of other persons.

17. While the decision of the Supreme Court in *Fleming* confirms that the values of autonomy and dignity are not absolute, the analysis in *Ward of Court* indicates that the right to life and the related constitutional commitment to dignity extend to the manner and process of dying. Moreover, the High Court decision in *PP v HSE* suggests that considerations of dignity may be capable of applying after the point of death.

18. The capacity of rights to be asserted on the part of the deceased could be a challenge in an Irish context. The recent Article 40.3.3° Supreme Court decision in *M* places considerable emphasis on the inability of the unborn to invoke constitutional rights because it has not been born and is therefore not a rights-holder. The corollary of the concept of rights-holder that emerges in that judgment (and that is consistent with some judicial decisions in recent cases about whether non-citizens are necessarily rights-holders) might be that deceased are not rights-holders for constitutional purposes. This would probably place the deceased in a position of being entitled to respect, but not to have specific rights under the Constitution invoked on their behalf.

19. The report of the Expert Technical Group also raises significant practical concerns about the results that would be obtained from any exhumation or retrieval. The obligations imposed on the State by the Constitution are to defend and vindicate the personal rights of the citizen "as far as practicable". The decision in *PP v HSE* highlights the important point in this context that the Constitution does not require the taking of steps to promote or vindicate a constitutional value (in that case the right to life of the unborn) if those steps will not produce any practical benefit. This suggests that the views expressed in the expert report should be given weight in considering the steps to be taken in this matter.

20. It also should be stated that there may be a countervailing dignity interest in disturbing the burial site. That could also be a factor that a court would weigh in assessing the practical benefits of exhumation. If there are countervailing constitutional considerations which may incline against exhumation, the fact that exhumation may not produce any practical benefits may weaken any claim that it is constitutionally required.

Statute Law

21. It may be the case that all deaths which took place at the Tuam Mother and Baby Home were duly notified to the registrar. There is no doubt, in any event, that a clear statutory duty existed in respect of such notification. Auditing the obligation to register a death should be considered in the context of Tuam. This might be undertaken by matching the death certificates to the number of juvenile human remains.

Common Law

22. At common law, the body of law derived from judicial decisions rather than statute or constitutions, there has long since been recognition of the right to a decent burial, and of a range of rights and duties concerning dead bodies. It seems that the operators of the Mother and Baby Home at Tuam may have been under a common law duty to bury those who died under their roof. This duty to bury incorporates a duty to bury decently and with dignity, in a Christian burial.[20]

23. A question that arises in the present review is whether the original actions of the operators of the Tuam Mother and Baby Home could have constituted prevention of a lawful and decent burial. Moreover, were the relevant authorities to refuse to exhume, sort and bury the remains, could this constitute a continuing offence of prevention of a lawful and decent burial? In contrast to the tortious claim considered below, this crime does not require there to be any identifiable family member who is affected by the failure to bury.

24. One option which may merit further consideration is whether there is an inherent jurisdiction on the part of the High Court to determine whether and how the remains should be dealt with. There is some (although limited) support from other jurisdictions for the proposition that the courts retain a common law power to

[20] It is probably the case that the modern duty to bury is not solely one of Christian burial but rather about burial reasonably appropriate to the deceased person's known values and religious practices. At the relevant time, it seems that Christian burial would have been the appropriate entitlement.

determine disputes concerning the duty to dispose of the body of the deceased. The legal context of any application here might be quite different. There is also the obvious factual difference that the question at Tuam would be one not of burial but of possible exhumation and re-burial. Nonetheless, the reasoning of the courts in these cases is based in part on the existence of a common law duty to dispose of remains. As discussed elsewhere in this Report it is arguable that duty is engaged and/or may have been breached in the situation in Tuam.

1. INTRODUCTION

It is worth noting at the outset that in international law, there are no unified mass-grave protection guidelines in place for States to follow when they are faced with the discovery of sites, such as the burial site at the former Mother and Baby Home in Tuam, despite the existence of guidelines to deal with situations of armed conflict and investigations of missing persons.[21] Calls have been made to work toward a more comprehensive set of legal guidelines for the protection of such graves at an international level. This would assist in achieving a number of desired aims, including ensuring that family members are informed of the fate of their relatives, allowing survivor populations be aware about what happened at the site in question and enabling proper investigations to take place - answering questions and finding those responsible where possible.[22] While the site at Tuam cannot be considered to be a mass grave in terms of what is typically associated with violence or conflict, physical investigation of the site has necessitated use of the skillset designed to forensically investigate mass graves and similar legal issues are thus raised.

[21] For instance, the Geneva Conventions and their Additional Protocols form the core of international humanitarian law, regulating the conduct of armed conflict and seeking to limit its effects. With regard to missing persons, the International Committee of the Red Cross (ICRC), "Guiding Principles/Model Law on the Missing" (2009) and the International Convention for the Protection of All Persons from Enforced Disappearance are of assistance.

[22] See Melanie Klinkner, "Towards mass-grave protection guidelines" *Human Remains and Violence,* Volume 3, No.1 (2017) 52-70. This article, however, concerns primarily the protection of mass-graves in post-conflict situations.

2. EUROPEAN CONVENTION ON HUMAN RIGHTS

The Convention for the Protection of Human Rights and Fundamental Freedoms, better known as the European Convention on Human Rights (ECHR) came into force in 1953. It was the first instrument to give effect to certain of the rights stated in the Universal Declaration of Human Rights and make them binding. Its contracting states are obliged to secure to everyone within their jurisdiction the rights and freedoms set out in section 1 of the ECHR. The ECtHR is tasked with enforcing the provisions of the ECHR and its judgments, in some cases, have broadened the interpretation of the Convention. In Ireland, the European Convention of Human Rights Act 2003 was introduced to give further effect to the ECHR in Irish law. The Act did not incorporate the Convention into Irish law, but rather requires Irish courts to interpret legislation in line with the Convention insofar as it is possible to do so. It also requires that certain public bodies perform their functions in a manner compatible with the Convention, unless precluded by law.

Section 1 of the ECHR contains the rights and freedoms that the Convention is designed to protect. Article 8 ECHR is of crucial importance for present purposes, however it is necessary to set out in full the following provisions;

> Article 2: **Right to life**
>
> 1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
>
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection.
>
> Article 3: **Prohibition of torture**
>
> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.
>
> Article 8: **Right to respect for private and family life**
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

2.1 Article 8 ECHR

Article 8 is crucial in considering the options available with respect to the Tuam Mother and Baby Home as it is most likely that the right to family life and privacy contained therein is particularly engaged in these circumstances, bearing in mind both the rights of the deceased and their family members. While Article 8 is therefore the primary provision of consideration, it is worth noting that the protections contained within Article 8 can operate at the same time as those contained in other articles. For instance, in cases of detention, the Court may find a violation of both Article 8 and Article 3 where the conditions are particularly poor and privacy concerns are raised. With regard to Article 8, while it specifically guarantees the right to respect for an individual's private and family life, home and correspondence, its scope has been interpreted in a broad manner by the ECtHR, with rights being inferred from its provisions even where same are not expressly enumerated therein.

In determining complaints as to whether Article 8 has been breached, the ECtHR will first consider whether the applicant's claim falls within the scope of Article 8 and the interests it is designed to protect. The Court will then examine whether there has been an interference with that right or whether the State's positive obligations to protect that right has been engaged. This will involve a consideration of the circumstances within which the State may curtail the enjoyment of a particular right as set out in Article 8.2 namely, where the interference is in accordance with law and necessary in a democratic society in the interests of national security, public safety, economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

It is worth noting at the outset that while Article 8 is couched in negative terms, giving individuals protection against arbitrary interferences with their private and family life and mandating that the State refrain from such interference, the ECtHR has held that there may

also be positive obligations placed upon the State to secure respect for private life. This may oblige the State to adopt measures designed to safeguard this right. This principle was first set out in the decision of *Marckx v Belgium.*[23] In this case, the parents of a child born out of wedlock challenged the provisions of the Belgian Civil Code which detailed the process of establishing the maternal affiliation of an "illegitimate" child. Essentially, under Belgian law at that time, no legal bond between an unmarried mother and her child resulted from the mere fact of birth. Instead, the maternal affiliation of an "illegitimate" child was established by means of either a voluntary recognition by the mother or of legal proceedings taken for this purpose. Furthermore, in order to increase the rights of the child, for example for inheritance purposes, the parents were required to adopt their own "illegitimate" child. The parents therefore complained that their rights pursuant to Article 8 were infringed.

The ECtHR duly held that the Belgian system infringed the right to private and family life by reducing inheritance rights for "illegitimate" children, finding that this Article made no distinction between the legitimate or "illegitimate" family. While the Court commented that the purpose of Article 8 is to protect the individual against arbitrary interference by the public authorities, it went on to state that Article 8 "...does not merely compel the State to abstain from such interference: in addition to this primarily negative undertaking, there may be positive obligations inherent in an effective 'respect' for family life." In this case, the indictment was against Belgian law which was found to be wanting in respect of the family life of the applicants. This positive obligation means that the State, in its domestic legal system, determines the provisions applicable to certain family ties, including to those between an unmarried mother and her child and the State must act in a manner to enable those concerned to lead a normal family life. Article 8 demands the existence in domestic law of legal safeguards that enable a child to integrate with his or her family from the moment of birth. A law of the State that fails to satisfy this requirement violates Article 8.1, without the necessity to examine the provisions of Article 8.2.

In cases where a positive obligation is claimed, the Court will consider whether the importance of the interest at issue requires the imposition of a positive obligation as sought by the applicant. The ECtHR in *Hämäläinen v Finland*[24] considered certain factors as relevant in assessing the content of positive obligations on the State. Specifically, the Court

[23] (1979) 2 EHRR 330.
[24] [GC], no. 37359/09, ECHR 2014.

stated that the importance of the interest at stake and whether 'fundamental values' or 'essential aspects' of private life are in issue are relevant, as well as the impact on an applicant of a discordance between the social reality and the law and the impact of the alleged positive obligation on the State concerned. In implementing their positive obligations, States enjoy a margin of appreciation, however that margin will be narrower where a particularly important facet of individuals' existence or identity is at stake.

In relation to the site at Tuam and the juvenile remains interred therein, the positive obligation inferred from Article 8 ECHR may be of relevance. Given the rights at issue, discussed in full below, the question arises as to whether the State has a duty to take particular action at Tuam – to investigate and where possible, to return the remains to family members and provide relatives with information on the fate of their loved ones.

An exhaustive examination of Article 8 is not possible herein. For present purposes, therefore, specific regard will be had to issues concerning the death and burial of family members and judgments given by the ECtHR interpreting Article 8 and addressing this subject. The question examined is whether there exists a right of family members to have the remains of their loved ones returned to them under the Convention. The existence of any such right should be considered in informing the State's response to the Tuam site. In the relevant ECtHR decisions, it is clear that the rights of the family of the deceased are engaged and not those of the deceased themselves. These cases have involved challenges brought by individuals against a State who they claim failed to grant access to the remains of their family members or where excessive delays have occurred in the restitution of a body after an autopsy or following completion of a criminal investigation. Essentially, in its line of authorities, the ECtHR has inferred a right to bury family members into Article 8's protection for private and family life. There also exists a right of family members to be informed and provided with information surrounding the circumstances of their relative's death, an additional entitlement that requires particular attention in assessing what course of action is best with regard to the Tuam site. Furthermore, decisions of the ECtHR regarding the treatment of the body of the deceased are considered, with a particular focus on the requirement for the consent of the deceased's next of kin.

The applications considered below have been brought in a variety of contexts and understandably, no case on its facts can be said to mirror the particular set of circumstances at

issue in relation to the discovery of human remains at the site of the former Mother and Baby Home in Tuam. Nevertheless, comparisons can be drawn and it is necessary to consider each case below to fully consider the applicable rights under ECHR law. It must be remembered that the rights recognised and vindicated therein are not absolute and a failure to return a dead body to the relatives for burial, or disclose where it was buried for instance, may only constitute a violation of Article 8 if the interference with these rights cannot be justified by the State in question. A key question is whether sufficient justification is given and whether the necessity and proportionality of the interference are considered.

2.2 Returning body to family member – delay between death and burial

In a number of cases that have come before the ECtHR, complaints have been made concerning the return of a deceased's body to his or her family members. Specifically, the length of time between death and the burial of the deceased is a pertinent issue. This warrants consideration bearing in mind that those interred in the Tuam site have not as of yet been returned to their family members for a respectful and appropriate burial. The proximity of family relationships is also likely to be relevant. The cases set out below all seem to concern immediate family members. I understand that may apply in some cases in Tuam but not necessarily in all cases. It is possible to envisage the Irish courts drawing a line between the rights of immediate family members and the interests of more distant relatives.

2.2.1 *Pannullo and Forte v France*[25]

In June 1996, the daughter of Italian parents had died following a postoperative check-up in France at age four. Investigations were carried out by French authorities into the cause of her death and an examination took place into her diagnosis and treatment. These investigations caused a delay in the return of her body to her parents. An autopsy had been carried out in July 1996, but the body was not returned to her parents until February 1997. Medical evidence demonstrated that there was no necessity to keep the body for investigative purposes after the autopsy had been completed. Furthermore, the forensic scientist carrying out an expert report had indicated to the investigating judge following the autopsy that the necessary samples had been taken and the body could be repatriated. Despite this

[25] Number 37794/97, ECHR 2001-X.

notification, the body was still not released. It was therefore claimed by her parents that the delay constituted an unjustified interference with their right to respect for their private and family life pursuant to Article 8 ECHR. On behalf of France, the delay was not disputed and it was accepted that it constituted an interference with the parent's Article 8 rights, but it was argued that the various formalities carried out in the release of the body had pursued a legitimate aim of preventing crime and therefore Article 8 was not breached.

The Court noted:

> ...[W]hile the essential object of Article 8 is to protect the individual against arbitrary interference by the public authorities, there may in addition be positive obligations inherent in effective "respect" for family life. In both contexts regard must be had to the fair balance that has to be struck between the competing interests of the individual and the community as a whole, and in both contexts the State is recognised as enjoying a certain margin of appreciation.[26]

It found that the interference with the applicants' rights was in accordance with law and pursued the legitimate aim of preventing crime. The question here therefore was whether the interference was necessary in a democratic society. In this regard, the Court took account of the fact that more than seven months passed between the child's death and the issuance of the burial certificate. While it determined that the deceased's body was required for the autopsy, it was clear that her body should have been returned to her parents immediately after same. Having regard to the circumstances of the case and the tragedy for the parents of losing their child, the Court concluded that the French authorities failed to strike a fair balance between the applicant's right to respect for private and family life and the legitimate aim pursued. The Court thus held that there was a violation of Article 8 ECHR.

This case makes it clear that the unjustified delay in the restitution of a body after an autopsy may constitute an interference with both the private life and family life of surviving family members.

2.2.2 *Girard v France*[27]

In this case, the applicants were two French nationals whose daughter had disappeared in November 1997. More than a year and a half later, she was found murdered. In an action

[26] Ibid., at para. 35.
[27] Number 22590/04, 30 June 2011.

against French authorities, relying on Article 2 of the Convention, the right to life, they argued that there had been a failure to properly investigate their daughter's disappearance. They further argued that the delay in returning samples taken from the deceased's body constituted an interference with their Article 8 rights.

The Court found that an extended delay in returning samples taken from the applicant's daughter's body by police, which prevented the applicants from burying her in a timely manner, violated Article 8. It placed weight on the delay of over four months that elapsed between the decision of the authorities to return the samples to the applicants and the actual return of said samples, similar to the unnecessary delay at issue in *Pannullo and Forte* demonstrated above. Furthermore, the Court held that there had been a violation of Article 2 ECHR due to the lack of an effective investigation into the deceased's disappearance. This case essentially recognises that under Article 8 – there exists a right to bury one's relatives – and demonstrates the link that may occur between Articles 2 and 8 in certain situations.

Distinct from a State's obligations under the ECHR, there is also an obligation on States under international humanitarian law, to 'facilitate the return of the remains of the deceased and of personal effects to the home country'. This obligation is included in Additional Protocol I to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), 8 June 1977, discussed in greater detail below.[28] While the Geneva Convention applies in circumstances of armed conflict, it is worthwhile noting that the aim even in these circumstances is to ensure the return of the deceased's body to his/her home county, to the family. Similarly, in the UN's Inter Agency Standing Committee's Operational Guidelines on Human Rights and Natural Disasters, it is recommended that appropriate measures should be taken "to facilitate the return of remains to the next of kin...Measures should allow for the possibility of recovery of human remains for future identification and reburial if required". On an international level, whether during times of armed conflict or natural disasters, there therefore also exists an obligation upon States to seek to secure the return of the deceased to their loved ones. As stated above, the international humanitarian law obligations are examined later in this report.

[28] Additional Protocol I, Art. 34(2).

2.3 Right to know the fate of a family member – information surrounding circumstances of death

Following the death of a loved one, it is understandable that his/her relatives will seek information concerning the circumstances of his/her passing. Where a family member is missing, his/her relatives will usually seek to obtain the truth of his/her fate. There are various reasons for seeking and ascertaining these details. It may assist in securing the return of remains for burial and commemoration purposes and enable a death certificate to be obtained. Information and investigations surrounding the death or disappearance of a relative may explain what happened, restoring the human dignity of the deceased, or ultimately leading to answers, accountability and criminal justice proceedings. On a larger scale, the provision of such information to the public itself may promote transparency and prevent similar situations from arising again. The right to know the fate of a family member has been at issue in certain ECtHR decisions, as set out below.

2.3.1 *Hadri-Vionnet v Switzerland*[29]

The case concerned the conditions under which the municipal authorities conducted the burial of the applicant's stillborn child without consulting her on the matter. In this case, the applicant gave birth to a stillborn baby while she was residing in a centre for asylum seekers in Switzerland. She and the child's father decided that they did not wish to see the child's body. An autopsy was then performed on the body and the baby was buried in a communal grave for stillborn babies. This burial took place without the parents being present and without a ceremony. The applicant mother challenged the manner in which this burial occurred, arguing that the burial took place without her knowledge in a communal grave and that she had not been entitled to attend. She contended that this was an infringement of her Article 8 rights under the Convention.

First, the ECtHR found that Article 8 was applicable in these circumstances. It thus found that the State's failure to inform the mother about the location and time or the burial of her still-born son was not authorised by law and violated her rights under Article 8. This arguably demonstrates that knowledge is crucial – namely, that a family member of a

[29] Number 55525/00, 14 February 2008.

deceased has the right to know where the deceased is buried and the failure to provide information regarding a burial may be in breach of Article 8 ECHR.

2.3.2 Marić v Croatia[30]

In *Marić v Croatia*, the ECtHR found again that the disposal of the body in a manner which left the parents with no information as to the whereabouts of the remains breached the parents Article 8 rights. The Court relied on its previous decisions as clearly establishing that Article 8 was engaged by the applicant's complaint that he was prevented from knowing where the child was buried. However, it might also be noted that the Court described the case as one where:

> it is not a question of whether the applicant had the right to a particular type of ceremony or to choose the exact location of the child's place of rest, as could be understood from the Government's arguments, but whether there has been an interference with the applicant's rights under Article 8 by the body of his stillborn child being disposed of as clinical waste.

It is clear that the Court in this case was responding to the Croatian government's arguments rather than making a positive decision on the scope of the Article 8 obligation. It does, however, draw attention to the fact that the Court's Article 8 case law has been concerned so far with negative interferences on the part of the State with the right of family members to the return or disposal of bodies, or to information about their disposal. The Court does not yet appear to have considered whether Article 8 imposes a more extensive positive obligation on the part of State authorities to assist or ensure that a burial takes place in the particular manner desired by the family.

2.3.3 *Zorica Jovanović v Serbia*[31]

A similar concern regarding being informed of the circumstances of a family member's death arose in the case of *Zorica Jovanović v Serbia.* In this case, in October 1983, the applicant gave birth to a healthy child in the Cuprija Medical Centre (CMC), a State-run hospital. A few days after his birth, the applicant's son was taken to a separate room for new-born babies as was standard procedure. The following day, the applicant was informed by a doctor that

[30] Application no. 50132/12.
[31] Number 21794/08, ECHR 2013.

he had died. She was told that an autopsy would be performed on his body in Belgrade, thus his body could not be released to his parents at that stage. His body was never returned to the applicant.

From 2001 onwards, the Serbian media began reporting extensively on numerous cases similar to that of the applicant's where new-born babies had "gone missing" following their alleged deaths in hospital wards. The applicant requested information regarding her son's death – seeking all relevant documentation from the CMC, requesting information from the Municipality of Cuprija and lodging a criminal complaint against the medical staff of the CMC for her son's "abduction". She was informed by the CMC that her son's death had been from an unknown cause and that no other information was available because its archives had been flooded and many documents had been destroyed. The Municipality informed her that her son's birth was registered in their records, but his death was not. The criminal complaint was rejected as unsubstantiated as "there was evidence that the applicant's son had died on 31 October 1983". The body of the applicant's son was never released to her, nor was she ever provided with an autopsy report or informed as to when and where he was allegedly buried.

It is worth noting, that in light of the hundreds of similar cases to that of the applicant, an Investigating Committee was established in Serbia. The findings of the Committee concluded that there had been serious shortcomings in the legislation in place at the relevant times and in the procedures in place; that the situation justified the parents' concerns as to what really happened to their children; and that a concerted effort should be made on the part of all government bodies to provide parents with adequate redress. An Ombudsman report similarly found that there were no coherent procedures in place at the time; that the autopsy reports were usually incomplete, inconclusive and of highly dubious veracity; and that it could not rule out that the babies in question were indeed removed from their family unlawfully. In response, Parliament adopted the findings of the Committee and new procedures were put in place in Serbia in 2003 regarding the burial of new-born babies who die in hospital, setting out a detailed procedure to prevent any unlawful removal of babies from hospital wards.

In its judgment, the Court noted that the applicant's son allegedly died or went missing on 31 October 1983, whilst the Convention came into force in Serbia in March 2004. Nevertheless,

the Court emphasised that it was claimed that the respondent State continued to fail to provide the applicant with any definitive and/or credible information as to the fate of her son and that said failure had continued. In these circumstances, the Court determined that the applicant's complaint related to a continuing situation and the Court was competent to examine the complaint in so far as it related to the respondent State's alleged failure to fulfil its procedural obligations under the ECHR as of March 2004. It could, however, consider the facts prior to ratification inasmuch as they could be considered to have created a continuous situation extending beyond that date.

With regard to "family life" the court stated that the mutual enjoyment by parent and child of each other's company constitutes a fundamental element of "family life" within the meaning of Article 8. It noted that the essential object of Article 8 is to protect the individual against arbitrary interference by public authorities, but that there may also be positive obligations inherent in this provision extending to the effectiveness of any investigating procedures relating to one's family life.

The Court determined that the failure of the hospital to provide information to the applicant regarding the death of her infant son and the subsequent disappearance of his body violated Article 8 and its respect for private and family life. Although the child had died in 1983, it found that there had been an ongoing failure of the State to provide the applicant with information surrounding what had occurred to her son. The Court noted that the amended legislation only improved the position for the future and effectively offered nothing to those parents who endured the ordeal in this case. It concluded that the applicant suffered a continuing violation of Article 8 of the Convention due to the respondent's continuing failure to provide her with credible information as to the fate of her son.

The two decisions (discussed above) of the ECtHR demonstrate that under the Convention, family members of a deceased have a right to information regarding the fate of their loved one – whether this means being informed of the burial time, autopsy results or the location of his or her last resting place. A State's failure to provide such information may violate Article 8 where it is in breach of the positive obligation upon it to have in place effective investigative procedures even where the death occurred prior to the coming into force of the ECHR in the State in question, as long as there was a continued failure post-ECHR to provide the relevant information. While there are differences between the situation in *Zorica*

Jovanovic and Tuam, the decision in *Zorica Jovanović* may be of potential relevance given that it is likely that the deaths of many of the juveniles interred in the Tuam site occurred prior to the coming into force of the ECHR in Ireland, but the discovery of unrecorded burials only took place in recent years.

However, it should be noted that the English courts have held that questions concerning the burial or exhumation of deceased persons do not necessarily engage the Article 8 rights of blood relatives. In *R (Rudewicz) v Secretary of State for Justice*,[32] the Court of Appeal held that the claimant's Article 8 rights were not affected by a decision to exhume a deceased relative. Although she was the deceased's closest living relative, she had never met him or had a close family connection to him. While the exhumation might offend her religious feelings or beliefs, Lord Neuberger MR (as he then was) held that this was different from impacting on her family or private life.

At a further historical remove, the Article 8 rights of blood relatives were also briefly discussed in *R (Plantagent Alliance Ltd) v Secretary of State for Justice*.[33] This was a challenge by a descendant of Richard III to decisions concerning his exhumation and proposed re-burial. Ultimately, the Article 8 arguments were not pursued at trial, an approach described by the Divisional Court as sensible given that they were "doomed to fail".

2.4 Treatment of body – samples and consent

In certain ECtHR cases, the treatment of a deceased's body is at issue – particularly in relation to the removal of bodily materials and samples from same for certain purposes. This also raises the issue of consent and whether permission must be sought from the deceased's family. Across all cultures, it is a common belief that the dead should be treated with respect. This is demonstrated in the criminal legislation of many States, which provide that mutilation of a corpse is an offence. In relation to the use of tissue or organs from a deceased person for donation or other purposes, the domestic law of most countries will specifically set out the circumstances in which this may take place. In Ireland, for example, at present there is an opt in/explicit consent position with regard to organ donation. If a person wishes to become an organ donor after his/her death, potential donors are advised to inform his/her next of kin of

[32] [2012] 3 WLR.
[33] [2014] EWHC 1662.

his/her intentions and to carry an organ donor card. Next of kin are always asked for consent in order for a donation to proceed and consent is never presumed, even if a donor card has been signed.[34]

2.4.1 *Petrova v Latvia*[35]

In this case, the applicant's son sustained serious injuries in a car accident in May 2002. He died in hospital a few days later. Immediately following his death, a laparotomy was performed on the body, in the course of which the kidneys and the spleen were removed for organ transplantation purposes. The applicant had not visited the hospital, but claimed that she was in permanent contact with the doctors there during her son's stay. She said that she had not been informed that his condition was deteriorating, had not been asked whether her son had consented to being an organ donor and had not been asked whether she would consent to organ transplantation in the absence of any wishes expressed by her son. She claimed that the removal of her son's organs without her consent constituted an interference with her private and family life. The State claimed that the hospital did not have any information on record providing the contact details of any relative – thus there was no contact with the applicant whatsoever when her son was in hospital. It argued that the "presumed consent system" in place in Latvia permitted interference with an individual's right to private life under Article 8 ECHR and that in this case, the organ removal had been carried out in accordance with the domestic law.

At that time in Latvia, the relevant law provided that every person with legal capacity was entitled to consent or object in writing to the use of his or her body after death. A person was required to apply to the Office of Citizenship and Migration Affairs to exercise the right to consent or object. Only such refusal or consent as was recorded in the Population Register had legal effect. The procedure which the State institutions had to follow to request and receive the relevant information from the Population Register, however, had not been adopted at the time of the applicant's son's death. The law also provided that the organs and tissues of a deceased person could not be used against his or her wishes as expressed during his or her lifetime. In the absence of express wishes, the organs could be used if none of the closest

[34] In July 2017, the Government approved the preparation of the General Scheme and Heads of a Human Tissue Bill, providing for an opt-out system of consent for organ donation in Ireland.
[35] Number 4605/05, 24 June 2014.

relatives objected. It went on to state that the organs could be removed if he or she had not objected to such removal during his or her lifetime and if the closest relatives had not prohibited it. A stamp on a person's passport added before 31 December 2001 denoting objection or consent to the use of his or her body after death had legal effect until a new passport was issued or an application to the Office of Citizenship was submitted. The domestic law was later amended in 2004.

At a domestic level, the applicant made numerous complaints and in response, the Inspectorate of Quality Control for Medical Care and Working Capability (the MADEKKI), carried out an investigation. It concluded that the hospital complied with the relevant domestic law in taking the decision to remove organs and carrying out the surgery. The MADEKKI noted that there was no information at its disposal as to whether or not there had been a stamp on the deceased's passport signifying an objection to the use of his body tissues and organs. As the applicant had not been informed about the imminent removal of her son's organs, it determined that she neither consented nor refused. It was further concluded by a prosecutor considering the criminal complaint that the domestic law required consent from parents or guardians only in cases where organs were removed from a deceased child's body for transplantation purposes.

The ECtHR, in considering the case, determined that the removal by the hospital of the deceased's organs without informing his mother and without seeking her consent was not carried out in accordance with law and violated her rights to private life under Article 8 ECHR. It noted that Article 8's purpose is to protect the individual against arbitrary interference by public authorities. Interferences may be justified as necessary in a democratic society if proportionate and they pursue a legitimate aim. This requires the domestic law to be formulated with sufficient precision to afford adequate legal protection against arbitrariness and it must indicate with sufficient clarity the scope of discretion conferred on the appropriate authorities. In this case, the dispute between the parties was not with regard to the content of the Latvian law – which expressly provided the deceased's closest relatives with a right to express their wishes on organ removal following the death - but how this right was to be exercised. The applicant contended that the domestic authorities had not fulfilled their duty to provide conditions whereby her wishes could be expressed. The State, on the other hand, claimed the relatives involved were expected to take positive steps if they wished to veto any organ removal. It was concluded by the Court that the law was not sufficiently

clear as regards the implementation of this right. At no time when the applicant's son was still alive, was a procedure in place for the State institution to follow in order to establish that person's own views on organ transplantation, nor was there a legal duty on State institutions to inform the closes relatives about imminent organ removal. It stated that it was unclear how the claimed "presumed consent system" operated in practice in the circumstances in which the applicant found herself whereby she had certain rights, but was not informed as to how and when these rights might have to be exercised. The Court thus found that the applicable Latvian law was not formulated with sufficient precision or afforded adequate legal protection against arbitrariness. The interference with the applicant's Article 8 rights was not in accordance with law and a violation of Article 8 was held to have had occurred.

On the same reasoning, the Court also upheld the applicant's complaint that she had been subjected to inhuman and degrading treatment on account of the fact that the removal of her son's organs had been carried out without his prior consent or the consent of the applicant.

2.4.2 *Elberte v Latvia*[36]

In 2001, the applicant's husband had died in hospital following a car accident. His body was transported from the hospital to the State Centre for Forensic Medical Examination in Riga. To establish the cause of death, an autopsy was carried out. Following the autopsy, tissue was removed from his body – the outer layer of the meninges - by a forensic expert who stated that he had verified that there was no stamp on the deceased's passport denoting his objection to the use of his body tissue. The applicant argued that the expert could not have verified that there was no stamp on her husband's passport as that passport had been in their home at the time.

The applicant only became aware that tissue had been removed from her husband's body two years later, when police informed her that a criminal inquiry had been opened into the illegal removal of organs and tissue for supply to a pharmaceutical company in Germany. There was in existence an agreement between the Forensic Centre and the German company to provide organs and tissue for scientific research. Under the agreement, experts carrying out tissue removal were to comply with domestic law and were to verify whether the potential

[36] Number 61243/08, ECHR 2015.

donor had objected to the removal of organs or tissues by checking his/her passport for the presence of the stamp. If relatives objected to the removal, their wishes were to be respected. Experts, however, did not attempt to contact relatives to establish their wishes. Ultimately, the criminal inquiry was discontinued. In this decision, it was held that the experts did not have any legal obligation to inform anyone about his/her right to consent to or refuse organ or tissue removal. While the domestic law provided for the right of the closest relatives to object to the removal of material from deceased persons, it did not place an obligation on experts to explain these rights to the relatives.

Reiterating the principles of clarity as set out in *Petrova,* the ECtHR held that Article 8 ECHR had been violated in this case. The domestic law was not formulated with sufficient precision to enable relatives to exercise their rights to object to the removal of bodily material from their family member. In this case, tissue was removed from the deceased without the knowledge and consent of his spouse. This occurred due to the lack of clarity in the domestic law and the absence of legal safeguards against arbitrariness. The ECtHR therefore held that Article 8 had been violated in this case.

2.4.3 *Estate of Kresten Filtenborg Mortensen v Denmark*[37]

The case concerned the removal of DNA from the body of a deceased for the purposes of a paternity suit. It was claimed by two brothers that the deceased was their biological father. Following other testing, the City Court decided that his body was to be exhumed for the purpose of taking DNA samples – this being the only remaining option to establish paternity. The estate of the deceased, represented by his legitimate son, appealed against the decision and the case ultimately was considered by the Supreme Court of Denmark. The Supreme Court permitted the taking of biological material from the corpse despite the fact that the relevant domestic legislation did not contain any specific rules on forensic genetic testing of deceased persons.

In the challenge to the ECtHR, the deceased's estate complained that the exhumation of the corpse for the purposes of taking DNA samples constituted a breach of Article 8 ECHR as same was not "in accordance with law".

[37] Number 1338/03, ECHR 2006-V.

In considering this case, the Court emphasised that the applicant for the purposes of these proceedings was "the estate of KFM". It was complained that the Supreme Court's decision violated "the rights of the estate of KFM". While the concept of "private life" is a broad term, the Court stated that it would stretch the reasoning developed in case law too far to hold that the proposed testing on the deceased in this case constituted an interference with the Article 8 rights of the deceased's estate. In cases such as *Pannullo and Forte* (discussed earlier), the Convention was relied upon by individuals who were alive when they lodged their complaint with the Court who maintained that their right to respect for private or family life had been breached, as opposed to the deceased person's right to respect for private or family life. The ECtHR stated:

> In the present case the individual in question, namely KFM, was deceased when the alleged violation took place and hence when his estate, on his behalf, lodged the complaint with the Court alleging an interference with his right, or rather his corpse's right, to respect for private life. In such circumstances, the Court is not prepared to conclude that there was an interference with KFM's right to respect for private life within the meaning of Article 8.1 of the Convention.

While the representative for the estate, the legitimate son, did not make a claim in his own right as a family member of the deceased, submissions were made to the Court that the exhumation of the corpse also constituted an intrusion of that son's privacy rights. On the facts of this case, however, the Court rejected this assertion on the grounds that there was no evidence that the son complained at any point during the domestic proceedings that his rights had been violated. This submission was therefore inadmissible due to the non-exhaustion of domestic remedies.

These cases demonstrate that in terms of pursuing any claim for violation of Convention rights, it is the family members alone who are capable of asserting these rights. The deceased no longer possess human rights and they are not capable of asserting same. This approach is similarly demonstrated in the Council of Europe's Additional Protocol on Transplantation of Organs and Tissues of Human Origin.[38] Pursuant to Article 18, "Respect for the human body", it is provided that during removal of organs and/or tissues, the human body must be treated with respect and all reasonable measures must be taken to restore the appearance of

[38] Adopted 24 January 2002, entered into force 1 May 2006; See Comment to Article 18, Additional Protocol on Transplantation of Organs and Tissues of Human Origin.

the corpse. The Explanatory Comment to Article 18 states; "A dead body is not legally regarded as a person, but nonetheless should be treated with respect."

2.5 Specific requests regarding burial

2.5.1 *Elli Poluhas Dödsbo v Sweden*[39]

In this case, the ashes of the applicant's husband were buried in a family grave in Fagersta, Sweden, where the family had been living for some time. Years later, the applicant moved to be closer to her children. She thus requested that the cemetery authorities allow the transfer of her husband's urn to her family plot in Stockholm. She submitted that her children agreed to the removal, that she had no connection to Fagersta any longer and that she was sure her husband would not have objected to the transfer. Her request was refused by authorities in deference to the notion of a "peaceful rest" under the Funeral Act 1990 and her appeals were also refused. The relevant domestic law provided that when a person dies, his or her wishes concerning cremation and burial should, as far as possible, be followed. Where a dispute arises between survivors, it is for the county administrative board to decide. Once remains or ashes have been buried, moving them from one place to another is in principle not allowed unless permission is granted if special reasons exist. These provisions were based on respect for the sanctity of the grave. This requires that the provisions regarding the removal of remains and ashes be restrictive. A deceased's grave should be left in peace and may only be disturbed in special circumstances.

The applicant therefore complained that the refusal to allow her to transfer the urn containing her husband's ashes to her family burial plot in Stockholm was in breach of Article 8 ECHR. It was not disputed by the State that the refusal to grant permission to remove the urn from one burial place to another involved an interference with the applicant's private life, but it was argued that the interference was in accordance with law, that it served legitimate aims and was justified under Article 8.2.

As to the legitimate aims, the government emphasised that the principle of the sanctity of graves had a long-standing tradition and was founded on respect of the deceased. Thus, the

[39] Number 61564/00, ECHR 2006-I.

strict approach taken by its law, and by the public authorities in applying the law, served to prevent disorder and to protect morals in society at large. It also submitted that the restrictive approach was necessary to prevent conflicts arising amongst relatives and that the living were entitled to be assured that, after death, their remains would be treated with respect. Regarding the issue of necessity, Sweden submitted that States should be afforded a wide margin of appreciation in cases of this kind, where the authorities had to balance the interests of the person requesting the removal with society's role in ensuring graves are not disturbed. In this case, there were no indications that the husband had not been buried in accordance with his wishes; he was buried in the region where he had lived and worked for twenty-five years; the burial site was a family grave, large enough for his entire family; and there was no obstacle to the applicant having her final resting place in the same cemetery as that of her husband.

The ECtHR acknowledged that the applicant's Article 8 right to private life was engaged. It stated that the concepts of "private and family life" are broad terms not susceptible to exhaustive definition and it noted the findings of the Commission that an applicant's wish to have his ashes spread over his own land fell within the sphere of private life in *X v Germany*.[40] It found, however, that the State's refusal to transfer an urn from one burial plot to another did not violate Article 8. The Court held that the decision to refuse to transfer the remains was made with due consideration to the interests of the deceased's wife and fell within the margin of appreciation available in such cases, finding that in such an important and sensitive issue, States should be afforded a wide margin of appreciation.

2.6 Application of Article 8 principles

It is clear from the foregoing body of case law that Article 8 of the ECHR may be of relevance in relation to the particular set of circumstances arising from the discovery of juvenile remains at Tuam. Article 8 has been broadly interpreted, providing family members of deceased persons with a substantial number of rights capable of assertion. While these rights are not absolute, and may be proportionately interfered with, their existence is of considerable importance and the State should be careful to ensure no illegitimate infringement of such rights. Family members may possess the right to have their loved one's

[40] Commission decision of 10 March 1981, no. 8741/79.

body returned to them. Moreover, relatives may have a right to know the fate of their family members, including information surrounding the death and/or burial of their loved ones. A failure to provide relatives with definite and/or credible information may fall foul of the positive obligation under Article 8, even where the death occurred before the Convention came into force in the relevant county, where the failure to provide information continues following the coming into force of the ECHR. It is also of note, that where samples are sought to be taken from a corpse, the consent of the family member is a relevant concern and should be borne in mind in any approach taken in relation to the subject matter of this report. Irish authorities are required to carry out their functions in a manner compatible with the ECHR and Article 8 rights in particular must be positively vindicated. Regard should be given to the distress and anguish of family members seeking information surrounding the death and/or burial of their loved ones. Nonetheless, it should also be borne in mind that there may be limits to the information which can or must be provided for the purposes of complying with Article 8. The decisions of the ECtHR confirm that Article 8 rights include information concerning the fate and place of burial of the deceased but it may not necessarily extend to additional matters (although these may be covered by Articles 2 and 3 ECHR).

Furthermore, any Article 8 ECHR right should be considered having regard to the extreme delicacy of any exhumation and further investigation at the Tuam site, as determined by the Expert Technical Group. The report of the ETG states that: "There are a number of factors that make this situation unique: The forensic requirement of the site; The 'significant' quantities of juvenile remains; The commingled or intermixed state of the remains; The position of the remains within subsurface chambers, with limited access." The report[41] concludes that the comingled state of the remains renders identification "particularly challenging". Moreover, the ETG states there is a "risk of destruction to human remains" that raises ethical issues.

It is clear from the foregoing that it is the family members who assert their rights under the Convention. They are not asserting the rights of the deceased, but their own as relatives. It is even questionable whether the deceased possess any human rights, as realistically due to their death, they are not capable of asserting same. This issue was considered by Rosenblatt in

[41] Report of the Expert Technical Group, December 2017, (i).

relation to the investigation of mass graves in *International Forensic Investigations and the Human Rights of the Dead.*[42] He states:

> ... [H]uman rights for the dead are philosophically unworkable and irreconcilable with the practical limitations of forensic work; therefore, we should not think of the dead as having human rights. However, this conclusion does not end discussion about what forensic investigators do for dead bodies. Rather, it makes room for a modest but rich sense of how exhumation can restore the identity, physical location, and care that have been denied to victims of atrocity.

2.7 Articles 2 and 3 ECHR

While much of the discussion above focuses on Article 8 ECHR rights and the right to respect private and family life, Articles 2 and 3 of the Convention also warrant consideration. Article 2 protects the right to life. The obligation of States to protect life is set out in the Convention, but is similarly recognised in other international human rights instruments, including the Universal Declaration of Human Rights (Article 3). As with Article 8, the ECtHR has interpreted Article 2 as placing a positive obligation on States. While, therefore, it requires States to refrain from the intentional and unlawful taking of life, they must positively take appropriate steps to safeguard the lives of those within their jurisdiction. Procedurally, there exists an obligation upon States to effectively investigate a killing or suspicious death within their territory. Article 3 prohibits torture, inhuman or degrading treatment or punishment. A similar obligation to investigate arises out of Article 3 ECHR. Where inhuman or degrading treatment is alleged, a State has a duty to investigate a complaint made.

2.8 Duty to investigate

The obligation to carry out an effective investigation was given explicit recognition by the European Court of Human Rights in the case of *McCann and Others v United Kingdom.*[43] In *McCann,* three IRA suspects had been shot dead by Special Forces operatives in Gibraltar as a result of a conjoined anti-terrorist operation involving British, Gibraltarian, and Spanish authorities. The Court provided a lengthy and detailed judgment which examined the

[42] *Human Rights Quarterly*, Volume 32, Number 4, November 2010, pp. 921-950 (Article) published by The Johns Hopkins University Press.
[43] Number 17/1994/464/545, 27 September 1995.

planning and control of the operation and it created an obligation to carry out an effective investigation inherent in Article 2:

> The obligation to protect the right to life under this provision (art 2) read in conjunction with the State's general duty under Article 1 of the Convention to 'secure to everyone within their jurisdiction the rights and freedoms defined in the [the] Convention', requires by implication that there should be some form of effective official investigation when individuals have been killed as result of the use of force by, inter alios, agents of the State.[44]

This principle has been applied in a number of subsequent cases since then, and its application has been extended to deaths which occur not just as a result of lethal force, but also in circumstances involving negligence within public health authorities.

2.8.1 *Osman v United Kingdom*[45]

In this case, the applicants were the wife and son of the deceased, Mr Ali Osman. The deceased was killed by his son's former teacher and his son, Ahmet, was seriously wounded in the same incident. The teacher, during the course of the son's time as a pupil at a school in London, formed a disturbing attachment to him, giving him money, taking photographs of him and following him home. The school authorities investigated the matter and a police officer visited the school on several occasions, but no further action was taken. As the behaviour of the teacher escalated, he was suspended from teaching duties pending an investigation by the education authority into his unprofessional conduct towards Ahmet Osman. A number of attacks were then made on the Osmans' property: a brick was thrown through a window of their house; the tyres of Mr Osman's car were slashed and the windscreen smashed; and paraffin and dog excrement were applied to their doorstep. Following each of those incidents, the Osman's complained to the police. A police officer interviewed the teacher on two occasions and he was later interviewed at his own request by officers from the education authority, to whom he stated he was thinking of doing a "Hungerford" (an indiscriminate mass killing carried out in the town of Hungerford).

The police were informed and in December 1987, the police went to the teacher's home to arrest him on suspicion of causing criminal damage to the Osmans' property. He was not at

[44] Ibid., at p. 161.
[45] Number 87/1997/871/1083, 28 October 1998.

home and he later failed to attend for work. Between January and March 1988, he travelled around England, periodically returning to his home address, and on 7 March 1988, he went to the Osmans' home where he shot and killed Ali Osman and shot and injured Ahmet. He was later convicted. It was argued by the applicants that the police authorities had failed to protect the lives of the deceased and his son.

The Court noted that it was not disputed that Article 2 of the Convention might in well-defined circumstances imply a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. However, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, this obligation must be interpreted in a manner which does not impose an impossible or disproportionate burden on the authorities.

The Court considered that where there was an allegation that the authorities had violated its positive obligation to protect the right to life in the context of its duty to prevent and suppress offences against the person it must be established to its satisfaction that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that it failed to take measures within the scope of its powers which, judged reasonably, might have been expected to avoid that risk. With regard to the particular circumstances at issue in this case, the Court found that there had not been a violation of Article 2 as the applicants had failed to point to any decisive stage in the sequence of the events leading up to the tragic shooting when it could be said that the police knew or ought to have known that the lives of the Osman family were at real and immediate risk from the teacher.

2.8.2 *Aslakhanova v Russia*[46]

This case concerned five joined applications by families who complained about the disappearance of their eight male relatives in two particular districts of Russia between 2002 to 2004. In all of the cases, the facts were similar in both the style of the abductions, which were conducted in a manner resembling a security operation, and in the resulting criminal

[46] Number 2944/06, 8300/07, 50184/07, 332/08, 42509/10, 18 December 2012.

investigations, which remained pending without having produced any tangible results. The Government did not dispute the principal facts of each case as presented by the applicants, but claimed that as the domestic investigations were pending, any conclusions about the exact circumstances of the crimes would be premature. It was also argued that it had not been established with sufficient certainty that the applicants' relatives had been detained by State agents or that they were dead.

In its decision, the ECtHR found that the evidence established that the family members of the applicants must be presumed dead following unacknowledged detention by State agents. It therefore held that there was a substantive violation of their right to life under Article 2 of the Convention. Importantly, the Court also found that a procedural violation of Article 2 had occurred due to the failure of the State to carry out effective investigations into the disappearances. Furthermore, there was found to be a violation of Article 3's prohibition on inhuman and degrading treatment as a result of the distress and anguish caused to the families by reason of the abduction of their relatives and due to the Russian authorities' response to their suffering.

2.8.3 *El-Masri v Former Yugoslav Republic of Macedonia*[47]

In this case, the ECtHR stressed the importance of an effective investigation in establishing the truth. This was recognised as not only being of benefit to the relatives of victims, but also for other victims, as well as for the general public who have the right to know what transpired.

In this case, the applicant was a German national of Lebanese origin. He had been a victim of a secret "rendition" operation in 2003 during which he was arrested, held in isolation, questioned and ill-treated in a hotel in Skopje hotel for 23 days regarding his alleged ties with terrorist organisations. He was then transferred to CIA agents who brought him to a secret detention facility in Afghanistan, where he was further ill-treated over four months. Amongst the legal action taken by the applicant, he lodged a criminal complaint against the former Yugoslav Republic of Macedonia against unidentified law-enforcement officials due to his unlawful detention and abduction. This complaint was dismissed by the Skopje public

[47] [GC] no. 39630/09, 13 December 2012.

prosecutor. The position of the Government of the former Yugoslav Republic of Macedonia was that the applicant had entered the country, had been interviewed by police on suspicion of travelling with false documents, had been allowed entry into the country and then had left the country, crossing into Kosovo. In the proceedings before the ECtHR, however, the Minister for the Interior of the former Yugoslav Republic of Macedonia confirmed that the Macedonia law-enforcement authorities, acting upon a valid international arrest warrant issued by US authorities, had detained the applicant and kept him in Skopje under the constant supervision of agents of the State Intelligence Service. He later had been handed over to the custody of the CIA rendition team.

The Court held that the applicant's allegations, in light of the evidence available, were sufficiently convincing and established beyond reasonable doubt. It therefore held that there had been a violation of Article 3 of the Convention in this case arising out of the inhuman and degrading treatment to which the applicant was subjected. The Court also held that there had been a violation of Article 3 due to the failure of the State to carry out an effective investigation into his allegations of ill-treatment. It observed that the applicant had brought his allegations of ill-treatment to the attention of the Macedonian public prosecutor, supported by evidence which had emerged from the international and other foreign investigations. The State, therefore, had been under an obligation to carry out an effective investigation. Apart from contacting the Ministry for the Interior for information, however, the prosecutor had not undertaken any investigative measure to examine those allegations before rejecting the complaint for lack of evidence. In particular, the applicant had not been interviewed, nor had the personnel working in the hotel at the time of his alleged captivity there. No steps were taken to establish why the aircraft suspected of having been used to transfer the applicant to Afghanistan had landed or to investigate the identity of the passenger who boarded it. The prosecutor had relied solely on the report of the Ministry, whose officials were suspected of having been involved in the applicant's alleged ill-treatment, thus this fell short of what should have been expected from an independent authority.

It was emphasised by the Court that investigation of the case was important not only for the applicant, but also for the victims of similar crimes and for the general public, who had the right to know what had happened. The summary investigation that had been carried out was not an effective one capable of establishing the truth and leading to the identification and

punishment of those responsible. The applicant's rights pursuant to Article 3 were thus violated with regard to the lack of an effective investigation into his allegations.

The ECtHR case law concerning Article 2 in particular demonstrates that the procedural obligation upon a State to investigate effectively arises where the death occurs in suspicious circumstances or where an individual has gone missing in life-threatening circumstances. The purpose of such investigations is to ensure that domestic law in place to protect the right to life is implemented. The Last Rights Project, in its article *The Dead, the Missing and the Bereaved at Europe's International Borders – Proposal for a Statement of the International Legal Obligations of States* (May 2017), sets out the criteria which the ECtHR has required to be met for an investigation to satisfy international human rights standards as follows:

- State initiative – the State authorities must take the initiative to investigate once the matter has come to their attention and may not leave it to the next of kin to bring proceedings;
- Independence – those carrying out the investigation must be independent from those implicated in their death;
- Effectiveness – the investigation must be capable of leading to a determination of whether the action taken by State officials was justified in the circumstances and to a determination of the culpability of those responsible for the death. Steps must be taken to secure all relevant evidence in relation to the death;
- Promptness – the investigation must take place promptly and must proceed with reasonable expedition;
- Transparency - the investigation must be open to public scrutiny to a degree sufficient to provide accountability in the circumstances of the case.[48]

2.9 Duty to investigate incidents which took place before the ECHR came into force

The Convention duty to investigate incidents may include incidents that happened some time ago. It is, however, a more limited duty in relation to historical incidents which occurred before the State in question signed the Convention. Nevertheless, relatives of the deceased should be involved in the investigation to a sufficient degree to safeguard their legitimate interests.[49]

[48] The Last Rights Project - *The Dead, the Missing and the Bereaved at Europe's International Borders – Proposal for a Statement of the International Legal Obligations of States* (May 2017) at p.11.
[49] *Edwards v UK* [2002] ECHR 303.

2.9.1 *Janowiec v Russia*[50]

The position with regard to atrocities and killings which took place before the Convention came into force was clarified by the Grand Chamber in *Janowiec v Russia*.[51] In this decision, the applicants, who were family members of Polish officers and officials detained in Soviet camps or prisons following the Red Army's invasion of Poland in 1939, complained about the alleged failure of the State to adequately account for the fate of these prisoners, believed to have been executed by Soviet secret police at Katyń in 1940 and buried in mass graves. Investigations into the mass murders were started in 1990 but discontinued in 2004. The ECtHR upheld Russia's preliminary objection based on the fact that the deaths occurred 58 years before the Convention entered into force in the respondent State.

It stated that its temporal jurisdiction to review a State's compliance with its procedural obligation under Article 2 to carry out an effective investigation into alleged unlawful killing by State agents was not open-ended where the deaths had occurred before the date the Convention entered into force in respect of that State. In such cases, the Court has jurisdiction only in respect of procedural acts or omissions in the period subsequent to the Convention's entry into force, provided there was a "genuine connection" between the death as the triggering event and the entry into force. For a "genuine connection" to be established, the period between the death and the entry into force had to have been reasonably short, no more than 10 years, and a major part of the investigation had or ought to have been carried out after the date of entry into force. The emergence of new, credible information about such past events, however, may trigger the duty to investigate.

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[50] [2014] 58 EHRR 30.

[51] See also *Silih v Slovenia* (2009) 49 EHRR 37 and *Mocanu v Romania* (2015) 60 EHRR 19. The ECtHR in *Silih* established that breaches which have taken place before the coming into force ('critical date') of the Convention might also give rise to an obligation to investigate. It found that the Article 2 duty to investigate is free-standing, and did not require the triggering event to have taken place during the relevant State's period of formal obligation under the Convention.

The Grand Chamber in *Silih* set out four constraints on when a pre-ratification free-standing obligation to investigate suspicious death crystallises:

(a) That only procedural acts and/or omissions occurring after the critical date fell within the court's temporal jurisdiction.

(b) That there must exist a genuine connection between the death and the entry into force of the Convention in respect of the Respondent State for the procedural obligation to come into effect.

(c) That a significant proportion of the procedural steps will have been or ought to have been carried out after the critical date.

(d) However, in certain circumstances, the connection could be based on the need to ensure that the guarantees and the underlying values of the Convention are protected in a real and effective manner.

On the evidence, the applicants' relatives were presumed to have been executed by the Soviet authorities in 1940. Russia did not ratify the Convention until May 1998. This period of time was much longer than the periods which had triggered the procedural obligation under Article 2 in previous cases and furthermore, the Court stated that it was too long in absolute terms for a genuine connection to be established between the deaths and the entry into force of the Convention in respect of Russia. The Court was unable to accept that a re-evaluation of the evidence, a departure from previous findings or a decision regarding the classification of the investigation materials could be said to have amounted to the "significant proportion of the procedural steps" required for establishing a "genuine connection" for the purposes of Article 2. It also noted that no relevant piece of evidence or substantive item of information had come to light in the period since the critical date. Accordingly, neither criterion for establishing the existence of a "genuine connection" had been fulfilled.

2.9.2 *Keyu v Secretary of State for Foreign and Commonwealth Affairs*[52]

The UK Supreme Court in *Keyu v Secretary of State for Foreign and Commonwealth Affairs* rejected an appeal against the decision of the UK's Foreign and Defence Secretaries to refuse to hold a public inquiry into the Batang Kali deaths. The Supreme Court held that as the alleged breach of Article 2 had come into effect prior to the 1998 Human Rights Act, there was no continuing breach beyond the creation of the Act.

In this case, the UK Supreme Court considered whether the respondents should be required to hold a public inquiry into the Batang Kali deaths – that is, a series of events in 1948 in which it is alleged that a Scots Guard patrol shot and killed 24 unarmed civilians in the village of Batang Kali, in Selangor. In 2008, a campaign group called 'The Action Committee Condemning the Batang Kali Massacre' presented a petition seeking a public inquiry from the British government. The respondents informed the appellants by letters on 29 November 2010 and 4 November 2011 of their decision to refuse to hold an inquiry into the killings.

The appellants sought to judicially review the refusal to hold a public inquiry, arguing that a public inquiry was required on three different grounds: (i) under Article 2 (right to life) of the ECHR; (ii) under the common law by virtue of its incorporation of principles of customary

[52] [2012] EWHC 2445 (Admin); [2015] UKSC 69.

international law; and (iii) under the common law by judicial review of the respondents' exercise of their discretion under section 1 of the Inquiries Act 2005. Treacy J. in the High Court had held that as the alleged breach of Article 2 ECHR had occurred prior to the 1998 Human Rights Act, there was no continuing breach beyond the creation of the Act and a public inquiry was refused. The applicant appealed this decision.

The Supreme Court ultimately dismissed the appeal, finding that a requirement for a public or other inquiry could not be imposed in this case. It noted that where a death occurs prior to the date upon which the relevant Member State contracted to the ECHR, two criteria must be satisfied if the investigative duty under Article 2 is to arise – there must be (i) relevant 'acts or omissions' after the critical date, and (ii) a 'genuine connection' between the death and the critical date. As to the second criterion, in order for there to be a genuine connection, the lapse of time between the death triggering the investigative duty and the critical date must remain reasonably short, and should not exceed ten years. In this case, the alleged deaths took place prior to the Convention. No further incident or supervening event occurred to create any obligation upon the State after the ECHR came into effect.

There was a distinction made by the Court on the question of whether the critical date is the date of the coming into force of the ECHR or the date when the right of petition was recognised by the UK. The ECHR came into force for the UK on 3 September 1953, whereas the UK recognised the right of an individual to petition the European Court of Human Rights in January 1966. The majority held that it was the date when the right to petition was recognised that is the relevant critical date and on this basis, as the killings occurred more than ten years before the critical date, there was no genuine connection. The Article 2 claim therefore failed. While Lady Hale similarly dismissed the Article 2 claim, she considered that the critical date was the date that the ECHR came into force. Nonetheless, she dismissed the Article 2 claim because the inquiry was sought for the purposes of establishing historical truth rather than legal liability and as a matter of principle, there was a difficulty in finding that there could be a "genuine connection" between killings which occurred before the coming into effect of the ECHR and obligations imposed by the ECHR.

The Court then considered the position of customary international law within the UK. It determined that same had not developed to impose a duty on the State to hold a public inquiry. However, even if that conclusion was incorrect, and it was a principle of customary

international law that a State must investigate deaths such as the alleged incident in Batang Kali, the Court took the view that this principle could not be incorporated into common law. It noted:

> ... Parliament has expressly provided for investigations into deaths (i) through the coroners' courts in the Coroners and Justices Act 2009, and its predecessors, and (ii) through inquiries in the 2005 Act, and its subject-specific predecessor statutes. It has also effectively legislated in relation to investigations into suspicious deaths through the incorporation of Article 2 in the 1998 Act. In those circumstances, it appears to be quite inappropriate for the courts to take it onto themselves, through the guise of developing the common law, to impose a further duty to hold an inquiry, particularly when it would be a duty which has such potentially wide and uncertain ramifications, given that it would appear to apply to deaths which had occurred many decades – even possibly centuries – ago.

2.9.3 *Re McGuigan*[53]

Re McGuigan concerned the interrogation of the "Hooded Men". During the period of internment in 1971 to 1972, twelve men in Northern Ireland suspected of being involved in terrorist activity were taken to an interrogation centre, now known to have been located at a British Army base. They there underwent "interrogation in depth" over the period from 11 to 17 August 1971. Two further men underwent similar interrogation in October 1971. The deep interrogation process involved "the five techniques" i.e. prolonged hooding, subjection to continuous loud noise, sleep deprivation, deprivation of food and water, and the maintenance of stress positions over long periods of time. Owing to the first of these techniques, these 14 men came to be known as the "Hooded Men".

In this case, the applicants challenged the decision of the Police Service of Northern Ireland not to take further steps to investigate the question of identifying and prosecuting those responsible for criminal acts during the interrogation of the "Hooded Men". They sought judicial review of the decision made by PSNI that there was no evidence to warrant an investigation, compliant with Articles 2 and 3 of the ECHR, into the allegation that the UK Government authorised the use of torture in Northern Ireland. They also challenged decisions of all three respondents as constituting a continuing failure to order and ensure a full, independent and effective investigation into torture at the hands of the United Kingdom

[53] [2017] NIQB 96.

Government and/or its agents in compliance with Articles 2 and 3 of the ECHR, common law, and customary international law. The application was brought by Francis McGuigan, one of the Hooded Men, and the daughter of another of the "Hooded Men".

McGuire J., in the High Court in Belfast, ultimately quashed the PSNI's decision, finding that the decision to end the inquiry was seriously flawed. Three legal issues were considered in this case.

First was the ECHR issue. The applicants argued that the respondents were guilty of failing to ensure an effective investigation was carried out relating to the performance by the UK of its procedural obligation under Articles 2 and 3; and that there was a duty enforceable in domestic law on the State to carry out an effective official investigation into the treatment of the "Hooded Men", capable of leading to the identification and punishment of those responsible for the methods used.

In determining whether there was a breach of Articles 2 and 3 of the ECHR on the facts of these cases upon which a domestic court could rule, the Court stated that two questions arose:

> ... the first is whether it is likely that the ECtHR would find a breach and the second is whether it is open to this Court to hold that there is a breach.

In considering whether the ECtHR would find a breach, in line with the Grand Chamber's decision in *Janowiec*,[54] Maguire J. stated that the Strasbourg Court, in cases of this type where a temporal problem exists, would consider whether the 'genuine connection' test is met. The Court took the view that for present purposes the 'critical date' must be viewed not as the date when a State acceded to the Convention or agreed to the right of individual petition, but as the date when the Human Rights Act commenced, namely 2 October 2000. He noted that the triggering event in these cases occurred in the early 1970s whereas the equivalent of the 'critical date' is 2 October 2000. In the context of the time factor, he noted that the lapse of time between these dates should be 'reasonably short', by which is meant a period not exceeding ten years, though there may be, based on some Strasbourg authorities, some room for an element of flexibility on this point. He concluded, however, that on this aspect the distance in time was simply too long to establish the existence of a genuine connection, the gap of over 40 years exceeding significantly the norm of ten years.

[54] [2014] 58 EHRR 30. See also section 2.9.1 above.

Looking at the balance of the process of investigation as between the period prior to the critical date and the period after it, the Court noted that this involves the question of whether much of the investigation into the relevant event took place or ought to have taken place in the period following the critical date. If the balance favours the view that the majority of relevant actions have or should have taken place after the critical date, this aspect may be satisfied. On the other hand, if the balance is in the other direction, this aspect may not be satisfied. With regard to the present cases, Maguire J. found that this aspect of the genuine connection test was not satisfied as the majority of the activity in respect of the events in this case at issue occurred in the period 1971 to 1978. Thereafter there was a long period when the issues were dormant and he stated that he could not conclude that post 2014 there had been extensive investigative measures taking place. The court therefore held that the two aspects of the 'genuine connection' test, both of which would ordinarily have to be satisfied, had not been established.

This, however, was not the end of the inquiry as the court then examined the "Convention values test" – which deals with extraordinary cases which have failed the 'genuine connection' test. The court noted the "extremely high hurdle" to fulfil this test and that the language in *Janowiec* describing the sort of circumstances which may meet the test is in very general terms;

> What may constitute the underlying values of the Convention or what sort of action or behaviour would amount to a negation of its very foundations invites the application of ideas which are difficult to define.

In considering this test, the court stated that it must bear in mind the circumstances in their totality which give rise to this issue, noting that this case involved the state and state authorities establishing a secret interrogation centre and a system for the deep interrogation of detainees which, when it reached the public domain, it produced such a reaction as to require the immediate establishment of the Compton Inquiry and that the events shortly became the subject of inter-State proceedings within the Convention system. In assessing whether this test was met, the court stated that the Convention is a living instrument and must be interpreted in the light of present day conditions. Maguire J. took the view that if the events herein were replicated today, the ECtHR would be likely to accept the description of torture in respect of these events as accurate. He therefore concluded that the sort of activity at issue in this case had a larger dimension than an ordinary criminal offence and thus would amount

to "...the negation of the very foundations of the Convention." The "Convention values" test was found to be established.

The court then considered whether the *Brecknell*[55] test was met – whether new information has arisen since the event at issue, reviving the obligation under Article 2 to investigate. The new information in this case comprised materials which were exposed in an RTÉ broadcast of 2014. These materials tended to suggest that torture had been authorised at the time by a senior United Kingdom Minister and that the UK Government had withheld from the Strasbourg institutions evidence which undermined their case that the after effects of the use of the five techniques were not long-lasting or severe. The question was whether the new material could be said to come within the description of 'plausible or credible allegation, piece of evidence or item of information relevant to the identification, and eventual prosecution or punishment of the perpetrator'. The court was satisfied that this information fell within the broad description referred to in *Brecknell* and, accordingly, was sufficient to cause, given that the Convention Values test had been surpassed, a revival of the obligation under Article 2 to carry out an effective official investigation. It concluded, therefore, that there was an obligation to take further investigative measures. The court held it was a matter for the authorities to take reasonable steps to comply with this obligation.

The Court, however, did not find in favour of the respondents on the Convention issue and held that, as a matter of domestic law Articles 2 and 3 were not engaged in this case because of the temporal restriction on the operation of the Human Rights Act. The Court stated that following the approach in *Keyu*[56] (in England and Wales) and *Finucane*[57] (in Northern Ireland), the decision in *McKerr*[58] remains the relevant governing authority. This meant that in the present cases no obligation under Article 2 or 3 could be held to operate under the Human Rights Act as a matter of domestic law as the events the court was dealing with long pre-dated 2 October 2000.

Maguire J. then determined the independence issue, namely the complaint regarding the independence of the investigator. He stated that as this argument derives from the jurisprudence of Articles 2 and 3, it must follow that if, as a matter of domestic law, Articles

[55] *Brecknell v United Kingdom* (2008) 46 EHRR 42 at paras. 66 to 72.
[56] [2015] UKSC 69.
[57] [2017] NICA 7.
[58] [2004] 1 WLR 807.

2 and 3 are not engaged because of the temporal restriction on the operation of the Human Rights Act, this ground of challenge must also fail. On the common law issue, however, he found in favour of the applicants. The applicants claimed that quite apart from any issue of Convention law, there is an obligation of a broadly parallel nature at common law which requires an effective official investigation into a death or an event involving inhuman or degrading treatment or torture. The Court agreed that even if the ECHR as a matter of domestic law does not require the steps referred to above to be taken, such steps were required as a matter of common law - finding that this ground was made out, considering the Supreme Court judgment in *Re McKerr*. Furthermore, it upheld the applicants' claim that the PSNI's decision to end the inquiry of the matter was premature. It found that the decision was seriously flawed and was inconsistent with the broad approach which the Chief Constable had adopted. The Court therefore quashed the decision made on behalf of the PSNI not to take further steps to investigate the question of identifying and, if appropriate, prosecuting those responsible for criminal acts.

In *Ireland v UK (request for revision of the judgment of 18 January 1978)*,[59] the ECtHR dismissed the application by the Irish Government for a revision of the ruling in the 1978 *Ireland v UK ("Hooded Men")* case. The 1978 judgment found that the UK violated the men's rights to be free from inhuman and degrading treatment, but that the treatment the men suffered did not amount to torture. I do not believe the 2018 judgment alters the above analysis regarding the temporality of the procedural obligations under Article 3 ECHR (including the Northern Ireland High Court's appraisal of its jurisdiction under the 1998 Human Rights Act), in that it only addressed the substantive question of whether the techniques would have been classified as torture in 1978 had the Court known what is now available in the public archives.

The case was decided on a narrow evidential ground – i.e. whether RTÉ's 2014 documentary based on newly released UK Government documents under the thirty-year rule constituted "new facts" for consideration. The Court rejected this submission. Moreover, the case also concerned a request for a revision of a previous decision under Rule 80 § 1 and therefore did not trigger any of the temporal issues explored above.

[59] Number 5310/74 and ECHR 110 (2018), 20.03.2018.

Summary

In relation to Ireland, while the European Convention on Human Rights Act was only introduced in 2003, the Convention was signed and ratified in this jurisdiction in 1953, entering into force on 3 September 1953. The deaths which occurred at the Tuam Mother and Baby Home are estimated to have occurred in the period between 1920 to 1960. While the majority of that period pre-dates the entry into force of the Convention in Ireland in 1953 and the adoption of the Convention itself in 1950, the remainder of that period post-dates Ireland's ratification of the Convention. Furthermore, the discovery of the remains interred therein only occurred in 2017. In light of the recent evidence of juvenile remains at the site of the former Mother and Baby Home in Tuam, therefore, a question arises as to whether the duty upon the State to investigate is triggered in the present circumstances. A further question to be considered is whether this is the kind of new information that would trigger an Article 2 obligation to investigate. In *Keyu*, one of the judges[60] felt that the ECHR rule was not a right to say that "any assertion or allegation can trigger a fresh investigative obligation under Article 2", but rather that "state authorities must be sensitive to any information or material which has the potential either to undermine the conclusions of an earlier investigation or to allow an earlier inconclusive investigation to be pursued further".

The unsettled position in the UK should be noted. In *Re McKerr*,[61] the UK Supreme Court held that an obligation to initiate an investigation under Article 2 only applies to deaths occurring after the Human Rights Act 1988 came into force in 2000. A similar approach was followed by the UK Supreme Court in *Keyu v Secretary of State for Foreign and Commonwealth Affairs*, discussed above. This approach, however, was called into question in other decisions and the current position is unclear.[62]

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[60] Para 103.
[61] [2004] 1 WLR 807.
[62] See *In Re McCaughey* ([2011] UKSC 20) where Lord Phillips reflected on the *Silih* judgment [(2009) 49 EHHR 372] of the Grand Chamber:

> I believe that the most significant feature of the decision ... is that it makes it quite clear that the Article 2 procedural obligation is not an obligation that continues indefinitely ... [j]ust because there has been a historic failure to comply with the procedural obligation imposed by Article 2 it does not follow that there is an obligation to satisfy that obligation now. In so far as Article 2 imposes any obligation, this is a new free-standing obligation that arises by reason of current events. The relevant event in these appeals is the fact that the coroner is to hold an inquest into [the applicants'] deaths. *Silih* ... establishes that this event gives rise to a free standing obligation to ensure that the inquest satisfies the procedural requirements of Article 2.

2.10 The rights of relatives under Articles 2 and 3 ECHR

The duty to investigate inherent in Article 2 as recognised by the abovementioned ECtHR case law may operate together with the protections set out in Article 3 ECHR in some circumstances. Article 3 prohibits inhuman or degrading treatment. Any violations of Article 3 are significant because the right is absolute making it more difficult to assert resource constraints arguments and time limits for complainants. As demonstrated above in *Aslakhanova v Russia*, relatives of deceased persons may be in great distress following the death of their family member in situations where the actions of or a failure by the State is involved. Accordingly, the Article 3 rights of these family members may be engaged where a State fails to investigate a suspicious death.

2.10.1 *Cyprus v Turkey*[63]

This case concerned the aftermath of military operations conducted by Turkey in 1974 wherein it occupied part of Northern Cyprus. Cyprus brought an application alleging violations of the Convention arising from the conduct of the Turkish authorities, particularly with regard to their failure to investigate the fate of persons who were missing as a result of the conflict.

Having considered the circumstances of the case, the ECtHR concluded that there had been a continuing violation of Article 2 of the Convention due to the failure of the Turkish authorities to conduct an effective investigation aimed at clarifying the whereabouts and fate of Greek-Cypriot missing persons who disappeared in life-threatening circumstances. It noted that States have a procedural obligation to effectively investigate, not only when individuals have been killed as a result of agents of the State, but also where individuals who were last seen in the custody of agents of the State, subsequently disappeared in a context which may be considered life-threatening. Such a situation was clearly demonstrated in this case. While Turkey had contributed to the investigatory work of the UN Committee on Missing Persons, the contribution thereto was not sufficient to meet the standards of an effective investigation under Article 2.

However in that same judgment, Baroness Hale doubted whether the decision grounded any free-standing right to open a new investigation. See also *Re McGuigan* [2017] NIQB 96.

[63] [GC] no. 25781/94, 10 May 2001.

The Court specifically considered the impact upon the relatives of those missing persons, noting the moral pain and mental suffering of relatives. It found that the silence of the Turkish authorities in the face of the real concerns of the relatives reached a "level of severity" which was to be categorised as inhuman treatment and Article 3 was therefore infringed. This decision makes it clear that a violation of Article 3 will be found where the State's actions go beyond a "minimum level of severity", inflicting moral pain and mental suffering on relatives.

2.10.2 *Çakici v Turkey* [64]

The applicant in this case alleged that her two sons and her grandson had disappeared in circumstances engaging the responsibility of the respondent State. She claimed they were taken into custody in 1994 by Turkish soldiers and never released. This was disputed by Turkey who did not acknowledge any such detention or disappearance. The European Commission of Human Rights conducted its own investigation with a view to establishing facts in light of the dispute surrounding the disappearance of the men in question. Reviewing the investigation, the ECtHR found that the applicant's sons must be presumed dead following an unacknowledged detention by security forces. Consequently, it held that the responsibility of the respondent State for their death was engaged. As the authorities did not provide any explanation of what occurred to the men after their apprehension and because they did not rely on any round to justify the use of lethal force by its agent, the Court held that there had been a violation of Article 2.

The Court then considered whether there had been an effective official investigation into the disappearance of the applicant's relatives. In this regard, the Court had regard to the length of time taken before an official investigation commenced and before witness statements were obtained. It also had regard to the manner in which relevant information was ignored by the investigating authorities. The Court concluded that the investigation carried out was inadequate and therefore in breach of the State's procedural obligations to protect the right to life and a violation of Article 2 took place on this account also.

[64] [GC] no. 23657/94, 8 July 1999.

Finally, the Court considered the applicability of Article 3 in this case – with regard to both the applicant's sons and the applicant herself. The applicant argued that the respondent State breached her sons' Article 3 rights. She emphasised the very fact that her sons' disappearance occurred in a context devoid of the most basic judicial safeguards, which she said must have exposed them to acute psychological torture. She referred to the ill-treatment that she had been told by witnesses that had occurred and she claimed that this must be considered even more compelling in view of the existence of a high level of torture of detainees in the respondent State. The Court found that there was no evidential basis upon which it could conclude that the applicant's sons endured ill-treatment contrary to Article 3, noting that it requires a standard of proof "beyond reasonable doubt" that ill-treatment of a minimum level of severity occurred. With regard to the claim made by the applicant herself the Court reiterated that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The Court noted that the applicant received no news of her sons for almost six years and was living with the fear that they were dead. Moreover, she had requested the authorities to at least be given their bodies. It stated that the "uncertainty, doubt and apprehension suffered by the applicant over a prolonged and continuing period of time has undoubtedly caused her severe mental distress and anguish". Having regard to this and the authorities' complacency in the face of her distress, the Court found the State to be in breach of Article 3 in respect of the applicant.

2.10.3 *Sabanchiyeva v Russia*[65]

In *Sabanchiyeva v Russia*, the applicants were relatives of deceased persons who died during or soon after an attack on local law enforcement agencies. The authorities determined that this was a terrorist attack and decided not to return the bodies of the deceased to their families but to have them cremated. The applicants claimed a breach of their rights arising from this, including under Articles 3 and 8 of the ECHR.

The Article 3 claim related to the manner in which the bodies were stored during the process of having them identified. This means it bears some similarities to the issues that could be raised in the Tuam context. It was argued that this caused mental suffering to the applicants in breach of Article 3. The Court emphasised the importance of Article 3, as illustrated by

[65] (2014) 58 EHRR 14.

the fact that it makes no provision for exceptions or derogations. However, the Court also reiterated the fact that ill-treatment must attain a minimum level of severity if is to fall within the scope of Article 3. In the context of mental suffering, the Court gave the example of the suffering "endured by applicants as a result of the acts of security forces who had burnt down their homes and possessions before their eyes". It also reiterated that allegations of ill-treatment must be proved beyond reasonable doubt.

Applying these principles, the Court accepted that the inadequate storage of the bodies meant relatives may have endured mental suffering. That was even more the case for those who witnessed the bodies in person.

However, the Court drew a distinction between these applicants and previous cases brought by relatives of victims who disappeared as a result of actions by the security forces. This may be an important point given that the situation in Tuam may be more similar to this case, than to the cases of persons 'disappeared' or killed by State security forces. The Court also held that the applicants did not suffer any prolonged uncertainty over the fate of their relatives; and that the manner of storage was due to logistical difficulties so that it could "hardly be said to have had as their purpose to subject the applicants to inhuman treatment, and in particular, to cause them psychological suffering". The Court therefore unanimously found that there was no violation of Article 3. While the applicants were likely to have experienced mental suffering, this was not of "a dimension and character distinct from the emotional distress which may be regarded as inevitably caused to any family member of a deceased person in a comparable situation" so as to violate Article 3.

This decision underlines the high factual and legal threshold that is applied by the Court to allegations of a breach of Article 3. The fact that a deceased's body is treated in a manner that causes relatives mental suffering is not of itself a contravention of Article 3. The Court's discussion of its previous case law suggests that substantially greater legal or moral culpability – such as the intentional infliction of mental suffering on relatives; or the direct involvement of security forces in killing or disappearing the deceased – is required to ground an Article 3 claim.

On the Article 8 issue, the Court held that the ban on participation in the funeral and on disclosing the location of the grave permanently cut the link between the applicants and the

deceased's remains in a manner that constituted a severe interference with their Article 8 rights. The Court accepted, however, that the authorities were entitled, in principle, to impose restrictions on the rights in this instance given the activities of the deceased and, in particular, the risk of disturbances or other unlawful actions during or after the burials. Nonetheless, the automatic nature of the measures was a disproportionate breach of Article 8 because it failed to give any consideration to individual situations or to the possibility of less intrusive alternative means.

In light of this decision, the question arises whether relatives of those interred in Tuam could contend that their rights pursuant to Article 3 ECHR have been violated. Whether any such claim would be successful would depend on the specific set of facts prevailing in each individual case as a minimum level of severity must be achieved.

2.11 Obligation to collect the bodies of the deceased

In light of the abovementioned discussion concerning the express and inherent rights pursuant to the Convention, the question arises as to whether there exists an obligation on States to collect the bodies of the deceased. The issue was considered by the Last Rights Project, in *The Dead, the Missing and the Bereaved at Europe's International Borders – Proposal for a Statement of the International Legal Obligations of States* (May 2017).[66] While this work concerns refugees and migrants who die or go missing at international land and sea borders, the principles discussed therein may be relevant to the issue under review. The Last Rights Project notes that while there is a substantial body of legal principles and rules in both customary and treaty law that apply regarding the treatment of the dead in the context of armed conflict, the position is less clear in respect of the treatment of the dead in peacetime contexts. To address this lacuna, it recommends that the principles established in international humanitarian law in relation to armed conflict can serve as a guide with regard to the treatment of the dead in some peacetime situations.

With regard to the collection of the bodies of deceased persons, in cases of armed conflict, international humanitarian law contains an express obligation to collect the bodies of the deceased. This is set out in Article 15 of the Geneva Convention, which provides:

[66] Lastrights.net.

> At all times, and particularly after an engagement, Parties to the conflict shall, without delay, take all possible measures to search for and collect the wounded and sick, to protect them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead and prevent their being despoiled.[67]

Similarly, Article 8 of the Additional Protocol II provides that "...whenever circumstances permit, and particularly after an engagement, all possible measures shall be taken, without delay ... to search for the dead, prevent their being despoiled, and decently dispose of them."[68]

While there does not appear to be express reference in the UDHR or the ECHR stating that there is an express obligation on States to collect the bodies of the dead, it is arguable that the protection of the other human rights obligations discussed above – to investigate the cause of death, to return the remains to family members, to know the fate of one's relative – necessarily require such collection. In reality, the failure of a State to ensure the collection of bodies of the deceased may prevent it from complying with the positive obligations set out in Articles 2, 3 and 8 ECHR and may constitute an interference with the Convention rights of the family members concerned.

This positive duty to collect remains is not absolute, and the usual limitations apply. In this vein, akin to that set out in the Geneva Convention where States are required to take all possible measures to search for the dead, in collecting the dead in peacetime circumstances, States may be required to take all reasonable measures to discharge this duty. This would prevent a State from being at fault in circumstances where recovery is simply not possible – for instance, where bodies are lost at sea or where, such as is the case with regard to the remains at Tuam, it may simply be impossible to retrieve all of the remains due to the limitations of forensic excavation.[69]

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[67] Article 15, Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (Geneva Convention 1), adopted 12 August 1949, entered into force 21 October 1950, 75 UNTS 85.

[68] Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 8 June 1977 1125 UNTS 609, Article 8.

[69] See Expert Technical Group Report.

Summary

In order to ensure the effective vindication of the abovementioned ECHR rights, there appears to be an inferred duty on the Irish State to collect, as far as reasonably possible, the remains of those interred at Tuam. The Tuam site, according to the Expert Technical Report, will test the boundaries of forensic investigation in every regard. The Expert Technical Group, due to the varied nature of the complexities at the site in Tuam, notes the limitations of the forensic possibilities involved in excavation and examination on the site. It states that given that the site holds a group of collectively interred individuals, "it may only ever be possible to provide collective answers", and the potential to identify individuals interred there poses many challenges. These limitations therefore must be borne in mind and where the State fails to collect remains for these reasons, it is unlikely to fall foul of its duty where it takes all reasonable steps to investigate the possibility of retrieval and, if proportionate and justified, undertakes reasonable measures to retrieve the bodies in question.

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3. INTERNATIONAL HUMAN RIGHTS LAW: THE UN FRAMEWORKS

International human rights law also warrants consideration. The Universal Declaration of Human Rights (UDHR) is crucial in this regard. Drafted by representatives with different legal and cultural backgrounds from all regions of the world, the Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly resolution 217 A) as a common standard of achievements for all peoples and all nations. It sets out the fundamental human rights that are to be universally protected. These are enforced through supervision and reporting by expert bodies, some of which may also deal with individual complaints. The state has an obligation to respect, protect and fulfil the rights guaranteed in these instruments pursuant to section 1 and as a member of the United Nations since 1955, Ireland is expected to uphold its principles, and to protect the rights set out in international treaties through its laws, policies and practices.

The right to life and the rights of the family are emphasised in the UDHR. Article 3 provides that everyone has the right to life, liberty and security of person. Article 8 states that; "Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law." The importance of the family unit is clear from Article 16 thereof, which recognises that the family is the natural and fundamental unit group of society and is entitled to protection by society and the State. The crucial rights capable of assertion and protection at European level therefore are also recognised within international law.

The Declaration contains a number of rights which are of relevance to the current review: Article 1 (equality and dignity); Article 2 (prohibition on sex discrimination); Article 4 (prohibition on slavery or servitude); Article 5 (prohibition on torture, or cruel, inhuman or degrading treatment or punishment); Article 6 (recognition as a person before the law); Article 7 (equality before the law); Article 9 (prohibition on arbitrary arrest, detention or exile); Article 10 (fair hearing); and Article 25 (minimum standard of living).

Within international human rights law, children are recognised as a specific group requiring particular special protection. In this regard, in 1989, the UN Convention on the Rights of the

Child (UNCRC) was adopted by the UN General Assembly and in 1990, it entered into force. All State parties, including Ireland which ratified the UNCRC in 1992, have duties under the Convention to ensure that their laws, policies and procedures promote the full enjoyment of all the rights contained therein for all children. Article 4 UNCRC provides that States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognised in the present Convention. Article 6 protects the right to life of every child.

Article 7 provides as follows:

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8 protects the child's identity:

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

The duty upon States to ensure the accurate identification of children demands the effective collection and preservation of essential data on children, and to collate all data. This necessarily would include the registration of the death of a child and collating the date of children who have died. As the site in Tuam contains a significant quantity of juvenile human remains, the provisions of the UNCRC may be of relevance.

International Covenant on Civil and Political Rights (ICCPR)

Ireland is a signatory, and since 1989 a State Party[70] to the ICCPR. As Ireland has ratified the Covenant, it can be held accountable for failures to realise the rights contained therein before international human rights fora and courts.

A number of Covenant Rights are relevant to this review: Article 3 (equal rights of men and women); Article 6 (right to life); Article 7 (prohibition on torture or cruel, inhuman or degrading treatment or punishment); Article 8 (prohibition on slavery); Article 9 (security and liberty); Article 10 (human dignity); Article 11 (prohibition on imprisonment "merely on the ground of inability to fulfil a contractual obligation"); Article 16 (recognition as a person before the law); Article 24 (child's rights including to registration at birth, and nationality); Article 26 (equality before the law).

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Ireland is a signatory, and since 1989 a State Party[71] to the ICESCR. As Ireland has ratified the Covenant, it can be held accountable for failures to realise the rights contained therein before international human rights fora and courts.

A number of Covenant Rights are relevant to this review: Article 7 (just and favourable conditions of work); Article 10 (rights of mothers during pregnancy and birth); Article 11 (adequate standard of living); Article 12 (right to health); Article 13 (right to education); and Article 15 (right to participate in cultural life).

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Ireland is a signatory, and since 1985 a State Party[72] to the CEDAW. As Ireland has ratified the Convention, it can be held accountable for failures to realise the rights contained therein before international human rights fora and courts.

[70] Having ratified the ICCPR.
[71] Having ratified the ICESCR.
[72] Having ratified the CEDAW.

A number of CEDAW rights are relevant to this review: Articles 1, 2, 7, 8, 9, 10, 11, 12 and 13. Other CEDAW rights of significance include: Article 16 (prohibition on discrimination against women); Article 3 (full advancement of women); Article 5 (elimination of prejudice; common responsibility of men and women in the upbringing and development of their children); Article 6 (prohibition on trafficking of women); and Article 14 (rights of rural women).

Enforced/Involuntary Disappearance

Laws prohibiting enforced/involuntary disappearance form part of both customary international humanitarian law,[73] and the UN framework of international human rights law.[74] When part of a widespread or systemic programme, enforced disappearance is a crime against humanity.[75]

Article 2 of the UN's 2006 International Convention for the Protection of All Persons from Enforced Disappearance states:

> For the purposes of this Convention, "enforced disappearance" is considered to be the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons or groups of persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law.[76]

Amnesty international states:

> [T]he human story is simple: People literally disappear, from their loved ones and their community, when state officials (or someone acting with state consent) grab them from the street or from their homes and then deny it, or refuse to say where they are. It is a crime under international law.[77]

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[73] See Rule 98 "Enforced Disappearance", in the *International Committee of the Red Cross, Customary International Humanitarian Law: Rules* (Cambridge 2005).

[74] The International Convention for the Protection of All Persons from Enforced Disappearance (ICPPED) (2005) http://www.ohchr.org/EN/HRBodies/CED/Pages/ConventionCED.aspx.

[75] Rome Statute of the International Criminal Court (1998), Article 7(1)(i) http://legal.un.org/icc/statute/99_corr/cstatute.htm. It is to be noted that Ireland is a State Party to the Rome Statute, having ratified the instrument in 2002.

[76] http://www.ohchr.org/EN/HRBodies/CED/Pages/ConventionCED.aspx.

[77] https://www.amnesty.org/en/what-we-do/disappearances/.

The crime of systemic enforced disappearance has its roots in the Nazi regime in Germany during the 1940s, and re-emerged into the public consciousness during the era of dictatorships in South American States during the 1960 to 1980s,[78] in international and national wars, and in other repressive regimes throughout the latter half of the 20th century. Enforced disappearances were first codified as a crime in international human rights law in the Vienna Declaration and Programme of Action in 1993,[79] and then again in the Rome Statute in 1998.

Enforced disappearances, involving coercive detaining of individuals or groups, is a legally complex phenomena involving a possible multitude of distinct human rights violations, including the right to security and personal dignity; not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment; to humane conditions of detention; to legal representation; to a fair trial; to a family life; and even the right to life, when the abducted person is killed.[80] Enforced disappearances and the prohibition thereof are therefore an integral legal mechanism for preventing and holding to account breaches of a State's obligations under the ICCPR and the ICESCR. The UN's Human Rights Committee, the principal treaty body tasked with overseeing the implementation and adherence to the ICCPR, has noted that enforced disappearances can violate Article 6 (right to life), Article 7 (prohibition on "torture or other cruel, inhuman or degrading treatment or punishment"), Article 9 (liberty and security), and Article 10 (inherent human dignity) of the Convention.[81]

The 2006 Convention, to which Ireland is a signatory, sets out detailed obligations on States to investigate alleged disappearances, and make appropriate accountability mechanisms (criminal and civil) a part of the domestic legal order.

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[78] Vitkauskaitė-Meurice and Žilinskas, "The Concept of Enforced Disappearances in International Law" (2010) 2 *Jurisprudence* 197, 198.

[79] Principle 62 states:

> The World Conference on Human Rights, welcoming the adoption by the General Assembly of the Declaration on the Protection of All Persons from Enforced Disappearance, calls upon all States to take effective legislative, administrative, judicial or other measures to prevent, terminate and punish acts of enforced disappearance. The World Conference on Human Rights reaffirms that it is the duty of all States, under any circumstances, to make investigations whenever there is reason to believe that an enforced disappearance has taken place on a territory under their jurisdiction and, if allegations are confirmed, to prosecute its perpetrators.

See http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx.

[80] Boot and Hall, "Crimes against Humanity", in Triffterer (ed), *Commentary on the Rome Statute of the International Criminal Court: Observer's Notes, Article by Article* (2nd ed, Bloomsbury 2008).

[81] See Communication No. 950/2000, *Sarma v Sri Lanka*, Views adopted on 16 July 2003.

The UN's Human Rights Council (formerly the UN Commission on Human Rights) has, since 1980, established a Working Group on Enforced or Involuntary Disappearance, one of the primary tasks of which "is to assist families in determining the fate or whereabouts of their family members who are reportedly disappeared."[82] The Working Group also monitors State compliance with the UN's 1992 Declaration on the Protection of all Persons from Enforced Disappearances.

The Working Group's General Comment on the Right to the Truth in Relation to Enforced Disappearances states that the "right to truth" is now "an autonomous right at the international level, and through State practice at the national level",[83] having been previously recognised by the Working Group in its first report.[84]

The Working Group's General Comment also echoes Principle 2 of the *Set of Principles for the Protection and Promotion of Human Rights through Action to Combat Impunity*[85] in emphasising the preventive and educative function of the right to truth: by learning of and understanding past atrocities, States and societies can prepare to avoid their re-occurrence.[86]

In the same General Comment the Working Group stated, applying Article 13 of the 1992 Declaration, that the duty to continue an investigation is not time-limited, as the nature of enforced disappearance is also continuing. It emphasises:

> the right of the relatives to know the truth of the fate and whereabouts of the disappeared persons is an absolute right, not subject to any limitation or derogation … This absolute character also results from the fact that the enforced disappearance causes "anguish and sorrow" (5th preambular paragraph of the Declaration) to the family, a suffering that reaches the threshold of torture, as it also results from article 1§2 of the same Declaration that provides: 'Any act of enforced disappearance (...) constitutes a violation of the rules of international law guaranteeing, (...) the right not

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[82] http://www.ohchr.org/EN/Issues/Disappearances/Pages/DisappearancesIndex.aspx.

[83] The Working Group further state:

> The existence of the right to the truth in international law is accepted by State practice consisting in both jurisprudential precedent and by the establishment of various truth seeking mechanisms in the period following serious human rights crises, dictatorships or armed conflicts.

See http://www.ohchr.org/Documents/Issues/Disappearances/GC-right_to_the_truth.pdf. See also *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraph 21.

[84] E/CN.4/1435, 22 January 1981, § 187.

[85] "The inalienable right to truth" https://documents-dds-ny.un.org/doc/UNDOC/GEN/G05/109/00/PDF/G0510900.pdf?OpenElement E/CN.4/2005/102/Add.1.

[86] "General Comment on the Right to the Truth in Relation to Enforced Disappearances" http://www.ohchr.org/Documents/Issues/Disappearances/GC-right_to_the_truth.pdf.

> to be subjected to torture and other cruel, inhuman or degrading treatment or punishment.[87]

On paragraph 6 of the General Comment, the Working Group deals with the question of DNA testing within the obligations of the State under the UN Declaration:

> The remains of the person should be clearly and indisputably identified, including through DNA analysis. The State, or any other authority, should not undertake the process of identification of the remains, and should not dispose of those remains, without the full participation of the family and without fully informing the general public of such measures. States ought to take the necessary steps to use forensic expertise and scientific methods of identification to the maximum of its available resources, including through international assistance and cooperation.

Paragraph 7 of the General Comment states:

> The right to know the truth about the fate and the whereabouts also applies to the cases of children who were born during their mothers' enforced disappearances, and who were thereafter illegally adopted. Article 20 of the Declaration provides that such acts of abduction, as well as the act of altering or suppressing documents attesting to their true identity, shall constitute an extremely serious offence, which shall be punished as such.

While this relates to situations of enforced and/or involuntary disappearances, arguably the mothers and children interred at the site at Tuam could be regarded as the victims of enforced disappearances and the principles set out above may be applicable.

The Right to Know/Right to Truth

Originally part of international humanitarian law[88],[89] and later the international legal developments in the area of enforced/involuntary disappearance (emerging from the jurisprudence on the American Convention on Human Rights[90]), the right to know has evolved to include instances of "gross" or "systemic" human right abuses[91] outside of

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[87] Ibid., para 4.
[88] Laws of war.
[89] *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraph 5.
[90] Ibid., at paragraph 8; Case 10.488, *Ignacio Ellacuría et al v El Salvador* Report No 136/99 (1999).
[91] Both Article 5 of the International Convention for the Protection of All Persons from Enforced Disappearance, and the commentary on the Principle to combat impunity suggests that 'massive or systematic violations' is as defined in current international law (United Nations Commission on Human Rights, *Report of the Independent Expert to Update the Set of Principles to Combat Impunity*, 18 February 2005, E/CN.4/2005/102, para 20).

wartime,[92] culminating in formal codification in Article 24(2) of the International Convention for the Protection of All Persons from Enforced Disappearance.[93] Various states and national courts have also recognised the right to truth, either as an implied component of their domestic law in the aftermath of gross or systemic human rights abuses, or as part of international human rights law.[94] For example, the Courts of Argentina have found that in cases of enforced disappearances the right to the truth is based on the right to mourning (*derecho al duelo*[95]), and also to add to the State's systemic capacity to prevent future re-occurrence.

The 2006 Convention on Enforced Disappearance grants each victim "the right to know the truth regarding the circumstances of the enforced disappearance, the progress and results of the investigation and the fate of the disappeared person. Each State Party must take appropriate measures in this regard." "Victim" in this area of law, also covers the family of the victims, their representatives, and often includes the society or community at large.[96] The 2006 Convention codifies what is already implied in many international human rights instruments to which Ireland is a party.

The right of victims to know is also to be found in the 2006 Basic Principles,[97] with Principles 24 holding:

> [V]ictims and their representatives should be entitled to seek and obtain information on the causes leading to their victimisation and on the causes and conditions pertaining to the gross violations of international human rights law and serious violations of international humanitarian law and to learn the truth in regard to these violations.

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[92] *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraph 8.

[93] Ireland has signed, but has yet to ratify the International Convention for the Protection of All Persons from Enforced Disappearance.

[94] *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraphs 21 and 23.

[95] See Agreement of 1 September 2003 of the National Chamber for Federal Criminal and Correctional Matters, Case ***Suárez Mason***, Rol 450 and Case ***Escuela Mecánica de la Armada***, Rol 761.

[96] Article 24(1) of the International Convention for the Protection of All Persons from Enforced Disappearance defines "victim" as "the disappeared person and any individual who has suffered harm as the direct result of an enforced disappearance."

[97] The Basic Principles - *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*. Adopted and proclaimed by General Assembly resolution 60/147 of 16 December 2005.

Klinker states the position as follows:

> At its core ... a positive action is required by the state to undertake continued and systematic efforts to investigate the abuses and to gather the evidence in an attempt to answer questions about what happened, why it happened, to identify those responsible, directly and indirectly, and understand the patterns of abuse.[98]

The UN's Commission on Human Rights' (since 2006 the UN Human Rights Council) *Report of the Independent Expert to Update the Set of Principles to Combat Impunity* sets out significant detail on the right to know: containing 17 distinct Principles.[99] These include: "the inalienable right to truth" (Principle 2); "the duty to preserve memory" (Principle 3); "the victim's right to know" (Principle 4). Similar to other literatures on the right to know in the context of abuses of international human rights,[100] these Principles emphasise the central role of commissions of investigation and truth commissions in achieving the right to know (Principles 6-13), along with detailed obligations on states to preserve evidence and archives (Principles 14-18). This approach to the right to truth highlights its value in avoiding future reoccurrence of the same human rights abuses, by holding perpetrators to account and challenging impunity in human rights violations.

The UN High Commissioner for Human Rights' 2006 wide-ranging *Study on the right to truth* found that the right is part of the State's broader duty to protect and guarantee human rights.[101]

Birth and Death Registration and International Human Rights

Birth Registrations

The UN High Commissioner for Human Rights, in a 2014 report to the UN Human Rights Council entitled *Birth Registration and the Right of Everyone to Recognition Everywhere as a Person Before the Law*, emphasised the right to a birth registration is a fundamental human

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[98] Klinker, "Towards Mass Grave Protection Guidelines" (2017) 3(1) *Human Remains and Violence* 52, 57.
[99] Report of Diane Orentlicher, independent expert to update the set of principles to combat impunity - Updated Set of principles for the protection and promotion of human rights through action to combat impunity (February 2005) https://documents-dds-ny.un.org/doc/UNDOC/GEN/G05/109/00/PDF/G0510900.pdf?OpenElement.
[100] *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraph 13-15.
[101] *Study on the right to the truth - Report of the Office of the United Nations High Commissioner for Human Rights* (E/CN.4/2006/91), paragraph 45.

right.[102] The report notes how the right is recognised in Article 24 of the ICCPR, as well as Article 7 of the Convention on the Rights of the Child. It argues that the right to birth registration is instrumentally beneficial/essential to the realisation of other fundamental human rights in the civil and socio-economic domains. The report states as follows:

> Birth registration is the continuous, permanent and universal recording within the civil registry of the occurrence and characteristics of birth, in accordance with the national legal requirements. It establishes the existence of a person under law, and lays the foundation for safeguarding civil, political, economic, social and cultural rights. As such, it is a fundamental means of protecting the human rights of the individual.[103]

There does not appear to be an express right to a birth certificate under the right to birth registration, though Gerber *et al*, writing on the experience of indigenous Australians, argue that such a right is implicit in the right to birth registration given its similarly central role in realising other civil, political and socio-economic rights.[104]

Death Registrations

There does not appear to be an equivalent right of families to death registration, though it may be implicit within the broader array of family rights under international humanitarian and human rights law discussed above. Drawing on numerous rights guaranteeing state recognition and registration of major life events[105] in conventions such as the ICCPR, Powell notes the fundamental relationship between human rights and the registration of "vital events" in general – which would include death.[106] He states:

> [T]he existence of such a right [to death registration] is implied in Article 12(2)(a) of the International Covenant on Economic, Social and Cultural Rights wherein it is stated that, to achieve the full realization of the right to health, the States Parties to the Covenant must make 'provision for the reduction . . . of infant mortality.' ... [T]he death register can provide the number of infant deaths (deaths under one year of age) – that is the basis for the measurement of infant mortality. Without this number, provided by a death register, and the number of live births from the register of births, it would not be feasible to compute the infant mortality rate over time and for various

[102] http://www.ohchr.org/EN/Issues/Children/BirthRegistration/Pages/ReportOnBirthRegistration.aspx.
[103] Ibid., at paragraph 4.
[104] Gerber, Gargett and Castan, "Does the Right to Birth Registration include the Right to a Birth Certificate?" (2011) 29(4) *Netherlands Quarterly of Human Rights* 434.
[105] See https://unstats.un.org/unsd/vitalstatkb/KnowledgebaseArticle50302.aspx.
[106] Nora Powell, *Human Rights and the Registration of Vital Events* (International Institute for Vital Registration and Statistics, March 1980) available at https://www.cdc.gov/nchs/data/isp/007_human_rights_and_registration_of_vital_events.pdf.

population groups. Hence, it would not be possible to monitor the trend of the rate and to plan for and assess its reduction.

4. CUSTOMARY INTERNATIONAL HUMANITARIAN LAW: TREATMENT OF THE DEAD AND THE RIGHT TO KNOW

Some of the strongest legal obligations on States with respect to treatment of human remains are based on customary international law, specifically the laws of war codified in the Geneva Conventions (1929 and 1949), of which Ireland is a signatory, and has ratified.

The main provisions, as set out in codified form in the International Committee of the Red Cross, are Rule 112 (Search for and collection of the dead); Rule 113 (Treatment of the Dead); Rule 115 (Disposal of the Dead); and Rule 116 (Accounting for the Dead).

The International Committee of the Red Cross (ICRC) has also concluded that the right to truth in relation to the treatment of war dead is a norm of customary international law applicable in both international and non-international armed conflict, according to which "each party to the conflict must take all feasible measures to account for persons reported missing as a result of armed conflict and must provide their family members with any information it has on their fate".[107] The Secretary General of the UN has also recognised the right to truth as being a customary norm of international humanitarian law.[108]

Applying Article 130 of the Fourth Geneva Convention ("honourably buried, if possible according to the rites of the religion to which they belonged, and that their graves are respected, properly maintained, and marked in such a way that they can always be recognized") in 2002,[109] the Israeli High Court upheld "that burial of the deceased must be

[107] Rule 117 in ICRC, *Customary International Humanitarian Law, Volume I, Rules*, (Cambridge 2005), 421. See also, *Practice Relating to Rule 117. Accounting for Missing Persons*, Section D. Right of the families to know the fate of their relatives https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_rul_rule117_section.

[108] Secretary General's bulletin, "Observance by United Nations Forces of international humanitarian law" (ST/SGB/1999/13).

[109] *Jenin (Mortal Remains) Case* [2002], Israel, High Court of Justice.

performed with respect, in a timely manner and according to religious custom, and if possible, the remains must be returned to the families of the deceased."[110]

Israeli courts have applied these customary international law norms on a number of occasions, emphasising the centrality of human dignity to such legal norms, even after death:

> Human dignity is not only a matter for the period of the life of the individual, but also relates to the time after the person passes away ... This fundamental value also includes respect for the dead, respect for the family of the deceased, and even respect for the public.[111]

Former President of the Supreme Court of Israel similarly found:

> Human dignity is not limited to the dignity of a living person. It also refers to dignity after death, and the dignity of his loved ones who preserve his memory in their hearts. This dignity is expressed, in part, by placing the gravestone, visiting the cemetery on memorial days and public ceremonies, and caring for the gravesite. This is the same relationship – at times rational and at times irrational – between the living and the dead, which develops the human being within us, and which gives expression to the yearnings of the soul. This is the 'hand' that the living extend to the dead. This is the external expression that reflects the internal relationship between the generations.[112]

In drawing on the foundational moral norm of human dignity, even in death, these international human rights law-based judgments echo core principles of the UDHR. Rosenblatt similarly finds human dignity, and its central status within the UDHR, as the core normative basis of his elucidation of the "human rights of the dead".[113]

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[110] "Special Focus: Holding the Bodies of Deceased Palestinians by Israel" http://www.alhaq.org/component/content/article/85-field-updates-201...pecial-focus-holding-the-bodies-of-deceased-palestinians-by-israel (visited 18 February 2018).

[111] Justice Menachem Alon, Civ App 506/88, *Yael Sheffer v State of Israel, Piskei Din* 38(1) 87, 102, 103.

[112] Iv App 294/91, *Hevra Kadisha v Kastenbaum, Piskei Din* 46(2) 464, 523.

[113] Rosenblatt, "International Forensic Investigations and the Human Rights of the Dead" (2010) 32(4) Human Rights Quarterly 921.

Mass Graves

Within the broader literature around treatment of the dead, and the distinct legal sphere of Forced/Involuntary Disappeared Persons (see above), there is an increasing concern over the legal status of mass graves in international law. More specifically, there are calls for discrete protections for mass graves, in the form of State obligations to preserve and protect such sites, in order to both realise traditional customary international human rights obligations of States with respect to war dead, but also to preserve evidence for possible future prosecution of individuals under domestic or international criminal law.

While there is no legal definition of 'mass grave', Klinker and Kather describe such sites as "a site containing a multitude of human remains; a site of harrowing human loss, suffering and unimaginable acts of cruelty."[114] Those authors also suggest that legal protection for mass graves is essential for the "realisation of the right to truth, effective remedies and reparation for families of the deceased", as required under the UN's *Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*[115] ('Basic Principles'), adding that such protections would "contribute to ensuring transparency, and ending impunity."

Genocide

It has been suggested that, given the scale of the Tuam site and the likelihood that there were common social and religious characteristics between the deceased, issues relating to the crime of genocide may arise. As a matter of law, however, it seems highly unlikely that criminal proceedings for genocide could be brought in respect of the Tuam site. Leaving aside the question of whether there may or may not be evidence which would establish a factual basis for a charge of genocide, there would be significant legal obstacles to such a charge.

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[114] Klinker and Kather, "The Legal Protection of Mass Graves", *Blog of the European Journal of International Law* https://www.ejiltalk.org/the-legal-protection-of-mass-graves/ (visited 17 February 2018).

[115] Adopted and Proclaimed by General Assembly Resolution 60/147 of 16 December 2005 http://www.ohchr.org/EN/ProfessionalInterest/Pages/RemedyAndReparation.aspx.

Section 2 (1) of the Genocide Act 1973 establishes the crime of genocide in Irish law. The definition of genocide is that provided by Article II of the 1948 Convention on the Prevention and Punishment of the Crime of Genocide:

> In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:
> (a) Killing members of the group;
> (b) Causing serious bodily or mental harm to members of the group;
> (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
> (d) Imposing measures intended to prevent births within the group;
> (e) Forcibly transferring children of the group to another group.

The definition makes clear that there are a number of elements which must be established before genocide legally arises. In particular, it should be emphasised that the fact that there has been mass murder or abuse of a large group of persons does not constitute genocide.

First of all, one of the acts identified in subsection (a) to (e) must have occurred.

Secondly, that act must have been carried out with the intention of destroying a group. In other words, the purpose of the acts must have been to destroy a particular group. It should be noted that the intention need not be to destroy the whole group. It is sufficient if the intention is to destroy part of a group, although it has generally been accepted that it must be a substantial part of the protected group.[116]

Thirdly, the group against whom the acts are directed must fall within one of the four categories identified by the Convention: a national, ethnic, racial or religious group. Membership of a social or economic group does not come within the definition.

It is also important to note that these requirements are rigorously applied. The International Criminal Tribunal for the former Yugoslavia reiterated that:

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[116] International Law Commission: "[T]he crime of genocide by its very nature requires the intention to destroy at least a substantial part of a particular group". See also the ICTY Chamber decision in *Prosecutor v Jelisic* (Case no IT-95–10-T) (Trial Chamber judgment, 14 December 1999) that "Given the goal of the Convention to deal with mass crimes, it is widely acknowledged that the intention to destroy must target at least a substantial part of the group".

> The gravity of genocide is reflected in the stringent requirements which must be satisfied before this conviction is imposed. These requirements—the demanding proof of specific intent and the showing that the group was targeted for destruction in its entirety or in substantial part—guard against a danger that convictions for this crime will be imposed lightly.[117]

Given this strict approach, there is a significant doubt that a court would regard the acts in Tuam (if proven) as coming within the remainder of the definition. The ICJ observed in *Application of the Convention on the Prevention and Punishment of the Crime of Genocide (Bosnia and Herzegovina v Serbia and Montenegro)* that:

> [G]enocide requires a positive identification of the group. The rejection of proposals to include within the Convention political groups and cultural genocide also demonstrates that the drafters were giving close attention to the positive identification of groups with specific distinguishing well-established, some said immutable, characteristics.[118]

Whether a particular group comes within one of the aforementioned four categories is to be assessed on a case-by-case basis.[119] Both the objective characteristics of the group and the subjective view of the alleged perpetrators and group members are relevant. However, while it is likely the deceased at the former Mother and Baby Home in Tuam may have some of the protected characteristics in common (such as religion), this would not be sufficient to demonstrate that they were seen as a targeted religious group by either group members or alleged perpetrators, or that this characteristic (i.e., that the deceased were Catholic) was the purpose for the targeting of the deceased. This would also mean that the necessary intention to target and destroy the protected group was lacking.

Furthermore, while it might be argued that these criteria could be given a different and more expansive interpretation in the modern era, any application of those criteria to the events at Tuam would likely constitute retrospective penal conduct. This is prohibited by Article 15.5.1° of the Constitution and by Article 7 of the ECHR. There is an exception to the principle under Article 7 for conduct which was recognised as criminal under the general principles of the law. However, an attempt to prosecute persons under a more expansive

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[117] *Prosecutor v Krstic*, (Case no IT-98–33-A) (ICTY Appeals Chamber judgment, 19 April 2004).
[118] [2007] ICJ Rep 43.
[119] *Prosecutor v Rutaganda* (Case no ICTR-96–3-T) (Trial Chamber of the International Tribunal for Rwanda, 6 December 1999).

definition of genocide for acts committed in 1953 was found by a majority of the Grand Chamber to violate Article 7 ECHR in *Vasiliauskas v Lithuania.*[120]

Status of International Obligations

It is important to bear in mind that the obligations imposed on the State by international agreements occur and are enforceable, if at all, under international law only. Article 29.6 of the Constitution provides that:

> No international agreement shall be part of the domestic law of the State save as may be determined by the Oireachtas.

The Supreme Court explained in *McD v L*[121] that this means that:

> The obligations undertaken by a government which has ratified the Convention arise under international law and not national law. Accordingly those obligations reside at international level and in principle the state is not answerable before the national courts for a breach of an obligation under the Convention unless express provision is duly made in national legislation for such liability.[122]

This means that even if it could be factually established that a breach of obligations under these international agreements has occurred in Tuam, this would not provide a right of action under Irish law or before an Irish court in respect of that breach.

Summary

The international human rights norms may not be directly relevant to this review, as Ireland has been quite slow to ratify the relevant instruments. The older humanitarian law is also not directly legally applicable, as they are legal norms that are active only when death occurred in, and as a result of, wartime atrocities, although the jurisprudence on dignity and State custom and practice may shed light on the requirement of the Irish constitution in this regard discussed later in this report.

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[120] Application no. 35343/05 (October 20, 2015).
[121] [2010] 2 IR 199.
[122] At p. 247.

Much of the material included in these last two sections are either human rights in times of war (customary international humanitarian rights), or instances of 'gross' or 'systemic' violations of human rights (under the various human rights frameworks of the United Nations). It is therefore subject to a number of qualifications.

Firstly, the UDHR is generally regarded as not legally binding.

The two International Covenants (the ICCPR and ICESCR) were not in existence until 1966, and Ireland did not ratify both until 1989. Ratification is key to legal effect in a particular jurisdiction. It is not clear therefore that there were any legally recognisable breaches of human rights in the 1920 to 1960 period. Moreover, it is not clear whether the right to know – which seems to be the legally strongest right – can be based on breaches of human rights before the state ratified the relevant instruments (as it cannot be stated at the time they were breaches).

In summary, if it was not a breach at the time, it is difficult to legally determine it so retrospectively. Therefore, there may be very limited grounds for the right to know which is parasitic upon the basic rights in the UN Charter (the conceptual instrument combining the UN Declaration and both Covenants together).

If inhuman or degrading treatment and violations of privacy can be characterised as continuing, it may constitute a violation of the UNCAT, ICCPR or CEDAW.

The most relevant jurisprudence on this matter relates to Enforced Disappearance. This is the most fruitful area of international human rights law to review, as it has an express right to truth/right of victims and their families to know. It is also closely tied to the ICCPR which, as stated above, Ireland ratified in 1989. It seems there may not be a requirement that the ICCPR was ratified by the member state when the 'disappearances' took place. There are interesting parallels between the experience in South America, where much of this law emerged, and the experience of the institutional abuse of women and children in settings such as the mother and baby homes. It should be noted, however, that Ireland has not ratified the International Convention for the Protection of All Persons from Enforced Disappearance, although it codifies what is already implied in many international human rights instruments to which Ireland is a party.

5. THE IRISH CONSTITUTION

In addressing the issues to be considered in this report, regard must be had to the rights and obligations arising under the Constitution of Ireland as well as the European Convention on Human Rights. While the Constitution is the superior legal instrument in domestic law, the Convention and case law of the European Court of Human Rights form part of Irish law at a sub-constitutional level in the European Convention on Human Rights Act 2003. Both the Constitution and Convention are therefore relevant to this report.

As can be seen throughout the jurisprudence of the ECtHR (discussed in section 2 of this report), the rights that have been held to exist concerning the circumstances of a relative's death and burial stem from Article 8 of the European Convention on Human Rights (ECHR) concerning privacy and the family. The duty upon States to investigate deaths arises so as to vindicate the right to life protected in Article 2 ECHR. In addition, the provision of information to relatives of the 'disappeared' is a matter engaging Article 3 of the ECHR. Irish authorities are required to carry out their functions in a manner compatible with the Convention. The State is also obliged to ensure that it does not violate any Constitutional provisions or rights of its citizens in performing its duties.

The Constitution of Ireland, within Articles 40 to 44, contains the list of fundamental rights to which all citizens of Ireland are entitled. The right to life, the family and children's rights are all protected explicitly therein. In addition to those rights which are expressly protected, the Courts have recognised that certain other rights are protected by the Constitution, and these are known as unenumerated rights.[123] Furthermore, the right to privacy has been inferred by the Supreme Court as also deserving of protection under the Constitution. Article 40.3 provides:

> The state guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.
>
> The state shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.

[123] *Ryan v AG* [1965] IR 294.

Pursuant to Article 41.1.1°, the state recognises the family as the natural primary and fundamental unit group of society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law. The Supreme Court reiterated in *HAH v SAA and ors*[124] and *M (Immigration-Rights of Unborn) v Minister for Justice and Equality & ors*[125] in the last 12 months that the family remains the married family for Article 41 purposes. While there is some indication in *M* that the Supreme Court might revisit this issue, I do not believe that Article 41 would apply to the issues engaged by this report.

Article 42A.1 recognises and affirms the natural and imprescriptible rights of all children. This requires that the State shall, as far as practicable, by its laws protect and vindicate those rights. A question arises as to whether this provision applies retrospectively and whether the deceased the subject of this report constitute children within the meaning of Article 42A. The above recent Supreme Court judgment in *M* does not appear to support Article 42A applying retrospectively in the present context.

A centrally important concept in the Irish Constitution is the dignity of the individual. The Irish Constitution is the oldest subsisting constitution to specifically refer to dignity. It provides in its preamble:

> We, the people of Éire … seeking to promote the common good, with due observance of Prudence, Justice and Charity, so that the dignity and freedom of the individual may be assured … [d]o hereby adopt, enact and give to ourselves this Constitution.

This makes it clear that one of the primary goals towards which the enactment of the Irish Constitution is directed is "… the assurance of the dignity of the individual." The Irish courts, in their interpretation of the various provisions of the Constitution, are obliged to interpret this concept harmoniously with the content of the Preamble and in particular, the aim of assuring the dignity of all individuals. The concept of dignity, however, has not yet been fully developed in Irish Constitutional case law. It is important to consider the role of dignity in any consideration of the constitutional rights that may be raised within the decision to be taken at Tuam. Undeniably, an argument can be made that those interred in Tuam did not have their right to dignity upheld in the circumstances of their burial.

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[124] [2017] IESC 40.
[125] [2018] IESC 14.

For present purposes the case of *Fleming v Ireland and ors*[126] is of particular relevance as it is the most significant recent Supreme Court ruling where the claim was based on the right to dignity as well as the rights to autonomy and self-determination. The Supreme Court acknowledged that dignity was a core constitutional value, and that its application in particular circumstances would depend on a concrete analysis of the particular facts in question. The Court observed:

> It is undoubted that the Constitution recognises and respects th[e] general values [of autonomy, self-determination and dignity] in the rights protected by it. It does not follow, and it is not claimed, however, that every law which impinges on the life of individuals is even *prima facie* inconsistent with the Constitution. Whether therefore values of autonomy, self-determination and dignity, as they find expression in the rights guaranteed by the Constitution, provide constitutional protection for the performance of specific acts depends on a concrete analysis of the impact of any law which is impugned in a particular case on the life of the individual, and a careful consideration of the provisions of the Constitution and the values it protects in the rights it guarantees.[127]

Ultimately, the Court concluded in *Fleming* that dignity did not provide support for the existence of a constitutional right to be assisted in suicide, noting:

> Thus, insofar as the Constitution, in the rights it guarantees, embodies the values of autonomy and dignity and more importantly the rights in which they find expression, it does not extend to a right of assisted suicide. Accordingly the court concludes that there is no constitutional right which the State, including the courts, must protect and vindicate, either to commit suicide, or to arrange for the termination of one's life at a time of one's choosing.[128]

It is clear, therefore, that dignity, whether framed as a constitutional right or as a constitutional value, does not provide support for a right to have death accelerated. That said, it is clear that dignity is highly relevant to the experience of death and dying.

In the earlier case of *Re a Ward of Court*[129] the Supreme Court considered the withdrawal of treatment from a woman who had been in an almost persistent vegetative state for 20 years. In finding that it was lawful for treatment to be withdrawn the Supreme Court found that the woman had a right to die a natural death, and for a majority of the Court this right was

[126] [2013] IESC 19.
[127] [2013] IESC 19 at para. 110.
[128] [2013] IESC 19 at para. 114.
[129] [1996] 2 IR 79.

founded, in part, on the right to dignity. Denham J found that dignity was a right protected by the Constitution, and that the woman had a right to dignity in life and death. This right supported the Court in making an order allowing treatment be withdrawn. Therefore, the woman was allowed to die naturally in the care of her family. The right to dignity in life and in death is potentially of significance in the context of the Tuam Mother and Baby Home. While the circumstances of the deaths are unknown, the conditions of burial suggest that there may have been an absence of dignity in the manner that the bodies were treated after death.

Subsequent case law has confirmed that as well as protecting the rights of living family members of the deceased, the Constitution may protect certain rights of deceased persons, and in particular the right to dignity. A relevant and instructive case is *PP v HSE.*[130] This case concerned a pregnant woman who had been diagnosed as clinically dead, while the foetus still had a heartbeat. The question before the court was whether life support could be withdrawn in such circumstances. It was suggested that the woman's rights were not engaged due to her having passed away. The High Court rejected this suggestion and commented:

> This does not mean that the Court discounts or disregards the mother's right to retain in death her dignity with proper respect for her autonomy with due regard to the grief and sorrow of her loved ones and their wishes. Such an approach has been the hallmark of civilised societies from the dawn of time. It is a deeply ingrained part of our humanity and may be seen as necessary both for those who have died and also for the sake of those who remain living and who must go on. The Court therefore is unimpressed with any suggestion that considerations of the dignity of the mother are not engaged once she has passed away.[131]

This passage confirms the importance of dignity under the Constitution and, in particular, the importance attached to the circumstances associated with a person's death. Clearly, this is of potential significance in the Tuam context. It raises the question as to whether there was a failure to take account of considerations of the dignity of the deceased children in the circumstances of their burial; and whether, if so, this would give rise to a breach of the Constitution? Applying the reasoning of the cited passage in *PP v HSE,* there is an argument that constitutional considerations of dignity may have continued to be engaged after the

[130] [2014] IEHC 622.

[131] What the decision records is "her right to retain her dignity in death" was outweighed by the interests of the unborn. The case focused on allowing her to die with dignity (which makes it very similar to the *Ward of Court* case).

deceased children had passed away. If that is the case, the questions then raised include how, to what acts and for what period of time, those considerations continued to apply. As the decision in *Fleming* indicates, there may also be a distinct question as to whether – assuming considerations of dignity did apply to the burial and may continue to apply thereafter – the circumstances give rise to an enforceable constitutional right or claim, whether on the part of the deceased or of other persons.

On this last question, Irish law recognises a cause of action for breach of constitutional rights, insofar as the right breached is not vindicated by other legal mechanisms.[132] Importantly, where a person is incapable of asserting a right on his/her own behalf, the Irish courts have recognised that the right can be asserted by another appropriate person.[133] As such, if this is a breach of constitutional rights and is not addressed by the law of torts (discussed below), a question arises as to whether there could potentially be an action in respect of a breach of constitutional rights, which would be actionable at the suit of the families of the deceased, or appropriate other parties, on behalf of the deceased.

While the decision of the Supreme Court in *Fleming* confirms that the values of autonomy and dignity are not absolute, the analysis in *Ward of Court* indicates that the right to life and the related constitutional commitment to dignity extend to the manner and process of dying. Moreover, the High Court decision in *PP v HSE* suggests that considerations of dignity may be capable of applying after the point of death.

The capacity of rights to be asserted on the part of the deceased could be a challenge in an Irish context. The recent Article 40.3.3° Supreme Court decision in *M* places considerable emphasis on the inability of the unborn to invoke constitutional rights because it has not been born and is therefore not a rights-holder. The corollary of the concept of rights-holder that emerges in that judgment (and that is consistent with some judicial decisions in recent cases about whether non-citizens are necessarily rights-holders) might be that the deceased are not rights-holders for constitutional purposes. This would probably place the deceased in a position of being entitled to respect, but not to have specific rights under the Constitution invoked on their behalf.

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[132] ***Meskell v Córas Iompair Éireann*** [1973] IR 121, *Hanrahan v Merck Sharpe and Dohme (Ireland) Ltd.* [1988] ILRM 629.

[133] *SPUC v Coogan (No.1)* [1989] 1 IR 734. The Society for the Protection of Unborn Life was entitled to litigate to protect the right to life of the unborn.

The rights that could be invoked to challenge any prosecutions brought include the right to a trial within a reasonable time. The courts may be reluctant to require the State to take steps if those steps are unlikely to produce any practical benefit.

The report of the Expert Technical Group also raises significant practical concerns about the results that would be obtained from any exhumation or retrieval. The obligations imposed on the State by the Constitution are to defend and vindicate the personal rights of the citizen "as far as practicable". The decision in *PP v HSE* highlights the important point in this context that the Constitution does not require the taking of steps to promote or vindicate a constitutional value (in that case the right to life of the unborn) if those steps will not produce any practical benefit. This suggests that the views expressed in the expert report should be given weight in considering the steps to be taken in this matter.

It also should be stated that there may be a countervailing dignity interest in disturbing the burial site. That could also be a factor that a court would weigh in assessing the practical benefits of exhumation. If there are countervailing constitutional considerations which may incline against exhumation, the fact that exhumation may not produce any practical benefits may weaken any claim that it is constitutionally required.

Finally, there is a general judicial reluctance to litigate matters after several decades, even though attitudes may have changed to the practices in question. On a practical level, a major problem for a claimant in any litigation could be the apparent indication that these deaths were registered. This makes it much more difficult to argue that there was a lack of knowledge or concealment. There might be a separate issue about the circumstances of the burials although this might run into factual problems if the indication was that it was known in the local area about the burials.

6. STATUTE LAW

The law governing death and dead bodies is primarily a matter of common law rather than statute. However, the requirements concerning the registration of deaths have long been regulated by statute. At the relevant time this was governed by the Births and Deaths Registration Acts (Ireland) 1863–1994 and relevant regulations.[134] These provisions imposed a general duty to report deaths to the registrar. The legislation specified an order of priority of persons on whom that duty was imposed. It fell, in the first instance, on the relatives of the deceased and then on persons present at the death, and then the occupier of the house in which the death took place.[135] House was expressly defined under the Act to include a public institution such as a hospital, and occupier to include the governor, keeper, master, matron, superintendent or other chief resident officer of every public institution.[136]

The following would appear to be the situation in respect of the registration of the deaths at the former Mother and Baby Home in Tuam:

- The 796 juvenile human remains were identified by local historian Catherine Corless by accessing the records of the General Register Office (GRO). They are all registered deaths but there are no records of the burial location of these deceased children.

- The inter-departmental group report, published in 2014, includes some of the data provided to the group by the GRO. This contains a complete list of the 796 names, ages, dates of death, and cause of death provided by the GRO.

It may be the case therefore that all deaths which took place at the Tuam Mother and Baby Home were duly notified to the registrar. There is no doubt, in any event, that a clear statutory duty existed in respect of such notification. Auditing the obligation to register a death should be considered in the context of Tuam. This might be undertaken by matching the death certificates to the number of juvenile human remains.

[134] Registration of Births and Deaths (Ireland) Act 1863 (26 Vict., c.11); Births and Deaths Registration Act (Ireland) 1880 (43 & 44 Vict., c.13); Regulations for Registrars of Births and Deaths 1880; Regulations for Superintendent Registrars 1981; Vital Statistics and Births, Deaths and Marriages Registration Act 1952; Births, Deaths and Marriages Act 1972; Births, Deaths and Marriages Act 1987; The Stillbirths Registration Act, 1994. Registration of deaths is now governed by the Civil Registration Act 2004.
[135] Sections 10 to 15 of the Births and Deaths Registration Act (Ireland) 1880.
[136] Sections 38 of the Births and Deaths Registration Act (Ireland) 1880.

7. COMMON LAW

At common law, the body of law derived from judicial decisions rather than statute or constitutions, there has long since been recognition of the right to a decent burial, and of a range of rights and duties concerning dead bodies. The common law of England and Ireland was a unified body of law until 1922. After that, Irish common law diverged in various ways, although in certain respects the common law in each jurisdiction remained the same. Because of the nature of this topic, many of the key common law precedents date from before 1922, and thus the English cases can be taken as a strong indication of the common law in both England and Ireland. Precedents from other common law jurisdictions such as Australia, Canada and the United States, are also of assistance in stating what, precisely, the common law of Ireland is in this area, and what it was in the relevant period.

Burial of Bodies and the Wishes of the Deceased

The leading English case, upon which the common law in Australia, Canada and New Zealand is also based, is *Williams v Williams*.[137] In this decision, the deceased had instructed the executors of his will to give his body to his friend so that she could dispose of him in accordance with a private letter he had given her, and to reimburse her for the costs of his disposal. In the letter, he had asked that his body be cremated, however his wife instead buried him. The friend later exhumed his body and had it cremated. She sought reimbursement for her expenses but the executors refused. In rejecting her claim, the Court held that; "It is quite clearly the law of this country that there can be no property in the dead body of a human being". It necessarily follows from this that a person cannot leave binding instructions regarding the disposal of his or her body. Executors therefore do not own the body of the deceased which they are obliged to dispose of. They do, however, have a right to possess the body until it is properly buried.

On the issue of a person's funeral and burial instructions, different approaches can be discerned in the different common law jurisdictions.[138] Courts in the United States have established a common law right for a person to be disposed of in accordance with his/her

[137] (1882) 20 Ch D 659, 665.
[138] See Victoria Law Reform Commission, *Funeral and Burial Instructions: Consultation Paper*, 9 November 2015, Chapter 3: Funeral and burial instructions in the common law.

wishes. The deceased's funeral and burial instructions must be carried out unless there is a compelling reason not to do so. On the other hand, in England, Australia and Canada, a person with the right to dispose of a body may do so as he/she wishes, regardless of the deceased person's instructions.[139] New Zealand exhibits a more mixed approach, requiring the person with the right to dispose of the body to make an appropriate decision about the method and place of disposal after taking into account the deceased's wishes, the views of family members and the deceased's cultural or religious background.

The Entitlement to Possess a Body for the Purpose of Burial

It is generally accepted that a property right, in the usual sense, does not exist in a corpse. However, the common law does recognise a right of possession over the body for the purposes of burial,[140] an entitlement that is akin to a 'right to bury'. For the purpose of burial, persons such as the executors of the deceased's will, the surviving spouse or next of kin have the right to possess the corpse for the purposes of proper burial alone.

The Common Law Duty to Bury

Alongside the right to possess a body for the purposes of burial, the common law imposes duties in respect of burial. It appears that this duty to bury is a public duty, which attaches to various persons, depending on where the death occurs. In the case of *R v Stewart*,[141] the High Court of England and Wales considered the nature of the public duty to bury. The case concerned the body of a pauper who had died in a hospital in a parish. The hospital sought an order of mandamus[142] seeking to compel the overseers of the parish to remove the dead body and cause it to be buried. Lord Denman CJ commented:

> Every person dying in this country, and not within certain exclusions laid down by the ecclesiastical law, has a right to a Christian burial; and that implies the right to be carried from the place where his body lies to the parish cemetery.[143]

Importantly, the court went on to explore the nature of that burial, commenting:

[139] *In re JS* [2016] EWHC 2859.
[140] *Sharp v Lush* (1879) 10 CH D 468.
[141] (1840) 113 ER 1007.
[142] This is a public law remedy whereby the court makes an order against a state body to take a particular action.
[143] (1840) 113 ER 1007 at 1009.

> "That bodies should be carried in a state of naked exposure to the grave, would be a real offence to the living, as well as an apparent indignity to the dead."[144] We have no doubt, therefore, that the common law casts on someone the duty of carrying to the grave, decently covered, the dead body of any person dying in such a state of indigence as to leave no funds for that purpose.[145]

It is clear from this passage that the common law imposed a public duty to bury, and crucially, that duty was not simply a duty to put the body in a grave of some description. Rather, it incorporated an obligation to afford to the dead body decency and dignity in that burial. The Court went on to consider on whom that common law duty fell, and concluded that it fell on the individual "under whose roof a poor person dies." This person was under a common law duty to carry the body decently covered to the place of burial, and could not keep the body unburied or do anything which prevented burial.[146]

This foundational case illustrates that the duty to bury is a public duty, which arises from the circumstances of a particular death. It is different, to some extent, from the criminal law rules discussed below, because it could be enforced through public law proceedings to enforce the duty, as were in issue in the case of *R v Stewart.* It appears, however, that a failure to bury – i.e. a breach of the duty to bury - is also a misdemeanour at common law.[147] In essence, the duty is a single common law duty which can be enforced through a range of types of public law proceedings.

Based on these precedents, it seems that the operators of the Mother and Baby Home at Tuam may have been under a common law duty to bury those who died under their roof. This duty to bury incorporates a duty to bury decently and with dignity, in a Christian burial.[148]

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[144] These words were quoted from an earlier judgment: Lord Stowell in *Gilbert* v *Buzzard* (2 Hagg. Consist. Rep. 333 to 344).
[145] (1840) 113 ER 1007 at 1009.
[146] On the facts, the court decided that the duty to bury lay on the hospital, not the parish.
[147] *R v Vann* (1851) 169 ER 523.
[148] It is probably the case that the modern duty to bury is not solely one of Christian burial but rather about **burial reasonably appropriate to the deceased person's known values and religious practices.** At the relevant time, it seems that Christian burial would have been the appropriate entitlement.

The Special Duty of Parents to Bury a Child

The operators of the Mother and Baby Home at Tuam were likely under a further duty to bury arising from the fact that they were in *loco parentis* in respect of the children living in their care. In addition to the public duty to bury at common law there is a specific duty to bury imposed upon those who have a special relationship to the deceased. Spouses were one such category.[149] The common law also imposed a duty on parents to bury their children. The leading case on this point is *R v Vann,*[150] which concerned the question of whether a man who had not the means to bury his child was liable for a misdemeanour for leaving it unburied and allowing it to cause a public nuisance. The court found that there was a general duty on a parent to bury his/her child, but that the parent was not liable for a misdemeanour if he lacked the funds for the burial. Of special relevance to the Tuam circumstances are the Court's comments that while the parent lacking funds could not be indicted for mere non-burial the parent "cannot sell the body, put it into a hole, or throw it into the river."[151] The implication is that such actions would themselves constitute breaches of the duty to bury, and thus would be misdemeanours.

Similar to the general duty to bury, the specific duty to bury has been described by the courts as being "in the nature of a public duty."[152] The special duty of the parent to bury has been confirmed on a number of occasions by the courts,[153] and while the common law duty of a husband to bury his wife is now qualified by the fact that a married woman now has full, independent legal status,[154] children remain in a dependent position as regards their parents or guardians.

It would seem that in addition to the general common law duty to bury, the operators of the Tuam Mother and Baby Home would have been under a special duty arising from the nature of the protective relationship between the operators and the residents of the home. Where a child was concerned, this was in the nature of being *in loco parentis.* As such, both the rights

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[149] *Rees v Hughes* [1946] All ER 2. This duty has now been altered by legislation, changing and enhancing the legal status of married women. Where a married woman dies leaving an estate sufficient to pay for her funeral expenses her husband is no longer liable to pay those expenses.
[150] (1851) 169 ER 523.
[151] (1851) 169 ER 523 at 526.
[152] *Rees v Hughes* [1946] All ER 2.
[153] *Clark v London General Omnibus Company* [1906] 2 KB 648.
[154] *Rees v Hughes* [1946] All ER 2.

and responsibilities of parenthood would have been enjoyed by the operators. As in the general case law on the duty to bury, this special category of duty clearly imports a concept of decency or dignity. The father in *R v Vann* was not entitled to put his child's body in a hole. Even if he as the parent considered that to be appropriate, the common law imposed a duty on him to provide the child with a decent burial, appropriate to the standards expected by society more generally.

Criminal Law – Prevention of a Lawful and Decent Burial

It is, therefore, widely accepted that at common law there is a right to a decent burial. As well as this being reflected in duties in respect of burial, the criminal law recognises the right to a decent burial through the common law offence of prevention of a lawful and decent burial. This offence, found in its modern incarnation in the law of England and Wales since 1974, has been used in recent prosecutions, is triable by indictment only and is punishable by a maximum sentence of life imprisonment, an unlimited fine, or both. In the decision of the Court of Appeal in *Hunter*,[155] the Court noted that the very existence of this offence requires that burials be decent. It stated:

> ...[I]f it is a crime for the person responsible for burial to prevent it, there is no reason for regarding the act of a stranger in preventing burial as any less reprehensible. We think that in this connection burial means lawful and decent burial.

In the 2008 case of *R v Skidmore,*[156] the notion of a lawful and decent burial was similarly at issue.[157] This case concerned the body of a child. The defendant was an undertaker, who accidentally failed to put the child's body into the correct coffin. Panicking, he placed the child's body in the coffin wherein lay the body of an old lady who was due to be cremated later that day. She and the child, unbeknownst to everyone other than the defendant, were subsequently cremated. Years later, what had transpired was discovered and the defendant was charged with conspiracy to prevent a lawful and decent burial of a corpse. It was claimed that the defendant had prevented the decent burial of the child's body by dealing with it in the manner in which he did and he had not acted in accordance with the wishes of the child's parents. He was convicted and on appeal, his conviction was upheld. The court

[155] [1974] QB 95 CA (Crim Div).
[156] [2008] EWCA Crim 1464 (CA (Crim Div)).
[157] See also *R v Parry and McLean* (1986) 8 Cr App R (S) 470.

rejected the defendant's argument that his lack of dishonest motive meant that the offence had not been committed.

This offence has been used recently in prosecutions in England.[158] Applying this offence to the Tuam context, a question that arises in the present review is whether the original actions of the operators of the Tuam Mother and Baby Home could have constituted prevention of a lawful and decent burial. Moreover, were the relevant authorities to refuse to exhume, sort and bury the remains, could this constitute a continuing offence of prevention of a lawful and decent burial? In contrast to the tortious claim considered below, this crime does not require there to be any identifiable family member who is affected by the failure to bury.

Tortious Actions in Respect of Dead Bodies

In certain jurisdictions, the common law recognises a tortious right in respect of interference with a dead body, which is actionable at the suit of the family of the deceased person. The law of most US states recognises a tort in respect of mistreatment of a dead body.[159] The American Law Institute's *Restatement of the Law, Second, Torts* expresses these various torts as a single cause of action, providing:

> [O]ne who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of a dead person or who prevents its proper interment or cremation is subject to liability to a member of the family who is entitled to disposition of the body.[160]

Similarly, the law of certain Canadian provinces recognises a right of action on the part of family members of the deceased where the body is interfered with if that interference causes emotional or physical harm to the surviving relations.[161] Tortious actions in such circumstances have met with less success in England. However, there is a basis in Scottish

[158] *R v Rausing*. Sentencing Remarks; available at https://www.judiciary.gov.uk/judgments/rausing-sentencing-remarks-01082012/ accessed 23 February 2018. 'Amanda Hutton jailed for Hamzah Khan killing' BBC News 4 October 2013; available at http://www.bbc.co.uk/news/uk-england-24401112 accessed 23 February 2018.
[159] See e.g. *Scarpaci v Milwaukee County* 292 NW 2d 816 (Wisc SC 1980).
[160] American Law Institute, *Restatement of the Law, Second, Torts* (Washington, American Law Institute 1965) § 868. As the US jurisdictions are all separate, there is no one common law of the US. The Restatement attempts to formulate general propositions of law that are applied across the States, but it does not, itself, have any legal status.
[161] See e.g. *Mason v Westside Cemeteries* (1996) 135 DLR (4th) 361, *Edmonds v Armstrong Funeral Home* [1931] 1 DLR 676 (SC).

law for recognising unauthorised interference with a dead body as a legal wrong in respect of which the family may claim damages.[162]

In view of the emphasis that Irish culture and tradition places on the dead body in the grieving process, there may be good reasons for saying that the common law of Ireland does recognise a tort of wrongful interference with a dead body. The wake remains central to Irish funeral practice, a feature which strongly distinguishes it from funeral practices in England. Because of this significant cultural difference, it may be that this is one instance in which Irish common law may be said to have diverged from English law, and that therefore the more persuasive precedents are those from Canada and the Unites States.

Applying these principles to the case of the Tuam Mother and Baby Home, it is possible that the actions and inactions in respect of the interment of the dead bodies were tortious wrongs at the time when they occurred. These wrongs would have been actionable at the suit of the family of the deceased. A question arises as to whether this could potentially also be framed as a present-day tortious duty on the part of the State in respect of the bodies. The Restatement refers to the *withholding* of a body and the *preventing* of its proper interment.

Other Procedural Options

One option which may merit further consideration is whether there is an inherent jurisdiction on the part of the High Court to determine whether and how the remains should be dealt with. There is some (although limited) support from other jurisdictions for the proposition that the courts retain a common law power to determine disputes concerning the duty to dispose of the body of the deceased. In the New Zealand Supreme Court decision of *Takamore v Clarke*,[163] Elias CJ suggested that "where there is a dispute as to burial, either party (meaning personal representatives) has standing to bring the dispute to the High Court for resolution". The High Court of England and Wales reached a similar conclusion in *Oldham MBC v Makin*[164] where a dispute arose as to the manner and timing of the disposal of the remains of

[162] *Stevens v Yorkhill NHS Trust* [2006] SLT 889. The payment is described as a 'solatium'.
[163] [2012] NZSC 116.
[164] [2017] EWHC 2543.

the Moors Murderer, Ian Stewart-Brady. While the Court decided the matter on other grounds, it observed that:

> In my judgment, the court does have an inherent jurisdiction to direct how the body of a deceased person should be disposed of. The court will normally, as I have said, be deciding between the competing wishes of different sets of relatives, and will only need to decide who should be responsible for disposal rather than what method of disposal should be employed. I cannot see, however, why the court's inherent jurisdiction over estates is not sufficiently extensive to allow it, in a proper case, to give directions as to the method by which a deceased's body should be disposed of.

Perhaps most relevantly, the High Court of England and Wales held in *In re K* that it had an inherent jurisdiction to authorise arrangements to be made for the disposal of a child's body where the parents had neglected to make any arrangements.[165]

It should be emphasised that this does not necessarily mean that the Irish courts have such an inherent power, or that it would be engaged in the case of the Tuam deceased. Aside from the fact that these cases provide limited persuasive authority for the existence of such a power, the courts in those cases are dealing with situations where there is a dispute between personal representatives of an estate; and where the body remains to be dealt with. The legal context of any application here might be quite different. There is also the obvious factual difference that the question at Tuam would be one not of burial but of possible exhumation and re-burial. Nonetheless, the reasoning of the courts in these cases is based in part on the existence of a common law duty to dispose of remains. As discussed elsewhere in this Report it is arguable that duty is engaged and/or may have been breached in the situation in Tuam.

[165] [2017] 4 WLR 112.

8. LIMITATION PERIODS

As regards the tortious actions and actions for breach of constitutional rights, the limitation period which would apply to legal proceedings arising out of events which occurred at the Tuam Mother and Baby Home is the standard limitation period of 6 years.[166] In respect of the original wrongs, this period has elapsed.[167] It is important to note that under the Statute of Limitations Act 1957, limitation periods do not apply in circumstances where (a) the action is based on the fraud of the defendant or (b) the right of action is concealed by the fraud of the defendant.[168] The fraud must either consist of *conduct* which is concealed from the plaintiff or of the failure to disclose the existence of facts known only to the defendant which, if disclosed, would found a cause of action. The fact that persons did not realise the illegality of the conduct in question or that no one in authority took steps to ensure that affected persons were made aware of their legal entitlements will not constitute fraud.[169]

As regards the criminal law, the position is a rather complex one. The question of time limits centres around the distinction between offences which are triable summarily and offences which are triable on indictment only. Generally there is no time limit for indictable offences, whereas in respect of an offence which is triable summarily, a complaint must be made within a period of six months.[170] The crimes identified in relation to failure to bury were misdemeanours, meaning they were relatively minor offences. The distinction between felonies and misdemeanours was abolished by section 3 of the Criminal Law Act 1997. Because there are no reported Irish cases on these common law crimes, it is unclear whether they would have been triable summarily or on indictment. It is important to note, however, that the crime of prevention of a lawful and decent burial is an indictable misdemeanour as a matter of English law.[171] That said, section 3(2) of the 1997 Act provides that "on all matters on which a distinction has previously been made between felony and misdemeanour,

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[166] Section 11 of the Statute of Limitations Act 1957 as amended. On constitutional rights, see *McDonnell v Ireland* [1998] 1 IR 141.
[167] See, however, the judgment of Geoghegan J. in *Murphy v Grealish* [2009] 3 IR 366.
[168] Section 71(1)(b) of the Statute of Limitations Act 1957, as amended.
[169] *O'Dwyer v Daughters of Charity of St Vincent de Paul* [2015] IECA 226.
[170] Petty Sessions (Ireland) Act 1851, section 10.
[171] *Re v Hunter* [1974] QB 95 CA (Crim Div) relying on JWC Turner Russell on Crime (London: Sweet and Maxwell, 12th edn, 1964).

including mode of trial, the law and practice in relation to all offences shall be the law and practice applicable at the commencement of this Act in relation to misdemeanour".[172]

Regard must also be had to the right under Article 38.1 of the Constitution to a trial within a reasonable period of time.[173] This right is not absolute and must be balanced against the community's interest in prosecution. One of the key issues in considering this balancing exercise is whether any delay has impacted on the ability of an accused to defend himself/herself so that there is a real and substantial risk of an unfair trial. That is a fact-based assessment which will depend on the circumstances of the case.[174] As a general principle, the risk of unfairness increases as time passes, especially in matters where the recollection of witnesses may be relevant to the issues to be tried. This could have some bearing on whether criminal prosecutions are constitutionally permissible after this period of time.

Historical abuse cases cover several potential civil causes of action - actions in tort such as negligence, assault or trespass to the person or false imprisonment and actions for breach of constitutional rights - both of which are treated as an action in tort for limitation period purposes. Gallen argues that it may not be fair, however, for these limitation periods to operate where victims of historical abuse may not have pursued litigation under these causes of action on the belief that the conduct under which they were abused was legal and endorsed by the State.[175] He also argues that it may be possible to claim that the lack of social and legal recognition of the wrongdoing in such contexts would render it unconstitutional for a state defendant to rely on the Statute, as expecting victims to have pursued legal action contemporaneously to their abuse ignores the traumatic impact of the abuse. This, he states, "...creates an artificially receptive historical context". Nonetheless, it should be noted that as a matter of Irish law, a number of actions brought by persons in respect of their historic mistreatment in mother and baby homes[176] or hospitals[177] have been found to be statute barred.

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[172] See also section 15 of the Act.
[173] See, for example, *PP v Director of Public Prosecutions* [2000] 1 IR 403; *PM v Malone* [2002] 2 IR 560.
[174] *Donoghue v DPP* [2014] IESC 56.
[175] *Statute Law Review,* 2016, Vol.00, No.00, 1-15.
[176] *O'Dwyer v Daughters of Charity of St Vincent de Paul* [2015] IECA 226.
[177] *Farrell v Ryan* [2016] IECA 281.

In contrast with the approach taken in other common law jurisdictions, the Irish limitation period regime is different. While the law in relation to limitation periods in Ireland and the UK is broadly similar, under the UK Limitation Act 1980, section 33, courts have an equitable discretion to allow an action to proceed, having regard to the degree to which the limitation periods for personal injuries prejudice the plaintiff or defendant. In exercising this jurisdiction, the court is required to have regard to a number of factors, including: the length of, and reasons for the delay on the part of the plaintiff in bringing his/her claim, the extent to which his/her evidence is likely to be less cogent than if the action was brought within the allowed time; and whether the plaintiff acted promptly once he/she knew the act or omission of the defendant might be capable of giving rising to an action for damages. Case law in the UK indicates that situations of both physical and sexual abuse can engage a court's discretion under section 33 of the Act – the key factor is to assess whether a fair trial is no longer possible even where a claimant had an ostensible strong case on the facts. The English approach highlights the restrictive position in Ireland, with no judicial discretion.

Regarding any pre-ratification violations: the Inter-American Court of Human Rights (IACtHR), the UN Human Rights Committee and ECtHR have each recognised that a failure to investigate pre-ratification substantive violations of the relevant Convention may, in certain circumstances, amount to ill-treatment in itself (which exists post-ratification and carries a right to a remedy).

Apart from the Committee against Torture (CAT), none of the treaty bodies appears to have stated that there is an indefinite right to redress for torture or ill-treatment. The ECtHR, Inter-American Commission on Human Rights (IACmHR) and Human Rights Committee (HRC) all apply time limits. Nonetheless, in some cases the IACmHR and ECtHR have extended the time limit for complaints regarding torture or ill-treatment on the basis of the violation's effects on the victim.[178]

[178] See *Mocanu v Romania* (2015) 60 EHRR 19, *Garcia Lucero v Chile*, judgment of 28 August 2013 (Preliminary Objection, Merits and Reparations) Series C No. 267, *Rio Negro Massacres v Guatemala*, judgment of 4 September 2012 (Preliminary Objection, Merits and Reparations) Series C No. 250 and the CAT's General Comment No. 3.

Submission to the Joint Committee on Children, Disability, Equality and Integration on the General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill

Irish Human Rights and Equality Commission

February202 1



Coimisiún na hÉireann um Chearta an Duine agus Comhionannas
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Irish Human Rights and Equality Commission

February 2021

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Introduction

The Irish Human Rights and Equality Commission ('the Commission') is both the national human rights institution and the national equality body for Ireland, established under the *Irish Human Rights and Equality Commission Act 2014* (the '2014 Act'). In accordance with its founding legislation, the Commission is mandated to keep under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights and equality and to examine any legislative proposal and report its views on any implications for human rights or equality.[1]

The Commission welcomes the opportunity to provide the Joint Committee on Children, Disability, Equality and Integration with its submission on the *General Scheme of a Certain Institutional Burials (Authorised Interventions) Bill* (the 'General Scheme'). The Commission has previously raised concerns about the human rights and equality issues arising in connection to this piece of legislation.[2]

The discovery of the mass grave site at the former Mother and Baby Home at Tuam in 2017 and the findings of the *Mother and Baby Homes Commission of Investigation Final Report* (2020) that many of the Mother and Baby Homes did not properly record the burials of children who died in these institutions engage serious human rights and equality issues both for the deceased and their family members.[3] In particular, for family members (some of whom are also survivors of these institutions) there is a need to know the fate and whereabouts of these children and to receive their mortal remains for burials or, a dignified commemoration. Therefore, effective legislation that will as far as practicable protect, and preserve mass graves, such as Tuam, and provide for the identification and return of mortal remains to family members plays an important part in providing truth and justice to these individuals.

Background to the General Scheme

The Commission of Investigation into Mother and Baby Homes was established by the Irish Government in February 2015. The terms of reference for the Commission of

[1] Section 10(2) of the Irish Human Rights and Equality Commission Act 2014.
[2] IHREC (Designate) Proposed Commission of Investigation to Inquire into Mother and Baby Homes, June 2014
[3] Mother and Baby Homes Commission of Investigation – Final Report, 30 October 2020.

Investigation included a commitment to an investigation of post-mortem practices and procedures in respect of children or mothers who died while resident in these institutions.[4]

On 9 March 2017, a significant number of human remains were discovered buried at the site of a former Mother and Baby Home in Tuam. In December 2018, a government-commissioned expert technical group published a report on how to respond. Following on from the publication of this report, Galway County Council conducted a public consultation in response to the expert group's findings and proposed options.[5] The consultation reported that although local residents largely wished for memorialisation and non-disturbance of remains, former residents of Tuam Mother and Baby Home and relatives of former residents of the home "overwhelmingly wished for full forensic excavation of the site along with DNA analysis".[6] The consultation concluded that "[p]articipants expressed the need for justice, truth and accountability and [that] this was consistent throughout dialogues".[7]

In 2018, the Minister announced plans for the site to be excavated forensically.[8] The *Fifth Interim report of the Commission of Investigation*, published 15 March 2019, highlighted that the major issues with regards to burials "arise in the cases of Bessborough and Tuam." On 10 December 2019, Cabinet approved the publication of the *General Scheme of the Certain Institutional Burials (Authorised Interventions) Bill.* The Bill provides the statutory basis and framework for the creation of an agency, which can then oversee the excavation, exhumation, identification and re-burial of any remains found at certain sites where "manifestly inappropriate burials have taken place".

The Final Report of the Commission of Investigation was published on 12 January 2021. The Final Report found that most of the Mother and Baby Homes did not hold burials registers. In particular, neither Tuam nor Bessborough kept a register of burials. While the Commission of Investigation believes it is likely that the children who died in Tuam

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[4] Statutory Instrument No.57 of 2015.
[5] B Walshe and C O'Connell, Consultation on the Options and Appropriate Courses of Action available to Government in relation to the site of the former Mother & Baby Home, Tuam, Co. Galway, 16 April 2018.
[6] Ibid, page 3.
[7] Ibid, page 18.
[8] Department of Children, Equality, Disability, Integration and Youth Government approves programme of action to respect the memory and dignity of children who died in Tuam Mother and Baby Home, October 2018

are buried inappropriately in the grounds of the institution, it has not been able to establish where the majority of the Bessborough children are buried.[9]

Relevant human rights and equality framework

The proposed legislation gives rise to a number of human rights and equality issues which are closely intertwined with the right to life, the right to family life, the prohibition against inhuman and degrading treatment, the right to an effective remedy, and women's and children's rights. These rights find expression in the Constitution of Ireland, the European Convention on Human Rights (the 'ECHR') and international human rights law.

Case law confirms the importance of dignity under the Constitution and, in particular, the importance attached to the circumstances associated with a person's death.[10] At common law, there has also been recognition of the right to a decent burial, and of a range of rights and duties concerning dead bodies.[11] Articles 2 and 3 of the ECHR place positive procedural obligation upon states to effectively investigate either a killing or, suspicious death within their territory or an allegation of inhuman or degrading treatment, respectively.[12] However, this is an obligation of means only, and not results.[13]

Article 8 of the ECHR has been broadly interpreted as providing family members of deceased persons with a number of rights, including the right to have their loved one's body returned to them and the right to know the fate of their family members, including information surrounding the death and/or burial of their loved ones.[14] The European Court of Human Rights (the 'ECtHR') has also held that the way in which a relatives

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[9] Mother and Baby Homes Commission of Investigation – Final Report, 30 October 2020, at page 29.

[10] See for example PP v. HSE [2014] IEHC, 633, Re a Ward of Court, [1996] 2 IR 79 and Fleming v. Ireland [2013] IESC 19.

[11] See Dr Geoffrey Shannon, Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway,12 April 2018: pp. 94-101.

[12] See for example; McCann and Others v. the United Kingdom, Number 17/1994/464/545, 27 September 1995; Osman v. the United Kingdom, Number 87/1997/871/1083, 28 October 1998, Aslakhanova v. Russia Number 2944/06, 8300/07, 50184/07, 332/08, 42509/10, 18 December 2012, El Masri v. Former Yugosla Republic of Macedonia GC] no. 39630/09, 13 December 2012.

[13] App. No. 32457/04, judgment of 27 Feb. 2008, available at: www.echr.coe.int/ECHR/EN/Header/Case-Law/Hudoc/Hudoc+database/., para 66.

[14] See for example, Pannullo and Forte v. France Number 37794/97, ECHR 2001-X., Girard v. France Number 22590/04, 30 June 2011, Hadri Vionet v. Switzerland Number 55525/00, 14 February 2008, MAric v. Croatia Application no. 50132/12; Zorica Jovanovic v. Serbia Number 21794/08, ECHR 2013.

remains is treated and the right to attend the funeral of a family member falls within Article 8.[15] In particular, it has found a positive obligation on authorities who are aware of a person's death to act with "reasonable diligence" to ensure that family members are so informed.[16] Article 8 of the ECHR is not an absolute and a state can justify such an interference if it can demonstrate that the inaction is:

> "in accordance with the law, is necessary in a democratic society, in the interests of national security, public safety or economic well-being, for the prevention of disorder or crime, for the protection of health or morals, of the for the protection of the rights and freedom of others".[17]

The ECtHR[18] has also recognised the right to know the truth in the context of investigations into complaints of torture, inhuman or degrading treatment, holding that:

> "...the Court also wishes to address another aspect of the inadequate character of the investigation in the present case, namely its impact on the right to the truth regarding the relevant circumstances of the case. In this connection it underlines the great importance of the present case not only for the applicant and his family, but also for other victims of similar crimes and the general public, who had the right to know what had happened.
>
> ...
>
> ...an adequate response by the authorities in investigating allegations of serious human rights violations, as in the present case, may generally be regarded as 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. For the same reasons, there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory..."[19]

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[15] Solska and Rybicka v. Poland, Applications 30491/17 and 31083/17, paras 104-108
[16] Lozovyye v. Russia, Application no 4587/09, para 46.
[17] See Article 8 (2) of the European Convention of Human Rights.
[18] European Court of Human Rights, El Masri v. Former Yugosla Republic of Macedonia GC] no. 39630/09, 13 December 2012.
[19] Ibid para 191 and 192.

In 2018, pursuant to a request from then Minister for Children, Dr Katherine Zappone TD, the Special Rapporteur on Child Protection, Dr Geoffrey Shannon, published a report on the *Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co. Galway.* This report set out the relevant human rights standards in both domestic and international law. Dr Shannon noted that; "in international law, there are no unified mass-grave protection guidelines in place for States to follow when they are faced with the discovery of sites". However, he also notes that in the absence of such guidelines, advocates have recommended that "the principles established in international humanitarian law in relation to armed conflict can serve as a guide with regard to the treatment of the dead in some peacetime situations".[20]

In addition to guidance that can be drawn from international law[21], three resources have developed in recent years that are instructive. First, the development of the *Bournemouth Protocol on Mass Grave Protection and Investigation (2020)* (the 'Bournemouth Protocol') which consolidates legal rules and best practice to support those protecting and investigating mass grave sites.[22] Second, the UN Special Rapporteur on extrajudicial, summary or arbitrary execution (hereafter 'the UN Special Rapporteur') published a report on mass graves (2020), which *inter alia* presents some of the complex normative and practical 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. Third, the Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains (2020) which aims to promote accountability and access to effective remedies and reparations for victims and their families in the case of extrajudicial killings and enforced disappearances in Latin America.[23]

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20 Dr Geoffrey Shannon, Human Rights Issues at the Former Site of the Mother and Baby Home, Tuam, Co Galway,12 April 2018: p. 5.

[21] For instance, the Geneva Conventions and their Additional Protocols form the core of international humanitarian law, regulating the conduct of armed conflict and seeking to limit its effects. With regard to missing persons, the International Committee of the Red Cross (ICRC), "Guiding Principles/Model Law on the Missing" (2009) and the International Convention for the Protection of All Persons from Enforced Disappearance are of assistance (although it should be noted that Ireland has not yet ratified this Convention).

[22] Bournemouth University Bournemouth Protocol on mass grave protection and investigation, 2020.

[23] Argentine Forensic Anthropology Team, Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains, August 2020 https://eaaf.org/wp-content/uploads/2020/11/EAAF-Forensic-Guide-for-the-investigation-recovery-and-analysis-of-human-skeletal-remains.pdf

General Observations

Transitional justice processes and gender perspectives

Transitional justice is based on five pillars; the right to truth, justice, reparation, non-recurrence and memory process.[24] The proposed legislation should form part of a larger transitional justice response to the treatment of women and children in Mother and Baby Homes and other institutions. To comply with international obligations, transitional justice mechanisms should seek to ensure that states safeguard the rights of victims to justice and reparations, the right of victims and societies to know the truth about violations, guarantees of non-recurrence of violations and memorialisation.[25]

Women and children's rights are clearly relevant given the background to the proposed legislation and accordingly should inform government's response and the Committee's scrutiny of the General Scheme. With specific regard to women as both survivors and as parents of the deceased transitional justice mechanisms, including this proposed legislation, should include special measures to ensure that women receive adequate redress, that they meaningfully participate in these processes and that their rights and perspectives are adequately addressed.[26] Transitional justice processes that incorporate a gender and women's human rights perspective can help ensure accountability for women's rights abuses and further ensure that such abuses against women, or other marginalised groups are not perpetuated into the future.[27]

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[24] UN Human Rights Council, Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Memorialization processes in the context of serious violations of human rights and international humanitarian law: the fifth pillar of transitional justice. A/HRC/45/45, 9 July 2020: p. 18

[25] See UN, Guidance Notes of the Secretary-General, UN Approach to Transitional Justice, March 2020. Also see UN, The gender perspective in transitional justice processes, 17 July 2020.

[26] The Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains states that participation with victims' families should not only be an integral part of the whole process - from investigation, identification to the return of any remains identified - but should also form part of the design process; "...there have been many different modes of participation, but in our opinion, the victims' families and their organizations should sit at the table where the political decision as to the type of mechanism to be used for search purposes is taken." Argentine Forensic Anthropology Team, Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains, August 2020 https://eaaf.org/wp-content/uploads/2020/11/EAAF-Forensic-Guide-for-the-investigation-recovery-and-analysis-of-human-skeletal-remains.pdf , page 7.

[27] UN, Guidance Notes of the Secretary-General, UN Approach to Transitional Justice, March 2020, p. 5. Also see UN, The gender perspective in transitional justice processes, 17 July 2020.

The Commission recommends examination of the General Scheme as part of a larger transitional justice response for the survivors of the Mother and Baby Homes and families of those who died within these institutions.

The Commission further recommends that a women's human rights perspective inform scrutiny of the General Scheme, with particular focus on the need for affected women to meaningfully participate in the drafting and operation of proposed legislation.

Mass grave investigations: obligation of means not results

Mass grave investigations are an "obligation of means and not results".[28] Mass grave investigations can be highly complex, lengthy and resource intensive. Depending on the grave and the evidence available, it may not always be possible to retrieve, identify and return remains to family members. Indeed, available research shows that identification of remains is low.[29] However, this does not diminish the obligation on the State to make best efforts to respect these rights. Rather it affirms that meaningful engagement must underpin the design and implementation of legislation of this nature, and further, that it be complemented by a transparent communication strategy. The UN Special Rapporteur acknowledging this specific challenge has stated:

> "There exists concern that the prevailing emphasis on identification fails the vast majority of families and may even intensify their pain, "creating almost a secondary trauma" should their hopes be unrealized. More thought should be given up front to methods of cooperation with families to minimise this possibility."[30]

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[28] Bournemouth University Bournemouth Protocol on mass grave protection and investigation, 2020, pp. 6-7.
[29] United Nations General Assembly (2020) Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, pp. 8- 9.
[30] United Nations General Assembly (2020) Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, p. 9.

The Commission recommends that any legislation of this kind be underpinned by meaningful engagement with affected individuals and complemented by a transparent communications strategy.

Observations on the General Scheme

Scope of the General Scheme (Head 3)

Head 3(1) provides that the State will only intervene where:

> "manifestly inappropriate burials have taken place at a site, associated with an institution, of persons who died while ordinarily resident at that institution".

"Institution" and "ordinarily resident" are not defined under the General Scheme. However, it is noted that the General Scheme states that its purpose is to authorise interventions where manifestly inappropriate burials have taken place that are:

> "associated with institutions operated by or on behalf of the State or in respect of which the State had clear regulatory or supervisory responsibilities."[31]

The State's positive obligation to protect the right to life requires an effective official investigation when individuals have died in suspicious circumstances, irrespective of whether those responsible are agents of the State or, private persons.[32] Also, international best practice does not define "mass grave" sites by state involvement. Instead, "mass grave" sites are given a broad scope of application to include:

> "burial site where the circumstances surrounding the death and/or the body-disposal method warrant an investigation as to their lawfulness".[33]

Accordingly, the scope of the General Scheme will limit interventions to burials of people who were "ordinarily resident" within certain "institutions" run by or on behalf of

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[31] The General Scheme, at page 2.

[32] *Iorga v. Moldova*, no. 12219/05, 23 March 2010, para 26.

[33] United Nations General Assembly (2020) Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, para 17(d). Also see Bournemouth Protocol.

the State. This restricted scope of application does not align with the States human rights obligations or, international best practice in this area. [34]

The Commission recommends that the scope of the General Scheme be revised to align with the international definition of mass grave sites; to include any burial site where the "circumstances surrounding the death and/or body-disposal method warrant an investigation as to their lawfulness."

[34] Ibid. Also see the Bournemouth Protocol.

Human rights and equality approach to mass graves (Heads 3 and 5)

Head 3 of the General Scheme provides that the Minister shall bring a proposal to Government where the Minister "is satisfied, on reasonable grounds, that manifestly inappropriate burials have taken place at a site".[35] If, on considering this proposal, Government forms the view that "it is necessary for the purpose of safeguarding important objectives of general public interest", it may make an order to establish a statutory agency to excavate, exhume and manage the identification and reinternment of any human remains found at a particular site.[36] Head 3(8) provides that after determining that there is a public interest in carrying out an intervention in a particular site, Government shall consider the proportionality of any intervention with regard to a number of specified factors.[37] Head 5 sets out the criteria that Government must take into consideration when deciding whether or not to make an order to intervene in a particular site, including whether certain burials are "manifestly inappropriate".[38] Head 6 sets out a wide range of circumstances that prevent the making of an order under Head 3.

It is noted with concern that the General Scheme, in particular, in relation to the making of an order to intervene (Head 3) and the criteria for intervention (Head 5) is silent on the relevant human rights and equality issues that, as set out above, are central to the objectives of legislation of this kind.[39]

The Commission recommends that Heads 3 and 5 be revised to ensure that Government, and other persons, performing functions under the proposed legislation have due regard to the need to protect human rights and equality of both victims and family members.

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[35] Head 3(1) of the General Scheme.
[36] Head 3(3) of the General Scheme.
[37] Head 3(8) of the General Scheme, provides for the following factors – "(a) public health, respect for the deceased, respect for the views of the relatives of the deceased, (d) the potential impacts on the site and surrounding area, including any potential impact on – (i) residents whose dwelling adjoins the site, and (ii) archaeological feature 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."
[38] Head 5(2) of the General Scheme.
[39] Section 42 of the Irish Human Rights and Equality Commission Act 2014 may be instructive.

Heads 3, 5 and in particular the restrictions set out under Head 6, are currently framed in a manner that allows wide discretion to Government when determining whether or not to intervene in a particular site, even where there are "reasonable grounds that manifestly inappropriate burials have taken place".[40]

The State is under a legal duty to investigate mass burials,[41] and to preserve and protect evidence at relevant sites.[42] Whilst an intervention may not be possible or appropriate in certain circumstances, such circumstances should be construed strictly and with due regard the relevant human rights and equality of survivors and family members of the deceased.

The Commission recommends further examination of the wide discretion given to the Government under Heads 3 and 5 and the extensive restrictions listed under Head 6, with a view to determining whether they pursue a legitimate aim, are necessary and proportionate.

Restrictions (Head 6)

As noted above, the restrictions under Head 6 are extensive and could have the effect of excluding many manifestly inappropriate burials, including potentially some burial sites identified in the Commission of Investigation Report. Although all exceptions warrant further examination, the following are of particular note:[43]The General Scheme states that certain sites are to be excluded from the Government order where "there is an ongoing Garda investigation into the circumstances surrounding the burials or the way the deaths took place".

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[40] Head 3(1) of the General Scheme.

[41] For instance, States are under an obligation to takes steps reasonably available to them to secure evidence. See for example - *Treskavica v Croatia*, Judgment, ECtHR Application No. 32036/13 (12 April 2016) para 60, noting that this includes forensic evidence. Also, under humanitarian law, Article 34(2)(b) of Additional Protocol I requires the protection of grave sites.

[42] Under the Constitution and the ECHR (obligation to protect life) the State is under a positive obligation to carry out effective investigations in to deaths.

[43]Other examples include; Head 6(5) which states "Exhumation would be unreasonably difficult or unsafe". It is submitted that this has been drafted in an overly broad, and vague manner. Also see Head 6(8) states "The land on which the burial site is located contains one or more dwellings". Although, such a scenario would likely engage the private property rights of other individuals they must be balanced against the rights of victims' families which are also engaged. Accordingly, property rights should not be in and of themselves grounds for a restriction.

The Minnesota Protocol states that "[u]pon completion of the necessary investigative procedures, human remains should be returned to family members".[44] The ECtHR has held that families have a right for human remains to be returned to them if there is no investigatory purpose for holding onto the remains.[45]

A criminal investigation should not be a reason to exclude sites from proposed legislation.[46] It may be possible to put in place procedures and safeguards to ensure that the exhumation process preserves evidence that can assist in identification or in any criminal investigation.[47]

The Commission recommends that an ongoing criminal investigation should not be used as a reason to exclude sites from Government orders.

The General Scheme provides for an exception where there is evidence that "informed family consent was given for burials arranged by the institution".
The Constitution and the ECHR place an obligation on the State to secure the right to effective respect for physical and psychological integrity, in particular in the context of health-related matters, when considering whether consent was free and informed.[48]

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[44] See The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), 2017:p. 9. Also, the ICRC Model Law provides that after a post-mortem examination, remains should be returned to the families of the deceased at the earliest time possible. See ICRC, Advisory Service on International Humanitarian Law, Guiding Principles/Model Law on the Missing, Principles for Legislating the Situation of Persons Missing as a Result of Armed Conflict or Internal Violence: Measures to prevent persons from going missing and to protect the rights and interests of the missing and their families, Feburary 2009:p. 46.

[45] *Panullo and Forte v. France*, ECtHR Application no. 37794/97, 30 October 2001, para 35-40.

[46] United Nations General Assembly, Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, 2020.

[47] The ICRC Model provides that "It is essential that all information be collected for the purpose of identification whenever exhumations are performed; regulations and procedures should be in conformity with the principles governing the protection of personal data and genetic information; it is important to preserve evidence conducive to the identification and that may be required for any criminal investigation, whether under national or international law." Article 21. See ICRC, Advisory Service on International Humanitarian Law, Guiding Principles/Model Law on the Missing, Principles for Legislating the Situation of Persons Missing as a Result of Armed Conflict or Internal Violence: Measures to prevent persons from going missing and to protect the rights and interests of the missing and their families, Feburary 2009 , p. 46.

[48] Article 40.3 of the Constitution protects the right to bodily integrity. See for example (Re a Ward of Court (withholding
medical treatment) (No 2), 1996 Also see the ECtHR judgments, Sentges v. the Netherlands (dec.) no. 27677/02, 8 July
2003; Nitecki v. Poland (dec.), no. 65653/01, 21 March 2002.

The General Scheme does not provide a definition of 'informed consent', so it is unclear how evidence of informed consent is to be established. Informed consent requires a person be provided with all available information before giving their consent.[49] This may be difficult to assess in respect of burials linked to the Mother and Baby Homes as they occurred decades ago. Moreover, the General Scheme does not indicate who is responsible for making the determination, nor does it address circumstances where families may wish to challenge a decision based on this restriction (or indeed other restrictions).

The Commission recommends further examination of the exclusion on the basis of stated "informed family consent" and that this should include consultation with affected individuals, including survivors and family members.

The General Scheme provides for an exception where "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".
The rationale for this particular cut-off date is unclear, and such a restriction could potentially exclude any burial sites prior to 1950. This is at odds with the Commission of Investigation into Mother and Baby Homes which examined the period of 1922 to 1998.

The Commission recommends revising the 70-year time limit particularly in light of the fact that the Commission of Investigation into Mother and Baby Homes examined the period of 1922 to 1998.

The General Scheme provides for an exception where "[g]overnment has formed the view that memorialisation of the site without further intervention is more appropriate". Memorialisation, the fifth pillar of transitional justice, is also recognised as an important

[49] In the context of healthcare the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has said "[i]nformed consent requires that communication is cognizant of varying levels of comprehension and not be too technical, complex, hasty, or in a language, manner or context that the patient does not understand." See the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Thematic study on the realization of the right to health of older persons, A/HRC/18/37, July 2011, para 5

feature in terms of addressing mass graves.[50] The UN Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence states:

> "Transitional justice systems require vigorous and active memory policies based on human rights approaches in order to adequately address past crimes committed by dictatorial or authoritarian regimes or crimes perpetrated in the context of an armed conflict. Without memory, the rights to trust and full reparation cannot be fully realised and there can be no guarantee of non-recurrence."[51]

However, the Special Rapporteur further explains;

> "Memory processes complement but do not replace mechanisms for truth, justice and guarantees of non-recurrence. Memory mechanisms should not serve as a pretext for granting de jure or de facto impunity to the perpetrators of gross violations of human rights or serious violations of international law."[52]

The General Scheme currently presents memorialisation as a reason not to carry out an investigation or exhume remains from mass graves, which may in turn impact on the rights of families and survivors to identify remains of loved ones. While a memory process is extremely important in the context of commemoration, and may in certain circumstances be an appropriate option, it should not be grounds, in and of itself, to prevent the identification of remains for family members. Furthermore, the views of survivors and family members must play a central role in any decision to memorialise a manifestly inappropriate burial.[53]

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[50] United Nations General Assembly, Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, 2020

[51] UN Human Rights Council, Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Memorialization processes in the context of serious violations of human rights and international humanitarian law: the fifth pillar of transitional justice. A/HRC/45/45, 9 July 2020, p. 17.

[52] UN Human Rights Council, Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Memorialization processes in the context of serious violations of human rights and international humanitarian law: the fifth pillar of transitional justice. A/HRC/45/45, 9 July 2020, p. 5.

[53] United Nations General Assembly, Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384,2020: p. 10.

The Commission recommends that this part be revised to ensure that memorialisation complements rather than replaces, the process for addressing mass graves.

The Commission recommends that any decisions concerning memorialisation include meaningful participation with survivors and family members.

Role of the Coroner (Head 7)

Head 7 provides that where the Government makes an order under Head 3 in relation to a site, the Coroner shall not have jurisdiction under the *Coroners Acts 1962 -2019* in respect of bodies exhumed from that site during the period of existence of the Agency. The purpose of this provision is to dis-apply section 47 of the *Coroners Acts 1962,*[54] which concerns the role of the Coroner in the exhumation process, and section 17,[55] which concerns the duty of the Coroner in circumstances where a death may have occurred in a violent or unnatural manner, unexpectedly and from unknown causes. The State's positive obligation to protect the right to life[56] requires "an effective official investigation when individuals have died in suspicious circumstances"..[57] Arguably, the families of the deceased are also recognised as victims themselves of ongoing violations, and as such, have the right to an effective remedy,[58] which includes a thorough and effective investigation.[59] The ECtHR has recognised that states are under

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[54] Section 47 of *Coroners Act 1962*, as amended by the *Coroners (Amendment) Act 2019* provides:
Where a coroner is informed by a member of the Garda Síochána not below the rank of inspector that, in his opinion, the death of any person whose body has been buried in the coroner's district may have occurred in a violent or unnatural manner, the coroner may request the Minister to order the exhumation of the body by the Garda Síochána.
(1a) Where there is a relevant Ombudsman Commission investigation and a coroner is informed by a designated officer of the Ombudsman Commission that, in his or her opinion, the death of the person concerned whose body has been buried in the coroner ' s district may have occurred in a violent or unnatural manner, the coroner may request the Minister to order the exhumation of the body by the Ombudsman Commission.

[55] Section 17 provides:
Subject to the provisions of this Act, where a coroner is informed that the body of a deceased person is lying within his district, it shall be the duty of the coroner to hold an inquest in relation to the death of that person if he is of opinion that the death may have occurred in a violent or unnatural manner, or unexpectedly 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.

[56] Under Article 2 of the European Convention on Human Rights.

[57] *Iorga v. Moldova*, no. 12219/05, 23 March 2010, para 26.

[58] Article 13 of the European Convention on Human Rights; Article 2(3) of the International Covenant on Civil and Political Rights.

[59] The European Court of Human Rights have held that an effective remedy includes the "payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the complainant to

an obligation to take further investigative measures if evidence surrounding the circumstances and causes of a death becomes known at a later stage.[60] *The Minnesota Protocol on the Investigation of Potentially Unlawful Death*[61] 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."[62]

In the absence of a coroner's inquest to establish a cause of death, it is unclear how the State intends to ensure family members know the truth about the cause and circumstances of the death, and the manner of the burial of their relative.[63]

The Commission recommends that Head 7 be amended to recognise that the jurisdiction of the Coroner applies to the burial sites. If Head 7 is retained, consideration should be given to amending proposed legislation to ensure that effective investigations are carried out to determine the truth about the cause and circumstances of the death, and manner of the burials of the deceased person.

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the investigatory procedure" *Kaya v. Turkey*, 19 February 1998, Reports of Judgments and Decisions 1998-I, para 10.

[60] Where there is a plausible, or credible, allegation, piece of evidence or item of information relevant to the identification, and eventual prosecution or punishment of the perpetrator of an unlawful killing, the authorities are under an obligation to take further investigative measures. See *Brecknell v. the United Kingdom*, no. 32457/04, 27 November 2007, para 71.

[61] The Minnesota Protocol 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. The Protocol sets a common standard of performance in investigating potentially unlawful death or suspected enforced disappearance and a shared set of principles and guidelines for States, as well as for institutions and individuals who play a role in the investigation. See The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), 2017.

[62] The Minnesota Protocol on the Investigation of Potentially Unlawful Death (2016), 2017, p. 4.

[63] The United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions stated that "[m]ass graves warrant investigations into the circumstances of unlawful death, the causes of death, as well as the manner of disposal of the bodies." See United Nations General Assembly (2020) Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, para 18.

Part 4 and 5 - Role and functions of the Agency

Independence, impartiality and transparency

Part 4 provides for the legal status of the Agency, stating that it "shall be independent in the performance of its functions".

According to the Bournemouth Protocol, "in order for an investigation to be perceived as legitimate in the eyes of an affected community ... any investigative team must not only operate with independence and impartiality, they must be seen to do so".[64] The Bournemouth Protocol also states that all stages of investigation, exhumation and return of remains should be as transparent as possible in order to support public scrutiny of the process.[65]

While Head 9(2) stipulates that the Agency shall be independent, other heads may compromise such independence. For example, in its description of how the performance of the Agency is to be monitored, Head 20 sets out a close reporting relationship between the sponsoring Minister and the Agency but it does not provide for such information to be made publicly available. In addition, Head 26 prohibits the disclosure of information relating to functions of the Agency. While this may be necessary in some circumstances, it is important that such a provision does not lead to the development of a working culture of secrecy and concealment.

The Commission recommends that such monitoring reports should be laid before the Houses of the Oireachtas to increase transparency and accountability around the work of the Agency.

Participation and access to information

The role and functions of the Agency does not adequately address the importance of survivor and family participation. For example, Head 27 requires the notification of landowners with respect to the conduct of works but there is no requirement to inform survivors or families members. Also, and linked to the issue of transparency, it is noted

[64] Bournemouth University, *Bournemouth Protocol on Mass Grave Protection and Investigation, 2020:* , p. 9.

[65] Bournemouth University, *Bournemouth Protocol on Mass Grave Protection and Investigation, 2020:* , p. 9.

that Head 44 and Head 45 will have the effect of sealing documents and records obtained by the Agency during the course of an intervention for a period of 30 years.[66]

The *United Nations Principles For The Protection And Promotion Of Human Rights Through Action To Combat Impunity*, states that the right to truth "includes an "inalienable right" to know the truth about past events, a duty to preserve memory, and a victim's right to know".[67]

The Minnesota Protocol also provides that:

> "States must enable the participation of families in investigations into unlawful deaths, 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".[68]

According to the UN Special Rapporteur on extrajudicial, summary or arbitrary executions, consultations with affected individuals should guide management and custodianship of both the site/s and their human remains, and that key principles such as "respect for the deceased; personalization for their loved ones, specifically when individuation is not possible; and memorialization" should form the basis of this engagement.[69]

Ability to obtain information, in particular archives, is also important in the context of transitional justice processes. Access to archives is essential for societies to learn and to know the truth about history. Although protecting archives is important, it is equally important to make archives publically available.[70]

The Commission recommends that the General Scheme, in particular the role and functions of the Agency, be revised to ensure ongoing and effective consultation and participation which includes survivors and families of the deceased.

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[66] Section 10 of the National Archives Act 1986
[67] UN Doc E/CN.4/2005/102, Principles 2-4.
[68] Minnesota Protocol, 2016.
[69] United Nations General Assembly (2020) Report of the Special Rapporteur of the Human Rights Council on extrajudicial, summary or arbitrary executions: Mass graves, highlighting the multitude of sites of mass killings and unlawful deaths across history and the world, UN Doc A/75/384, para 77.
[70] UN Human Rights Council, Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Memorialization processes in the context of serious violations of human rights and international humanitarian law: the fifth pillar of transitional justice. A/HRC/45/45, 9 July 2020, p. 19.

The Commission recommends further examination of the need to ensure that affected individuals and the public have access to information, including access to relevant archives.

Return of human remains to family members (Head 33)

Head 33 states that where remains have been exhumed, the Agency shall, in consultation with the Sponsoring Minister, make such final arrangements for the remains as it deems appropriate, including but not limited to arranging re-internment at a place and in a manner chosen by the Agency, or where "feasible to do so, releasing remains to family members of the deceased".

When determining the most appropriate manner of re-internment the Agency shall have regard to:

(a) the dignity of the deceased;
(b) the stated wishes of family members;
(c) the extent, if any, to which it may be feasible to return remains to family members;
(d) the religious practices of the deceased, if any; and
(e) the conditions of the remains.

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.

The ECtHR has found breaches of the right to respect for family and private life where there was an unjustified delay in returning bodies to family members to bury the deceased.[71]. The ECtHR has also held that the non-return of human remains and burial in unspecific locations could constitute a violation of the right to private and family life. Also, international law makes clear that States are under an obligation to return any remains to the family, as well as any personal effects, or to provide the families with access to the burial site.[72]

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[71] See for example Pannullo and Forte v. France, Number 37794/97, ECHR 2001-X and Gerard v. France, Number 22590/04 *Sabanchiyeva and others v Russia*, Judgment, ECtHR Application No 38450/05 (6 June 2013) paras 117-134.

[72] See for further guidance: International Committee of the Red Cross, Rule 114. Also see Principle (2) 4 of the Guiding Principles that specified that "the return [of human remains] should also involve the means and procedures need to ensure a dignified burial consistent with the wishes of and cultural customs of

The Commission recommends that this Head be revised to 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.

The Commission further recommends that where human remains cannot be returned that that proposed legislation should specify that the State shall bury the remains in a specified location and in a manner that respects the religious or cultural belief of the deceased, and where relevant, that this occurs in close consultation with family members.

The obligation to preserve and protect

The General Scheme is silent on the steps the State should take to preserve and protect human remains that have been identified but not claimed, or that have not been identified.[73] The Bournemouth Protocol advises that in relation to human remains that are identified but not claimed or, where identification is not possible:

> "[a] record should be kept active in order to allow future identification and subsequent notification to relatives and interested parties, including state authorities. Preservations and longer-term storage measures are needed to safeguard the prospect of future identification. Where preservation and storage measures are unavailable or inappropriate, unidentified human remains may be buried in marked graves according to the likely cultural or appropriate religious customs of the deceased. In order to ensure the possibility of identification in the future. [C]remation should, wherever possible, be avoided".[74]

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the families and their communities". Furthermore, Article 21(4) of the ICRC Model Law on Missing Persons states that "human remains and personal effects shall be returned to families". Also, although Ireland has not ratified the CED, it states that states the obligation on States to return the human remains of disappeared to family members. Of note jurisprudence from the Inter-American Court of Human Rights has states that "When the mortal remains are found and identified, the State must return them to their next of kin as soon as possible, as having proved the relationship genetically, so that they can be honoured according to their respective creeds." - *Pueblo Bello Massacre Colombia*, Judgment on Merits, Reparations and Costs, Inter-American Court of Human Rights Series C No 140 (31 January 2006) para 273.

[73] See a Minnesota Protocol, section E on Identification of Dead Bodies, p. 24.

[74] Bournemouth University, *Bournemouth Protocol on Mass Grave Protection and Investigation, 2020: p. 13*. Also, It is noted that burial of unclaimed and unidentified remains is deemed appropriate by the Mytilini Declaration concerned with the dignified treatment of missing and deceased persons and their

The Bournemouth Protocol also identifies specific methods to ensure traceability, including:

- Documentation and mapping of the site, including mapping of the location of individual bodies within the site;
- Numbering and tagging of each body and bag/coffin with reference to DNA sample number and storage;
- The use of signs to mark the site; and
- The safe storage of information to ensure its security.[75]

The Commission recommends that proposed legislation address the need to preserve, protect and ensure the traceability of unclaimed or unidentified human remains to allow for possible future identification. In this regard, proposed legislation should expressly prohibit cremation as a final arrangement for unclaimed or unidentified remains.

The General Scheme is equally silent on the steps that should be taken to preserve and protect sites that relate to 'manifestly inappropriate burial', but where an intervention was not ordered under Head 3, or excluded under Head 6. A legal framework that, as far as practicable, protects and preserves all 'manifestly inappropriate burials' will ensure the integrity of evidence should a possibility to investigate arise in the future.[76]

The Commission recommends that proposed legislation should, as far as practicable, protect and preserve sites, even where intervention has been deemed inappropriate in order to allow for investigation in the future.

Part 6: The identification process

Multidisciplinary approach to the identification process

families as a consequence of migrant journeys (The Mytilini Declaration for the Dignified Treatment of all Missing and Deceased Persons and their Families as a Consequence of Migrant Journeys (2018) at A.16). The ICRC Model Law on the Missing in its commentary to Article 22 (Burial and exhumation) states '[c]remation should be avoided, except where necessary (e.g. for reasons of public health) and a record of the reason for it kept, as well as the ashes' (p. 48).

[75] Ibid.

[76] Bournemouth University, *Bournemouth Protocol on Mass Grave Protection and Investigation, 2020: p.* 16.

The General Scheme focuses on DNA as the sole technique for the identification process.

However, international guidance suggests a more comprehensive approach which examines all the relevant and available information, such as for example, sex, age, ancestry, stature, distinguishing traits in the body, personal effects, historical context information, circumstances of disappearance/death, burial type, relationship with other persons in the same grave.[77] The *Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains*, states that although genetic analysis is extremely important, it nevertheless has its limitations.[78] Therefore it states that it is necessary that a "multidisciplinary and comprehensive analysis of all the information should be undertaken". In this regard, it recommends the creation of an identification commission where forensic experts and laboratory teams can discuss all the characteristics of this case to provide an integrated forensic report that sets out a "unique and unequivocal position on the identification achieved".[79]

The Commission recommends that Part 6 of the General Scheme be revised to facilitate a comprehensive and multidisciplinary approach to the identification process.

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[77] See the Bournemouth Protocol. Also see Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains, August 2020 https:

[78] The Guide states that "[i]t should be borne in mind that, despite the extraordinary discriminatory power
of genetic testing and its possibility of expressing its results in statistical terms, as a percentage of likelihood, there are also some limitations, namely:

- Degraded DNA in bone/tooth.
- Contaminated DNA.
- PCR inhibition.
- False positives and negatives.
- Incomplete reference samples: absence of close biological relatives of the missing person.
- Closed, endogamous groups in the community affected.
- Lack of knowledge of the context of death/disappearance.
- Lack of a priori and a posteriori information.
- Difficulties in the follow-up of genetic matches by making a comparison
- with all the non-genetic data available.
- Lack of an identification statistical value.

All these potential limitations make it necessary that the genetic results be considered in the general context of the case; for this purpose, a multidisciplinary and comprehensive analysis of all the information should be undertaken." Argentine Forensic Anthropology Team, Forensic Guide to the Investigation, Recovery and Analysis of Human Skeletal Remains, August 2020 https://eaaf.org/wp-content/uploads/2020/11/EAAF-Forensic-Guide-for-the-investigation-recovery-and-analysis-of-human-skeletal-remains.pdf, at page 24=25.

[79] Ibid.

'Pilot programme' (Head 47)

Head 47 allows for the Agency to direct a 'pilot programme' of analysis to be carried out on a sample number of bodies exhumed from the site and, based on the sample results, the Director of the Agency will determine whether to proceed to a full identification programme. In making this determination, the Director shall have particular regard to the "proportion of samples tested from which DNA profiles were derived of sufficient standard to enable analysis". The Director shall not proceed to full identification programme unless she or he has "reason to believe that there is a reasonable prospect that bodies exhumed from a site may be identified through such a programme."

States are under an obligation to make best efforts to identify the human remains found in mass graves. Identification is arguably linked to the positive obligation to investigate an individual's death or disappearance. Also, it is a precondition for the return of human remains to families to facilitate burial and also for families to receive death certificates. Indeed, customary international humanitarian law provides that once the fate of a missing person has been determined to be death, all available means must be undertaken to ensure recovery of the body and any personal affects.[80]

> "The obligation to identify the dead is an obligation of means, and parties have to use their best efforts and all means at their disposal in this respect. According to the practice collected, the measures envisaged here include collecting one half of the double identity disk, autopsies, the recording of autopsies, the establishment of death certificates, the recording of the disposal of the dead, burial in individual graves, prohibition of collective graves without prior identification, and the proper marking of graves. Practice also suggests that exhumation combined with the application of forensic methods, including DNA testing, may be an appropriate method of identifying the dead after burial."[81]

It is unclear how the proposed pilot programme will work in practice. Implementation of a pilot project based on limited sample analysis may have the effect of preventing

[80] ICRC, Customary International Humanitarian Law, Rule 116
[81] Ibid, see interpretation at https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule116

individual identification which may in turn fall short of the State's human rights obligations to ensure the proper investigation into missing persons determined to be dead. Also, it is noted that potential family members have no recourse to appeal a determination of this kind which may have significant implications on their private and family life. In cases that engage fundamental rights, the Irish Courts have recognised the need for procedural safeguards such as an independent review mechanism.[82]

The Commission recommends further examination of the proposed pilot programme to ensure that it aligns with the State's obligations to carry out an effective investigation and that it reflects the State's 'best efforts' to identify and return remains to family members.

Should a pilot programme proceed, the Commission recommends revising this Head to ensure that necessary safeguards are in place to protect the rights of potential family members, including a mechanism to independently review decisions under this Head.

DNA (Historic Remains) Database System (Heads 48 and 49)

Head 48 provides that the DNA (Historic Remains) Database – either as a standalone database or using the DNA Database System established under the *Criminal Justice (Forensic Evidence and DNA Database System) Act 2014*[83] – will be utilised by Forensic Science Ireland to confidentially store DNA profiles created in accordance with this General Scheme. Head 49 provides that "the purpose of the DNA (Historic Remains) Database is to facilitate the analysis of DNA profiles in order to achieve a familial match with a person or persons who believe they may be related to persons exhumed from a specified site." Head 48(8) provides that it will be an offence to use DNA samples or other personal or biological data for any other purpose. Heads 60 and 61 provide for the destruction of biological samples and DNA profiles within a specified time-frame. Legislation providing for the taking of bodily samples, the creation of DNA profiles, the use of DNA profiles, and the retention and storage of DNA profiles engages important questions of human rights, particularly in relation to the fundamental constitutional

[82] See most recently for example Damache v. Minister for Justice [2020] IESC 63.
[83] This Act provided for the establishment of a DNA Database System for use by An Garda Síochána as an intelligence source for criminal investigations.

rights of bodily integrity[84] and privacy.[85] The ECtHR has held that the collection and retention of DNA profiles constitutes an interference with the right to respect for private life.[86] An interference with this right can be justified if is in accordance with the law, pursues a legitimate aim,[87] and is necessary in a democratic society.[88] The ECtHR has emphasised the importance of having clear and detailed rules that govern the scope and application of measures that allow for the taking of bodily samples and the creation of DNA profiles, as well as minimum safeguards concerning duration, storage, usage, access to third parties, procedures for preserving the integrity and confidentiality of data and procedures for its destruction.[89]

The Bournemouth Protocol states that; "data must be collected in a sensitive manner that protects the rights of survivors and the deceased" and that: "practices relating to personal data, genetic information and storage of such information must conform with domestic data provisions and be cognisant of international standards".[90]

The International Committee of the Red Cross (the 'ICRC') Model Rules states that it is important to ensure that a DNA analysis performed for the purpose of identification of a missing person be separated from any other use, for example, in criminal proceedings, otherwise it may inhibit recourse to this form of information gathering on the part of relatives and interested parties. It further warns:

> "these measures of protection must not in any way serve as an obstacle to locating or identifying the missing person. It is imperative therefore that within

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[84] Ryan v Attorney General [1965] IR 294.

[85] Article 40.3.1 of the Irish Constitution guarantees the unenumerated right to respect for private life as one of the fundamental personal rights of the citizen. See McGee v AG [1974] IR 284; Norris v AG [1984] IR 36 See also IHRC, Safeguards in DNA Database Scheme of Bill 'Inadequate', Press release, 08 August 2007; IHRC, Observations on the Criminal Justice (Forensic Evidence and DNA Database System) Bill 2010, March 2010; IHRC, Observations on the Criminal Justice (Forensic Evidence DNA Database System) Bill 2013, March 2014.

[86] See S. and Marper v. the United Kingdom, [GC], Nos. 30562/04 and 30566/04, 4 December 2008, paras 75-77.

[87] In the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

[88] Article 8(2) of the ECHR. The ECtHR has recognised this last factor, "necessary in a democratic society", involves a proportionality test in which the Court asks whether the interference is proportionate to the legitimate aim being pursued.

[89] S. and Marper v. the United Kingdom, [GC], Nos. 30562/04 and 30566/04, 4 December 2008, para 99.

[90] Bournemouth University, The Bournemouth Protocol on Mass Grave Protection and Investigation, 2020, p. 12.

organizations that collect, process or store personal data, clear procedures are put in place to ensure respect of privacy together with a system of accountability and control".[91]

The Commission recommends that legislation of this kind should be underpinned by rigorous safeguards governing the taking, retention, storage, sharing and destruction of bodily samples and DNA profiles, and the operation of the DNA (Historic Remains) Database System.

Participation in the programme (Head 53)

Head 53 provides that the Agency may invite people who believe "on reasonable grounds" that they may be the parent, child, sibling or half sibling of a person believed to be deceased and to have been interred at a specified site to participate in the identification programme.

There is no international guidance on the definition of family in the context of mass burials. The *Red Cross Guidelines for the use of forensic genetics in investigations into human rights and international humanitarian law violations* recommend that:

> "[s]amples should be collected from as many relatives of the missing person as necessary, preferably first-degree relatives (parents, siblings and offspring)".[92]

The Guidelines also state that if it is not possible to collect reference samples from the victim's first-degree relatives, samples should be collected from second-degree relatives. In this case, a greater number of relatives are required. It further states that when there are not enough informative relatives, a request can be made to exhume the bodies of relatives in order to take bone samples and obtain valuable genetic information.[93]

Whilst there may be strong scientific grounds to prioritise the sampling of first-degree relatives, access to the programme need not be drafted in a manner that automatically

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[91] ICRC, Advisory Service on International Humanitarian Law, Guiding Principles/Model Law on the Missing, Principles for Legislating the Situation of Persons Missing as a Result of Armed Conflict or Internal Violence: Measures to prevent persons from going missing and to protect the rights and interests of the missing and their families, p. 40.

[92] ICRC, Guidelines for the Use of Forensic Genetics in Investigations into Human Rights and International Humanitarian Law Violations, 2019, pp. 56-57.

[93] Ibid.

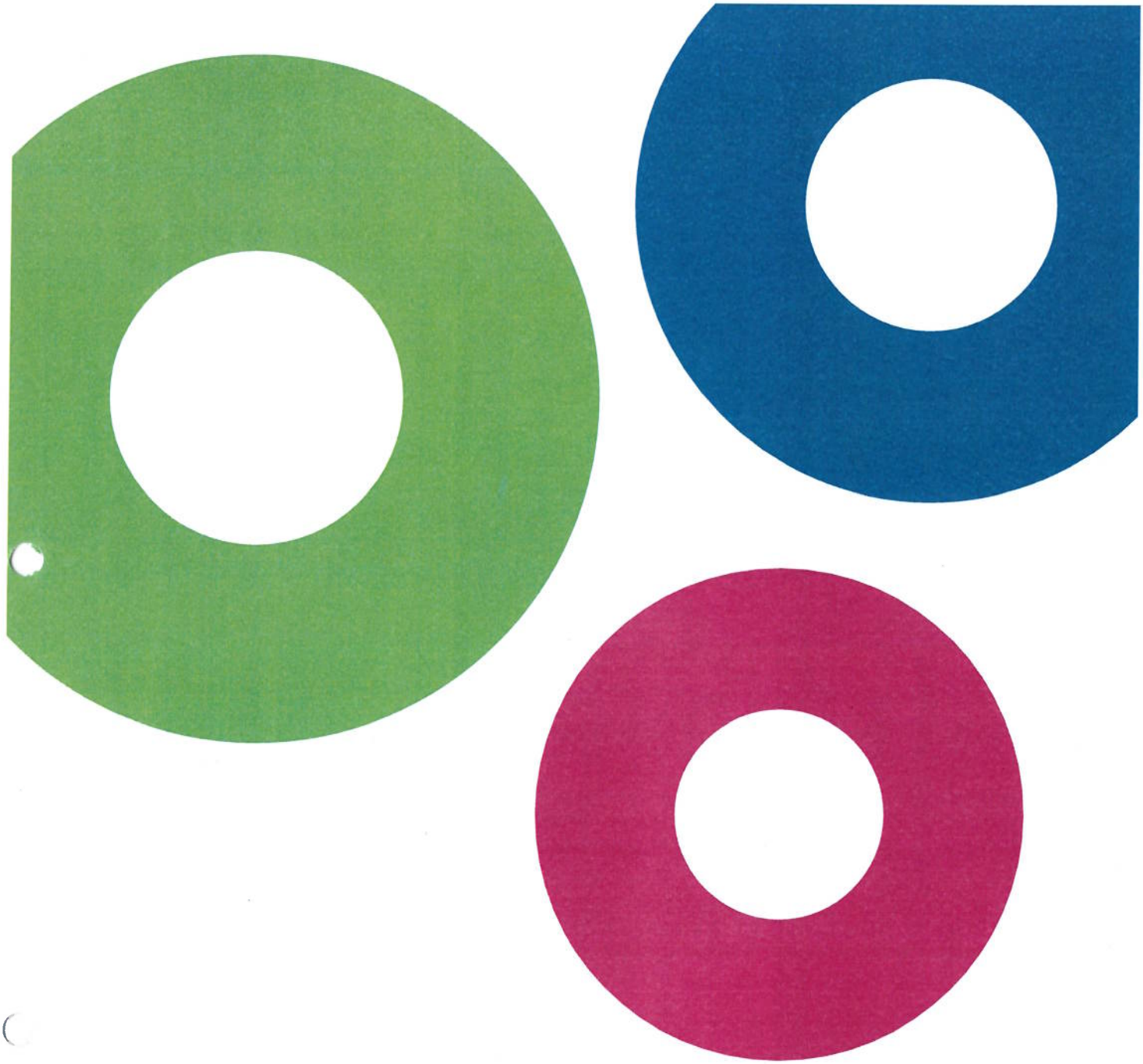
excludes other relatives, including for example, grand-parents or nieces and nephews of the deceased. This may be of particular relevance in the context of identification where it is not possible to collect DNA from first-degree relatives.

The Commission recommends further examination of the categories of persons deemed eligible to participate in the programme.

Review (Head 62)

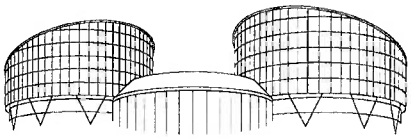
Head 62 provides that the Minister of Justice may, at his/her own initiative or on request by the Sponsoring Minister, review the operation of this Part insofar as it relates to the operation of the DNA (Historic Remains) Database System.
There is a lack of clarity over how, or when, such a review would be carried out (i.e. would there be a public consultation with relevant individuals, and would a report be published and presented before the Houses of the Oireachtas.

The Commission recommends that Head 62 be amended to clarify the purpose, structure, and scope of the review into the operation of Part 6. This should include an explicit requirement to review the operation after a set period of time. Any such review should include the meaningful participation of families, groups representing survivors and/or families, persons with human rights and/or data protection expertise, and other relevant persons or groups.



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EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

Guide on Article 2 of the European Convention on Human Rights

Right to life

Updated on 31 August 2025

Prepared by the Registry. It does not bind the Court.



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Note to readers

This Guide is part of the series of Guides on the Convention published by the European Court of Human Rights (hereafter "the Court", "the European Court" or "the Strasbourg Court") to inform legal practitioners about the fundamental judgments and decisions delivered by the Strasbourg Court. This particular Guide analyses and sums up the case-law on Article 2 of the European Convention on Human Rights (hereafter "the Convention" or "the European Convention"). Readers will find herein the key principles in this area and the relevant precedents.

The case-law cited has been selected among the leading, major, and/or recent judgments and decisions.*

The Court's judgments and decisions serve not only to decide those cases brought before it but, more generally, to elucidate, safeguard and develop the rules instituted by the Convention, thereby contributing to the observance by the States of the engagements undertaken by them as Contracting Parties (*Ireland v. the United Kingdom*, § 154, 18 January 1978, Series A no. 25, and, more recently, *Jeronovičs v. Latvia* [GC], no. 44898/10, § 109, 5 July 2016).

The mission of the system set up by the Convention is thus to determine issues of public policy in the general interest, thereby raising the standards of protection of human rights and extending human rights jurisprudence throughout the community of the Convention States (*Konstantin Markin v. Russia* [GC], § 89, no. 30078/06, ECHR 2012). Indeed, the Court has emphasised the Convention's role as a "constitutional instrument of European public order" in the field of human rights (*Bosphorus Hava Yolları Turizm ve Ticaret Anonim Şirketi v. Ireland* [GC], no. 45036/98, § 156, ECHR 2005-VI, and more recently, *N.D. and N.T. v. Spain* [GC], nos. 8675/15 and 8697/15, § 110, 13 February 2020).

Protocol No. 15 to the Convention recently inserted the principle of subsidiarity into the Preamble to the Convention. This principle "imposes a shared responsibility between the States Parties and the Court" as regards human rights protection, and the national authorities and courts must interpret and apply domestic law in a manner that gives full effect to the rights and freedoms defined in the Convention and the Protocols thereto (*Grzęda v. Poland* [GC], § 324).

This Guide contains references to keywords for each cited Article of the Convention and its Additional Protocols. The legal issues dealt with in each case are summarised in a List of keywords, chosen from a thesaurus of terms taken (in most cases) directly from the text of the Convention and its Protocols.

The HUDOC database of the Court's case-law enables searches to be made by keyword. Searching with these keywords enables a group of documents with similar legal content to be found (the Court's reasoning and conclusions in each case are summarised through the keywords). Keywords for individual cases can be found by clicking on the Case Details tag in HUDOC. For further information about the HUDOC database and the keywords, please see the HUDOC user manual.

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* The hyperlinks to the cases cited in the electronic version of the Guide refer to the text in English or French (the two official languages of the Court) of the judgment or decision delivered by the Court and of the decisions or reports of the European Commission of Human Rights (hereafter "the Commission"). Unless otherwise indicated, all references are to a judgment on the merits delivered by a Chamber of the Court. The abbreviation "(dec.)" indicates that the citation is of a decision of the Court and "[GC]" that the case was heard by the Grand Chamber. Chamber judgments that were not final when this update was published are marked with an asterisk (*).

I. General considerations

Article 2 of the Convention

"1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

HUDOC keywords

Expulsion (2) – Extradition (2) – Positive obligations (2)

Life (2-1) – Death penalty (2-1): Prescribed by law (2-1); Accessibility (2-1); Foreseeability (2-1); Safeguards against abuse (2-1); Competent court (2-1) – Effective investigation (2-1)

Use of force (2-2) – Absolutely necessary (2-2): Defence from unlawful violence (2-2); Effect lawful arrest (2-2); Prevent escape (2-2); Quell riot or insurrection (2-2)

A. Interpretation of Article 2

1. The Court's approach to the interpretation of Article 2 must be guided by the fact that the object and purpose of the Convention as an instrument for the protection of individual human beings requires that its provisions must be interpreted and applied so as to make its safeguards practical and effective (*McCann and Others v. the United Kingdom*, 1995, § 146).

2. Article 2 ranks as one of the most fundamental provisions in the Convention, one which in peace time, admits of no derogation under Article 15. Together with Article 3, it enshrines one of the basic values of the democratic societies making up the Council of Europe (*Giuliani and Gaggio v. Italy* [GC], 2011, § 174). As such, its provisions must be strictly construed (*McCann and Others v. the United Kingdom*, 1995, § 147).

B. State obligations under Article 2

3. Article 2 contains two substantive obligations: the general obligation to protect by law the right to life, and the prohibition of intentional deprivation of life, delimited by a list of exceptions (*Boso v. Italy* (dec.), 2002). Having regard to its fundamental character, Article 2 of the Convention also contains a procedural obligation to carry out an effective investigation into alleged breaches of its substantive limb (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 229).

C. Applicability of Article 2 in near death situations

4. The Court has emphasised on many occasions that Article 2 of the Convention may come into play even if a person whose right to life was allegedly breached did not die. In particular, the Court has held that in exceptional circumstances, depending on considerations such as the degree and type of force used and the nature of the injuries, use of force by State agents which does not result in death

may disclose a violation of Article 2 of the Convention, if the behaviour of the State agents, by its very nature, puts the applicant's life at serious risk even though the latter survives (*Makaratzis v. Greece* [GC], 2004, § 55; *Soare and Others v. Romania*, 2011, §§ 108-109; *Trévalec v. Belgium*, 2011, §§ 55-61). In all other cases where a person is assaulted or ill-treated by State agents, their complaints will rather fall to be examined under Article 3 of the Convention (*Makaratzis v. Greece* [GC], 2004, § 51; *İlhan v. Turkey* [GC], 2000, § 76). In cases concerning applicants who survived a potentially lethal attack by non-State actors, the Court has adopted a similar approach to the one taken in respect of cases concerning use of force by State agents (*Yotova v. Bulgaria*, 2012, § 69; see also *Selçuk v. Türkiye*, 2024, § 73).

5. The Court has also found the allegations of persons suffering from serious illnesses to fall under Article 2 of the Convention when the circumstances potentially engaged the responsibility of the State (*L.C.B. v. the United Kingdom*, 1998, §§ 36-41, concerning an applicant suffering from leukaemia; *G.N. and Others v. Italy*, 2009, concerning applicants suffering from a potentially life-threatening disease, hepatitis; *Hristozov and Others v. Bulgaria*, 2012, concerning applicants suffering from different forms of terminal cancer; *Oyal v. Turkey*, 2010, in which the applicant had been infected with the HIV virus, which endangered his life; *Aftanache v. Romania*, 2020, § 53, where the medical personnel refused to administer the usual insulin treatment to a diabetic in a precarious condition and *a contrario Brincat and Others v. Malta*, 2014, § 84, where the Court considered that Article 2 did not apply to the applicants, former employees of a Government-run ship repair yard, who had been exposed to asbestos, since their current health conditions were neither an inevitable precursor to the diagnosis of a rare cancer associated with asbestos exposure nor life-threatening).

6. The Court has also examined, on the merits, allegations made under Article 2 by persons claiming that their life was at risk, although no such risk had yet materialised, when it was persuaded that there had been a serious threat to their lives (*R.R. and Others v. Hungary*, 2012, §§ 26-32, where the applicants complained of having been excluded from a witness protection programme; *Makuchyan and Minasyan v. Azerbaijan and Hungary*, 2020, §§ 93-94 where the perpetrator threatened to kill the applicant whilst trying to break down the door of his room with an axe; and, by contrast, *Selahattin Demirtaş v. Turkey*, 2015, §§ 30-36, where the applicant complained that a newspaper Article had put his life at risk).

7. Likewise, in cases concerning potentially lethal accidents (*Alkın v. Turkey*, 2009, § 29; *Çakmakçı v. Turkey* (dec.), 2017, § 32; *Fergec v. Croatia*, 2017, §§ 21-24; *Kotelnikov v. Russia*, 2016, § 98; *Cavit Tınarlıoğlu v. Turkey*, 2016, § 67; *Marius Alexandru and Marinela Ştefan v. Romania*, 2020, § 75), or environmental disasters (*Kolyadenko and Others v. Russia*, 2012, § 155), the Court has examined under Article 2 of the Convention the complaints of the applicant who had fortuitously survived the incident. The principle is that in such situations Article 2 applies either if (a) the activity at issue was dangerous by its very nature and put the life of the people concerned at real and imminent risk, or if (b) the injuries suffered by them were seriously life-threatening. The assessment of the relevant risk or injury depends on various factors (*Nicolae Virgiliu Tănase v. Romania* [GC], 2019, §§ 139-145).

8. In *Jeanty v. Belgium*, 2020, where a detainee with psychological difficulties failed in his numerous attempts to commit suicide, the Court considered that Article 2 was applicable in the circumstances of the case, irrespective of the fact that the injuries he had sustained were not serious, in view of the nature of the action at issue which put the applicant's life at a real and imminent risk (§ 62).

9. In fact, the Court has underlined that Article 2 also comes into play in situations where the person concerned was the victim of an activity or conduct, whether public or private, which by its nature put his or her life at real and imminent risk and he or she has suffered injuries that appear life-threatening as they occur, even though he or she ultimately survived (*Tërshana v. Albania*, 2020, § 132; *Lapshin v. Azerbaijan*, 2021, § 71).

10. The Court has recently clarified that, in order for Article 2 to apply to complaints about State action and/or inaction in the context of climate change, it needs to be determined that there is a "real

and imminent" risk to life, understood as referring to a serious, genuine and sufficiently ascertainable threat to the life of a specific applicant, containing an element of material and temporal proximity of the threat to the harm impugned by the applicant *(Verein KlimaSeniorinnen Schweiz and Others v. Switzerland* [GC], 2024, § 513). The case of *Cannavacciuolo and Others v. Italy,* 2025, §§ 384-392 concerned a particularly complex and widespread form of pollution stemming from illegal dumping, burying and/or uncontrolled abandonment of hazardous, special and urban waste, often carried out by criminal organized groups and frequently combined with incineration. The Court accepted the existence of a sufficiently serious, genuine and ascertainable risk to life, which was also imminent given the applicants' residence over a considerable period in the municipalities officially identified by the domestic authorities as being affected by systematic large-scale pollution.

II. Protection of life

Article 2 § 1 of the Convention

"1. Everyone's right to life shall be protected by law. ..."

HUDOC keywords

Positive obligations (2) – Life (2-1)

A. The nature of the positive obligations of the State

11. Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life but also to take appropriate steps to safeguard the lives of those within its jurisdiction (*Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], 2014, § 130). In broad terms, this positive obligation has two aspects: (a) the duty to provide a regulatory framework; and (b) the obligation to take preventive operational measures.

B. The scope of the positive obligations of the State

12. The Court has found the positive obligation under Article 2 to take appropriate steps to safeguard the lives of those within its jurisdiction to apply in the context of any activity, whether public or not, in which the right to life may be at stake (*Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], 2014, § 130).

13. Thus, the Court has found positive obligations to arise under Article 2 in a number of different contexts, such as, for example:

- in the context of healthcare (*Calvelli and Ciglio v. Italy* [GC], 2002; *Vo v. France* [GC], 2004);
- in the context of dangerous activities, including industrial or environmental disasters (*Öneryıldız v. Turkey* [GC], 2004; *Budayeva and Others v. Russia,* 2008; *Kolyadenko and Others v. Russia,* 2012; *Brincat and Others v. Malta,* 2014; *M. Özel and Others v. Turkey,* 2015; *Durdaj and Others v. Albania*, 2023; *Erdal Muhammet Arslan and Others v. Türkiye*, 2023);
- in the context of incidents on board a ship (*Leray and Others v. France* (dec.), 2001), on trains (*Kalender v. Turkey*, 2009), on a construction site (*Pereira Henriques v. Luxembourg*, 2006), at a playground (*Koceski v. the former Yugoslav Republic of Macedonia* (dec.), 2013); or at a school (*Ilbeyi Kemaloğlu and Meriye Kemaloğlu v. Turkey*, 2012);

- in the context of road safety (*Rajkowska v. Poland* (dec.), 2007; *Anna Todorova v. Bulgaria*, 2011); the provision of emergency services (*Furdík v. Slovakia* (dec.), 2008); or diving operations in deep sea (*Vilnes and Others v. Norway*, 2013);
- in the context of medical care and assistance given to vulnerable persons institutionalised in State facilities (*Nencheva and Others v. Bulgaria*, 2013; *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], 2014; *Dumpe v. Latvia* (dec.), 2018);
- in the context of the State's failure to properly secure an area mined by the military (*Paşa and Erkan Erol v. Turkey*, 2006; *Albekov and Others v. Russia*, 2008); to secure and supervise a firing range containing unexploded ordonance (*Oruk v. Turkey*, 2014); and to react promptly to a disappearance in life-threatening circumstances (*Osmanoğlu v. Turkey*, 2008; *Dodov v. Bulgaria*, 2008);
- in the context of an operation to rescue migrants who were drowning while trying to cross borders at sea (*Safi and Others v. Greece*, 2022) or a river (*Alhowais v. Hungary*, 2023);
- in the context of emergency medical assistance to military servicemen (*Dimaksyan v. Armenia*, 2023).

14. In a case where the applicant's husband died after being hit by a tree in a health resort, the Court has held that the State's duty to safeguard the right to life extended to the taking of reasonable measures to ensure the safety of individuals in public places (*Ciechońska v. Poland*, 2011, § 67).

15. However, the Court has underlined, many times, that Article 2 of the Convention cannot be interpreted as guaranteeing to every individual an absolute level of security in any activity in which the right to life may be at stake, in particular when the person concerned bears a degree of responsibility for the accident having exposed himself or herself to unjustified danger (*Molie v. Romania* (dec.), 2009, § 44; *Koseva v. Bulgaria* (dec.), 2010; *Gökdemir v. Turkey* (dec.), 2015, § 17; *Çakmak v. Turkey* (dec.), 2017).

16. Nonetheless, in the very particular context of detention, the Court has held that there are certain basic precautions which the authorities are expected to take in all cases in order to minimise any potential risk to protect the health and well-being of persons deprived of their liberty (*Daraibou v. Croatia*, 2023, § 84; see also *Ainis and Others v. Italy*, 2023, § 58 where the applicant's relative died of a drug overdose while in police custody).

C. Protection of life in context

17. As mentioned above, the positive obligations of the State arise in different contexts, some of which are referred to below.

1. Protection of persons from lethal use of force by non-State actors

18. The Court has held that Article 2 of the Convention implies in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual (*Osman v. the United Kingdom*, 1998, § 115; *Branko Tomašić and Others v. Croatia*, 2009, § 50).

19. However, bearing in mind the difficulties involved in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, such an obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, for the Court not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising (*Osman v. the United Kingdom*, 1998, § 116; *Choreftakis and Choreftaki v. Greece*, 2012, § 46).

20. In this respect, the Court takes into consideration the need to ensure that the police exercise their powers to control and prevent crime in a manner which fully respects the due process and other guarantees which legitimately place restraints on the scope of their action to investigate crime and bring offenders to justice, including the guarantees contained in Articles 5 and 8 of the Convention (*Osman v. the United Kingdom*, 1998, § 116).

21. For a positive obligation to arise it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual or individuals from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (*Mastromatteo v. Italy* [GC], 2002, § 68; *Paul and Audrey Edwards v. the United Kingdom*, 2002, § 55).

22. In this regard, the Court has underlined that the duty to take preventive operational measures under Article 2 is an obligation of means, not of result. Thus, in circumstances where the competent authorities have become aware of a real and immediate risk to life triggering their duty to act, and have responded to the identified risk by taking appropriate measures within their powers in order to prevent that risk from materialising, the fact that such measures may nonetheless fail to achieve the desired result is not in itself capable of justifying the finding of a violation under this head. On the other hand, the Court observes that in this context, the assessment of the nature and level of risk constitutes an integral part of the duty to take preventive operational measures where the presence of a risk so requires. Thus, an examination of the State's compliance with this duty under Article 2 must comprise an analysis of both the adequacy of the assessment of risk conducted by the domestic authorities and, where a relevant risk triggering the duty to act was or ought to have been identified, the adequacy of the preventive measures taken (*Kurt v. Austria* [GC], 2021, § 160).

23. For the Court it is sufficient for an applicant to show that the authorities did not do all that could be reasonably expected of them to avoid a real and immediate risk to life of which they have or ought to have knowledge. This question in its view could only be answered in the light of all the circumstances of the case at hand (*Osman v. the United Kingdom*, 1998, § 116). Moreover, the Court must be cautious about revisiting events with the wisdom of hindsight. This means that a given case in which a real and immediate risk materialised must be assessed from the point of view of what was known to the competent authorities at the relevant time (*Kurt v. Austria* [GC], 2021, § 160).

24. If the Court considers that it has not been established that the authorities knew or ought to have known at the relevant time of the existence of a risk which was both real and immediate, no obligation would be triggered to take preventive operational measures in that regard (*Kurt v. Austria* [GC], 2021, § 211; see also *Derenik Mkrtchyan and Gayane Mkrtchyan v. Armenia*, 2021, §§ 59-60, which concerned the death of a child of ten years with pre-existing health issues, during a fight with his peers in class while the teacher was absent; *Tagiyeva v. Azerbaijan*, 2022, §§ 60-66, where a well-known writer and columnist, who had a fatwa issued against him several years prior to the events in Iran, was fatally stabbed by an unknown person and *Fernandes de Oliveira v. Portugal* [GC], 2019, § 131-132, albeit in a different context, namely suicide).

25. The Court has considered the State to have an obligation to take preventive operational measures to protect one or more individuals identifiable in advance as the potential target of a lethal act in contexts such as:

- murder of a prisoner (*Paul and Audrey Edwards v. the United Kingdom*, 2002, §57);
- domestic violence (*Branko Tomašić and Others v. Croatia*, 2009, §§ 52-53; *Opuz v. Turkey*, 2009, § 129; *Tkhelidze v. Georgia*, 2021, § 57; *A and B v. Georgia*, 2022, § 49; *N.D. v. Switzerland*, 2025, § 67);
- protection of witnesses in criminal proceedings (*Van Colle v. the United Kingdom*, 2012, and *A and B v. Romania*, 2020, § 118);

- killing of individuals in a conflict zone (*Kılıç v. Turkey*, 2000, § 63; *Mahmut Kaya v. Turkey*, 2000, § 88);
- killing of a conscript during military service by a fellow conscript (*Yabansu and Others v. Turkey*, 2013, § 91; see also *Hovhannisyan and Karapetyan v. Armenia*, 2023).
- kidnapping of an individual (*Olewnik-Cieplińska and Olewnik v. Poland*, 2019, § 125).

26. The Court has also applied the aforementioned principles to cases giving rise to an obligation to afford general protection to society in certain specific contexts, such as:

- murder committed by convicts on prison leave or placed under a semi-custodial regime (*Mastromatteo v. Italy* [GC], 2002, § 69);
- killing by convicted murderer following his release on licence (*Choreftakis and Choreftaki v. Greece*, 2012, §§ 48-49);
- killing by an off-duty police officer (*Gorovenky and Bugara v. Ukraine*, 2012, § 32);
- murder of a lawyer by her client's mentally disturbed husband (*Bljakaj and Others v. Croatia*, 2014, § 121);
- killings perpetrated during a large-scale hostage-taking by terrorists (*Tagayeva and Others v. Russia*, 2017, §§ 482-492; by contrast, *Finogenov and Others v. Russia* (dec.), 2010, § 173);
- injuries sustained by the applicant in the course of a demonstration following a terrorist attack where a hundred people died (*Selçuk v. Türkiye*, 2024, §§ 96-97).

27. In a recent case the authorities did not preventively confiscate a gun from a student whose internet postings prior to committing school killings, while not containing specific threats, cast doubt on his fitness to safely possess a firearm. The Court has laid emphasis on the fact that the use of firearms entails a high level of inherent risk to life and that therefore the State had to put in place and rigorously apply a system of adequate and effective safeguards designed to counteract and prevent any improper and dangerous use of such weapons (*Kotilainen and Others v. Finland*, 2020, § 88; see also *Svrtan v. Croatia*, 2024, § 99 where, in the context of the phenomenon of widespread illegal possession of weapons post-war, the applicants' son was killed by a person with an alleged history of alcohol abuse, violent behavior and unlawful possession of firearms.

28. The case of *Ribcheva and Others v. Bulgaria*, 2021, concerned the death of a law-enforcement officer during a planned operation. The Court considered that, when deciding to involve the applicants' relative in the operation in his capacity as a specialised officer tasked with dealing with dangerous individuals, the authorities had a positive duty to do what could reasonably be expected of them to protect him from the risks of such an operation. In this respect, drawing on its well-established case-law, the Court emphasised that the standard of reasonableness in relation to this *positive* obligation (Article 2 § 1) was not as stringent as that in respect of the *negative* obligation (Article 2 § 2) to refrain from using force "more than absolutely necessary" (a strictly proportionate use of force excluding any margin of appreciation). Rather, the scope and content of the positive operational obligation at issue had to be defined in a way which does not impose an impossible or disproportionate burden on the authorities given the choices they face (priorities and resources) and given the unpredictability of human conduct (§ 165). On the basis of the information contained in the case-file, the Court found that, while the authorities had made mistakes in the planning and execution of the operation, the steps they had taken to minimise the risk to the officer's life were reasonable (§180).

29. In a recent domestic violence case where the applicants' relative was killed by her husband, from whom she had been *de facto* separated for three years and who had been harassing her for nine months, the Court found that the authorities failed to respond immediately to the complaints of the deceased, save on one occasion, and failed to carry out any proactive, autonomous, and comprehensive risk assessment having regard to the context of domestic violence. It considered that, had the authorities carried out such a risk assessment, they would have appreciated that there was a real and immediate risk to the life of the applicants' relative and they could have taken various steps,

including ensuring proper coordination amongst themselves, to avert the risk to her life. The only preventive measure undertaken by the authorities, namely, protective orders remained without any tangible effect. Therefore, given the circumstances in the case, the authorities failed to take adequate preventive measures to protect the life of the applicants' relative (*Y and Others v. Bulgaria*, 2022, §§ 91-110; see also *Landi v. Italy*, 2022, where the authorities' failure to take preventive action against recurrent domestic violence led to the applicant's attempted murder by her partner and to the murder of their son).

2. Protection of persons from self-harm

30. The Court has held that Article 2 may imply in certain well-defined circumstances a positive obligation on the part of the authorities to take preventive operational measures in particular circumstances to protect an individual from himself or herself (*Renolde v. France*, 2008, § 81).

31. In particular, persons in custody are in a vulnerable position and the authorities are under a duty to protect them (*Keenan v. the United Kingdom*, 2001, § 91). The prison authorities, similarly, must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case (*Renolde v. France*, 2008, § 83).

32. Likewise, in the context of individuals carrying out military service, the Court has underlined that, as with persons in custody, conscripts and contractual military servicemen, whose conditions of life and service correspond to those of conscripts, are within the exclusive control of the authorities of the State and that the authorities are under a duty to protect them (*Beker v. Turkey*, 2009, §§ 41-42; *Mosendz v. Ukraine*, 2013, § 92; *Boychenko v. Russia*, 2021, § 80).

33. Persons with mental disabilities are considered to constitute a particularly vulnerable group who require protection from self-harm (*Renolde v. France*, 2008, § 84 and *S.F. v. Switzerland*, 2020, § 78).

34. In particular, the authorities have a general operational duty to take reasonable measures to prevent a person from self-harm, irrespective of whether there has been voluntary or involuntary hospitalisations. In this respect, the specific measures required will depend on the particular circumstances of the case, and those specific circumstances will often differ depending on whether the patient is voluntarily or involuntarily hospitalised. However, in the case of patients who are hospitalised following a judicial order, and therefore involuntarily, the Court, in its own assessment, may apply a stricter standard of scrutiny (*Fernandes de Oliveira v. Portugal* [GC], 2019, § 124).

35. Ultimately, for a positive obligation to arise where the risk to a person derives from self-harm, such as a suicide in custody or in a psychiatric hospital, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (*Younger v. the United Kingdom* (dec.), 2003; *Fernandes de Oliveira v. Portugal* [GC], 2019, § 110).

36. In order to establish whether the authorities knew or ought to have known that the life of a particular individual was subject to a real and immediate risk, triggering the duty to take appropriate preventive measures, the Court takes into account a number of factors, including: i) whether the person had a history of mental health problems; ii) the gravity of the mental condition; iii) previous attempts to commit suicide or self-harm; iv) suicidal thoughts or threats; and v) signs of physical or mental distress (*Fernandes de Oliveira v. Portugal* [GC], 2019, § 115 and *Boychenko v. Russia*, 2021, § 80).

37. Moreover, the Court also reiterates that the obligation to protect the health and well-being of persons in detention clearly encompasses an obligation to protect the life of arrested and detained

persons from a foreseeable danger (*Eremiášová and Pechová v. the Czech Republic* (revision), 2013, § 117; *Keller v. Russia*, 2013, § 88).

38. The duty to take preventive operational measures has arisen so far mainly in the following contexts:

- detention in custody or in prison (*Trubnikov v. Russia*, 2005; *Akdoğdu v. Turkey*, 2005; *De Donder and De Clippel v. Belgium*, 2011; *Ketreb v. France*, 2012; *Volk v. Slovenia*, 2012; *Mitić v. Serbia*, 2013; *Keller v. Russia*, 2013; *S.F. v. Switzerland*, 2020);
- compulsory military service (*Kılınç and Others v. Turkey*, 2005; *Ataman v. Turkey*, 2006; *Perevedentsevy v. Russia*, 2014; *Malik Babayev v. Azerbaijan*, 2017) or contractual military service (*Boychenko v. Russia*, 2021);
- voluntary/involuntary psychiatric care (*Reynolds v. the United Kingdom*, 2012; *Fernandes de Oliveira v. Portugal* [GC], 2019; *Hiller v. Austria*, 2016).

39. The Court has underlined that, when considering whether the duty to take preventive operational measures arises in a particular situation, it takes account of the context in which a death takes place, and the degree of control that the authorities exercise over the events (*Hasani v. Sweden*, 2025, § 64). For example, in a case where the applicant's wife set herself on fire in protest at a forced eviction, the Court held that, in a situation where an individual threatens to take his or her own life in plain view of State agents and, moreover, where this threat is an emotional reaction directly induced by the State agents' actions or demands, the latter should treat this threat with the utmost seriousness as constituting an imminent risk to that individual's life, regardless of how unexpected that threat might have been. In such circumstances, if the State agents become aware of such a threat sufficiently in advance, a positive obligation arises under Article 2 requiring them to prevent this threat from materialising by any means which are reasonable and feasible in the circumstances (*Mikayil Mammadov v. Azerbaijan*, 2009, § 115).

40. Likewise, the Court found the State's **positive obligation** engaged in the very particular circumstances where a young asylum-seeker - unaccompanied by adult family members, suffering from visual impairment and mental health problems and dependent to a large extent on the care and accommodation provided by the Swedish authorities - committed suicide (*Hasani v. Sweden*, 2025, § 70).

3. Protection of persons from environmental or industrial disasters

41. In the context of industrial activities, which the Court has deemed to be by their very nature dangerous, the Court has placed a special emphasis on regulations geared to the special features of the activity in question, particularly with regard to the level of the potential risk to human lives. It considered that they must govern the licensing, setting up, operation, security and supervision of the activity and must make it compulsory for all those concerned to take practical measures to ensure the effective protection of citizens whose lives might be endangered by the inherent risks.

42. Among these preventive measures, a particular weight should be placed on the public's right to information, as established in the case-law of the Convention institutions and relevant regulations must also provide for appropriate procedures, taking into account the technical aspects of the activity in question, for identifying shortcomings in the processes concerned and any errors committed by those responsible at different levels (*Öneryıldız v. Turkey* [GC], 2004, § 90; *Budayeva and Others v. Russia*, 2008, § 132; *Kolyadenko and Others v. Russia*, 2012, § 159).

43. As to the choice of particular practical measures, the Court has consistently held that where the State is required to take positive measures, the choice of means is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues to ensure Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means. In this respect an impossible or disproportionate

burden must not be imposed on the authorities without consideration being given, in particular, to the operational choices which they must make in terms of priorities and resources; this results from the wide margin of appreciation States enjoy, as the Court has previously held, in difficult social and technical spheres (*Budayeva and Others v. Russia*, 2008, §§ 134-135; *Vilnes and Others v. Norway*, 2013, § 220; *Brincat and Others v. Malta*, 2014, § 101).

44. In assessing whether the respondent State complied with its positive obligation, the Court must consider the particular circumstances of the case, regard being had, among other elements, to the domestic legality of the authorities' acts or omissions, the domestic decision-making process, including the appropriate investigations and studies, and the complexity of the issue, especially where conflicting Convention interests are involved. The scope of the positive obligations imputable to the State in the particular circumstances would depend on the origin of the threat and the extent to which one or the other risk is susceptible to mitigation (*Budayeva and Others v. Russia*, 2008, §§ 136-137; *Kolyadenko and Others v. Russia*, 2012, § 161).

45. Whenever a State undertakes or organises dangerous activities, or authorises them, it must ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum (*Mučibabić v. Serbia*, 2016, § 126). If nevertheless damage arises, it will only amount to a breach of the State's positive obligations if it was due to insufficient regulations or insufficient control, but not if the damage was caused through the negligent conduct of an individual or a concatenation of unfortunate events (*Stoyanovi v. Bulgaria*, 2010, § 61).

46. While States have no control over natural events such as earthquakes, it is nonetheless the responsibility of States to ensure the prevention of foreseeable natural risks and to adopt measures aimed at reducing their effects in order to minimise their catastrophic dimension. In this respect, the scope of the obligation of prevention, which remains an obligation of means, consists of strengthening the State's capacity to deal with this type of natural and violent phenomenon (*Erdal Muhammet Arslan and Others v. Türkiye*, 2023, § 128).

47. More detailed information can be found in the Case-Law Guide on the Environment.

4. Protection of persons in the context of healthcare

a. General population

48. In the context of healthcare, the positive obligations require States to make regulations compelling hospitals, whether private or public, to adopt appropriate measures for the protection of patients' lives (*Calvelli and Ciglio v. Italy* [GC], 2002, § 49; *Vo v. France* [GC], 2004, § 89; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 166).

49. In this connection, the States' obligation to regulate must be understood in a broader sense which includes the duty to ensure the effective functioning of that regulatory framework. The regulatory duties thus encompass necessary measures to ensure implementation, including supervision and enforcement (*Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 190).

50. However, the question whether there has been a failure by the State in its regulatory duties calls for a concrete assessment of the alleged deficiencies rather than an abstract one. Therefore, the mere fact that the regulatory framework may be deficient in some respect is not sufficient in itself to raise an issue under Article 2 of the Convention. It must be shown to have operated to the patient's detriment (*Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 188).

51. The Court has underlined that even in cases where medical negligence was established, it would normally find a substantive violation of Article 2 only if the relevant regulatory framework failed to ensure proper protection of the patient's life (*Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 187). In this connection, the Court considered that where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of

patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient cannot be considered sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life (*Powell v. the United Kingdom* (dec.), 2000; *Dodov v. Bulgaria*, 2008, § 82; *Kudra v. Croatia*, 2012, § 102; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 187).

52. However, it has not excluded the possibility that the acts and omissions of the authorities in the context of public health policies, may, in certain circumstances, engage the Contacting Parties' responsibility under the substantive limb of Article 2 (*Powell v. the United Kingdom* (dec.), 2000) and that an issue may arise under Article 2 where it is shown that the authorities of a Contracting State have put an individual's life at risk through the denial of the health care which they have undertaken to make available to the population generally (*Cyprus v. Turkey* [GC], 2001, § 219; *Hristozov and Others v. Bulgaria*, 2012, § 106).

53. In two very exceptional circumstances, the Court has accepted that the responsibility of the State under the substantive limb of Article 2 was engaged as regards the acts and omissions of health-care providers: firstly, where an individual patient's life was knowingly put in danger by a denial of access to life-saving emergency treatment (*Mehmet Şentürk and Bekir Şentürk v. Turkey*, 2013) and, secondly, where a systemic or structural dysfunction in hospital services resulted in a patient being deprived of access to life-saving emergency treatment where the authorities knew about or ought to have known about that risk and failed to take the necessary measures to prevent that risk from materialising, thus putting the patients' lives, including the life of the particular patient concerned, in danger (*Aydoğdu v. Turkey*, 2016).

54. For the Court, in order for a case to be qualified as denial of access to life-saving emergency treatment, the following factors, taken cumulatively, must be met:

- firstly, the acts and omissions of the health-care providers had to go beyond a mere error or medical negligence in that those health-care providers, in breach of their professional obligations, denied a patient emergency medical treatment despite being fully aware that the person's life is at risk if that treatment is not given;
- secondly, the impugned dysfunction had to be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities;
- thirdly, there had to be a link between the impugned dysfunction and the harm sustained; and
- finally, the dysfunction must have resulted from the failure of the State to meet its obligation to provide a regulatory framework in the broader sense (*Lopes de Sousa Fernandes v. Portugal* [GC], 2017, §§ 191-196).

55. The Court examined a number of cases raising issues of medical negligence and/or denial of access to treatment in hospital, such as:

- administration of drugs to a disabled child despite his mother's opposition (*Glass v. the United Kingdom* (dec.), 2003);
- death of an elderly woman from bronchopneumonia (*Sevim Güngör v. Turkey* (dec.), 2009);
- death of a pregnant woman suffering from ulcerative colitis (*Z v. Poland*, 2012);
- death in hospital related to pulmonary complications and patient's refusal to consent to treatment (*Arskaya v. Ukraine*, 2013);
- death of a pregnant woman due to the doctors' refusal to carry out an urgent operation owing to her inability to pay medical fees (*Mehmet Şentürk and Bekir Şentürk v. Turkey*, 2013);

- death of a new-born baby in an ambulance after being refused admission to a number of public hospitals (*Asiye Genç v. Turkey*, 2015);
- death after a heart attack caused by the administration of a drug (*Altuğ and Others v. Turkey*, 2015);
- death of the applicant's son in a hospital where unlicensed medical acts were carried out on him by doctors who lacked either the necessary licences or qualifications in violation of domestic law (*Sarishvili-Bolkvadze v. Georgia*, 2018).

56. In a number of cases the Court examined allegations of denial of access to medical treatment because of the refusal of the State to fully cover the costs of a particular form of conventional treatment. See, for example, *Nitecki v. Poland* (dec.), 2002; *Pentiacova and Others v. Moldova* (dec.); 2005, *Gheorghe v. Romania* (dec.), 2005; *Wiater v. Poland* (dec.), 2012.

57. In the case of *Hristozov and Others v. Bulgaria*, 2012, where terminal cancer patients complained that they had been denied access to an unauthorised experimental drug, the Court did not find fault with the regulations governing access to such unauthorised medicinal products in situations where conventional forms of medical treatment appeared insufficient, and considered that Article 2 of the Convention could not be interpreted as requiring access to unauthorised medicinal products for terminally ill patients to be regulated in a particular way (§ 108).

58. Where applicants were unable to obtain access to funds raised, in order to pay for the medical treatment abroad of their dying son, due to a statutory prohibition, the question whether Article 2 was applicable was left open, since the Court found that, in any event, having regard to the particular circumstances, there was no failure on the part of the State to comply with the requirements of that provision to protect life (*Pitsiladi and Vasilellis v. Greece,* §§ 54-55).

59. In *Traskunova v. Russia*, 2022, the applicant's daughter died while she was participating in two sets of clinical trials of a new drug for schizophrenia. The Court emphasised the importance for individuals, who are facing risks to their health, to have access to information enabling them to assess those risks. In this regard, it considered that States were bound to adopt the necessary regulatory measures to ensure that doctors consider the foreseeable impact of a planned medical procedure on their patients' physical integrity and to inform patients of these consequences beforehand in such a way that the latter are able to give informed consent (*ibid.*, § 70). The Court underlined the need for persons with mental disabilities to enjoy heightened protection and that their participation in clinical trials be accompanied by particularly strong safeguards, with due account given to the particularities of their mental condition and its evolution over time (*ibid.*, § 79). On the facts of the case, the Court considered that the implementation of the regulatory framework was deficient and that the guarantees concerning informed consent of participants of clinical trials had not been complied with. It therefore found that the State had failed to protect the right to life of the applicant's daughter, who was particularly vulnerable (*ibid.*, § 80).

b. Persons deprived of their liberty and vulnerable persons under the care of the State

60. The Court has emphasised the right of all prisoners to conditions of detention which are compatible with human dignity, so as to ensure that the manner and method of execution of the measures imposed do not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention; in addition, besides the health of prisoners, their well-being also has to be adequately secured given the practical demands of imprisonment (*Dzieciak v. Poland*, 2008, § 91).

61. The Court accepts that the medical assistance available in prison hospitals may not always be of the same standard as in the best medical institutions for the general public. Nevertheless, the State must ensure that the health and well-being of detainees are adequately secured by, among other

things, providing them with the requisite medical assistance. The authorities must also ensure that the diagnoses and care are prompt and accurate, and that where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at curing the detainee's diseases or preventing their aggravation (*Pitalev v. Russia*, 2009, § 54). However, the Convention cannot be construed as laying down a general obligation to release detainees on health grounds (*Dzieciak v. Poland*, 2008, § 91).

62. Since the State has direct responsibility for the welfare of persons deprived of their liberty, where such a person dies as a result of a health problem, the State must offer an explanation as to the cause of death and the treatment administered to the person concerned prior to their death (*Slimani v. France*, 2004, § 27; *Kats and Others v. Ukraine*, 2008, § 104).

63. The Court has found fault in the medical treatment administered to persons deprived of their liberty when, for example:

- the authorities, despite been fully aware of his problems, failed to properly examine and provide medical treatment to a convict with chronic illnesses; the latter was transferred to a hospital belatedly and the surgery he received was deficient. He was discharged from hospital, despite the knowledge of the doctors that he needed immediate further surgery for his post-operative complications. They also withheld crucial details of his surgery and developing complications. The prison hospital staff treated him as an ordinary post-operative patient rather than an emergency case with the consequence that surgery was performed too late. Furthermore, the prison hospital was not adequately equipped for dealing with massive blood loss (*Tarariyeva v. Russia*, 2006, §§ 88-89);
- there was a lack of cooperation and coordination between the various State authorities; a failure to transport the applicant to hospital for two scheduled operations, the lack of adequate and prompt information to the trial court on the applicant's state of health, the failure to secure him access to doctors during the final days of his life and the failure to take into account his health in the automatic extensions of his detention (*Dzieciak v. Poland*, 2008, § 101);
- lack of medical attention given to a HIV-positive person suffering from numerous serious diseases; refusal to transfer her to a medical facility and refusal to examine her request for release promptly when her condition seriously deteriorated and subsequent belated release during which time she died of HIV-related diseases (*Kats and Others v. Ukraine*, 2008, §§ 105-112);
- the treatment given to the first applicant, who had suffered from multi-drug resistant tuberculosis, was deficient because the diagnosis and treatment with second-line drugs was belated and the medical staff did not have the requisite expertise in the management of his illness (*Makharadze and Sikharulidze v. Georgia*, 2011, §§ 90-93).

64. The Court has adopted a similar approach in respect of the medical treatment of vulnerable persons under the care of the State when the domestic authorities, despite been aware of the appalling conditions that later led to the death of persons placed in social care homes or hospitals, had nonetheless unreasonably put the lives of these people in danger (see, in particular, *Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], 2014, §§ 131 and 143-144, which concerned the death of a young mentally disabled HIV positive Roma due to lack of adequate care, including medical care, in a psychiatric hospital and, by contrast, *Dumpe v. Latvia* (dec.), 2021, §§ 56 and 57, which concerned allegations of medical negligence in the care provided to the applicant's son who was suffering from several serious illnesses in a State social care institution).

5. Protection of persons in the context of accidents

65. The Court has held that the positive obligations under Article 2 require States to adopt regulations for the protection of people's safety in public spaces, and to ensure the effective functioning of that regulatory framework (*Ciechońska v. Poland*, 2011, § 69; *Banel v. Lithuania*, 2013, § 68).

66. In this respect, it could not be ruled out, that in certain circumstances, the acts and omissions of the authorities in the context of policies to ensure safety in public places could engage their responsibility under the substantive limb of Article 2 of the Convention. Nevertheless, where a Contracting State has adopted an overall legal framework and legislation tailored to the different contexts with regard to public spaces, in order to protect the persons using them, the Court could not accept that matters such as an error of judgment on the part of an individual player or negligent coordination among professionals, whether public or private, were sufficient of themselves to make a Contracting State accountable from the standpoint of its positive obligation under Article 2 of the Convention to protect life (*Marius Alexandru and Marinela Ștefan v. Romania*, 2020, § 100; *Smiljanić v. Croatia*, 2021, § 70).

67. The Court further underlined that the positive obligation is not to be interpreted in such a way as to impose an excessive burden on the authorities, bearing in mind, in particular, the unpredictability of human conduct and operational choices which must be made in terms of priorities and resources (*Ciechońska v. Poland*, 2011, § 64; *Marius Alexandru and Marinela Ștefan v. Romania*, 2020, § 100).

68. Moreover, it recalled that the choice of means for ensuring the positive obligations under Article 2 is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues to ensure Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means (*Ciechońska v. Poland*, 2011, § 65; *Marius Alexandru and Marinela Ștefan v. Romania*, 2020, § 102).

69. Ultimately, the question of whether there has been a failure by the State in its regulatory duties calls for a concrete, rather than an abstract, assessment of the alleged deficiencies (*Marius Alexandru and Marinela Ștefan v. Romania*, 2020, § 103 and *Smiljanić v. Croatia*, 2021, § 72).

70. In the context of activities which may pose a risk to human life due to their inherently hazardous nature, such as activities carried out on construction sites, States are required to take reasonable measures to ensure the safety of individuals as necessary, including through regulations geared to the special features of the activity (*Cevrioğlu v. Turkey*, 2016, § 57 with further references). In particular, in the absence of necessary safety precautions, any construction site, especially one in a residential area, has the potential for life-endangering accidents that may impact on not only professional construction workers, who are more familiar with the possible risks, but also on the public at large, including vulnerable groups such as children, who may easily become subject to those risks (*Zinatullin v. Russia*, 2020, § 28).

71. In a case which concerned allegations of deficiencies in the implementation of the regulatory framework concerning road safety, the Court underlined that the State's positive obligations in this context entailed, in the first place, the obligation to have in place an appropriate set of preventive measures geared to ensuring public safety and minimizing the number of road accidents and, secondly, to ensure the effective functioning of those measures in practice (*Smiljanić v. Croatia*, 2021, § 69).

72. The Court has found that the respondent State failed in its duty to protect the right to life in:

- *Kalender v. Turkey*, 2009, § 49, which concerned the death of two people in a railway accident;
- *Banel v. Lithuania*, 2013, § 69, where the applicants' son died from injuries sustained when part of a balcony broke off from a building and fell on him while he was playing outside;

- *Cevrioğlu v. Turkey*, 2016, § 72, which concerned the death of the applicant's ten-year-old son who drowned after failing into an uncovered water-filled hole on a construction site; see also *Binnur Uzun and Others v. Turkey*, 2017, § 49, where the applicants' father fell down the shaft of a lift in a building the construction of which had been abandoned.
- *Smiljanić v. Croatia*, 2021, § 85, where the applicant was killed in a traffic accident caused by a repeat offender driving under the influence of alcohol.

73. By contrast, the Court found no failure on the part of the respondent State to protect the right to life in:

- *Cecilia Pereira Henriques and Others v. Luxembourg* (dec.), 2003, where a labourer was killed in an accident at work when a wall of a building which was being demolished collapsed on top of him;
- *Furdík v. Slovakia* (dec.), 2008, which concerned an emergency mountain-rescue operation;
- *Molie v. Romania* (dec.), 2009, § 47, which concerned a fatal accident in a school sports facility;
- *Cavit Tınarlıoğlu v. Turkey*, 2016, § 107, which concerned life-threatening injuries sustained by the applicant, who was swimming in a bathing area that was not cordoned off, when he was struck by a motorboat.
- *Marius Alexandru and Marinela Ştefan v. Romania*, 2020, § 109, which concerned a traffic accident due to a tree falling on the applicants' car while they were driving on a public main road.
- *Soares Campos v. Portugal*, 2020, § 172, which concerned the death of the applicant's son, who was swept out to sea while taking part on a beach in a gathering linked to a student tradition involving hazing activities.
- *Vardosanidze v. Georgia*, 2020, § 61, which concerned the death of the applicant's son from carbon monoxide poisoning following reconnection of an improperly installed gas-operated water heater despite a warning from gas company.

D. Temporal limitations

1. Beginning of life

74. Unlike Article 4 of the American Convention on Human Rights, which provides that the right to life must be protected "in general, from the moment of conception", Article 2 of the Convention is silent as to the temporal limitations of the right to life and, in particular, does not define "everyone" ("*toute personne*") whose "life" is protected by the Convention (*Vo v. France* [GC], 2004, § 75).

75. The Court, having regard to the absence of any European consensus on the scientific and legal definition of the beginning of life, held that the issue of when the right to life begins comes within the margin of appreciation which it generally considers that States should enjoy in this sphere (*Vo v. France* [GC], 2004, § 82).

76. In the case of *Vo v. France* [GC], 2004, where the applicant had to undergo a therapeutic abortion as a result of medical negligence, the Court considered it unnecessary to examine whether the abrupt end to the applicant's pregnancy fell within the scope of Article 2, seeing that, even assuming that that provision was applicable, there was no failure on the part of the respondent State to comply with the requirements relating to the preservation of life in the public-health sphere (§ 85; see also for a similar approach *Mehmet Şentürk and Bekir Şentürk v. Turkey*, 2013, § 109).

77. In *Evans v. the United Kingdom* [GC], 2007, where the applicant complained that British legislation authorised her ex-partner to withdraw his consent to the storage and use of jointly created embryos,

the Court found that, under English law, an embryo did not have independent rights or interests and could not claim – or have claimed on its behalf – a right to life under Article 2 and that therefore the embryos in question did not have a right to life within the meaning of Article 2 (§§ 54-56).

2. Issues related to end of life

a. Euthanasia

78. The Court has held that no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention. It underlined that the consistent emphasis in all the cases before it has been the obligation of the State to protect life (*Pretty v. the United Kingdom*, 2002, § 39 and *Mortier v. Belgium*, 2022, § 119). However, the Court further held that the right to life enshrined under Article 2 could not be interpreted as *per se* prohibiting the conditional decriminalisation of euthanasia. However, in order to be compatible with Article 2, that decriminalisation had to be accompanied by suitable and sufficient safeguards to prevent abuse and thus secure respect for the right to life (*Mortier v. Belgium*, 2022, §§ 138-139)

79. In *Mortier v. Belgium* an act of euthanasia was performed on the applicant's mother, who had been suffering from chronic depression for over forty years. The Court, when examining whether the State complied with their positive obligations to protect her life, took into account the following elements: whether there was a legislative framework for pre-euthanasia procedures which met the requirements of Article 2; whether it had been complied with in the particular circumstances of the case; and whether the post-euthanasia review mechanism afforded all the safeguards required by Article 2 (§ 141). It emphasised that, in view of the complexity of this area and the lack of a European consensus, States had to be afforded a margin of appreciation, which was not unlimited (§ 143). On the facts of the case, the Court found no violation of Article 2 as regards the legislative framework governing the pre-euthanasia procedure (§§ 155-156) and that the act in question had been performed in compliance with this procedure (§ 165). However, it found a violation as regards the post-euthanasia review mechanism, given the lack of independence of the specialised review board and the length of the criminal investigation (§ 184).

b. Withdrawal of life-sustaining treatment

80. In the case of *Lambert and Others v. France* [GC], 2015, which concerned the decision of the authorities to discontinue nutrition and hydration allowing a patient in state of total dependence to be kept alive artificially, the Court noted that no consensus existed among the Council of Europe member States in favour of permitting the withdrawal of artificial life-sustaining treatment, although the majority of States appear to allow it. In this respect, it noted that while the detailed arrangements governing the withdrawal of treatment vary from one country to another, there was nevertheless a consensus as to the paramount importance of the patient's wishes in the decision-making process, however those wishes are expressed. It therefore considered that in this sphere concerning the end of life, as in that concerning the beginning of life, States must be afforded a margin of appreciation, not just as to whether or not to permit the withdrawal of artificial life-sustaining treatment and the detailed arrangements governing such withdrawal, but also as regards the means of striking a balance between the protection of patients' right to life and the protection of their right to respect for their private life and their personal autonomy. The Court underlined, however, that this margin of appreciation is not unlimited and it reserves the power to review whether or not the State has complied with its obligations under Article 2 (§§ 147-148).

81. In addressing the question of the administering or withdrawal of medical treatment, the Court takes into account the following elements: the existence in domestic law and practice of a regulatory framework compatible with the requirements of Article 2; whether account had been taken of the applicant's previously expressed wishes and those of the persons close to him, as well as the opinions

of other medical personnel and the possibility to approach the courts in the event of doubts as to the best decision to take in the patient's interest (*Gard and Others v. the United Kingdom* (dec.), 2017, § 83 and *Parfitt v. the United Kingdom* (dec.), 2021, § 37).

III. Prohibition of intentional deprivation of life

A. The death penalty

Article 2 § 1 of the Convention

"1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

HUDOC keywords

Expulsion (2) – Extradition (2)

Life (2-1) – Death penalty (2-1): Prescribed by law (2-1); Accessibility (2-1); Foreseeability (2-1); Safeguards against abuse (2-1); Competent court (2-1)

1. Interpretation of Article 2 § 1 of the Convention in light of Protocols Nos. 6 and 13 of the Convention

82. When the Convention was drafted, the death penalty was not considered to violate international standards. An exception was therefore included to the right to life, so that Article 2 § 1 provides that "no one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law". However, there has subsequently been an evolution towards the complete *de facto* and *de jure* abolition of the death penalty within the member States of the Council of Europe (*Al-Saadoon and Mufdhi v. the United Kingdom*, 2010, § 116).

83. Protocol No. 6 to the Convention, which abolished the death penalty except in respect of "acts committed in time of war or of imminent threat of war", was opened for signature on 28 April 1983 and came into force on 1 March 1985. All the member States of the Council of Europe have now signed Protocol No. 6 and all, save Russia, have ratified it (*Al-Saadoon and Mufdhi v. the United Kingdom*, 2010, § 116). Protocol No. 13, which abolishes the death penalty in all circumstances, was opened for signature on 3 May 2002 and came into force on 1 July 2003. In 2010 all but two of the member States of the Council of Europe (Azerbaijan and Russia) had signed this Protocol and all but three of the States which had signed it have ratified it (*ibid.*, § 117).[1]

84. The aforementioned figures, together with consistent State practice in observing the moratorium on capital punishment, have been found by the Court to be strong indications that Article 2 has been amended so as to prohibit the death penalty in all circumstances (*Al-Saadoon and Mufdhi v. the United Kingdom*, 2010, § 120).

2. State responsibility under Article 2 in extradition and expulsion cases

85. Article 2 of the Convention prohibits the extradition or deportation of an individual to another State where substantial grounds have been shown for believing that he or she would face a real risk

1. Note that the Russian Federation ceased to be a member of the Council of Europe on 16 March 2022 and ceased to be a party to the Convention on 16 September 2022. At the date of the latest update to this Guide, the numbers of signatures and ratifications for Protocol No. 6 is still accurate. As regards Protocol No. 13, it has been signed by all member States of the Council of Europe and ratified by all but one (Azerbaijan).

of being subjected to the death penalty there (*Al Nashiri v. Poland*, 2014, § 577; *F.G. v. Sweden* [GC], 2016, § 110; *Al-Hawsawi v. Lithuania*, 2024, § 258).

86. More detailed information can be found in the Case-Law Guide on Immigration.

B. Use of lethal force by State agents

Article 2 of the Convention

"1. Everyone's right to life shall be protected by law. ...

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

HUDOC keywords

Life (2-1) – Use of force (2-2) – Absolutely necessary (2-2): Defence from unlawful violence (2-2); Effect lawful arrest (2-2); Prevent escape (2-2); Quell riot or insurrection (2-2)

1. Assessment of evidence

87. As master of its own procedure and its own rules, the Court has complete freedom to assess not only the admissibility and relevance but also the probative value of each item of evidence before it. The Court is not bound, under the Convention or under the general principles applicable to international tribunals, by strict rules of evidence and there are no procedural barriers to the admissibility of evidence in the proceedings before it (*Carter v. Russia*, 2021, § 97).

88. However, the Court must be cautious in taking on the role of a first-instance tribunal of fact, where this is not rendered unavoidable by the circumstances of a particular case (*McKerr v. the United Kingdom* (dec.), 2000). As a general rule, where domestic proceedings have taken place, it is not the Court's task to substitute its own assessment of the facts for that of the domestic courts and it is for the latter to establish the facts on the basis of the evidence before them (see, among many other authorities, *Edwards v. the United Kingdom*, 1992, § 34; *Klaas v. Germany*, 1993, § 29). Though the Court is not bound by the findings of domestic courts and remains free to make its own appreciation in the light of all the material before it, in normal circumstances it requires cogent elements to lead it to depart from the findings of fact reached by the domestic courts (*Avşar v. Turkey*, 2001, § 283; *Barbu Anghelescu v. Romania*, 2004, § 52). In this regard, the Court has underlined that its reliance on evidence obtained a result of a domestic investigation and on facts established within domestic proceedings depends on the quality of the domestic investigative process, and the thoroughness and consistency of the proceedings in question (*Carter v. Russia*, 2021, § 98).

a. Standard of proof

89. A number of principles have been developed by the Court as regards applications in which it is faced with the task of establishing the facts of events on which the parties disagree: the factual findings should be based on the standard of proof "beyond reasonable doubt"; such proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact. In this context, the conduct of the parties when evidence is being obtained may

also be taken into account (*Tanış and Others v. Turkey*, 2005, § 160; *Tagayeva and Others v. Russia*, 2017, § 586 and *Kukhalashvili and Others v. Georgia*, 2020, § 148).

b. Burden of proof

90. The level of persuasion necessary for reaching a particular conclusion and, in this connection the distribution of the burden of proof are intrinsically linked to the specificity of the facts, the nature of the allegation made and the Convention right at stake (*Tagayeva and Others v. Russia*, 2017, § 586).

91. Where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation (*Salman v. Turkey* [GC], 2000, § 100).

92. This principle also applies to cases in which, although it has not been proved that a person has been taken into custody by the authorities, it is possible to establish that he or she was officially summoned by the military or the police, entered a place under their control and has not been seen since. In such circumstances, the onus is on the Government to provide a plausible explanation as to what happened on the premises and to show that the person concerned was not detained by the authorities, but left the premises without subsequently being deprived of his or her liberty (*Tanış and Others v. Turkey*, 2005, § 160).

93. Likewise, in cases concerning armed conflicts, the Court has further extended this principle to situations where individuals were found injured or dead, or disappeared, in areas of the State under the exclusive control of the authorities and where there was *prima facie* evidence that State agents could be involved (*Akkum and Others v. Turkey*, 2005, § 211; *Aslakhanova and Others v. Russia*, 2012, § 97 with further references).

94. For example, in a series of cases concerning allegations of disappearances in the Russian North Caucasus, the Court has considered it sufficient for the applicants to make a *prima facie* case of abduction by State agents, thus falling within the control of the authorities, and it would then be for the Government to discharge their burden of proof, either by disclosing documents in their exclusive possession or by providing a satisfactory and convincing explanation of how the events in question occurred. If the Government failed to discharge its burden of proof, this would entail a violation of Article 2 of the Convention in its substantive part. Conversely, if the applicants failed to make out a *prima facie* case, the burden of proof could not be reversed (*Estemirova v. Russia*, 2021, § 63).

95. In fact, the Court has underlined that, in all cases where it is unable to establish the exact circumstances of a case for reasons objectively attributable to the State authorities, it is for the respondent Government to explain, in a satisfactory and convincing manner, the sequence of events and to exhibit solid evidence that can refute the applicant's allegations (*Mansuroğlu v. Turkey*, 2008, § 80 and *Carter v. Russia*, 2021, § 152; see, for example, *Bagirova v. Azerbaijan*, 2024, §§ 66-69). The Court has also noted the difficulties for applicants to obtain the necessary evidence in support of allegations in cases where the respondent Government are in possession of the relevant documentation and fail to submit it. If the authorities then fail to disclose crucial documents to enable the Court to establish the facts or otherwise provide a satisfactory and convincing explanation, strong inferences may be drawn (*Varnava and Others v. Turkey* [GC], 2009, § 184). The Court's reliance on evidence obtained as a result of the domestic investigation and on the facts established within the domestic proceedings will largely depend on the quality of the domestic investigative process, its thoroughness and consistency (*Tagayeva and Others v. Russia*, 2017, § 586 and *Lapshin v. Azerbaijan*, 2021, § 95).

96. Finally, when there have been criminal proceedings in the domestic courts concerning those same allegations, it must be borne in mind that criminal law liability is distinct from international law

responsibility under the Convention. The Court's competence is confined to the latter. Responsibility under the Convention is based on its own provisions which are to be interpreted and applied on the basis of the objectives of the Convention and in the light of the relevant principles of international law. The responsibility of a State under the Convention, arising for the acts of its organs, agents and servants, is not to be confused with the domestic legal issues of individual criminal responsibility under examination in the national criminal courts. The Court is not concerned with reaching any findings as to guilt or innocence in that sense (*Tanlı v. Turkey*, 2001, § 111; *Giuliani and Gaggio v. Italy* [GC], 2011, § 182).

2. Protection of persons from lethal use of force by State agents

a. Legal framework

97. In the context of use of force by State agents, the primary duty on the State to secure the right to life entails, in particular, putting in place an appropriate legal and administrative framework defining the limited circumstances in which law enforcement may use force and firearms, in the light of the relevant international standards (*Giuliani and Gaggio v. Italy* [GC], 2011, § 209; *Makaratzis v. Greece* [GC], 2004, §§ 57-59).

98. In line with the principle of strict proportionality inherent in Article 2, the national legal framework must make recourse to firearms dependent on a careful assessment of the situation (*Giuliani and Gaggio v. Italy* [GC], 2011, § 209) and, in particular, on an evaluation of the nature of the offence committed by the person in question and of the threat he or she posed (*Nachova and Others v. Bulgaria* [GC], 2005, § 96). Furthermore, the national law regulating policing operations must secure a system of adequate and effective safeguards against arbitrariness and abuse of force and even against avoidable accident (*Giuliani and Gaggio v. Italy* [GC], 2011, § 209; *Makaratzis v. Greece* [GC], 2004, § 58).

99. The Court, distinguishing between "routine police operations" and situations of large-scale anti-terrorist operations, held that, in the latter case, often in situations of acute crisis requiring "tailor-made" responses, States should be able to rely on solutions that would be appropriate to the circumstances. That being said, it has also underlined that, in a lawful security operation which is aimed, in the first place, at protecting the lives of people who find themselves in danger of unlawful violence from third parties, the use of lethal force remains governed by the strict rules of "absolute necessity" within the meaning of Article 2 of the Convention. Thus, it is of primary importance that the domestic regulations be guided by the same principle and contain clear indications to that extent, including the obligations to decrease the risk of unnecessary harm and exclude the use of weapons and ammunition that carry unwarranted consequences (*Tagayeva and Others v. Russia*, 2017, § 595).

b. Training and vetting of State agents

100. The Court has underlined that law enforcement agents must be trained to assess whether or not there is an absolute necessity to use firearms, not only on the basis of the letter of the relevant regulations, but also with due regard to the pre-eminence of respect for human life as a fundamental value (*Nachova and Others v. Bulgaria* [GC], 2005, § 97; *Kakoulli v. Turkey*, 2005, § 110).

101. For example, in cases concerning the use of force to quell a riot or insurrection, the Court's assessment includes an examination as to whether the security forces were properly equipped (*Güleç v. Turkey*, 1998, § 71; *Şimşek and Others v. Turkey*, 2005, § 117); whether they received effective training with the objective of complying with international standards for human rights and policing and whether they received clear and precise instructions as to the manner and circumstances in which they make use of firearms (*ibid.*, § 109). In particular, the Court has underlined that opening fire should, whenever possible, be preceded by warning shots (*Giuliani and Gaggio v. Italy* [GC], 2011, § 177).

102. Moreover, States are expected to set high professional standards within their law-enforcement systems and ensure that law-enforcement officers meet the requisite criteria. In particular, when equipping police forces with firearms, not only must the necessary technical training be given, but the selection of agents allowed to carry such firearms must also be subject to particular scrutiny (*Sašo Gorgiev v. the former Yugoslav Republic of Macedonia*, 2012, § 51).

c. Illustrations

103. Applying these principles, the Court has, for instance, characterised as deficient the Bulgarian legal framework which permitted the police to fire on any fugitive member of the armed forces who did not surrender immediately in response to an oral warning and the firing of a warning shot in the air. There were no clear safeguards to prevent the arbitrary deprivation of life (*Nachova and Others v. Bulgaria* [GC], 2005, §§ 99-102).

104. Likewise the Court has also identified deficiencies in the Turkish legal framework, adopted in 1934, which listed a wide range of situations in which a police officer could use firearms without being liable for the consequences (*Erdoğan and Others v. Turkey*, 2006, §§ 77-79). On the other hand, in another case, it considered that a regulation setting out an exhaustive list of situations in which gendarmes could make use of firearms was compatible with the Convention. That regulation specified that the use of firearms should only be envisaged as a last resort and had to be preceded by warning shots, before shots were fired at the legs or indiscriminately (*Bakan v. Turkey*, 2007, § 51).

105. In the case of *Makaratzis v. Greece* [GC], 2004, which concerned a chaotic police chase in which the applicant, who had ignored a red light, was seriously injured by gun shots, the Court found that Greece's domestic law did not afford law-enforcement officials clear guidelines and criteria governing the use of force in peacetime. It also found that, in the absence of proper training and instructions, it was unavoidable that the police officers who chased and eventually arrested the applicant enjoyed a greater autonomy of action and were able to take unconsidered initiatives (§ 70).

106. In *Alkhatib and Others v. Greece*, 2024 a member of the applicants' family, who was travelling in a boat with other migrants with a view to illegally entering Greece, sustained a serious gunshot wound as a result of shots fired by the coast guard. The Court found that the respondent State had failed to put in place an adequate legal and administrative framework governing the use of potentially lethal force in maritime surveillance operations, given the uncertainty of the applicable legal framework in such circumstances (§§ 130-132).

107. The Court held that the authorities had failed to properly vet a police officer before issuing him a firearm in *Gorovenky and Bugara v. Ukraine*, 2012, § 39, where an off-duty police officer, involved in a quarrel, opened fire with his service weapon killing the applicants' relatives. See also *Sašo Gorgiev v. the former Yugoslav Republic of Macedonia*, 2012, § 52.

108. **Where the applicant's son died**, after being restrained by prison officers in a prone position leg lock for about thirteen minutes while trying to move him to another cell, the Court considered that the authorities had failed to give prison guards clear and adequate instructions on the use of the prone position when restraining prisoners and that, due to their failure to train their law-enforcement officials, the prison officers involved in the incident had lacked the high level of competence required when dealing with a situation that presented a risk to life (see *Kalkan v. Denmark*, 2025, § 129).

3. Permitted exceptions to use force

109. The exceptions delineated in paragraph 2 indicate that Article 2 extends to, but is not concerned exclusively with, intentional killing. The text of Article 2, read as a whole, demonstrates that paragraph 2 does not primarily define instances where it is permitted to kill an individual, but describes the **situations where it is permitted to "use force" which may result, as an unintended outcome**, in the deprivation of life. **The use of force, however, must be no more than "absolutely necessary" for the**

achievement of one of the purposes set out in sub-paragraphs (a), (b) or (c) (*McCann and Others v. the United Kingdom*, 1995, § 148; *Yüksel Erdoğan and Others v. Turkey*, 2007, § 86; *Ramsahai and Others v. the Netherlands* [GC], 2007, § 286; *Giuliani and Gaggio v. Italy* [GC], 2011, § 17).

a. Standard of scrutiny to be applied

110. As a rule, the use of the term "absolutely necessary" in Article 2 § 2 indicates that a stricter and more compelling test of necessity must be employed than that normally applicable when determining whether State action is "necessary in a democratic society" under paragraph 2 of Articles 8 to 11 of the Convention. In particular, the force used must be strictly proportionate to the achievement of the aims set out in sub-paragraphs 2 (a), (b) and (c) (*McCann and Others v. the United Kingdom*, 1995, § 149).

111. That being said, the Court has underlined that it is acutely conscious of the difficulties faced by modern States in the fight against terrorism and the dangers of hindsight analysis. In this connection, it has underlined the need to differentiate between the political choices made in the course of fighting terrorism, that remain by their nature outside of such supervision, and other, more operational aspects of the authorities' actions that have a direct bearing on the protected rights. Therefore, the absolute necessity test formulated in Article 2 is bound to be applied with different degrees of scrutiny, depending on whether and to what extent the authorities were in control of the situation and other relevant constraints inherent in operative decision-making in this sensitive sphere (*Tagayeva and Others v. Russia*, 2017, § 481).

112. In the specific context of hostage rescue operations the Court has held that, normally, the planning and conduct of the rescue operation can be subjected to a heightened scrutiny. In doing so, the Court has taken into account the following factors: (i) whether the operation was spontaneous or whether the authorities could have reflected on the situation and made specific preparations; (ii) whether the authorities were in a position to rely on some generally prepared emergency plan, not related to that particular crisis; (iii) that the degree of control of the situation is higher outside the building, where most of the rescue efforts take place; and (iv) that the more predictable a hazard, the greater the obligation is to protect against it (*Tagayeva and Others v. Russia*, 2017, § 563).

b. General approach

113. In keeping with the importance of this provision in a democratic society, the Court must, in making its assessment, subject deprivations of life to the most careful scrutiny, particularly where deliberate lethal force is used, taking into consideration not only the actions of the agents of the State who actually administer the force but also all the surrounding circumstances, including such matters as the planning and control of the actions under examination (*McCann and Others v. the United Kingdom*, 1995, § 150; *Ergi v. Turkey*, 1998, § 79).

114. It goes without saying that a balance must be struck between the aim pursued and the means employed to achieve it (*Güleç v. Turkey*, 1998, § 71).

115. For example, the Court has underlined that the legitimate aim of effecting a lawful arrest can only justify putting human life at risk in circumstances of absolute necessity. Therefore in principle there can be no such necessity where it is known that the person to be arrested poses no threat to life or limb and is not suspected of having committed a violent offence, even if a failure to use lethal force may result in the opportunity to arrest the individual concerned being lost (*Nachova and Others v. Bulgaria* [GC], 2005, § 95; *Kakoulli v. Turkey*, 2005, § 108).

116. Likewise, in the context of border control, the Court emphasised that while Contracting States may, in principle, put arrangements in place at their borders designed to prevent unauthorised entry into the territory as well as use the force necessary to prevent illegal entry to the territory, the need

for border control cannot justify resort to practices which are not compatible with the Convention or the Protocols thereto (*Bişar Ayhan v. Turkey*, 2021, § 65).

i. The actions of the State agents

117. The use of force by agents of the State in pursuit of one of the aims delineated in paragraph 2 of Article 2 of the Convention may be justified under this provision where it is based on an honest belief which is perceived, for good reasons, to be valid at the time but subsequently turns out to be mistaken. To hold otherwise would be to impose an unrealistic burden on the State and its law-enforcement personnel in the execution of their duty, perhaps to the detriment of their lives and the lives of others (*McCann and Others v. the United Kingdom*, 1995, § 200; *Andronicou and Constantinou v. Cyprus*, 1997, § 192; *Bubbins v. the United Kingdom*, 2005, § 138; *Huohvanainen v. Finland*, 2007, § 96).

118. The Court had also added that, detached from the events in issue, it cannot substitute its own assessment of the situation for that of an officer who was required to react in the heat of the moment to avert an honestly perceived danger to his life or the lives of others (*Bubbins v. the United Kingdom*, 2005, § 139; *Huohvanainen v. Finland*, 2007, § 97).

119. When examining the actions of the State agents the principal question to be addressed is whether the person had an honest and genuine belief that the use of force was necessary. In addressing this question, the Court will have to consider whether the belief was subjectively reasonable, having full regard to the circumstances that pertained at the relevant time. If the belief was not subjectively reasonable (that is, it was not based on subjective good reasons), it is likely that the Court would have difficulty accepting that it was honestly and genuinely held (see *Armani Da Silva v. the United Kingdom* [GC], 2016, § 248, albeit in the context of procedural obligations).

ii. The planning and control of the operation

120. In determining whether the force used is compatible with Article 2, it may therefore be relevant whether a law enforcement operation has been planned and controlled so as to minimise to the greatest extent possible recourse to lethal force or incidental loss of life (*Bubbins v. the United Kingdom*, 2005, § 136; *Huohvanainen v. Finland*, 2007, § 94).

121. In carrying out its assessment of the planning and control phase of the operation from the standpoint of Article 2 of the Convention, the Court must have particular regard to the context in which the incident occurred as well as to the way in which the situation developed (*Andronicou and Constantinou v. Cyprus*, 1997, §182; *Yüksel Erdoğan and Others v. Turkey*, 2007, § 86).

122. Its sole concern must be to evaluate whether in the circumstances the planning and control of the operation showed that the authorities had taken appropriate care to ensure that any risk to his life had been minimised and that they were not negligent in their choice of action (*Bubbins v. the United Kingdom*, 2005, § 141).

iii. Illustrations

123. The Court did not consider that the use of force was strictly proportionate or absolutely necessary in the pursuit of one of the aims delineated in paragraph 2 of Article 2 of the Convention in:

- *Güleç v. Turkey*, 1998, § 71, where the applicant's son was killed during a demonstration where the security forces – confronted with acts of violence – and not having any batons, riot shields, water cannon, rubber bullets or tear gas – deployed machine guns; see also *Evrim Öktem v. Turkey*, 2008, where a minor was seriously injured by stray bullet fired from a police officer's gun during an operation to break up a demonstration; see also *Fraisse and Others v. France*, 2025, § 135 where the applicants' relative died as a result of an explosion of a stun grenade launched by a gendarme during violent clashes between protesters and mobile gendarmes forces.

- *Kakoulli v. Turkey*, 2005, § 121, where an unarmed Greek Cypriot, who had entered into the buffer zone between northern and southern Cyprus, was shot dead by Turkish soldiers;
- *Wasilewska and Kałucka v. Poland*, 2010, § 57, where a suspect was shot dead during a police operation;
- *Trévalec v. Belgium*, 2011, § 87, where a journalist was shot by a special operations police unit which had not been informed that his presence in the police operation had been authorised;
- *Nachova and Others v. Bulgaria* [GC], 2005, § 109, where two unarmed Roma fugitives were shot dead by military police during an attempted arrest;
- *Tagayeva and Others v. Russia*, 2017, § 611, where a number of hostages were killed in the course of a rescue operation in the context of a large scale hostage-taking by terrorists in a school in Beslan, North Ossetia; see, by contrast, *Finogenov and Others v. Russia*, 2011, §§ 226 and 236, where a number of hostages were killed in the course of a rescue operation in the context of hostage-taking by terrorists in a theatre in Moscow;
- *Kukhalashvili and Others v. Georgia*, 2020, §157, where indiscriminate and excessive use of lethal force was used by the police during an anti-riot operation in prison;
- *Yukhymovych v. Ukraine*, 2020, § 86, where the applicant's son was killed during a police operation organized in the context of a criminal investigation into extortion;
- *Pârvu v. Romania,* 2022, § 87, where the applicant's husband, wrongly identified as a dangerous fugitive, was shot in the head by a police officer in the course of a planned operation to capture him.
- *Alkhatib and Others v. Greece*, 2024, § 155, where the applicant's relative, who was travelling in a boat with a view to illegally entering Greece, was shot by a coast guard. See also *Almukhlas and Al-Maliki v. Greece*, 2025, § 154 where a minor hiding on a boat illegally transporting migrants was shot by a coast guard who was aiming at one of the skippers during an operation to intercept the boat.

124. By contrast, the Court held that the use of force was strictly proportionate in the pursuit of one of the aims delineated in paragraph 2 of Article 2 of the Convention in:

- *Bubbins v. the United Kingdom*, 2005, § 141, where the applicant's brother was shot by police officers in his flat following a two-hour siege; see also *Huohvanainen v. Finland*, 2007, § 107;
- *Giuliani and Gaggio v. Italy* [GC], 2011, § 194, which concerned the fatal shooting of a demonstrator by a member of the security forces at a G8 summit;
- *Perk and Others v. Turkey*, 2006, § 73, which concerned the killing of the applicants' relatives during a police operation against a radical armed movement (see also *Yüksel Erdoğan and Others v. Turkey*, 2007, § 100, which concerned the killing of the applicants' relatives during from an armed clash with police officers);
- *Mendy v. France* (dec.), 2018, §§ 31-33, where a mentally disturbed person threatening a man's life with a knife was shot dead by a police officer during his arrest.
- *Ghaoui v. France,* 2025, §§ 114-115, where the applicant was left paraplegic as a result of a shot fired at his car by a police officer while driving away to evade questioning.

C. Specific contexts

Article 2 of the Convention

"1. Everyone's right to life shall be protected by law. ...

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

(a) in defence of any person from unlawful violence;

(b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;

(c) in action lawfully taken for the purpose of quelling a riot or insurrection."

HUDOC keywords

Positive obligations (2) – Life (2-1)

Use of force (2-2) – Absolutely necessary (2-2): Defence from unlawful violence (2-2); Effect lawful arrest (2-2); Prevent escape (2-2); Quell riot or insurrection (2-2)

1. Death hastened by use of specific arrest techniques

125. In a number of cases where death was hastened by the use of specific arrest techniques which were not lethal by themselves, the Court examined whether there was a causal link between the force used and the death of the individual and whether State agents protected the right to life by providing that individual with requisite medical assistance (*Scavuzzo-Hager and Others v. Switzerland*, 2006, § 55, which concerned the arrest by police officers of a very agitated drug addict who subsequently died; see also *Saoud v. France*, 2007, which concerned the death by gradual asphyxia of a young man who was handcuffed and held face down on the ground by police officers for over thirty minutes; *Boukrourou and Others v. France*, 2017, where the applicants' relative, a mentally disabled person, died during a police operation from heart failure; *Semache v. France*, 2018, which concerned the death of an elderly drunk driver who was immobilised by being bound over with his head touching his knees (**"double seated embrace"**) and *Kutsarovi v. Bulgaria*, 2022, where the applicant's son died from a cardiac arrest during his police transfer while in the vehicle.

126. In a recent case where the applicant's partner, who had a history of mental health problems, died during a police intervention, the Court could not exclude that his death was caused by his immobilisation in prone position, since he died shortly thereafter as he was being transported to a hospital. However, in order to engage the international responsibility of the respondent State, it considered that it was also necessary that the State agents were reasonably able to realise that the **victim was in a state of vulnerability requiring a high degree of precaution in the choice of "usual"** arrest techniques (*T.V. v. Croatia*, 2024, § 58; see also *V v. the Czech Republic*, 2023, § 99, which concerned the death of a psychiatric hospital patient following his repeated tasing by the police followed by the administration of a tranquiliser by a nurse).

2. Death in custody

127. Persons in custody are in a vulnerable position and the authorities are under a duty to protect them. Consequently, when an individual is taken into police custody in good health and is found to be injured on release, it is incumbent on the State to provide a plausible explanation of how those injuries were caused. The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent where that individual dies (*Salman v. Turkey* [GC], 2000, § 99; *Tanlı v. Turkey*, 2001, § 141; *Tekın and Arslan v. Belgium*, 2017, § 83).

128. The Court was not convinced by the respondent State's explanations regarding the circumstances surrounding the death of the applicants in the following cases:

- *Anguelova v. Bulgaria*, 2002, § 121, where the applicant's relative died from a skull injury a couple of hours after being detained;
- *Kişmir v. Turkey*, 2005, § 105, which concerned the death of the applicant's son in Diyarbakir police headquarters from respiratory failure related to lung oedema;
- *Aktaş v. Turkey*, 2003, § 294, where the applicants' relative died from mechanical asphyxia sustained during custody;
- *Mojsiejew v. Poland*, 2009, § 65, which concerned the death of the applicant's son in a sobering-up centre;
- *Khayrullina v. Russia*, 2017, §§ 84-85, where the applicant's husband died from the injuries he sustained during his unlawful detention in police custody.

3. Extra-judicial killings

129. The Court has also been confronted with applications where it is undisputed that the applicants' relatives died in circumstances falling outside the exceptions set out in the second paragraph of Article 2. In these cases, if the Court, on the basis of the evidence in the case-file, establishes that the applicants' relatives were killed by State agents or with their connivance or acquiescence, it will find the respondent Government liable for their death (*Avşar v. Turkey*, 2001, §§ 413-416; *Khashiyev and Akayeva v. Russia*, 2005, § 147; *Estamirov and Others v. Russia*, 2006, § 114; *Musayeva and Others v. Russia*, 2007, § 155; *Amuyeva and Others v. Russia*, 2010, §§ 83-84; see also *Lapshin v. Azerbaijan*, 2021, § 119, where the applicant survived an attempt to his life while in prison and by contrast *Denizci and Others v. Cyprus*, 2001, § 373; *Buldan v. Turkey*, 2004, § 81; *Nuray Şen v. Turkey (no. 2)*, 2004, § 173; *Seyhan v. Turkey*, 2004, § 82 and *Carter v. Russia*, 2021, §§ 170-172; see also *Ukraine and the Netherlands v. Russia* [GC], 2025, §§ 1034-1045, where the Court found Russia responsible for an administrative practice of extrajudicial killing of civilians and Ukrainian military personnel *hors de combat* in occupied territory in Ukraine).

130. However, even in circumstances where the Court cannot establish beyond reasonable doubt that any State agent was involved in the killing, the Court may nonetheless find the respondent State responsible, if it considers that the authorities failed to take reasonable measures available to them to protect the right to life of the applicant in question (*Mahmut Kaya v. Turkey*, 2000, §§ 87 and 101; *Kılıç v. Turkey*, 2000, §§ 64 and 77; *Gongadze v. Ukraine*, 2005, §§ 170-171; and by contrast *Denizci and Others v. Cyprus*, 2001, §§ 374 and 377).

4. Security or military operations

131. In the particular context of security operations, the Court has held that the responsibility of the State is not confined to circumstances where there is significant evidence that misdirected fire from State agents has killed a civilian. It may also be engaged where they fail to take all feasible precautions in the choice of means and methods for a security operation mounted against an opposing group with a view to avoiding and, in any event, to minimising incidental loss of civilian life (*Ahmet Özkan and Others v. Turkey*, 2004, § 297).

132. In this context, the Court has found, for example, that:

- the military had undertaken insufficient precautions to protect the lives of the civilian population (*Ergi v. Turkey*, 1998, § 81, where the applicant's sister was killed in the course of an ambush operation conducted by the security forces against the PKK);
- while the security forces' choice to open intensive fire in response to shots fired at them from a village was "absolutely necessary" for the purpose of protecting life, Turkey had failed

in its obligations to protect life under Article 2 because the security forces failed subsequently to verify whether there were any civilian casualties (*Ahmet Özkan and Others v. Turkey*, 2004, §§ 306-308, concerning a military raid conducted on a village in order to capture terrorists leading to the death of two children);

- the military operation was not planned and executed with the requisite care for the lives of the civilians (*Isayeva and Others v. Russia*, 2005, § 199, which concerned the bombing of a convoy by Russian military jets during the Chechen war, with loss of civilian life); see also *Abuyeva and Others v. Russia*, 2010, § 203; and *Benzer and Others v. Turkey*, 2013, § 184, where the Court reiterated that an indiscriminate aerial bombing of civilians and their villages could not be acceptable in a democratic society or reconcilable with any of the grounds regulating the use of force set out in Article 2 § 2 of the Convention, the customary rules of international humanitarian law or any of the international treaties regulating the use of force in armed conflicts.
- In the case of *Şirin Yılmaz v. Turkey*, 2004, where the applicant's wife was killed by artillery shells, the Court was unable to conclude that she was, beyond reasonable doubt, intentionally or recklessly killed by the security forces (§ 76; see also *Zengin v. Turkey*, 2004, § 44).
- By contrast, the Court found that the wounding of the first applicant and the killing of the remaining applicants' relative from the firing of mortars by soldiers near the Iranian border as they were illegally crossing over through a prohibited military area constituted a disproportionate use of force which was not absolutely necessary (*Bişar Ayhan v. Turkey*, 2021, § 74).

133. The Court has further underlined that Article 2 must be interpreted in so far as possible in light of the general principles of international law, including the rules of international humanitarian law which play an indispensable and universally accepted role in mitigating the savagery and inhumanity of armed conflict. In a zone of international conflict Contracting States are under an obligation to protect the lives of those not, or no longer, engaged in hostilities. This would also extend to the provision of medical assistance to the wounded; where combatants have died, or succumbed to wounds, the need for accountability would necessitate proper disposal of remains and require the authorities to collect and provide information about the identity and fate of those concerned, or permit bodies such as the International Committee of the Red Cross to do so (*Varnava and Others v. Turkey* [GC], 2009, § 185). Therefore, even in situations of international armed conflict, the safeguards under the Convention continue to apply, albeit interpreted against the background of the provisions of international humanitarian law (*Hassan v. the United Kingdom* [GC], 2014, § 104).

134. For example, in *Ukraine and the Netherlands v. Russia* [GC], 2025, the Court found Russia responsible for an administrative practice of military attacks in Ukraine, in the context of the conduct of hostilities in the period between 11 May 2014 and 16 September 2022, **in breach of that State's** both negative and positive obligations (§ 772). As regards the complaint concerning the downing of flight MH17 as a consequence of the firing, from separatist-controlled territory, of a missile supplied by Russia, resulting in the deaths of all 298 civilians on board, the Court noted that **a conflict between Article 2 of the Convention and the provisions of international humanitarian law might arise if the impugned act was compatible with the latter. However, it found that the launching of the missile towards the aircraft was an indiscriminate attack in breach of international humanitarian law, and thus not constituting a lawful act of war. Therefore, no potential conflict could arise from the absence in Article 2 § 2 of the Convention of any accommodation of deaths compatible with international humanitarian law. It went on to find that the intentional use of force leading to the deprivation of the lives of the civilians on board the flight could not be justified under any of the grounds listed in Article** 2 § 2 (§§ 452-462). The Court further found that the Russian federation had also failed to take appropriate steps to safeguard the lives of those on board the flight by deploying such a missile in an area where civilian flights had still been operating and by failing to undertake a number of measures

which could have significantly reduced or even eliminated the risk, posed by the deployment of such a missile, to civilians travelling in civilian aircraft over eastern Ukraine (§§ 463-466).

5. Disappearances

a. Presumption of death

135. Where an individual is taken into custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation of how those injuries were caused, failing which an issue arises under Article 3 of the Convention. In the same vein, Article 5 imposes an obligation on the State to account for the whereabouts of any person taken into detention and who has thus been placed under the control of the authorities. Whether the failure on the part of the authorities to provide a plausible explanation as to a detainee's fate, in the absence of a body, might also raise issues under Article 2 of the Convention will depend on all the circumstances of the case, and in particular on the existence of sufficient circumstantial evidence, based on concrete elements, from which it may be concluded to the requisite standard of proof that the detainee must be presumed to have died in custody (*Timurtaş v. Turkey*, 2000, § 82).

136. In this respect the period of time which has elapsed since the person was placed in detention, although not decisive in itself, is a relevant factor to be taken into account. It must be accepted that the more time goes by without any news of the detained person, the greater the likelihood that he or she has died. The passage of time may therefore to some extent affect the weight to be attached to other elements of circumstantial evidence before it can be concluded that the person concerned is to be presumed dead. In this respect the Court considers that this situation gives rise to issues which go beyond a mere irregular detention in violation of Article 5. Such an interpretation is in keeping with the effective protection of the right to life as afforded by Article 2, which ranks as one of the most fundamental provisions of the Convention (*Tanış and Others v. Turkey*, 2005, § 201).

137. However, this presumption of death is not automatic and is only reached on examination of the circumstances of the case, in which the lapse of time since the person was seen alive or heard from is a relevant element (*Varnava and Others v. Turkey* [GC], 2009, § 143; *Aslakhanova and Others v. Russia*, 2012, § 100).

138. Moreover, a finding of State involvement in the disappearance of a person is not a condition *sine qua non* for the purposes of establishing whether that person can be presumed dead; in certain circumstances the disappearance of a person may in itself be considered as life-threatening (*Medova v. Russia*, 2009, § 90).

139. For example, in the context of the conflict in Chechnya, the Court has concluded that when a person is detained by unidentified servicemen without any subsequent acknowledgement of detention, this can be regarded as life-threatening (*Baysayeva v. Russia*, 2007, § 119; *Beksultanova v. Russia*, 2011, § 83).

140. Likewise, the Court has deemed that the disappearance of a person in south-east Turkey between 1992 and 1996 could be regarded as life-threatening (*Osmanoğlu v. Turkey*, 2008, §§ 57-58; *Meryem Çelik and Others v. Turkey*, 2013, § 58), particularly if that person was suspected by the authorities of PKK involvement (*Enzile Özdemir v. Turkey*, 2008, § 45).

141. Where the Ukrainian Government maintained that the Russian Federation was responsible for an administrative practice of enforced disappearances in Crimea, the Court held that, when determining the existence of such a practice, the overall examination should not be confined only to those individuals who had ultimately remained unaccounted for. While the presumption of death applied only to those individuals, having regard to the overall context including the large number of instances of irregular deprivation of liberty perpetrated by persons whose acts entailed the responsibility of Russia, the fact that victims were those perceived as opponents to the events that

unfolded in Crimea at the time and the fact that the abductions followed a particular pattern and were used as a means to intimidate and persecute such individuals to supress the existing opposition in Crimea to the Russian "occupation", the Court considered that there had been "sufficiently numerous" instances of abduction to amount to a pattern or system ("repetition of acts") which was itself life-threatening to engage the applicability of Article 2 as regards that administrative practice (*Ukraine v. Russia (re Crimea)* [GC], 2024, § 970).

b. State liability for the presumed death

142. Once the Court considers that it has been established beyond reasonable doubt that the disappeared person must be presumed dead following his or her unacknowledged detention by State agents, the responsibility of the State is engaged. Since such circumstances do not provide any justification on any of the grounds listed in Article 2 § 2 of the Convention, the Court finds the respondent Government liable for the presumed death of the disappeared person (*Akdeniz and Others v. Turkey*, 2001, § 101; *Orhan v. Turkey*, 2002, § 331; *İpek v. Turkey*, 2004, § 168; *Bazorkina v. Russia*, 2006, § 111; *Magomadov v. Russia*, 2007, § 99; *Meryem Çelik and Others v. Turkey*, 2013, § 60; *Mikiyeva and Others v. Russia*, 2014, § 160; *Kushtova and Others v. Russia (no. 2)*, 2017, § 83; and by contrast *Tahsin Acar v. Turkey* [GC], 2004, §§ 217-219; *Nesibe Haran v. Turkey*, 2005, § 68; *Shafiyeva v. Russia*, 2012, § 79; *Kagirov v. Russia*, 2015, § 97).

c. State responsibility to protect the right to life

143. The disappearance of a person in life-threatening circumstances requires the State, pursuant to the positive obligation inherent in Article 2 of the Convention, to take operational measures to protect the right to life of the disappeared person (*Koku v. Turkey*, 2005, § 132; *Osmanoğlu v. Turkey*, 2008, § 75)[2].

144. In this connection, any negligence displayed by the investigating or supervising authorities in the face of real and imminent threats to an identified individual's life emanating from State agents who were acting outside their legal duties may entail a violation of the positive obligation to protect life (*Gongadze v. Ukraine*, 2005, § 170; *Turluyeva v. Russia*, 2013, §§ 100-101).

145. In a recent case, where a young woman with schizophrenia went missing, the Court found that the authorities, who were aware of the existence of a real and immediate risk of suicide, took immediate and appropriate action with a view to finding her alive. The State's substantive obligation to protect the right to life was therefore fulfilled (*Goncalves Monteiro v. Portugal*, 2022, § 118; see also *Tunç v. Turkey* (dec.), 2022, §§ 82-83, where the Court found no indication that the authorities knew or ought to have known that there was a real and immediate risk to the life of the applicants' relative, who had disappeared while criminal proceedings were pending against him for his alleged involvement in a terrorist organisation and thus no indication that they had failed to take measures which could reasonably have been expected of them).

6. Killings committed by State agents in their private capacity

146. A Contracting State will be responsible under the Convention for violations of human rights caused by acts of its agents carried out in the performance of their duties (*Krastanov v. Bulgaria*, 2004, § 53). Whether a person is an agent of the State for the purposes of the Convention is defined on the basis of a multitude of criteria, one of them being functional (*Fergec v. Croatia*, 2017, § 36). The Court has also held that, where the behaviour of a State agent is unlawful, the question of whether the impugned acts can be imputed to the State requires an assessment of the totality of the circumstances and consideration of the nature and circumstances of the conduct in question (*Sašo Gorgiev v. the former Yugoslav Republic of Macedonia*, 2012, §§ 47-48).

[2] See Section "Protection of life".

147. In particular, the Court has found that States are, in principle, not directly responsible for any killing or injury committed by State agents in their private capacity unless those agents made use of their position while committing the unlawful act in question with at least the connivance or acquiescence by the authorities irrespective of whether the agent concerned had been on or off-duty at the time of the events (*Enukidze and Girgvliani v. Georgia*, 2011, § 290; *Kotelnikov v. Russia*, 2016, § 93; *Fergec v. Croatia*, 2017, § 36).

148. However, in such circumstances, the State's obligation to take appropriate steps to safeguard the lives of those within its jurisdiction remains (see, for example, the approach taken in *Gorovenky and Bugara v. Ukraine*, 2012, §§ 31-40).

149. In a recent case where an Azerbaijani officer killed an Armenian officer and threatened to kill another Armenian soldier while taking part in a NATO course in Budapest, the Court considered that Azerbaijan could not be held responsible for the acts in question. In this respect, it attached crucial importance to the fact that the perpetrator was not acting in the exercise of his official duties or on the orders of his superiors. The Court also rejected the applicants' argument, based on Article 11 of the UN Draft Articles on the Responsibility of States of Internationally Wrongful Acts: while the measures taken by the Azerbaijani Government manifestly **demonstrated its "approval" and "endorsement" of** the perpetrator's criminal acts, it was not convincingly demonstrated that **Azerbaijan had "clearly and unequivocally" "acknowledged" and "adopted"** his **acts "as its own", thus** directly and categorically assuming, as such, responsibility for the actual killing of one victim and the attempted murder of another (*Makuchyan and Minasyan v. Azerbaijan and Hungary*, 2020, §§ 111-118).

150. By contrast, in a case which concerned the targeted killing of a Russian political defector and dissident in the United Kingdom with a high level of polonium 210, the Court, given the *prima facie* evidence of State involvement which the respondent Government failed to displace, found that the two Russian individuals, which the domestic inquiry in the United Kingdom had established as the perpetrators, were acting as State agents and that the act complained of was thus attributable to Russia (*Carter v. Russia*, 2021, §§ 162-169).

IV. Procedural obligations

Article 2 § 1 of the Convention

"1. Everyone's right to life shall be protected by law. ..."

HUDOC keywords

Effective investigation (2-1)

A. The scope of the procedural obligations

151. The procedural obligations of the State was first formulated in the context of the use of lethal force by State agents where the Court held that a general legal prohibition of arbitrary killing by the agents of the State would be ineffective, in practice, if there existed no procedure for reviewing the lawfulness of the use of lethal force by State authorities. The Court underlined that the obligation to protect the right to life under this provision, read in conjunction with the State's general duty under Article 1 of the Convention to "secure to everyone within their jurisdiction the rights and freedoms defined in the Convention", requires by implication that there should be some form of effective official

investigation when individuals have been killed as a result of the use of force by, *inter alios*, agents of the State (*McCann and Others v. the United Kingdom*, 1995, § 161).

152. Since then the Court has accepted that this obligation arises in a variety of situations where an individual has sustained life-threatening injuries, died or has disappeared in violent or suspicious circumstances, irrespective of whether those allegedly responsible are State agents or private persons or are unknown or self-inflicted (see, for example, concerning inter-prisoner violence: *Paul and Audrey Edwards v. the United Kingdom*, 2002, § 69; concerning homicides by prisoners benefiting from early release or social re-integration schemes: *Maiorano and Others v. Italy*, 2009, §§ 123-26; concerning high-profile assassinations: *Kolevi v. Bulgaria*, 2009, §§ 191-215; concerning domestic violence: *Opuz v. Turkey*, 2009, § 150; concerning suspicious deaths or disappearances: *Iorga v. Moldova*, 2010, § 26; *Tahsin Acar v. Turkey* [GC], 2004, § 226; concerning suicide: *Trubnikov v. Russia*, 2005; *Mosendz v. Ukraine*, 2013, § 92; *Vasîlca v. the Republic of Moldova*, 2014, § 28).

This stems from Article 2 which imposes a duty on that State to secure the right to life by putting in place effective criminal-law provisions to deter the commission of offences against the person, backed up by law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. This obligation requires by implication that there should be some form of effective official investigation when there is reason to believe that an individual has sustained life-threatening injuries in suspicious circumstances, even where the presumed perpetrator of the fatal attack is not a State agent (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 171).

153. The Court has further extended the scope of this obligation to circumstances where an individual has sustained life-threatening injuries or where lives have been lost in circumstances potentially engaging the responsibility of the State due to alleged negligence (see, for example, in the context of healthcare: *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 214; and road traffic accidents: *Anna Todorova v. Bulgaria*, 2011, § 72). In such cases, the Court has held that Article 2 of the Convention must also be considered to require the State to have in place an effective independent judicial system so as to secure legal means capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim (*Sinim v. Turkey*, 2017, § 59; *Ciechońska v. Poland*, 2011, § 66). In such cases, the Court has transposed, with certain adaptions and in a piecemeal fashion, the general principles regarding the duty to investigate, notably; the minimum required standards[3].

154. When the victim of a lethal attack is a State agent carrying out his official duties, the Court has underlined that the procedural obligation of the State required an additional investigation as to whether negligent acts or omissions on the part of officials had also directly contributed to that death (*Ribcheva and Others v. Bulgaria*, 2021, §§ 125-130).

B. Relationship between the substantive and the procedural limb

155. The State's obligation to carry out an effective investigation has in the Court's case-law been considered as an obligation inherent in Article 2, which requires, *inter alia*, that the right to life be "protected by law". Although the failure to comply with such an obligation may have consequences for the right protected under Article 13, the procedural obligation of Article 2 is seen as a distinct obligation (*İlhan v. Turkey* [GC], 2000, §§ 91-92; *Šilih v. Slovenia* [GC], 2009, §§ 153-154). It can give rise to a finding of a separate and independent "interference". This conclusion derives from the fact that the Court has consistently examined the question of procedural obligations separately from the question of compliance with the substantive obligation (and, where appropriate, has found a separate violation of Article 2 on that account) and the fact that on several occasions a breach of a procedural obligation under Article 2 has been alleged in the absence of any complaint as to its substantive aspect (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 231).

3. See Section Procedural obligations in respect of deaths or serious injuries.

C. The purpose of the investigation

156. The essential purpose of an investigation under Article 2 is to secure the effective implementation of the domestic laws safeguarding the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility (*Hugh Jordan v. the United Kingdom*, 2001, § 105; *Nachova and Others v. Bulgaria* [GC], 2005, § 110; *Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 163).

D. The form of the investigation

157. What form of investigation will achieve the purposes of Article 2 may vary depending on the circumstances. However, whatever mode is employed, the authorities must act of their own motion once the matter has come to their attention. They cannot leave it to the initiative of the next-of-kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures (*Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 165).

158. In the context of killings allegedly perpetrated by or in collusion with State agents, civil proceedings, which are undertaken on the initiative of the next-of-kin, not the authorities, and which do not involve the identification or punishment of any alleged perpetrator, cannot be taken into account in the assessment of the State's compliance with its procedural obligations under Article 2 of the Convention (*Hugh Jordan v. the United Kingdom*, 2001, § 141) because, in such cases, the procedural obligation of the State under Article 2 cannot be satisfied merely by awarding damages (*McKerr v. the United Kingdom* (dec.), 2000, § 121; *Bazorkina v. Russia*, 2006, § 117; *Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 165).

159. The Court has explained that this is because in cases of homicide the interpretation of Article 2 as entailing an obligation to conduct an official investigation is justified not only because any allegations of such an offence normally give rise to criminal liability, but also because often, in practice, in the context of killings allegedly perpetrated by or in collusion with State agents, the true circumstances of the death are, or may be, largely confined within the knowledge of State officials or authorities so that the bringing of appropriate domestic proceedings such as a criminal prosecution, disciplinary proceedings and proceedings for the exercise of remedies available to victims and their families, will be conditioned by an adequate official investigation (*Makaratzis v. Greece* [GC], 2004, § 73; *Khashiyev and Akayeva v. Russia*, 2005, §§ 120-121).

E. The nature and degree of scrutiny

160. The nature and degree of scrutiny which satisfy the minimum threshold of the investigation's effectiveness depends on the circumstances of the particular case. It must be assessed on the basis of all relevant facts and with regard to the practical realities of investigation work (*Centre for Legal Resources on behalf of Valentin Câmpeanu v. Romania* [GC], 2014, § 147). It is not possible to reduce the variety of situations which might occur to a bare check-list of acts of investigation or other simplified criteria (*Velikova v. Bulgaria*, 2000, § 80).

161. Where a suspicious death has been inflicted at the hands of a State agent, particularly stringent scrutiny must be applied by the relevant domestic authorities to the ensuing investigation (*Enukidze and Girgvliani v. Georgia*, 2011, § 277; *Armani Da Silva v. the United Kingdom* [GC], 2016, § 234).

162. In the context of disappearances, having regard to the fact that a disappearance is a distinct phenomenon, characterised by an ongoing situation of uncertainty and unaccountability in which there is a lack of information or even a deliberate concealment and obfuscation of what has occurred and that this situation is very often drawn out over time, prolonging the torment of the victim's relatives with the additional distinctive element of subsequent failure to account for the whereabouts

and fate of the missing person gives rise to a continuing situation. Thus, in such cases, the procedural obligation will, potentially, persist as long as the fate of the person is unaccounted for; the ongoing failure to provide the requisite investigation will be regarded as a continuing violation. This is so, even where death may, eventually, be presumed (*Varnava and Others v. Turkey* [GC], 2009, § 148).

163. In cases of contract killing, the Court took the view that the investigation could not be considered adequate in the absence of genuine and serious investigative efforts taken with the view to identifying the intellectual author of the crime, that is, the person or people who had commissioned the assassination. In such cases the domestic authorities' scrutiny had to aim to go beyond identification of a hitman (*Mazepa and Others v. Russia*, 2018, §§ 75-79; see also *Nemtsova v. Russia*, 2023, §§ 111 and 116).

164. Where the victim of a killing is a journalist, the Court, referring to Recommendation CM/Rec (2016) 4 on the protection of journalism and safety of journalists and other media actors, has considered that it was of utmost importance to check a possible connection of the crime to the journalist's professional activity (*Mazepa and Others v. Russia*, 2018, § 73).

165. Similarly, where the victim was a prominent politician and an opposition leader, the Court considered that it was vital to explore whether there was a possible political motive for his murder and whether certain State officials could have been involved (*Nemtsova v. Russia*, 2023, §§ 117-127; see also *Navalnyy v. Russia (no. 3)*, 2023, where the authorities refused to institute criminal proceedings into the attempted murder of a prominent opposition figure with a substance identified as a chemical nerve agent).

F. The standards of the investigation

1. Independence

166. For an investigation into alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence. What is at stake here is nothing less than public confidence in the State's monopoly on the use of force (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 232).

167. The requirements of Article 2 call for a concrete examination of the independence of the investigation in its entirety, rather than an abstract assessment (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 222).

168. Moreover, Article 2 does not require that the persons and bodies responsible for the investigation enjoy absolute independence, but rather that they are sufficiently independent of the persons and structures whose responsibility is likely to be engaged. The adequacy of the degree of independence is assessed in the light of all the circumstances, which are necessarily specific to each case (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 223).

169. However, where the statutory or institutional independence is open to question, such a situation, although not decisive, will call for a stricter scrutiny on the part of the Court of whether the investigation has been carried out in an independent manner. Where an issue arises concerning the independence and impartiality of an investigation, the correct approach consists in examining whether and to what extent the disputed circumstance has compromised the investigation's effectiveness and its ability to shed light on the circumstances of the death and to punish those responsible (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 224).

170. In this respect, the Court has emphasised that public prosecutors inevitably rely on the police for information and support and that this is not in itself sufficient to conclude that they lack sufficient

independence vis-à-vis the police. Rather, problems arise if a public prosecutor has a close working relationship with a particular police force (*Ramsahai and Others v. the Netherlands* [GC], 2007, § 344).

171. The Court has found that independence was lacking in investigations where, for example, the investigators:

- were potential suspects (*Bektaş and Özalp v. Turkey*, 2010, § 66; *Orhan v. Turkey*, 2002, § 342);
- were direct colleagues of the persons subject to investigation or likely to be so (*Ramsahai and Others v. the Netherlands* [GC], 2007, §§ 335-341; *Emars v. Latvia*, 2014, §§ 85 and 95);
- were in a hierarchical relationship with the potential suspects (*Şandru and Others v. Romania*, 2009, § 74; *Enukidze and Girgvliani v. Georgia*, 2011, §§ 247 et seq.).

172. In some cases the Court has interpreted the specific action of the investigative bodies as an indication of a lack of independence, such as,

- the failure to carry out certain measures which would elucidate the circumstances of the case (*Sergey Shevchenko v. Ukraine*, 2006, §§ 72-73);
- the excessive weight given to the suspects statements (*Kaya v. Turkey*, 1998, § 89);
- the failure to explore certain obvious and necessary lines of inquiry (*Oğur v. Turkey* [GC], 1999, §§ 90-91);
- inertia (*Rupa v. Romania (no. 1)*, 2008, §§ 123-124).

173. The Court did not find an issue regarding the independence of the investigation in the following circumstances:

- the mere fact that the investigators and the investigated were sharing living quarters in the particular context of military operations conducted abroad (*Jaloud v. the Netherlands* [GC], 2014, § 189);
- where the military court which carried out the review of the investigation failed to enjoy full statutory independence but there was absence of direct hierarchical, institutional or other ties between it and the main potential suspect and the specific conduct of that court did not reflect a lack of independence or impartiality in the handling of the investigation (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 254).

2. Adequacy

174. In order to be "effective" as this expression is to be understood in the context of Article 2 of the Convention, an investigation into a death that engages the responsibility of the Contracting Party under that Article must firstly be adequate (*Ramsahai and Others v. the Netherlands* [GC], 2007, § 324). That means that, it must be capable of leading to a determination of whether the force used was or was not justified in the circumstances and of identifying and – if appropriate – punishing those responsible (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 243). This is not an obligation of result, but of means (*Tahsin Acar v. Turkey* [GC], 2004, § 223; *Jaloud v. the Netherlands* [GC], 2014, § 186).

175. The authorities must take whatever reasonable steps they can to secure the evidence concerning the incident, including, *inter alia*, eyewitness testimony, forensic evidence and where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of the clinical findings, including the cause of death. (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 233). In this connection, the Court has held that an effective investigation may, in some circumstances, require the exhumation of the bodies of the deceased, despite the family's opposition (*Solska and Rybicka v. Poland*, 2018, §§ 120-121). Moreover, where there has been a use of force by State agents, the investigation must also be effective in the sense that it is capable of leading to a

determination of whether the force used was or was not justified (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 233). Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk failing foul of this standard (*Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 166).

176. In particular, the investigation's conclusions must be based on a thorough, objective and impartial analysis of all relevant elements. Failing to follow an obvious line of inquiry undermines to a decisive extent the investigation's ability to establish the circumstances of the case and the identity of those responsible (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 175).

177. The Court has found the investigation inadequate when, for example:

- the investigation into a fatal shooting by the police during an attempted arrest had been undermined by shortcomings such as the failure to test the hands of officers in question for gunshot residue; to stage a reconstruction of the incident; to examine their weapons or ammunition; the lack of an adequate pictorial record of the trauma caused to the victim's body by the fatal bullet; and the failure to separate the officers involved in the incident before their questioning (*Ramsahai and Others v. the Netherlands* [GC], 2007, §§ 326-332);
- the forensic investigation was defective (*Tanlı v. Turkey*, 2001, § 153; see by contrast *A.P. v. Austria,* 2024, §§ 154-58);
- the authorities accepted the version of facts presented by the accused State agents without hearing any further witnesses (*Özalp and Others v. Turkey*, 2004, § 45) or placed heavy reliance on the report prepared by them (*İkincisoy v. Turkey*, 2004, § 78);
- no investigation had been conducted into the flight log which constituted a key element in the possible identification and prosecution of those responsible for the bombing of civilian villages by military aircraft (*Benzer and Others v. Turkey*, 2013, § 196);
- the investigation into the contract killing of an investigative journalist focused only on a single line of inquiry without exploring other allegations (*Mazepa and Others v. Russia*, 2018, §§ 77-79);
- the investigation into the circumstances leading to the death of the applicant's son following his accidental shooting by a fellow conscript during his military service failed to elucidate some important factual matters, such as the overall time taken for the hospital transfer as well as the nature and origins of a number of injuries detected during the autopsy (*Dimaksyan v. Armenia*, 2023, § 102).

178. By contrast, having regard to the various steps undertaken by the domestic authorities, the Court did not find an issue with respect to the adequacy of the investigation in:

- *Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 209, which concerned the investigation into the death of the applicants' son and brother during his military service;
- *Armani Da Silva v. the United Kingdom* [GC], 2016, § 286, which concerned the investigation into the fatal shooting of person mistakenly identified as a suspected terrorist;
- *Giuliani and Gaggio v. Italy* [GC], 2011, § 309, which concerned the investigation into the fatal shooting of a demonstrator by a member of the security forces during a G8 summit;
- *Palić v. Bosnia and Herzegovina*, 2011, §§ 64-66, which concerned the investigation into the disappearance of the applicant's husband during the war in Bosnia and Herzegovina;
- *Tunç v. Turkey* (dec.), 2022, §§ 96-97, which concerned the authorities' investigation into the disappearance of the applicants' relative, against whom criminal proceedings were pending for his alleged involvement in a terrorist organisation;
- *Fraisse and Others v. France*, 2025, §§ 161-162, which concerned the investigation into the death of a student as a result of an explosion of a stun grenade launched by a gendarme during violence clashes between protesters and mobile gendarmes forces.

3. Promptness and reasonable expedition

179. Article 2 requires investigations to be prompt (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 237) and to proceed with reasonable expedition (*Giuliani and Gaggio v. Italy* [GC], 2011, § 305).

180. The Court accepts that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation, but it considers that a prompt response by the authorities in investigating a use of lethal force, may generally be regarded as 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 (*Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 167; *Tahsin Acar v. Turkey* [GC], 2004, § 224; *Armani Da Silva v. the United Kingdom* [GC], 2016, § 237).

181. The Court observes that the passage of time is liable not only to undermine an investigation, but also to compromise definitively its chances of being completed (*Mocanu and Others v. Romania* [GC], 2014, § 337).

182. The Court has found that the domestic authorities have, *inter alia*, failed to investigate with sufficient promptness and reasonable expedition in the following cases:

- *Kelly and Others v. the United Kingdom*, 2001, § 136: the inquest proceedings into the killing of the applicants' relatives by the security forces in an operation commenced eight years after the deaths;
- *Nafiye Çetin and Others v. Turkey*, 2009, § 42: the criminal proceedings instituted with a view to elucidating the facts and identify and punish those responsible for the death of their relative in police custody were pending for almost fifteen years;
- *Mocanu and Others v. Romania* [GC], 2014, § 348: the investigation into the killing of Mr Mocanu during 1990 demonstrations against the Romanian regime was pending, overall, for more than twenty-three years;
- *Hemsworth v. the United Kingdom*, 2013, § 74: the inquest hearing began 13 years after the killing of the applicants' relatives allegedly by security forces in Northern Ireland;
- *Jelić v. Croatia*, 2014, § 91: the investigation into the abduction and killing of the applicant's husband in 1991 was plagued by inexplicable delays;
- *Mazepa and Others v. Russia*, 2018, § 81: the investigation into the contract killing of an investigative journalist, notably, as regards the identity of the persons who had commissioned the crime, was still pending after more than eleven years;
- *Durdaj and Others v. Albania*, 2023, § 235: the criminal proceedings against a high level State official, concerning his role in the explosion of a weapon decommissioning facility that resulted in deaths and grievous bodily injuries, were still pending more than fourteen years after the events.

183. However, the Court did not consider that the length of the investigation and/or ensuing criminal proceedings were ineffective in cases concerning killings allegedly perpetrated by Hizbullah. Taking note of the nature of the crime, a killing by an unknown perpetrator and the efforts needed to dismantle a criminal organisation, the Court considered that the investigations conducted in these cases, while lengthy, were not devoid of effect and it could not be maintained that the authorities took no action with regard to the killing of the applicants' relatives (*Bayrak and Others v. Turkey*, 2006, §§ 54-55; *Adıyaman v. Turkey* (dec.), 2010). See also, in the context of investigations into deaths and disappearances during an armed conflict, *Palić v. Bosnia and Herzegovina*, 2011, § 70; *Zdjelar and Others v. Croatia*, 2017, §§ 91-94.

4. Public scrutiny and the participation of the next-of-kin

184. There must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. This requirement does not, however, go so far as to

require all aspects of all proceedings following an inquiry into a violent death to be public as disclosure or for example, publication of police reports and investigative materials may involve sensitive issues with possible prejudicial effects on private individuals or other investigations and, therefore, cannot be regarded as an automatic requirement under Article 2 of the Convention. The degree of public scrutiny required may vary from case to case (*Ramsahai and Others v. the Netherlands* [GC], 2007, § 353; *Giuliani and Gaggio v. Italy* [GC], 2011, § 304).

185. However, in all cases, the victim's next-of-kin must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests (*Al-Skeini and Others v. the United Kingdom* [GC], 2011, § 167). This does not mean that the investigating authorities have to satisfy every request for a particular investigative measure made by a relative in the course of the investigation (*Ramsahai and Others v. the Netherlands* [GC], 2007, § 348; *Giuliani and Gaggio v. Italy* [GC], 2011, § 304). Moreover, the lack of public scrutiny of police investigations may be compensated by providing the requisite access of the public or the victim's relatives during other stages of the procedure (*Hugh Jordan v. the United Kingdom*, 2001, § 121).

186. The Court has found that the investigation was not accessible to next-of-kin or that it did not allow for adequate public scrutiny where:

- the family of the victim had no access to the investigation or the court documents (*Oğur v. Turkey* [GC], 1999, § 92; see also *Tagiyeva v. Azerbaijan*, 2022, § 73 where the applicant had no access to the case-file) or was not informed of significant developments in the investigation (*Betayev and Betayeva v. Russia*, 2008, § 88; see also *Boychenko v. Russia*, 2021, § 99 where the applicant was not granted victim status and was not informed about any steps in the investigation).
- the wife of the victim was not provided with any information on the progress of the investigation; was not able to examine properly the case-file and was not given any record concerning witness statements or other procedural steps (*Mezhiyeva v. Russia*, 2015, § 75);
- the father of the victim was not informed of the decision not to prosecute (*Güleç v. Turkey*, 1998, § 82);
- the participation of the next-of-kin in the investigation was conditioned on them having lodged a criminal complaint together with an application to join the proceedings as a civil party (*Slimani v. France*, 2004, § 47);
- the prosecution authorities attempted to withhold the investigation documents from the applicants (*Benzer and Others v. Turkey*, 2013, § 193).
- the father of the deceased did not have access to documents in the criminal case file or the administrative inquiry and had only been informed of his son's death after an autopsy had taken place, even though the deceased's body had been identified earlier (*Fountas v. Greece*, 2019, § 96).
- complete lack of publicity and involvement of the applicants in two internal investigations by the Ministry of Internal Affairs into the death of their relative – a police officer killed by a dangerous individual during a police operation – which impacted on the possibility for them to lodge an action for compensation (*Ribcheva and Others v. Bulgaria*, 2021, §§ 146-147).

187. The Court did not find an issue with accessibility of the investigation to the next-of-kin or of the public in:

- *Giuliani and Gaggio v. Italy* [GC], 2011, § 315, which concerned the investigation into the fatal shooting of a demonstrator by a member of the security forces during the G8 summit;
- *Bubbins v. the United Kingdom*, 2005, § 161, where the applicant's brother was shot by police officers in his flat following a two-hour siege;

- *Palić v. Bosnia and Herzegovina*, 2011, § 69, which concerned the investigation into the disappearance of the applicant's husband during the war in Bosnia and Herzegovina.
- *Waresiak v. Poland*, 2020, § 95, which concerned restrictions applicable to the victim's next-of-kin in criminal proceedings concerning a minor.

G. Issues related to prosecution, sanction and compensation

188. There is no right to obtain a prosecution or conviction or indeed a particular sentence and the fact that an investigation ends without concrete, or with only limited, results is not indicative of any failings as such (*Giuliani and Gaggio v. Italy* [GC], 2011, § 306). To date, the Court has not faulted a prosecutorial decision which flowed from an investigation which was in all other respects Article 2 compliant nor required the competent domestic court to order a prosecution if that court had taken the considered view that application of the appropriate criminal legislation to the known facts would not result in a conviction (*Hanan v. Germany* [GC], 2021, § 210).

189. However, the requirements of Article 2 under its procedural limb go beyond the stage of the official investigation. Therefore, if the investigation has led to the institution of proceedings in the national courts, then the proceedings as a whole including the trial stage, must satisfy the requirements of the positive obligation to protect lives through the law (*Öneryıldız v. Turkey* [GC], 2004, § 95; *Ali and Ayşe Duran v. Turkey*, 2008, § 61).

190. In this respect, the Court recalls that in the normal course of events a criminal trial, with an adversarial procedure before an independent and impartial judge must be regarded as furnishing the strongest safeguards of an effective procedure for the finding of facts and the attribution of criminal responsibility (*McKerr v. the United Kingdom* (dec.), 2000, § 134). Nonetheless, it cannot be excluded, for example, that defects in an investigation may fundamentally undermine the ability of a court to determine responsibility for a death (*Ağdaş v. Turkey*, 2004, § 102).

191. The Court grants substantial deference to the national courts in the choice of appropriate sanctions for ill-treatment and homicide by State agents. However, it must exercise a certain power of review and intervene in cases of manifest disproportion between the offence committed and the sanction imposed (*Armani Da Silva v. the United Kingdom* [GC], 2016, § 285).

192. For example, the Court has underlined that the procedural obligations arising under Articles 2 and 3 of the Convention can hardly be considered to have been met where an investigation is terminated through statutory limitation of criminal liability resulting from the authorities' inactivity (*Association "21 December 1989" and Others v. Romania*, 2011, § 144).

193. Likewise, in the context of death following ill-treatment by State agents, the Court has considered that the suspension of the execution of the convicted police officers' prison sentences was comparable to a partial amnesty and that such measures cannot be considered permissible under its jurisprudence since, consequently, the convicted officers enjoyed virtual impunity despite their conviction (*Ali and Ayşe Duran v. Turkey*, 2008, § 69).

194. Moreover, the Court's review is not limited to the severity of the sentences as initially imposed by the domestic courts but includes also the manner of their subsequent implementation (*Enukidze and Girgvliani v. Georgia*, 2011, §§ 269 and 275, where the Court found a violation of Article 2 under its procedural limb, *inter alia*, because of the unreasonable leniency shown towards the convicts by their early release; *Kitanovska Stanojkovic and Others v. the former Yugoslav Republic of Macedonia*, 2016, § 33, where the Court found a violation of Article 2 under its procedural limb because of the unjustified delays in the enforcement of the custodial sentence). In this connection, the Court has stressed that the requirement of effectiveness of a criminal investigation under Article 2 can be also interpreted as imposing a duty on States to execute their final judgments without undue delay. It has found that it is so since the enforcement of a sentence imposed in the context of the right to life must

be regarded as an integral part of the procedural obligation of the State under this Article (*Kitanovska Stanojkovic and Others v. the former Yugoslav Republic of Macedonia*, 2016, § 32, *Akelienė v. Lithuania*, 2018, § 85, where the Court, having regard to the measures taken by the State to find the absconded convict after his conviction and to have him extradited, found no violation of Article 2 under its procedural limb).

195. It follows that the Court considers that granting an amnesty in respect of the killing or ill-treatment of civilians would run contrary to the State's obligations under Articles 2 and 3 of the Convention since it would hamper the investigation of such acts and necessarily lead to impunity for those responsible (*Marguš v. Croatia* [GC], 2014, § 127). Likewise, as a matter of principle, it would be wholly inappropriate and would send a wrong signal to the public if the perpetrator of very serious crimes were to maintain eligibility for holding public office in the future (*Makuchyan and Minasyan v. Azerbaijan and Hungary*, 2020, § 171).

196. In a case which raised the issue of the respective obligations of States in the context of the transfer of sentenced persons, the Court considered that, while the sentencing State (Hungary) had undertaken all it could to ensure the completion of the sentence by a prisoner after his transfer to another State (Azerbaijan), the latter's actions in effect granted impunity and thus were not compatible with that State's obligation under Article 2 to effectively deter the commission of offences against the lives of individuals (*Makuchyan and Minasyan v. Azerbaijan and Hungary*, 2020, §§ 195-197 and §§ 163- 173 respectively).

197. Finally, in another case where the applicant was refused authorisation by the domestic courts to join, as a civil party, the criminal proceedings relating to his brother's murder by a private person and to obtain compensation, the Court considered that the State's obligation to set up a judicial system capable of providing "appropriate redress" for the purposes of Article 2 required a remedy that would have enabled him - as the only family member and his deceased brother's sole heir, with whom he had enjoyed a close relationship - to claim compensation for the non-pecuniary damage that the applicant may have sustained (*Vanyo Todorov v. Bulgaria*, 2020, § 66).

H. The revival of procedural obligations

198. The procedural obligation binds the State throughout the period in which the authorities can reasonably be expected to take measures aimed at elucidating the circumstances of a death and establish responsibility for it (*Šilih v. Slovenia* [GC], 2009, § 157). In some cases, however, information purportedly casting new light on the circumstances of a killing may come to light at a later stage. The issue then arises as to whether, and in what form, the procedural obligation to investigate is revived. To that end, the Court has held that where there is a plausible, or credible, allegation, piece of evidence or item of information relevant to the identification, and eventual prosecution or punishment of the perpetrator of an unlawful killing, the authorities are under an obligation to take further investigative measures (*Brecknell v. the United Kingdom*, 2007, § 71).

199. The nature and extent of any subsequent investigation required by the procedural obligation will inevitably depend on the circumstances of each particular case and may well differ from that to be expected immediately after the death has occurred (*Harrison and Others v. the United Kingdom* (dec.), 2014, § 51). The lapse of time will, inevitably, be an obstacle as regards, for example, the location of witnesses and the ability of witnesses to recall events reliably. Such an investigation may in some cases reasonably be restricted to verifying the credibility of the source, or of the purported new evidence (*Cerf v. Turkey*, 2016, § 65). Moreover, the standard of expedition in such cases is very different to the standard applicable in recent incidents where time is often of the essence in preserving vital evidence at a scene and in questioning witnesses when their memories are fresh and detailed (*Gurtekin and Others v. Cyprus* (dec.), 2014, § 21 with further references).

200. In light of the primary purpose of any renewed investigative efforts, the authorities are entitled to take into account the prospects of success of any prosecution (*Brecknell v. the United Kingdom*, 2007, § 71).

201. However, there is little ground to be overly prescriptive as regards the possibility of an obligation to investigate unlawful killings many years after the events since the public interest in obtaining the prosecution and conviction of perpetrators is firmly recognised, particularly in the context of war crimes and crimes against humanity (*Jelić v. Croatia*, 2014, § 52).

I. Investigation of hate crimes

202. When investigating violent attacks, the authorities must take all reasonable steps to unmask any possible discriminatory motives for them. Treating violence with a discriminatory intent on an equal footing with violence having no such overtones is tantamount to turning a blind eye to the specific nature of acts that are particularly destructive of fundamental rights (*Stoyanova v. Bulgaria*, 2022, § 64). Failure to make a distinction in the manner in which situations that are essentially different are handled may constitute unjustified treatment irreconcilable with Article 14 of the Convention in conjunction with Article 2 (*Nachova and Others v. Bulgaria* [GC], 2005, § 160).

203. For example, where the circumstances of an attack have the hallmarks of gender-based violence, the authorities should react with special diligence in carrying out the investigative measure. Whenever there is a suspicion that an attack might be gender motivated, it is particularly important that the investigation is pursued with vigour (*Tërshana v. Albania*, 2020, § 160).

204. Likewise, in cases where there is an allegation of racially motivated violence, it is particularly important that the investigation is pursued with vigour and impartiality, having regard to the need to reassert continuously society's condemnation of racism and to maintain the confidence of minorities in the ability of the authorities to protect them from the threat of racist violence (*Menson v. the United Kingdom* (dec.), 2003; *Gjikondi and Others v. Greece*, 2017, § 118).

205. The duty to respond appropriately to such attacks extends to the judicial proceedings in which it is decided whether and how to convict and punish alleged perpetrators (*Stoyanova v. Bulgaria*, 2022, § 64). For example, where the applicant's son was murdered by three men who perceived him as being homosexual, the Court found a violation of Article 14 taken together with Article 2 because the domestic courts could not attach any tangible legal consequences to the homophobic motives of the crime when sentencing the perpetrators. This stemmed from a *lacuna* in the criminal law where murder, motivated by hostility towards the victim on account of his or her actual or presumed sexual orientation, is not as such an **"aggravated"** offence or otherwise treated as a more serious offence on account of the special discriminatory motive which underlies it (*Stoyanova v. Bulgaria*, 2022, §§ 70-76).

206. More detailed information can be found in the Case-Law Guide on Article 14 and Article 1 of Protocol No. 12 - Prohibition of Discrimination.

J. Procedural obligations in trans-border contexts

207. The Court has underlined that, in general, the procedural obligation falls on the Contracting State under whose jurisdiction the victim was at the time of death (*Emin and Others v. Cyprus, Greece and the United Kingdom* (dec.), 2010), unless there are special features which require a departure from this general approach (*Rantsev v. Cyprus and Russia*, 2010, §§ 241-242).

208. Moreover, Article 2 does not require member States' criminal laws to provide for universal jurisdiction in cases involving the death of one of their nationals (*Rantsev v. Cyprus and Russia*, 2010, § 244).

209. Nonetheless, even in the absence of special features, the Court has underlined that, the corollary of the obligation on an investigating State to secure evidence located in other jurisdictions is a duty on the State where evidence is located to render any assistance within its competence and means sought under a legal assistance request (*Rantsev v. Cyprus and Russia*, 2010, § 245).

210. In particular, where there are cross-border elements to an incident of unlawful violence leading to loss of life, the Court has observed that the authorities of the State to which the perpetrators have fled and in which evidence of the offence could be located may be required by Article 2 to take effective measures in that regard, if necessary of their own motion (*Cummins and Others v. the United Kingdom* (dec.), 2005; *O'Loughlin and Others v. the United Kingdom* (dec.), 2005).

211. In cases where an effective investigation into an unlawful killing which occurred within the jurisdiction of one Contracting State requires the involvement of more than one Contracting State, the Convention's special character as a collective enforcement treaty entails in principle an obligation on the part of the States concerned to cooperate effectively with each other in order to elucidate the circumstances of the killing and to bring the perpetrators to justice. Thus, Article 2 may require from both States a two-way obligation to cooperate with each other, implying at the same time an obligation to seek assistance and an obligation to afford assistance. The nature and scope of these obligations depend, however, on the circumstances of each particular case (*Güzelyurtlu and Others v. Cyprus and Turkey* [GC], 2019, §§ 232-233; see *Israilov v. Russia*, 2023, §§ 121-126 and 127-136, concerning the Russian authorities failure to cooperate with Austrian authorities in the investigation into the murder of the applicant's son in Austria; see also *Romeo Castaño v. Belgium*, 2019, where the Court considered that a Member State of the European Union must cooperate with another Member State within the framework of the European Arrest Warrant (EAW) system and duly consider whether to surrender an alleged terrorist fugitive for prosecution (2019, §§ 41-42 and 79-82).

212. In this respect, the Court has underlined that this obligation to cooperate could only be one of means, not of result. This means that the States concerned must take whatever reasonable steps they can to cooperate with each other, exhausting in good faith the possibilities available to them under the applicable international instruments on mutual legal assistance and cooperation in criminal matters. Thus, the procedural obligation to cooperate, in this context, will only be breached in respect of a State required to seek cooperation if it has failed to trigger the proper mechanism for cooperation under the relevant international treaties; and in respect of the requested State, if it has failed to respond properly or has not been able to invoke a legitimate ground for refusing the cooperation requested under those instruments (*Güzelyurtlu and Others v. Cyprus and Turkey* [GC], 2019, §§ 235-236). For instance, with respect to a person whose surrender has been requested by way of a European Arrest Warrant (EAW), a finding by the courts of the executing State that the conditions of detention in the requesting State would be inhuman and degrading which is based on incomplete and out-of-date material is not a legitimate ground to refuse cooperation (*Romeo Castaño v. Belgium*, 2019, §§ 85-90). In cases involving a Contracting State and a *de facto* entity under the effective control of another Contracting State, the duty to cooperate, in the absence of formal diplomatic relations, may require these States to use other more informal or indirect channels of cooperation, for instance through third States or international organisations. In such circumstances, the Court takes into account whether the States concerned used all informal or *ad hoc* channels of cooperation used by them outside the cooperation mechanisms foreseen by the relevant international treaties, while at the same time guided by the provisions of those treaties as an expression of the norms and principles applied in international law (*Güzelyurtlu and Others v. Cyprus and Turkey* [GC], 2019, §§ 237-238).

K. Procedural obligations in the context of armed conflict

213. The Court has held that the procedural obligation under Article 2 continues to apply in difficult security conditions, including in the context of armed conflict. In this respect, it is clear that where the death to be investigated under Article 2 occurs in circumstances of generalised violence, armed

conflict or insurgency, obstacles may be placed in the way of investigators and concrete constraints may compel the use of less effective measures of investigation or may cause an investigation to be delayed. Nonetheless, the obligation under Article 2 entails that, even in difficult security conditions, all reasonable steps must be taken to ensure that an effective, independent investigation is conducted into alleged breaches of the right to life (*Hanan v. Germany* [GC], 2021, § 204; *Georgia v. Russia (II)* [GC] (merits), 2021, § 326).

214. However, the Court has clarified that, in the context of investigations into deaths which occurred in an armed conflict, the procedural duty under Article 2 must be applied realistically (*Georgia v. Russia (II)* [GC] (merits), 2021, § 327). Thus, when the challenges for/constraints on the investigation authorities (from the fact that the deaths occurred in active hostilities in an extraterritorial armed conflict) pertain to the investigation as a whole and continue to influence the feasibility of the investigative measures that could be undertaken throughout the investigation (including investigative measures conducted by civilian authorities in the territory of the member State), the Court held that the standards applied to the investigation conducted by the civilian prosecution authorities in that member State were guided by those established in respect of investigations into deaths in an extraterritorial armed conflict (*Hanan v. Germany* [GC], 2021, § 200).

215. In *Ukraine and the Netherlands v. Russia* [GC], 2025, the Court found that Russia had failed to conduct an effective investigation into the downing of flight MH17 as a consequence of the firing, from separatist-controlled territory, of a missile supplied by Russia, resulting in the deaths of all 298 civilians on board. In this regard, it noted, *inter alia*: that inquiries made by the authorities had been piecemeal, focusing on certain aspects of the incident with a view to showing the lack of any Russian involvement and deflecting responsibility into Ukraine; that the next-of- kin of those killed had not been involved in any inquiries and had not been directly informed of the outcome; and that the authorities had failed to cooperate effectively with the investigation of the international joint investigation team (JIT).

L. Procedural obligations in respect of deaths or serious injuries occurring as a result of negligence

216. As mentioned above, the Court has extended the scope of the procedural obligations under Article 2 to circumstances where individuals have sustained life-threatening injuries or where lives have been lost due to negligence. In doing so, it has transposed the general principles, notably, the standards of investigation referred to above, albeit tailored to the circumstances of such cases.

1. General principles

217. The Court has held that an issue of State responsibility under Article 2 of the Convention might arise in the event of the domestic legal system's inability to secure accountability for negligent acts endangering or resulting in loss of human life (*Banel v. Lithuania*, 2013, § 70).

218. Thus, it has held that, in cases where negligence by a private individual resulted in the victim's death or serious injury, the States' duty to take appropriate steps to safeguard the lives of those within its jurisdiction includes an obligation to have in place an effective independent judicial system securing the availability of legal means capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim (*Fergec v. Croatia*, 2017, § 32, which concerned the effectiveness of proceedings concerning the explosion of a grenade in a pizza parlour; *Ciechońska v. Poland*, 2011, § 66, which concerned proceedings regarding the death of the applicant's husband after being hit by a tree in a health resort; *Anna Todorova v. Bulgaria*, 2011, § 72, which concerned proceedings regarding the death of the applicant's son in a road traffic accident; *Ilbeyi Kemaloğlu and Meriye Kemaloğlu v. Turkey*, 2012, § 38, which concerned the death of the applicant's seven-year old

son who froze to death while trying to walk home in a blizzard; *Kotelnikov v. Russia*, 2016, §§ 99-101, where the applicant was seriously injured in a traffic accident).

219. In the context of healthcare, the Court has interpreted the procedural obligation of Article 2 as requiring States to set up an effective and independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable (*Šilih v. Slovenia* [GC], 2009, § 192; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 214).

220. In this connection, the Court has underlined that, if the infringement of the right to life or to physical integrity is not caused intentionally, the positive obligation to set up an "effective judicial system" will be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts, enabling any responsibility to be established and any appropriate civil redress to be obtained. (*Calvelli and Ciglio v. Italy* [GC], 2002, § 51; *Mastromatteo v. Italy* [GC], 2002, § 90; *Vo v. France* [GC], 2004, § 90; *Anna Todorova v. Bulgaria*, 2011, § 73; *Cevrioğlu v. Turkey*, 2016, § 54; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, §§ 137 and 215). Where agents of the State or members of certain professions are involved, disciplinary measures may also be envisaged (*Nicolae Virgiliu Tănase v. Romania* [GC], 2019, § 159 and *Zinatullin v. Russia*, 2020, § 32).

221. The Court has further emphasised in this connection that the choice of means for ensuring the respect for positive obligations under Article 2 is in principle a matter that falls within the Contracting State's margin of appreciation. There are different avenues for ensuring Convention rights, and even if the State has failed to apply one particular measure provided by domestic law, it may still fulfil its positive duty by other means. However, for this obligation to be satisfied, such proceedings must not only exist in theory but also operate effectively in practice (*Cevrioğlu v. Turkey*, 2016, §§ 53 and 55; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 216).

222. Therefore the Court is called to examine whether the available legal remedies, taken together, as provided in law and applied in practice, could be said to have constituted legal means capable of establishing the facts, holding accountable those at fault and providing appropriate redress to the victim. In other words, rather than assessing the legal regime *in abstracto*, the Court must examine whether the legal system as a whole adequately dealt with the case at hand (*Valeriy Fuklev v. Ukraine*, 2014, § 67).

223. Nevertheless, even in the context of non-intentional infringements of the right to life, there may be exceptional circumstances where an effective criminal investigation is necessary to satisfy the requirement of Article 2 of the Convention (*Cevrioğlu v. Turkey*, 2016, § 54; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 215). The Court has found such exceptional circumstances to arise in cases where the negligence which led to an infringement of the right to life went, *inter alia*, beyond a mere error of judgment or carelessness. Such as for example:

- in the context of dangerous industrial activities (*Öneryıldız v. Turkey* [GC], 2004, § 71; *Durdaj and Others v. Albania*, 2023, § 184);
- in the context of a denial of healthcare (*Asiye Genç v. Turkey*, 2015, § 73);
- in the context of military activities (*Oruk v. Turkey*, 2014, §§ 50 and 65) see also *Ceyhan v. Türkiye*, 2024, §§ 85-87;
- in the context of transportation of dangerous goods (*Sinim v. Turkey*, 2017, §§ 62-64);
- in the context of road safety (*Smiljanić v. Croatia*, 2021, § 93);
- in the context of police inaction in a domestic violence case (*Tkhelidze v. Georgia*, 2021, §§ 59-60; see also *Penati v. Italy*, 2021, §§ 158-162, where the Court has also required a criminal investigation into the killing of a child by his father during a protected contact session organized by the social welfare department).

224. Likewise, the Court has admitted that, in cases where it is not clearly established from the outset that the death has resulted from an accident or another unintentional act, and where the hypothesis of unlawful killing is at least arguable on the facts, the Convention requires that an investigation which satisfies the minimum threshold of effectiveness be conducted in order to shed light on the circumstances of the death. The fact that the investigation ultimately accepts the hypothesis of an accident has no bearing on this issue, since the obligation to investigate is specifically intended to refute or confirm one or other hypothesis (*Mustafa Tunç and Fecire Tunç v. Turkey* [GC], 2015, § 133; *Nicolae Virgiliu Tănase v. Romania* [GC], 2019, §§ 160-164, where the Court extensively elaborated on the point).

225. Once it has been established in such an initial investigation that a life-threatening injury has not been inflicted intentionally, a civil remedy is normally regarded as sufficient, save for cases involving exceptional circumstances where it is necessary to pursue an effective criminal investigation (*Nicolae Virgiliu Tănase v. Romania* [GC], 2019, § 163; *Zinatullin v. Russia*, 2020, § 35).

226. In the context of healthcare, the Court has held that a requirement of independence of the domestic system set up to determine the cause of death of patients in the care of the medical profession is implicit in this context. This requires not only a lack of hierarchical or institutional connection but also that all parties tasked with conducting an assessment in the proceedings for determining the cause of death of patients enjoy formal and *de facto* independence from those implicated in the events (*Bajić v. Croatia*, 2012, § 90). This requirement is particularly important when obtaining medical reports from expert witnesses (*Karpisiewicz v. Poland* (dec.), 2012), as such reports are very likely to carry crucial weight in a court's assessment of the highly complex issues of medical negligence, which gives them a particularly important role in the proceedings (*Bajić v. Croatia*, 2012, § 95; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 217).

227. In the negligence context the relevant proceedings must be completed within a reasonable time (*Šilih v. Slovenia* [GC], 2009, § 196; *Cavit Tınarlıoğlu v. Turkey*, 2016, § 115; *Fergec v. Croatia*, 2017, § 38).

228. In the context of healthcare, the Court has emphasised in that connection that, apart from the concern for the respect of the rights inherent in Article 2 of the Convention in each individual case, more general considerations also call for a prompt examination of cases concerning medical negligence in a hospital setting. Knowledge of the facts and of possible errors committed in the course of medical care is essential to enable the institutions and medical staff concerned to remedy the potential deficiencies and prevent similar errors. The prompt examination of such cases is therefore important for the safety of all users of health-care services (*Oyal v. Turkey*, 2010, § 76).

229. Unlike in cases concerning the lethal use of force by State agents or in cases concerning accidents, where the competent authorities must of their own motion initiate investigations, in cases concerning medical negligence where the death is caused unintentionally, the States' procedural obligations may come into play upon the institution of proceedings by the deceased's relatives (*Šilih v. Slovenia* [GC], 2009, § 156; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 220).

230. In this context also, the Court underlines that this procedural obligation is not one of result but of means only (*Banel v. Lithuania*, 2013, § 66; *Lopes de Sousa Fernandes v. Portugal* [GC], 2017, § 221). Thus, the mere fact that the domestic proceedings have ended unfavourably for the person concerned does not in itself mean that the respondent State has failed in its positive obligation under Article 2 of the Convention (*ibid.*, § 221; *E.M. and Others v. Romania* (dec.), 2014, § 50).

2. Illustrations

a. Cases concerning alleged medical negligence

231. The Court considered that the legal system failed to provide an adequate and timely response consonant with the State's procedural obligations under Article 2 where, *inter alia*:

- domestic proceedings were excessively lengthy (*Byrzykowski v. Poland*, 2006, §§ 114-116; *Šilih v. Slovenia* [GC], 2009, §§ 202-210; *Zafer Öztürk v. Turkey*, 2015, §§ 56-57; *Bilbija and Blažević v. Croatia*, 2016, §§ 105-107);
- the medical experts' professional relationship with the accused was such that the medical experts could not be seen as objectively impartial (*Bajić v. Croatia*, 2012, §§ 98-102; and by contrast *Karpisiewicz v. Poland* (dec.), 2012);
- there was lack of cooperation between the forensic medical experts and the investigating bodies and the experts' opinions lacked reasons (*Eugenia Lazăr v. Romania*, 2010, §§ 81-85);
- the domestic legal system did not afford a deceased victim's surviving next-of-kin the ability to claim and receive non-pecuniary damages (*Sarishvili-Bolkvadze v. Georgia*, 2018, §§ 90-98).
- the amount of compensation awarded for medical negligence in civil courts was inadequate (*Scripnic v. the Republic of Moldova*, 2021, §§ 43-48).

232. By contrast, the Court considered that there was no failure to provide a mechanism whereby the criminal, disciplinary or civil responsibility of persons could be established in:

- *Vo v. France* [GC], 2004, § 95 (involuntary termination of pregnancy);
- *Ursu v. Romania* (dec.), 2005, (death caused by cardiac arrest);
- *Maruseva v. Russia* (dec.), 2006, (death of a child in the course of a cardiac surgery operation);
- *Sevim Güngör v. Turkey* (dec.), 2009, (death of an elderly patient from bronchopneumonia in hospital);
- *Besen v. Turkey* (dec.), 2012, (death of the applicant's mother following surgery);
- *Vakrilov v. Bulgaria* (dec.), 2012, § 41 (death due to acute cardiovascular and respiratory failure);
- *E.M. and Others v. Romania* (dec.), 2014, § 56 (death in hospital due to a bacterial infection following surgery);
- *Buksa v. Poland* (dec.), 2016, §§ 15-16 (death of a baby due to an undiagnosed abdominal non-malignant tumour in her liver).

b. Cases concerning accidents

233. The Court has found that the State had failed to provide an effective judicial response in relation to the death of an individual in an accident where, *inter alia*:

- domestic proceedings were excessively lengthy due to lack of diligence on the part of the national authorities (*Anna Todorova v. Bulgaria*, 2011, § 83; *Igor Shevchenko v. Ukraine*, 2012, § 61; *Starčević v. Croatia*, 2014, § 67; *Mučibabić v. Serbia*, 2016, § 135; *Sıdıka İmren v. Turkey*, 2016, § 67; *Fergec v. Croatia*, 2017, §§ 41-42);
- there were shortcomings in the manner in which evidence was taken, which negatively affected any prospect of establishing the facts of the case and the responsibility of the accused in subsequent proceedings (*Ciechońska v. Poland*, 2011, § 75; *Antonov v. Ukraine*, 2011, § 50; *Vovk and Bogdanov v. Russia*, 2020, § 77).

234. By contrast, the Court considered that there was no failure to provide a mechanism whereby criminal, disciplinary or civil responsibility of persons who may be held answerable could be established in:

- *Furdík v. Slovakia* (dec.), 2008, (death of a climber);
- *Koceski v. the former Yugoslav Republic of Macedonia* (dec.), 2013, § 28 (death of a child in a playground when heavy concrete pillars fell on top of her);
- *Cavit Tınarlıoğlu v. Turkey*, 2016, § 125 (serious injuries sustained by an applicant when he was struck by a motorboat while swimming in a bathing area that had not been cordoned off);
- *Mikhno v. Ukraine*, 2016, § 151 (military aircraft crash killing spectators at a public air show);
- *Çakmak v. Turkey* (dec.), 2017, § 34 (electrocution of the applicants' relative while picking up pinecones from a tree in the garden of a primary school);
- *Aktaş v. Turkey* (dec.), 2019, § 29 (death of the applicant's son when his motorcycle collided with a pickup truck).
- *Huci v. Romania*, 2024, §§ 59-60 (death of the applicants' relative in a crash of an uncertified small ultralight motorised airplane during a test flight).

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The case-law cited in this Guide refers to judgments or decisions delivered by the European Court of Human Rights and to decisions or reports of the European Commission of Human Rights.

Unless otherwise indicated, all references are to a judgment on the merits delivered by a Chamber of the Court. The abbreviation "(dec.)" indicates that the citation is of a decision of the Court and "[GC]" that the case was heard by the Grand Chamber.

Chamber judgments that were not final within the meaning of Article 44 of the Convention when this update was finalised are marked with an asterisk (*) in the list below. Article 44 § 2 of the Convention provides: "The judgment of a Chamber shall become final (a) when the parties declare that they will not request that the case be referred to the Grand Chamber; or (b) three months after the date of the judgment, if reference of the case to the Grand Chamber has not been requested; or (c) when the panel of the Grand Chamber rejects the request to refer under Article 43". In cases where a request for referral is accepted by the Grand Chamber panel, the Chamber judgment does not become final and thus has no legal effect; it is the subsequent Grand Chamber judgment that becomes final.

The hyperlinks to the cases cited in the electronic version of the Guide are directed to the HUDOC database (http://hudoc.echr.coe.int) which provides access to the case-law of the Court (Grand Chamber, Chamber and Committee judgments and decisions, communicated cases, advisory opinions and legal summaries from the Case-Law Information Note), of the Commission (decisions and reports) and to the resolutions of the Committee of Ministers.

The Court delivers its judgments and decisions in English and/or French, its two official languages. HUDOC also contains translations of many important cases into more than thirty non-official languages, and links to around one hundred online case-law collections produced by third parties. All the language versions available for cited cases are accessible via the 'Language versions' tab in the HUDOC database, a tab which can be found after you click on the case hyperlink.

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FOR IMMEDIATE RELEASE | FRIDAY 17 DECEMBER 2021 | DUBLIN

IRISH HIGH COURT DECLARES THAT MOTHER AND BABY HOMES COMMISSION OF INVESTIGATION TREATED SURVIVORS UNLAWFULLY

SURVIVORS AND CLANN PROJECT CALL ON GOVERNMENT TO AMEND REDRESS SCHEME TO RECOGNISE ALL HUMAN RIGHTS VIOLATIONS

Government agrees to High Court declaration that Commission of Investigation wrongly denied survivors the right to comment on many draft findings

Commission's redress recommendations are among findings which do not accurately reflect the survivors' evidence, as claimed by the Court cases

Government will permanently deposit today's High Court declarations in Oireachtas Library alongside the final Commission Report and will list impugned paragraphs alongside Commission Report online

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- 'Fatally flawed' Commission Report no longer stands as credible record, say survivors and the Clann Project
- Government must now drastically amend the redress scheme and extend redress to formerly 'boarded out' children
- Redress must also be extended to all affected by forced family separation, illegal vaccine trials, forced labour, abuse as an adopted child, institutional abuse of any duration, and death
- Inquests must be held into the deaths and disappearances of children and mothers and Government must give full access to the Commission's archive

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The Irish High Court has today declared that eight survivors including Philomena Lee, Mary Harney, Mari Steed, Mary Isobelle Mullaney and others not identified publicly were denied fair procedures by the State's Mother and Baby Homes Commission of Investigation which operated between 2015 and 2021.

The Government has agreed to, and will not be appealing, the High Court's declaration that the survivors were wrongly refused their statutory right under section 34 of the Commissions of Investigation Act 2004 to reply to a draft of the Commission's findings. This right was afforded to the religious orders and other alleged wrongdoers.

In its Final Report the Commission of Investigation reached conclusions diametrically opposed to the litigants' testimony without any explanation as to why, and without offering them any opportunity to comment on a draft of these conclusions as was their statutory right.

Today's High Court declaration will appear alongside the Commission's Final Report on the Government website and it will be deposited for permanent preservation in the Oireachtas Library alongside the Commission's Report. The Government will also list online and in the Oireachtas Library all paragraphs in the Commission's Report which the survivors' High Court actions claimed did not accurately reflect their testimony.

The impugned parts of the Commission's Final Report include findings and recommendations upon which the Government is relying to limit its proposed redress scheme. For example, the Commission concluded that redress should not be granted for forced or illegal adoption, forced labour in Mother and Baby Homes generally, vaccine trials in Mother and Baby Homes, or the abuse of 'boarded out' or adopted people as children.

The Commission's findings were heavily contested by those personally affected when published in January 2021. Today's High Court declaration confirms that these findings were reached following an unlawful process that denied survivors' fair procedures rights.

The Clann Project will lodge the High Court's declaration with the eight United Nations human rights bodies that **wrote** to the Government earlier this month. The eight human rights bodies criticised the State's ongoing failure to remedy abuses that occurred in the institutional and forced family separation system such as the sale of children, enforced disappearance, torture and ill-treatment, arbitrary detention, servitude and forced labour, and gender-based violence. The human rights bodies emphasised the need for comprehensive redress, unfettered access to records, and immediate inquests into deaths and disappearances at sites including Tuam and Bessborough.

CASE SUMMARIES AND QUOTES SHARED ON BEHALF OF SEVERAL OF THE LITIGANTS

Mary Harney's Claim: Mary Harney was born in Bessborough in 1949 and illegally 'boarded out' (fostered) to an abusive family aged 2 ½. The Commission's Report ignores her sworn evidence that she was not properly fed by her foster parents and that she was routinely subjected to physical abuse leading to her placement aged 5 in an Industrial School. It also ignores the evidence of 30 formerly boarded out children in the Confidential Committee Report. Given today's High Court declaration, the Government cannot continue to exclude boarded out children from the redress scheme, says Mary Harney.

The Commission concluded that the nature of the violence suffered by boarded out children 'cannot be established'. The Commission further concluded that 'the evidence relating to boarded out children and children at nurse is scant' notwithstanding Mary Harney's sworn testimony and 19 pages of testimony in the Commission's Confidential Committee report amounting to what the Confidential Committee itself called a 'stream of similar accounts of beatings and abuse of all kinds'. The 19 pages include tens of graphic descriptions of extreme violence including serial rape and routine whipping, servitude, abject neglect and denial of education. Reflecting the Commission's conclusions, the Government's proposed payment scheme does not provide any payment for abuse suffered while a boarded out child. This cannot stand, say Mary Harney and the Clann Project.

Mary Harney said: *'We have been vindicated. Today's declaration by the High Court and the Department of Children, Equality, Disability, Integration and Youth, is a step towards justice for all of the women and children incarcerated in the Mother and Baby Institutions and separated from each other, and for those of us who were boarded out to abusive guardians. The declaration given today demonstrates that the Commission of Investigation failed in its statutory duty to witnesses and that the government is not willing to stand over its work.*

The administrative files and documents of the Commission must now be made available for scrutiny, and the proposed redress scheme must take into account the breaches of our constitutional and human rights. Almost 25 years has passed since the last Mother and Baby Home closed its doors in Ireland—it is time for the Government to grant those still alive their chance to find healing and peace in the information that has always been rightfully theirs; if not, the epitaph 'Deny Till They Die' will be written on the tombstone of Irish justice.'

Philomena Lee's Claim: Directly contrary to the sworn testimony of Philomena Lee, the Commission's Report claims that women 'were not incarcerated' in mother and baby institutions; that there is 'no evidence' of women being denied full, free and informed consent to their child's separation from them; that there is 'no evidence that women in mother and baby homes were denied pain relief or other medical interventions' that were available to public hospital patients; that the forced labour which women were subjected to in mother and baby homes 'was generally work which they would have had to do if they were living at home' and not of the type that should have been remunerated; and that the religious orders' records are 'the property of the holders and they have the right to determine who gets access'.

Lee, like Harney, is calling for the government to change its 'restorative recognition' plans, to open the administrative records gathered by the Commission of Investigation, and to meaningfully recognise the human rights abuses perpetrated.

Philomena Lee, now 88, said: *'The Commission of Investigation failed in its duty to impartially and fairly investigate and establish the truth. This has been confirmed by the High Court's declaration today. In my sworn evidence in 2017, I explained to the Commission how I was confined in Sean Ross Abbey and kept away from my son Anthony for all but one hour each day. When Anthony was 3 ½ I was forced to sign a consent form for his adoption. The nuns refused to tell me what it said. We had no privacy in Sean Ross Abbey and no way to provide for our child—I worked for no pay six days a week at heavy laundry work, and I had no way out of the institution. When Anthony and I sought to find each other the nuns lied to us, and they prevented us meeting before Anthony died.*

The Commission's findings are deeply hurtful and troubling to me. Those findings deny what we lived – they deny the truth. I call on the Government to denounce this Report now, and to open up the Commission's archive of documents to survivors and adopted people so that they can access information still withheld to this day. The secrecy and obstruction by state and church must end. It has gone on for far too long.'

Bridget, one of the litigants, who has not been named publicly: Bridget gave birth to her baby boy William at Bessborough Mother and Baby Home in October 1960. Bridget gave evidence to the Commission of Investigation that Baby William died in December 1960 alone in St Finbarr's Hospital, following serious medical neglect of both mother and child by the nuns in Bessborough. When they finally transferred William to hospital the nuns refused to allow Bridget to accompany him and Bridget was denied knowledge of the cause of William's death, the location of William's grave or even whether he was buried in a coffin.

The Commission of Investigation refused to give Bridget records it held demonstrating William's burial location. It summarised her evidence inaccurately in its Report. It further ignored her evidence when it concluded that women 'were not "incarcerated"' in Mother and Baby Homes and were 'always free to leave'; that 'there is very little evidence of physical abuse'; that women in Mother and Baby Homes were not subjected to unlawful forced labour; and that women in Mother and Baby Homes received 'superior' maternity care.

The Commission further ignored Bridget's evidence by concluding that 'In cases where the mothers were in the homes when the child died, it is possible that they knew the burial arrangements or would have been told if they asked'. The Commission gave no reasoning for its finding that efforts to locate disappeared children would be 'prohibitively' expensive.

Bridget said: *'I welcome the Government's acknowledgement that there was a breach of Statutory Duty. I was denied my right to read a copy of the Commission of Investigation's draft Report and to correct the inaccuracies it contained in relation to the circumstances that I and my baby faced when incarcerated in Bessboro, Cork. I was blatantly lied to by those in charge at Bessboro about the burial place of my beautiful baby William. Nothing can bring my son back but at the very least the Government must ensure that the truth is told and that all records are released to those concerned.*

There are several areas of the Executive Summary of the Commission of Investigation's Report which do not reflect the truth and my lived experience.

The facts are that I was incarcerated in Bessboro and denied access to my baby who became seriously ill and despite me begging for a doctor to see my child, he was denied medical intervention for 16 days, after which he was finally sent to hospital. I was not allowed to be with my baby at the hospital and he died there without his mother by his side.

I am pleased that I have survived to tell William's story and to speak the truth of what happened to him and me. An inquest into the death of my baby should be carried out, just as it most certainly would if my child had not been born in Bessboro to an unmarried mother.'

Another of the litigants, who has not been named publicly, gave sworn evidence to the Commission of Investigation that two months after her birth at St Patrick's Mother and Baby Home she was placed for adoption, following which she was subjected to extreme physical, mental and sexual abuse at the hands of her adoptive parents throughout her childhood.

Her abuse included being starved, being force-fed and forced to eat her vomit, severe beatings, being washed with bleach, and being scalded with boiling water from a kettle. She was sexually abused by a number of members of her adoptive family, and verbally abused constantly.

Her adoptive parents also adopted a boy, who she witnessed being severely beaten. She eventually ran away from her adopters at the age of 15 or 16 to escape the abuse.

The Commission of Investigation Report contains an incomplete summary of her evidence, omitting important parts of her testimony. The Commission's findings do not address the inadequacy of the State's oversight of adoptive placements and prospective adopters' suitability, ignoring the witness testimony received. The Commission made no finding about abuse suffered by adopted people as children.

Without explanation the Commission's Report concludes that 'The Commission has no doubt that, whatever the shortcomings of the legal adoption system, it was preferable to placing children in industrial schools or to boarding out or placing at nurse.' The Commission did not recommend any redress for people abused as adopted children, and the Government's redress scheme copies this approach. Following today's High Court declaration, this exclusion must be reversed.

This litigant said: *'My birth mother came from an industrial school and at 8 weeks pregnant was placed in St Patrick's Mother and Baby home. I have no idea if my adoption was consented to by her as I was placed at two months old in my adopted family.*

The State failed me and mother by not ensuring that I had a safe, secure upbringing and that I did not suffer abuse and torture at the hands of my adopted family. The commission did not take my testimony into consideration when making its finding and recommendations. I want all my information that the Government and Church have in relation to my early life. I also want redress for all I have endured in my early life and the impact it still continues to have today.'

Another of the litigants who has not been identified publicly, S Kil, said: *'This is a victory for survivors and our cases. We were readily identifable in the Commission's report and were denied a draft of the report and as a result our testimonies were mis-represented.*

One of the key elements in my case is that the Commission denied me my religious identity and changed my religion in my testimony. My religion is central to my Mother and Baby Home experience as the women in Denny House told me – "a handful of Protestant babies come up each year for adoption and yours is one of them".

From the moment I was locked up in Denny House my unborn baby was seen as an adoptee. I was put under constant excessive coercion to put my baby up for adoption by the women in Denny House. In order to have my baby adopted these women in Denny House broke me down, destroying my self-confidence and self-worth and told me I would never be a good mother and my baby would be better off without me. This is not reflected in the summary of my testimony in the report or in the chapter on Denny House. In addition, to change my religion was unconstitutional and disrespectful to my identity and my particular experience and to any other survivor who is from a minority group and was in a Mother and Baby Home.

From the outset, the Commission's Confidential Committee stage-managed my testimony giving, only focusing on a particular narrative and points they wanted to include in the report. I instantly recognised myself, twice, in the Confidential Committee part of the report. It greatly upset me that the Confidential Committee completely twisted my words, misrepresented what I said and did not present a factual account of what happened to my son and I.

The report never acknowledged this or the fact that Denny House was another Mother and Baby Home hell-hole were babies were left to scream for hours and hours on end while their mothers were made to work in the house. The house was a terrifying place to be regardless of what the report says. My experience in this institution has had a profoundly negative affect on my life.

I believe this report should be consigned to the dustbins of history. I call on the government to repudiate this report and for the Commissioners and Commission employees who falsely misrepresented my testimony and paperwork, and whose findings are abhorrent, to apologise for the incredible pain their report has caused survivors.'

Dr Mary Isobelle Mullaney said: *'I, Dr Mary Isobelle Mullaney, gave testimony before the Commission in good faith in the hope of highlighting the plight of my birth mother who died five days after my six week premature birth in Sean Ross Abbey, she was aged 21 years. I was adopted by wonderful parents both of whom I loved deeply. The report of the commission got several details of my testimony wrong, a trail of chinese whispers evident from the recording, to the summarised 'transcription' , to what appeared in the final report.*

The implication that I had anything less than the best of love and care from my adoptive mother and father was hurtful and retraumatising and a lie and to have it corrected was the reason I took this high court action- I could not have had better parents and I wanted the report corrected to reflect my experience and what I had actually told the Commission.

I welcome the acknowledgement by the Minister that I should have gotten the opportunity to correct this record and only wish it could actually be corrected.

Even though my birth mother died with what should be obvious questions about her care and though I was institutionalised and unloved for four months and my adoptive mother was not made aware that my birth mother was dead, and even though the Minister has acknowledged that proper procedures were not followed by the Commission and despite the money spent by the government on the Commission, the flawed report, the money spent on Oak Consultants (whose recommendations were largely ignored) and the money spent by the state on the High Court action; we still do not qualify for any redress under the terms of the proposed redress scheme for any of the trauma and subsequent re traumatisation that we have been subjected to.

The trauma of the 'primal wound' of severing the relationship between the baby and the birth mother has not been acknowledged in the report, my birth mothers sacrifice has in no way been acknowledged and what more could a person do than give her life?

However the nuns in Sean Ross did keep me alive and facilitate my adoption into a wonderful family and I wanted to acknowledge that and did so in my testimony to the Commission and welcome the opportunity to restate that publicly.'

THE CLANN PROJECT

Philomena Lee, Mary Harney, Mari Steed and other litigants who have not been named publicly gave sworn written evidence to the Commission of Investigation with the assistance of the **Clann Project**: a voluntary evidence-gathering and advocacy collaboration between global law firm Hogan Lovells International LLP and the groups **Justice for Magdalenes Research** and **Adoption Rights Alliance**.

Claire McGettrick of the Clann Project said: *'The Commission's conclusions currently stand as the State's official historical record and are informing the Government's highly restrictive and problematic 'restorative recognition' plans. This is a further abuse of affected people's dignity and rights, which the Government must put right. The Commission of Investigation examined 18 institutions, which represents a tenth of the institutions, agencies and individuals that were involved in the forcible separation of children from their mothers. The Mother and Baby Homes were just one element of the forced family separation system in Ireland. These abuses occurred both inside and outside institutional settings; social class and/or financial stability were no refuge. The Government is ignoring the thousands of women who gave birth outside Mother and Baby Homes who were also forced to suffer in silence after the devastating loss of their children to adoption. The Government is also refusing to acknowledge the myriad abuses suffered by adopted and boarded out people, regardless of where they were born, including abuses in adoptive families and the injustice of closed, secret adoption. This is exemplified in the Government's current adoption legislation proposals which have been described as grossly offensive by adopted people but have nonetheless been characterised by Minister O'Gorman as a form of redress. The Government's acceptance of the High Court declaration must now represent a turning point and an end to the management and compartmentalisation of affected people.'*

Dr Maeve O'Rourke of the Clann Project said: *'The Clann Project, with the help of global law firm Hogan Lovells International LLP, repeatedly and publicly drew attention to the unfairness of the Commission of Investigation's procedures from 2016 until the Commission's dissolution in 2021. The government knew that the Commission was refusing to provide survivors or adopted people with any personal data, or even a transcript of their own evidence. Those personally affected had no way of accessing or commenting on any of the evidence being gathered by the Commission, and the Commission refused to allow any survivor a public hearing despite their express requests. In fact the Commission refused to advertise or allow all survivors to meet its Investigation Committee; it directed survivors generally to its Confidential Committee and then declined to treat the testimony given to the Confidential Committee as having evidentiary value for the purpose of the report's conclusions. We hope that today's judgment will change how Commissions of Investigation and all state inquiries treat people who have suffered abuse: they deserve to be treated as rights holders and enabled to fully participate in investigations. The Clann Project is extremely grateful to the many survivors, adopted people, lawyers and others who have contributed voluntarily since 2015 to the effort to hold the Mother and Baby Homes Commission of Investigation accountable to those whose lives it was affecting.*

The Clann Project also wishes to thank the lawyers representing the litigants in the judicial review actions settled today: Wendy Lyon and all at Abbey Law Solicitors; Stephen Kirwan, Maryse Jennings and all at KOD Lyons Solicitors; Gary Moloney BL, Cillian Bracken BL, Nóra Ní Loinsigh BL, Ceile Varley BL, April Duff BL, Alan DP Brady BL, Colin Smith BL, Siobhan Phelan SC and Michael Lynn SC.

GOVERNMENT REDRESS SCHEME MUST BE AMENDED

Philomena Lee, Mary Harney, Mari Steed and several more of the litigants together with the Clann Project now call on the Government:

- To amend its 'restorative recognition' plans to recognise all rights violations perpetrated in the institutional and family separation system, and

- To respond to what participants said in the **OAK Consulting independent consultation process** on the development of its 'Restorative Recognition Scheme'.

- **The Government's Birth (Information and Tracing) Bill must be drastically amended to guarantee without exception the rights to know one's identity, to access one's personal data, to access administrative records, to access truth regarding serious human rights violations, and to know the truth of the fate and whereabouts of disappeared relatives**—as emphasised by eight UN human rights Special Rapporteurs in a **letter** to Government last month and by the Oireachtas Children's Committee in its recent **pre-legislative scrutiny report**. The Birth (Information and Tracing) Bill in its current form does not grant information access to mothers or to relatives of the deceased, and the Bill would deny adopted people and those subjected to illegal adoption and illegal birth registration access to any identifying information about their siblings or information about a parent's or guardian's care of them. The Bill requires a person's medical information to be given to a health professional rather than directly to them. The Bill does not mandate information disclosure by any data controllers other than TUSLA (the Child and Family Agency) and the Adoption Authority of Ireland. Furthermore, the Bill proposes to restrict the right to birth identity by requiring people whose parent has expressed a 'no contact' preference to attend a discriminatory and unnecessary Information Session at which they will be informed not of their own entitlements but of their parent's 'privacy rights, and...the importance of respecting their contact preferences.'

- **Participants in the scheme must not be forced to legally waive their rights to go to court in return for payments as small as €5,000.** The proposed waiver can only be understood as an attempt by the State to buy survivors' silence, and it follows an unlawful Commission of Investigation process that portrayed those affected as untruthful. Those affected must retain their right to seek justice; if necessary a future court award can be reduced by the amount already paid. The UN Committee Against Torture already ruled in the case of **Elizabeth Coppin v Ireland** that it is contrary to Ireland's international law obligations to force survivors of inhuman or degrading treatment to give up their right to the truth and accountability in exchange for a so-called 'ex gratia' payment. In November 2021, eight UN Special Rapporteurs **wrote** to the Government to emphasise that its payment scheme must be 'without prejudice to the right to seek further remedies for human rights violations experienced'.

- **The Government must by order of the Attorney General initiate inquests to establish the identities and circumstances of death of the children and women who remain in unmarked, unrecorded graves following their disappearance in mother and baby and related institutions.** The existing Coroners Act provides for such action. Instead, however, the Government is proposing through its Institutional Burials (Authorised Interventions) Bill to establish a specialised agency to exhume remains for identification purposes only—and not to investigate. A key criterion for such an agency's establishment under the Government's Bill is that there is no evidence of violent or unnatural death, and once the agency takes control of the site the Coroner's jurisdiction and obligation to hold an inquest will be disapplied. It is unacceptable that the Government refuses to recognise any evidence of violent or unnatural death at mother and baby institutions, given the incarceration and neglect, inordinately high death rates, and ongoing denial of information about the whereabouts of the deceased that is clearly evident from the testimony and other data provided to the Commission of Investigation.

- **The Government's planned payment scheme, as stressed by the eight UN Special Procedures last month, must recognise the harms of sale of children and illegal adoption, forced labour and servitude, torture and inhuman and degrading treatment and gender-based violence against women and girls, arbitrary detention, and enforced disappearances**—all of which occurred in the institutional and family separation system. The Government's payment scheme plans do not recognise forced family separation or the erasure of identity as abusive; nor do they recognise the grave abuse of many boarded out and adopted people, among other harms. The Government must rectify, among other flaws in its plans:

    - Its exclusion of those who were boarded out as children;
    - Its exclusion of those who were adopted or otherwise separated from their mother in an institution before the age of six months;
    - Its exclusion of those who were in institutions not investigated by the Commission of Investigation;
    - Its exclusion of mothers and their now-adult children who were separated in non-institutionalised settings including through adoption agencies and private facilitators, and through illegal adoption, including via illegal birth registration;
    - Its refusal to recognise forced labour or servitude other than of a type that the Government deems to have been 'commercial';
    - Its exclusion of those who received payment previously from the Residential Institutions Redress Board (RIRB). The abuse recognised by the RIRB was of a different nature to forced family separation;
    - Its restriction of the 'enhanced medical card' to those institutionalised for more than six months and its restriction of healthcare for those now living abroad to a once-off €3,000 payment; and
    - Its gross undervaluing of the abuses perpetrated through the proposed payment amounts.

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NOTES TO EDITORS

- The sworn evidence given to the Commission of Investigation by Philomena Lee, Mary Harney and Bridget is available to view on the Clann Project website here and further statements will be added in the coming days: http://clannproject.org/clannarchive/statements/

- Among the Commission of Investigation's conclusions, which contradicted survivors' clear testimony and were reached without offering survivors a right of reply while this right was afforded to alleged wrongdoers, were that:

  - Responsibility for the harsh treatment of women who gave birth outside marriage during the 20th century 'rests mainly with the fathers of their children and their own immediate families' and 'it must be acknowledged that the institutions under investigation provided a refuge' (Executive Summary prologue)

  - Although some mothers 'are of the opinion that their consent was not full, free and informed', there is 'no evidence that this was their view at the time of the adoption' (Executive Summary para 254)

  - 'The Commission found very little evidence that children were forcibly taken from their mothers; it accepts that the mothers did not have much choice but that is not the same as 'forced' adoption.' (Recommendations para 34)

  - There is 'no evidence that women in mother and baby homes were denied pain relief or other medical interventions that were available to a public patient who gave birth in a Dublin or Cork maternity unit' (Executive Summary para 245)

  - Women in mother and baby homes 'were not "incarcerated" in the strict meaning of the word...They were always free to leave if they took their child' (Recommendations para 27)

  - The forced labour which women were subjected to in mother and baby homes 'was generally work which they would have had to do if they were living at home' (Recommendations para 30) and not of the type that should have been remunerated (Recommendations para 31)

  - The 'Diocesan records and the records of the religious orders involved in the institutions are the property of the holders and they have the right to determine who gets access' (Recommendations para 52)

  - The criticism by many survivors and adopted people of the information and tracing arrangements in place is 'quite vitriolic' and 'unfair and misplaced' (Recommendations para 3)

  - Accounts of mothers being required to cut the grass at Bessborough mother and baby home with scissors were invented or contaminated by a work of creative writing (Chapter 18 footnote 78)

  - While 'it must be assumed that many foster children, perhaps the majority, were beaten – how violently cannot be established' (Chapter 11 para 90) and 'the evidence relating to boarded out children and children at nurse is scant' (Chapter 11 para 142)

  - The abuse of boarded out children was not relevant to the Commission's recommendations on redress (Recommendations paras 19, 22, 23, 39)

- Procedural flaws in the Commission of Investigation's methods, additional to the statutory breach recognised in today's High Court declaration, are summarised in a letter of 30 July 2021 from Hogan Lovells International LLP to the Oireachtas Committee on Children, Disability, Equality and Integration, available here: http://clannproject.org/wp-content/uploads/Hogan-Lovells-Letter-to-Childrens-Committee_30-07-21-1.pdf

- Clann Project recommendations on the Restorative Recognition Scheme: http://clannproject.org/restorative-recognition-scheme/clann-project-recommendations-on-restorative-recognition-scheme/

- Clann Project joint submissions on GDPR to the Oireachtas Justice Committee: http://clannproject.org/wp-content/uploads/Submission-to-Oireachtas-Justice-Committee-Re-GDPR-MOR-CMG-LON-26.3.21.pdf

- Clann Project submissions on the Birth (Information and Tracing) Bill: http://clannproject.org/wp-content/uploads/Clann-Project-Submission-to-Oireachtas-Childrens-Committee.pdf

- Clann Project joint submissions on the Institutional Burials Bill: http://clannproject.org/wp-content/uploads/Institutional-Burials-Bill_Joint-Submission-26.2.21.pdf

- The letter from eight United Nations human rights expert bodies, delivered to government on 5 November concerning ongoing violations of the rights of Mother and Baby Homes and County Homes survivors, adopted people and relatives was signed by:

    - Luciano Hazan, Chair-Rapporteur of the Working Group on Enforced or Involuntary Disappearances
    - Mama Fatima Singhateh, Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material
    - Tomoya Obokata, Special Rapporteur on contemporary forms of slavery, including its causes and consequences
    - Nils Melzer, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment
    - Siobhán Mullally, Special Rapporteur on trafficking in persons, especially women and children
    - Fabian Salvioli, Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence
    - Reem Alsalem, Special Rapporteur on violence against women, its causes and consequences
    - Melissa Upreti, Chair-Rapporteur of the Working Group on discrimination against women and girls

United Nations CAT/C/GC/3

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

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Committee against Torture

General comment No. 3 (2012)

Implementation of article 14 by States parties

1. This general comment explains and clarifies to States parties the content and scope of the obligations under article 14 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Each State party is required to "ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible." The Committee considers that article 14 is applicable to all victims of torture and acts of cruel, inhuman or degrading treatment or punishment (hereafter "ill-treatment") without discrimination of any kind, in line with the Committee's general comment No. 2.

2. The Committee considers that the term "redress" in article 14 encompasses the concepts of "effective remedy" and "reparation". The comprehensive reparative concept therefore entails restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition and refers to the full scope of measures required to redress violations under the Convention.

3. Victims are persons who have individually or collectively suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that constitute violations of the Convention. A person should be considered a victim regardless of whether the perpetrator of the violation is identified, apprehended, prosecuted or convicted, and regardless of any familial or other relationship between the perpetrator and the victim. The term "victim" also includes affected immediate family or dependants of the victim as well as persons who have suffered harm in intervening to assist victims or to prevent victimization. The term "survivors" may, in some cases, be preferred by persons who have suffered harm. The Committee uses the legal term "victims" without prejudice to other terms which may be preferable in specific contexts.

4. The Committee emphasizes the importance of victim participation in the redress process, and that the restoration of the dignity of the victim is the ultimate objective in the provision of redress.

5. The obligations of States parties to provide redress under article 14 are two-fold: procedural and substantive. To satisfy their procedural obligations, States parties shall enact legislation and establish complaints mechanisms, investigation bodies and institutions, including independent judicial bodies, capable of determining the right to and awarding redress for a victim of torture and ill-treatment, and ensure that such mechanisms and

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bodies are effective and accessible to all victims. At the substantive level, States parties shall ensure that victims of torture or ill-treatment obtain full and effective redress and reparation, including compensation and the means for as full rehabilitation as possible.

Substantive obligations: the scope of the right to redress

6. As stated in paragraph 2 above, redress includes the following five forms of reparation: restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition. The Committee recognizes the elements of full redress under international law and practice as outlined in the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (Basic Principles and Guidelines).[1] Reparation must be adequate, effective and comprehensive. States parties are reminded that in the determination of redress and reparative measures provided or awarded to a victim of torture or ill-treatment, the specificities and circumstances of each case must be taken into consideration and redress should be tailored to the particular needs of the victim and be proportionate to the gravity of the violations committed against them. The Committee emphasizes that the provision of reparation has an inherent preventive and deterrent effect in relation to future violations.

7. Where State authorities or others acting in their official capacity have committed, know or have reasonable grounds to believe that acts of torture or ill-treatment have been committed by non-State officials or private actors and failed to exercise due diligence to prevent, investigate, prosecute and punish such non-State officials or private actors in accordance with the Convention, the State bears responsibility for providing redress for the victims (general comment No. 2).

Restitution

8. Restitution is a form of redress designed to re-establish the victim's situation before the violation of the Convention was committed, taking into consideration the specificities of each case. The preventive obligations under the Convention require States parties to ensure that a victim receiving such restitution is not placed in a position where he or she is at risk of repetition of torture or ill-treatment. In certain cases, the victim may consider that restitution is not possible due to the nature of the violation; however the State shall provide the victim with full access to redress. For restitution to be effective, efforts should be made to address any structural causes of the violation, including any kind of discrimination related to, for example, gender, sexual orientation, disability, political or other opinion, ethnicity, age and religion, and all other grounds of discrimination.

Compensation

9. The Committee emphasizes that monetary compensation alone may not be sufficient redress for a victim of torture and ill-treatment. The Committee affirms that the provision of monetary compensation only is inadequate for a State party to comply with its obligations under article 14.

10. The right to prompt, fair and adequate compensation for torture or ill-treatment under article 14 is multi-layered and compensation awarded to a victim should be sufficient to compensate for any economically assessable damage resulting from torture or ill-treatment, whether pecuniary or non-pecuniary. This may include: reimbursement of

[1] United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, General Assembly resolution 60/147.

medical expenses paid and provision of funds to cover future medical or rehabilitative services needed by the victim to ensure as full rehabilitation as possible; pecuniary and non-pecuniary damage resulting from the physical and mental harm caused; loss of earnings and earning potential due to disabilities caused by the torture or ill-treatment; and lost opportunities such as employment and education. In addition, adequate compensation awarded by States parties to a victim of torture or ill-treatment should provide for legal or specialist assistance, and other costs associated with bringing a claim for redress.

Rehabilitation

11. The Committee affirms that the provision of means for as full rehabilitation as possible for anyone who has suffered harm as a result of a violation of the Convention should be holistic and include medical and psychological care as well as legal and social services. Rehabilitation, for the purposes of this general comment, refers to the restoration of function or the acquisition of new skills required as a result of the changed circumstances of a victim in the aftermath of torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual concerned, and may involve adjustments to the person's physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society.

12. The Committee emphasizes that the obligation of States parties to provide the means for "as full rehabilitation as possible" refers to the need to restore and repair the harm suffered by a victim whose life situation, including dignity, health and self-sufficiency may never be fully recovered as a result of the pervasive effect of torture. The obligation does not relate to the available resources of States parties and may not be postponed.

13. In order to fulfil its obligations to provide a victim of torture or ill-treatment with the means for as full rehabilitation as possible, each State party should adopt a long-term, integrated approach and ensure that specialist services for victims of torture or ill-treatment are available, appropriate and readily accessible. These should include: a procedure for the assessment and evaluation of individuals' therapeutic and other needs, based on, inter alia, the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol); and may include a wide range of inter-disciplinary measures, such as medical, physical and psychological rehabilitative services; re-integrative and social services; community and family-oriented assistance and services; vocational training; education etc. A holistic approach to rehabilitation which also takes into consideration the strength and resilience of the victim is of utmost importance. Furthermore, victims may be at risk of re-traumatization and have a valid fear of acts which remind them of the torture or ill-treatment they have endured. Consequently, a high priority should be placed on the need to create a context of confidence and trust in which assistance can be provided. Confidential services should be provided as required.

14. The requirement in the Convention to provide these forms of rehabilitative services does not extinguish the need to provide medical and psychosocial services for victims in the direct aftermath of torture, nor does such initial care represent the fulfilment of the obligation to provide the means for as full rehabilitation as possible.

15. States parties shall ensure that effective rehabilitation services and programmes are established in the State, taking into account a victim's culture, personality, history and background and are accessible to all victims without discrimination and regardless of a victim's identity or status within a marginalized or vulnerable group, as illustrated in paragraph 32, including asylum seekers and refugees. States parties' legislation should establish concrete mechanisms and programmes for providing rehabilitation to victims of torture or ill-treatment. Torture victims should be provided access to rehabilitation

programmes as soon as possible following an assessment by qualified independent medical professionals. Access to rehabilitation programmes should not depend on the victim pursuing judicial remedies. The obligation in article 14 to provide for the means for as full rehabilitation as possible can be fulfilled through the direct provision of rehabilitative services by the State, or through the funding of private medical, legal and other facilities, including those administered by non-governmental organizations (NGOs), in which case the State shall ensure that no reprisals or intimidation are directed at them. The victim's participation in the selection of the service provider is essential. Services should be available in relevant languages. States parties are encouraged to establish systems for assessing the effective implementation of rehabilitation programmes and services, including by using appropriate indicators and benchmarks.

Satisfaction and the right to truth

16. Satisfaction should include, by way of and in addition to the obligations of investigation and criminal prosecution under articles 12 and 13 of the Convention, any or all of the following remedies: effective measures aimed at the cessation of continuing violations; verification of the facts and full and public disclosure of the truth to the extent that such disclosure does not cause further harm or threaten the safety and interests of the victim, the victim's relatives, witnesses, or persons who have intervened to assist the victim or prevent the occurrence of further violations; the search for the whereabouts of the disappeared, for the identities of the children abducted, and for the bodies of those killed, and assistance in the recovery, identification, and reburial of victims' bodies in accordance with the expressed or presumed wish of the victims or affected families; an official declaration or judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connected with the victim; judicial and administrative sanctions against persons liable for the violations; public apologies, including acknowledgement of the facts and acceptance of responsibility; commemorations and tributes to the victims.

17. A State's failure to investigate, criminally prosecute, or to allow civil proceedings related to allegations of acts of torture in a prompt manner, may constitute a de facto denial of redress and thus constitute a violation of the State's obligations under article 14.

Guarantees of non-repetition

18. Articles 1 to 16 of the Convention constitute specific preventive measures that the States parties deemed essential to prevent torture and ill-treatment. To guarantee non-repetition of torture or ill-treatment, States parties should undertake measures to combat impunity for violations of the Convention. Such measures include issuing effective, clear instructions to public officials on the provisions of the Convention, especially the absolute prohibition of torture. Other measures should include any or all of the following: civilian oversight of military and security forces; ensuring that all judicial proceedings abide by international standards of due process, fairness and impartiality; strengthening the independence of the judiciary; protecting human rights defenders and legal, health and other professionals who assist torture victims; establishing systems for regular and independent monitoring of all places of detention; providing, on a priority and continued basis, training for law enforcement officials as well as military and security forces on human rights law that includes the specific needs of marginalized and vulnerable populations and specific training on the Istanbul Protocol for health and legal professionals and law enforcement officials; promoting the observance of international standards and codes of conduct by public servants, including law enforcement, correctional, medical, psychological, social service and military personnel; reviewing and reforming laws contributing to or allowing torture and ill-treatment; ensuring compliance with article 3 of the Convention prohibiting refoulement; ensuring the availability of temporary services for

individuals or groups of individuals, such as shelters for victims of gender-related or other torture or ill-treatment. The Committee notes that by taking measures such as those listed herein, States parties may also be fulfilling their obligations to prevent acts of torture under article 2 of the Convention. Additionally, guarantees of non-repetition offer important potential for the transformation of social relations that may be the underlying causes of violence and may include, but are not limited to, amending relevant laws, fighting impunity, and taking effective preventative and deterrent measures.

Procedural obligations: implementation of the right to redress

Legislation

19. Under article 2 of the Convention, States parties shall enact "effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction." As clarified by the Committee in its general comment No. 2, "States parties must make the offence of torture punishable as an offence under its criminal law, in accordance, at a minimum, with the elements of torture as defined in article 1 of the Convention, and the requirements of article 4." The failure of States parties to enact legislation that clearly incorporates their obligations under the Convention and criminalizes torture and ill-treatment, and the resulting absences of torture and ill-treatment as criminal offences, obstructs the victim's capacity to access and enjoy his or her rights guaranteed under article 14.

20. To give effect to article 14, States parties shall enact legislation specifically providing a victim of torture and ill-treatment with an effective remedy and the right to obtain adequate and appropriate redress, including compensation and as full rehabilitation as possible. Such legislation must allow for individuals to exercise this right and ensure their access to a judicial remedy. While collective reparation and administrative reparation programmes may be acceptable as a form of redress, such programmes may not render ineffective the individual right to a remedy and to obtain redress.

21. States parties should ensure that their domestic laws provide that a victim who has suffered violence or trauma should benefit from adequate care and protection to avoid his or her re-traumatization in the course of legal and administrative procedures designed to provide justice and reparation.

22. Under the Convention, States parties are required to prosecute or extradite alleged perpetrators of torture when they are found in any territory under its jurisdiction, and to adopt the necessary legislation to make this possible. The Committee considers that the application of article 14 is not limited to victims who were harmed in the territory of the State party or by or against nationals of the State party. The Committee has commended the efforts of States parties for providing civil remedies for victims who were subjected to torture or ill-treatment outside their territory. This is particularly important when a victim is unable to exercise the rights guaranteed under article 14 in the territory where the violation took place. Indeed, article 14 requires States parties to ensure that all victims of torture and ill-treatment are able to access remedy and obtain redress.

Effective mechanisms for complaints and investigations

23. The Committee has, in its concluding observations, identified other State obligations that shall be met in order to ensure that the article 14 rights of a victim are fully respected. In this regard, the Committee underscores the important relationship between States parties' fulfilment of their obligations under article 12 and 13, and their obligation under article 14. According to article 12, States parties shall undertake prompt, effective and impartial investigations, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction as the result of its actions or omissions and,

as set out in article 13 and affirmed by the Committee in its general comment No. 2, ensure that impartial and effective complaints mechanisms are established. Full redress cannot be obtained if the obligations under articles 12 and 13 are not guaranteed. Complaints mechanisms shall be made known and accessible to the public, including to persons deprived of their liberty, whether in detention, psychiatric facilities, or elsewhere, via, for example, telephone hotlines or confidential complaints boxes in detention facilities, and to persons belonging to vulnerable or marginalized groups, including those who may have limited communication abilities.

24. At the procedural level, States parties shall ensure the existence of institutions competent to render enforceable final decisions through a procedure established by law to enable victims of torture or ill-treatment to secure redress, including adequate compensation and rehabilitation.

25. Securing the victim's right to redress requires that a State party's competent authorities promptly, effectively and impartially investigate and examine the case of any individual who alleges that she or he has been subjected to torture or ill-treatment. Such an investigation should include as a standard measure an independent physical and psychological forensic examination as provided for in the Istanbul Protocol. Undue delays in initiating or concluding legal investigations into complaints of torture or ill-treatment compromise victims' rights under article 14 to obtain redress, including fair and adequate compensation and the means for as full rehabilitation as possible.

26. Notwithstanding the evidentiary benefits to victims afforded by a criminal investigation, a civil proceeding and the victim's claim for reparation should not be dependent on the conclusion of a criminal proceeding. The Committee considers that compensation should not be unduly delayed until criminal liability has been established. Civil liability should be available independently of criminal proceedings and the necessary legislation and institutions for such purpose should be in place. If criminal proceedings are required by domestic legislation to take place before civil compensation can be sought, then the absence of or undue delay in those criminal proceedings constitutes a failure on the part of the State party to fulfil its obligations under the Convention. Disciplinary action alone shall not be regarded as an effective remedy within the meaning of article 14.

27. Under article 14, a State party shall ensure that victims of any act of torture or ill-treatment under its jurisdiction obtain redress. States parties have an obligation to take all necessary and effective measures to ensure that all victims of such acts obtain redress. This obligation includes an obligation for State parties to promptly initiate a process to ensure that victims obtain redress, even in the absence of a complaint, when there are reasonable grounds to believe that torture or ill-treatment has taken place.

28. The Committee strongly encourages States parties to recognize the Committee's competence to consider individual complaints under article 22 to allow victims to submit communications and seek the views of the Committee. The Committee furthermore encourages States parties to ratify or accede to the Optional Protocol to the Convention against Torture in order to strengthen preventive measures against torture and ill-treatment.

Access to mechanisms for obtaining redress

29. The Committee highlights the importance of the State party affirmatively ensuring that victims and their families are adequately informed of their right to pursue redress. In this regard, the procedures for seeking reparation should be transparent. The State party should moreover provide assistance and support to minimize the hardship to complainants and their representatives. Civil proceedings, or other proceedings, should not impose a financial burden upon victims that would prevent or discourage them from seeking redress. Where existing civil proceedings are unable to provide adequate redress to victims, the

Committee recommends implementing mechanisms that are readily accessible to victims of torture and ill-treatment, including the establishment of a national fund to provide redress for victims of torture. Special measures should be adopted to ensure access by persons belonging to groups which have been marginalized or made vulnerable.

30. Judicial remedies must always be available to victims, irrespective of what other remedies may be available, and should enable victim participation. States parties should provide adequate legal aid to those victims of torture or ill-treatment lacking the necessary resources to bring complaints and to make claims for redress. States parties shall also make readily available to the victims all evidence concerning acts of torture or ill-treatment upon the request of victims, their legal counsel, or a judge. A State party's failure to provide evidence and information, such as records of medical evaluations or treatment, can unduly impair victims' ability to lodge complaints and to seek redress, compensation and rehabilitation.

31. The State party should also take measures to prevent interference with victims' privacy and to protect victims, their families and witnesses and others who have intervened on their behalf against intimidation and retaliation at all times before, during and after judicial, administrative or other proceedings that affect the interests of victims. Failure to provide protection stands in the way of victims filing complaints and thereby violates the right to seek and obtain redress and remedy.

32. The principle of non-discrimination is a basic and general principle in the protection of human rights and fundamental to the interpretation and application of the Convention. States parties shall ensure that access to justice and to mechanisms for seeking and obtaining redress are readily available and that positive measures ensure that redress is equally accessible to all persons regardless of race, colour, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual orientation, gender identity, mental or other disability, health status, economic or indigenous status, reason for which the person is detained, including persons accused of political offences or terrorist acts, asylum-seekers, refugees or others under international protection, or any other status or adverse distinction, and including those marginalized or made vulnerable on bases such as those above. Culturally sensitive collective reparation measures shall be available for groups with shared identity, such as minority groups, indigenous groups, and others. The Committee notes that collective measures do not exclude the individual right to redress.

33. Judicial and non-judicial proceedings shall apply gender-sensitive procedures which avoid re-victimization and stigmatization of victims of torture or ill-treatment. With respect to sexual or gender-based violence and access to due process and an impartial judiciary, the Committee emphasizes that in any proceedings, civil or criminal, to determine the victim's right to redress, including compensation, rules of evidence and procedure in relation to gender-based violence must afford equal weight to the testimony of women and girls, as should be the case for all other victims, and prevent the introduction of discriminatory evidence and harassment of victims and witnesses. The Committee considers that complaints mechanisms and investigations require specific positive measures which take into account gender aspects in order to ensure that victims of abuses such as sexual violence and abuse, rape, marital rape, domestic violence, female genital mutilation and trafficking are able to come forward and seek and obtain redress.

34. To avoid re-victimization and stigmatization of victims of torture or ill-treatment, the protections outlined in the preceding paragraph equally apply to any person marginalized or made vulnerable on the basis of identities and groups such as those examples listed under the principle of non-discrimination in paragraph 32. In judicial and non-judicial proceedings sensitivity must be exercised toward any such person. Accordingly, the Committee notes that judicial personnel must receive specific training on

the various impacts of torture and ill-treatment, including those on victims from marginalized and vulnerable groups, and on how to exercise sensitivity towards victims of torture and ill-treatment, including in the form of sexual or gender-based discrimination, in order to prevent re-victimization and stigmatization.

35. The Committee considers the training of relevant police, prison staff, medical personnel, judicial personnel and immigration personnel, including training on the Istanbul Protocol, to be fundamental to ensuring effective investigations. Furthermore, officials and personnel involved in efforts to obtain redress should receive methodological training in order to prevent re-traumatization of victims of torture or ill-treatment. This training should include, for health and medical personnel, the need to inform victims of gender-based and sexual violence and all other forms of discrimination of the availability of emergency medical procedures, both physical and psychological. The Committee also urges States parties to establish human rights offices within police forces, and units of officers specifically trained to handle cases of gender-based and sexual violence, including sexual violence perpetrated against men and boys, and violence against children and ethnic, religious, national or other minorities and other marginalized or vulnerable groups.

36. The Committee furthermore underlines the importance of appropriate procedures being made available to address the needs of children, taking into account the best interests of the child and the child's right to express his or her views freely in all matters affecting him or her, including judicial and administrative proceedings, and of the views of the child being given due weight in accordance with the age and maturity of the child. States parties should ensure the availability of child-sensitive measures for reparation which foster the health and dignity of the child.

Obstacles to the right to redress

37. A crucial component of the right to redress is the clear acknowledgement by the State party concerned that the reparative measures provided or awarded to a victim are for violations of the Convention, by action or omission. The Committee is therefore of the view that a State party may not implement development measures or provide humanitarian assistance as a substitute for redress for victims of torture or ill-treatment. The failure of a State party to provide the individual victim of torture with redress may not be justified by invoking a State's level of development. The Committee recalls that subsequent governments as well as successor States still have the obligation to guarantee access to the right of redress.

38. States parties to the Convention have an obligation to ensure that the right to redress is effective. Specific obstacles that impede the enjoyment of the right to redress and prevent effective implementation of article 14 include, but are not limited to: inadequate national legislation, discrimination with regard to accessing complaints and investigation mechanisms and procedures for remedy and redress; inadequate measures for securing the custody of alleged perpetrators, State secrecy laws, evidential burdens and procedural requirements that interfere with the determination of the right to redress; statutes of limitations, amnesties and immunities; the failure to provide sufficient legal aid and protection measures for victims and witnesses; as well as the associated stigma, and the physical, psychological and other related effects of torture and ill-treatment. In addition, the failure of a State party to execute judgements providing reparative measures for a victim of torture, handed down by national, international or regional courts, constitutes a significant impediment to the right to redress. States parties should develop coordinated mechanisms to enable victims to execute judgements across State lines, including recognizing the validity of court orders from other States parties and assisting in locating the assets of perpetrators.

39. With regard to the obligations in article 14, States parties shall ensure both de jure and de facto access to timely and effective redress mechanisms for members of groups marginalized and/or made vulnerable, avoid measures that impede the ability of members of such groups to seek and obtain redress, and address formal or informal obstacles that they may face in obtaining redress. These may include, for example, inadequate judicial or other procedures for quantifying damages which may have a negative disparate impact on such individuals in accessing or keeping money. As the Committee has emphasized in its general comment No. 2, "gender is a key factor. Being female intersects with other identifying characteristics or status of the person...to determine the ways that women and girls are subject to or at risk of torture or ill-treatment". States parties shall ensure due attention to gender in providing all the elements cited above in the process of ensuring that everybody, in particular members of groups made vulnerable, including lesbian, gay, bisexual and transgender (LGBT) people, must be treated fairly and equally and obtain fair and adequate compensation, rehabilitation and other reparative measures which respond to their specific needs.

40. On account of the continuous nature of the effects of torture, statutes of limitations should not be applicable as these deprive victims of the redress, compensation, and rehabilitation due to them. For many victims, passage of time does not attenuate the harm and in some cases the harm may increase as a result of post-traumatic stress that requires medical, psychological and social support, which is often inaccessible to those who have not received redress. States parties shall ensure that all victims of torture or ill-treatment, regardless of when the violation occurred or whether it was carried out by or with the acquiescence of a former regime, are able to access their rights to remedy and to obtain redress.

41. The Committee has consistently held that amnesties for the crime of torture are incompatible with the obligations of States parties under the Convention, including under article 14. As was pointed out in general comment No. 2, "amnesties or other impediments which preclude or indicate unwillingness to provide prompt and fair prosecution and punishment of perpetrators of torture or ill-treatment violate the principle of non-derogability." The Committee considers that amnesties for torture and ill-treatment pose impermissible obstacles to a victim in his or her efforts to obtain redress and contribute to a climate of impunity. The Committee therefore calls on States parties to remove any amnesties for torture or ill-treatment.

42. Similarly, granting immunity, in violation of international law, to any State or its agents or to non-State actors for torture or ill-treatment, is in direct conflict with the obligation of providing redress to victims. When impunity is allowed by law or exists de facto, it bars victims from seeking full redress as it allows the violators to go unpunished and denies victims full assurance of their rights under article 14. The Committee affirms that under no circumstances may arguments of national security be used to deny redress for victims.

43. The Committee considers reservations which seek to limit the application of article 14 to be incompatible with the object and purpose of the Convention. States parties are therefore encouraged to consider withdrawing any reservations to article 14 that limit its application so as to ensure that all victims of torture or ill-treatment have access to redress and remedy.

United Nations Voluntary Fund for Victims of Torture

44. Voluntary contributions to international funds for victims of torture play an important role in providing assistance to them. The Committee highlights the important work done by the United Nations Voluntary Fund for Victims of Torture, which provides humanitarian assistance to victims of torture. The Committee highlights also the possibility

for States parties to make voluntary contributions to this fund, irrespective of the national measures taken or contributions made.

Monitoring and reporting

45. States parties shall establish a system to oversee, monitor, evaluate, and report on their provision of redress measures and necessary rehabilitation services to victims of torture or ill-treatment. Accordingly, States parties should include in their reports to the Committee data disaggregated by age, gender, nationality, and other key factors regarding redress measures afforded to victims of torture or ill-treatment, in order to meet their obligation as recalled in general comment No. 2 to provide continual evaluation of their efforts to provide redress to victims.

46. On the implementation of article 14, the Committee has observed the need to **provide adequate information on the implementation of article 14 in States parties' reports.** Therefore, the Committee wishes to underscore that specific information should be provided on the following:

(a) The number of victims of torture or ill-treatment who have sought compensation through legal, administrative and other means and the nature of the violations alleged; the number of victims who have been awarded compensation; and in what amounts;

(b) The measures taken to assist victims in the direct aftermath of torture;

(c) The rehabilitation facilities available to victims of torture or ill-treatment and the accessibility thereof, as well as the budget allocation for rehabilitation programmes and the number of victims who have received rehabilitative services appropriate to their needs;

(d) The methods available for assessing the effectiveness of rehabilitation programmes and services, including the application of appropriate indicators and benchmarks, and the result of such assessment;

(e) The measures taken to ensure satisfaction and guarantees of non-repetition;

(f) The domestic legislation which provides victims of torture or ill-treatment with the right to remedy and redress, and relevant implementation measures taken by the State party. Where such legislation is lacking, reports should include information on the measures taken by the State party to adopt and implement such legislation.

(g) The measures taken to ensure that all victims of torture or ill-treatment are able to exercise and enjoy their rights under article 14.

(h) The complaints mechanisms available for victims of torture or ill-treatment, including how such mechanisms are made known and accessible to all victims. States parties should also include data disaggregated by age, gender, nationality, location and alleged violation, on the number of complaints received through such mechanisms.

(i) The measures taken by States parties to ensure that all allegations of torture and ill-treatment are effectively investigated.

(j) The legislation and policy measures designed to positively identify victims of torture in order to provide them with redress.

(k) The available avenues for a victim of torture or ill-treatment to obtain redress, including all criminal, civil, administrative and non-judicial procedures, such as administrative reparation programmes, as well as information on the number of victims who have accessed such mechanisms, how many obtained redress and reparative measures, and in what forms and/or amounts.

(l) The legal aid and witness protection available to victims of torture or ill-treatment as well as witnesses and others who have intervened on behalf of victims, including how such protection is made known and how it is made available in practice; the number of victims who have been granted legal aid; the number of persons who have been protected by State witness protection; and the State party's evaluation of the effectiveness of such protection.

(m) The steps taken to implement judgements by national, regional or international courts, including the amount of time lapsed from the date of the judgement and the actual provision of compensation or other forms of redress. States parties should also include disaggregated data on the number of victims designated to receive reparative measures in court judgements and the number who actually received redress, and for what violations.

(n) The safeguards available for the special protection of members of marginalized or vulnerable groups, including women and children seeking to exercise their rights guaranteed under article 14 of the Convention.

(o) Any such other matters that the Committee may require.

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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Memorialization processes in the context of serious violations of human rights and international 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

Summary

The Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Fabián Salvioli, presents his report on memorialization processes in the context of serious violations of human rights and international humanitarian law as the fifth pillar of transitional justice.

The report deals with the regulatory framework concerning the obligation to adopt memory processes and ensure their non-regression, analyses the challenges and opportunities surrounding these processes in situations of conflict and transition, and addresses the problem of the weaponization of memory on social networks. The report highlights the need for vigorous, active and multidimensional memory policies in order to respond adequately to past crimes and prevent their recurrence. The report concludes with recommendations that are addressed primarily to States but also to the United Nations.

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Introduction

1. The present report is submitted to the Human Rights Council by the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Fabián Salvioli, pursuant to Council resolution 36/7. In the report, the Special Rapporteur lists the main activities that he undertook between July 2019 and June 2020 and provides an analysis of memorialization processes in the context of serious violations of human rights and international humanitarian law as the fifth pillar of transitional justice.

2. In 2019, the Special Rapporteur held an expert meeting at the United Nations Office at Geneva to obtain input for the present report. He also organized an open-ended consultation with States, international organizations, national human rights institutions and non-governmental organizations to give them an opportunity to express their views on the issue. The Special Rapporteur is grateful for the valuable contributions received.

I. Activities undertaken by the Special Rapporteur

3. Between 1 July 2019 and 30 June 2020, the Special Rapporteur sent visit requests to Bosnia and Herzegovina, Croatia, the Gambia, the Republic of Korea, Serbia and Tunisia. He is grateful for the positive responses received from these countries. He also renewed his request to visit Côte d'Ivoire.

4. On 10 September 2019, the Special Rapporteur met with Commissioner Antonia Urrejola of the Inter-American Commission on Human Rights.

5. On 11 September 2019, the Special Rapporteur participated in the forty-second session of the Human Rights Council, at which he presented his thematic report on domestic reparation programmes.

6. On 24 October 2019, the Special Rapporteur participated in the seventy-fourth session of the General Assembly, at which he presented his report on apologies for serious human rights violations.

7. On 22 October 2019, the Special Rapporteur held a meeting with the Assistant Secretary-General for Peacebuilding Support, Oscar Fernández-Taranco, and with the interregional Group of Friends on the Responsibility to Protect.

8. On 25 October 2019, the Special Rapporteur met with representatives of the office of the Special Adviser to the Secretary-General on the Prevention of Genocide, Adama Dieng.

9. From 20 to 27 November 2019, the Special Rapporteur made an official visit to the Gambia.

10. From 6 December 2019 to 31 January 2020, the Special Rapporteur collected contributions for the present report through an open-ended consultation.

11. On 10 and 11 December 2019, the Special Rapporteur held an expert meeting to obtain input for the present report.

12. On 26 February 2020, the Special Rapporteur participated in a lunchtime briefing in New York with representatives of Member States to discuss the role of the Security Council and the United Nations in the area of transitional justice.

13. From 27 April to 29 May 2020, through an open-ended consultation, the Special Rapporteur collected input on the gender perspective in transitional justice processes, for use in preparing his next report to the General Assembly.

14. Owing to the coronavirus disease (COVID-19) pandemic, the Special Rapporteur had to postpone his official visit to Bosnia and Herzegovina and an expert meeting on the gender perspective in transitional justice processes, and was unable to participate in several other events.

II. General considerations

15. The present report on memorialization processes in the context of serious violations of human rights and humanitarian law is a continuation of the work already initiated by the Special Rapporteur, and the Special Rapporteur in the field of cultural rights, on the writing and teaching of history,[1] memory processes in divided societies,[2] the prevention of gross human rights violations,[3] and archives.[4] The report focuses on the crucial role played by memorialization processes in the context of transitional justice, which is fully recognized by the rules and standards of contemporary international law. The work carried out on these past violations serves as a basis for reflection on the present and identification of contemporary issues related to exclusion, discrimination, marginalization and abuses of power, which are often linked to toxic political cultures. Positive work in the area of memory not only helps to build democratic cultures in which human rights are respected but also fulfils the legal obligation of States to guarantee human rights.

16. The present report seeks to identify the obligations of States and other stakeholders with regard to memory work. It is based on the assumption that memory work, like history, cannot be dissociated from the political influences and debates of the present, although it has clear limits: memory processes should never result in the revictimization of victims of human rights and/or humanitarian law violations by failing to recognize or attach sufficient importance to the harm that such victims have suffered.

17. The report describes good practices in memorialization processes and focuses on finding answers to three particular challenges: memorialization in times of conflict, memorialization in post-conflict situations and weaponization of memory in connection with the politicization of social networks.

18. These three challenges cannot be considered in isolation in a world where multilateralism and the human rights system are being called into question and populist and xenophobic ideologies are on the rise in different parts of the world. This situation is reflected in the upsurge in racism, antisemitism, anti-Muslim hatred and persecution of Christians, as well as in the increasing flashpoints in inter-State relations.[5]

19. This report mirrors the views of the Secretary-General, António Guterres, who highlighted the "pivotal moment" that the world is experiencing:

> No country alone, no organization alone, can provide the solutions we need for today's global challenges, but multilateralism is under attack. The world is threatened by global warming, but also by a heating up of global political tensions. We are seeing an increasing deficit of trust in governments and politicians, and the rising appeal of nationalist and populist voices that demonize and divide. This is very dangerous at a time when collective action is essential.[6]

III. Objectives and regulatory framework of memorialization processes

A. Objectives

20. The underlying assumption of transitional justice is that past crimes – committed during an armed conflict, or by a repressive regime – must be adequately addressed in order to build a democratic, pluralistic, inclusive and peaceful society. The acknowledgement of war crimes and mass human rights violations is essential for restoring dignity to victims,

[1] A/68/296.
[2] A/HRC/25/49.
[3] A/HRC/37/65, A/72/523.
[4] A/HRC/30/42, annex.
[5] www.un.org/en/genocideprevention/documents/advising-and-mobilizing/Action_plan_on_hate_speech_EN.pdf.
[6] Guterres, António, "Multilateralism: The Backbone of Lasting Peace", in Pierre Hazan and others (eds.), *War and Peace*, Gallimard and Fondation Martin Bodmer, 2019.

enabling society to regain trust and initiating a process of reconciliation – both vertical (between citizens and State authorities) and horizontal (between different groups in cases involving conflicts between populations) – that duly complements the criminal prosecution and sentencing of perpetrators and the award of reparations to victims. Failure to recognize and punish the crimes and violations that have occurred leads to denialism and perpetuates and legitimizes violence.

21. The approach to be taken to such crimes is based on the pillars of transitional justice: without the memory of the past, there can be no right to truth, justice, reparation, or guarantees of non-recurrence. For this reason, memory processes in connection with serious violations of human rights and international humanitarian law constitute the fifth pillar of transitional justice. It is both a stand-alone and a cross-cutting pillar, as it contributes to the implementation of the other four pillars and is a vital tool for enabling societies to emerge from the cycle of hatred and conflict and begin taking definite steps towards building a culture of peace.

22. In addressing past violations, transitional justice processes seek to contribute to the fulfilment of several objectives associated with different time frames:

(a) To shed light on past violations (by establishing the facts and criminally punishing the perpetrators);

(b) To address the challenges of the present (by recognizing, honouring and commemorating the memory of victims, providing reparation, allowing stories to be told, making public apologies, combating denialism, bringing calm and restoring trust in the State and between communities); and

(c) To prepare for the future (by preventing future violence through education and awareness-raising and establishing a culture of peace). Memory processes help to promote commitment to a democratic society, encourage debates on the representation of the past and allow the problems of the present to be addressed in a relevant manner.

23. In the Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, adopted in Durban in 2001, the role of memory is understood as a tool for combating injustice and promoting peace:

> Remembering the crimes and wrongs of the past, wherever and whenever they occurred, unequivocally condemning its racist tragedies and telling the truth about history are essential elements for international reconciliation and the creation of societies based on justice, equality and solidarity.[7]

24. Memorialization deals with events that took place long ago, such as the slave trade, and violations committed in the recent past or during ongoing conflicts.

B. United Nations regulatory framework and standards

25. States have adopted various instruments that recognize the fundamental role played by memory in creating an environment conducive to coexistence in the wake of violations of human rights and international humanitarian law.

26. It is first necessary to emphasize the general obligation to guarantee the right not to be a victim of serious violations, such as enforced disappearance, arbitrary execution, torture and genocide. The prohibition and prevention of such violations are provided for in the Convention on the Prevention and Punishment of the Crime of Genocide,[8] the International Covenant on Civil and Political Rights,[9] the Convention against Torture and

[7] https://www.ohchr.org/Documents/Publications/Durban_text_en.pdf, para. 106.

[8] Art. 1.

[9] Art. 2.

Other Cruel, Inhuman or Degrading Treatment or Punishment [10] and the International Convention for the Protection of All Persons from Enforced Disappearance.[11]

27. The updated set of principles for the protection and promotion of human rights through action to combat impunity [12] establishes the right to know the truth about such violations (also called the right to the truth) as an individual right of every victim, or his or her family members, and also as a collective right whose "full and effective exercise ... provides a vital safeguard against the recurrence of violations".[13] The same instrument establishes the duty of States in connection with memory and their responsibility for transmitting history with a view to "preserving the collective memory from extinction and, in particular, ... guarding against the development of revisionist and negationist arguments".[14]

28. All too often, this fundamental obligation of States remains a dead letter in many societies that have suffered under authoritarian regimes or endured internal conflicts: violence in the present, which is closely bound up with past events, is related to the fact that generations have grown up knowing almost nothing about the past.

29. The updated set of principles for the protection and promotion of human rights through action to combat impunity, formulated by Louis Joinet and his successor, Diane Orentlicher, supplements the principles developed by the Special Rapporteur of the Subcommission, Theo van Boven, [15] and updated by the Special Rapporteur of the Commission on Human Rights, Cherif Bassiouni,[16] which formed the basis for the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, adopted by the General Assembly in resolution 60/147.

30. In this resolution, which was adopted by consensus in 2005, the General Assembly recalled that memorialization processes are also part of the right to reparation. The resolution specified that satisfaction should include the following measures: verification of the facts and full and public disclosure of the truth; an official declaration or a judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connected with the victim; public apologies, including acknowledgement of the facts and acceptance of responsibility; commemorations and tributes to the victims; and the inclusion of accurate information on violations in training courses on international human rights law and international humanitarian law and in educational materials used at all levels.

31. In societies that have suffered gross violations of human rights or serious violations of international humanitarian law, the general obligation to safeguard human rights acquires a distinct and particular dimension insofar as it relates to memory processes. The duty to carry out memory processes in such cases derives from primary (covenants and conventions) and secondary (principles and guidelines) sources of international human rights law. It must also be stressed that memory processes cut across all aspects of full reparation – especially the dimensions of satisfaction and guarantees of non-recurrence – as a new obligation arising from the violations committed.

IV. Memory as a battlefield

32. Memorialization takes many forms and should be a tool for fostering recognition of otherness, the consideration of all persons as rights holders and the promotion of peace, justice and social coexistence. But it is also part of a broader cultural framework in which different visions, values and narratives come together. Culture is a prism through which we

[10] Art. 2 (1).

[11] Preamble, seventh para.; the substantive articles contain several provisions concerning the duty of prevention.

[12] E/CN.4/2005/102/Add.1, report by Diane Orentlicher, building on work previously carried out by Louis Joinet.

[13] Principle 2: The inalienable right to the truth.

[14] Principle 3: The duty to preserve memory.

[15] E/CN.4/1997/104.

[16] E/CN.4/2000/62.

perceive the world and other people perceive us. Celebrating certain pieces of music; glorifying certain events, heroes or heroines, whether real, mythological or fictional; and repudiating other events form perceptions and help to define relationships.[17]

33. Conversely, the logic of marginalization, exclusion, negative stereotyping, dehumanization and denialism makes perverse use of these instruments, with the opposite results.

34. The legal and regulatory framework for transitional justice has changed radically over the period between its origins and the present day. The current view is that transitional justice processes must be focused on and implemented in line with the effective fulfilment of States' human rights obligations.[18]

35. States must play an active and decisive role in this area, in accordance with international standards. The Special Rapporteur concurs with the view of the Inter-American Commission on Human Rights, which recommends the adoption of comprehensive public policies on memorialization.[19]

36. As a part of transitional justice, memory must take and be consistent with a human rights approach. The purpose of the proper use of memory is to establish "a dialogic truth",[20] that is, to create the conditions for a debate within society on the causes and consequences of past crimes and violence and on the attribution of direct and indirect responsibility. This makes it possible to go beyond "completely separate and unreconciled accounts of what had happened"[21] and thus narrow "the range of permissible lies".[22]

37. The aim is to enable victimized populations to explain a brutal past without justifying it, thereby easing existing tensions and allowing society to live more peacefully with the legacy of past divisions. Without falling prey to a dangerous relativism or establishing a homogeneous way of thinking, different narratives and interpretations of past violence can coexist in a democratic society, and this feeds into the dynamics of social reconstruction.

38. The process referred to in the previous two paragraphs should never result in the denial or downplaying of the violations committed, nor should it give rise to scepticism about the findings of truth commissions and/or legal proceedings, which provide a verified minimum record of violations, whose real number, in practice, is usually much higher. The voices of the victims of human rights violations must play a key role in the construction of memory, thereby avoiding the distortions that the perpetrators may attempt to impose.

39. In specific cases involving armed conflict between different groups, including tribal or ethnic groups, the process of memory must not give rise to competition between victims. This occurs when certain groups receive the backing of the authorities while others are marginalized, either deliberately or because they do not have sufficient sway in political circles or the media to make their voices heard in the public arena.

40. Memory processes related to armed conflict can lead to the manipulation of history and the cult of martyrdom, which tends to reopen past wounds, intensify hatred and incite new acts of violence. The 2010 report on the mapping exercise documenting the human rights violations committed between 1993 and 2003 within the territory of the Democratic Republic of the Congo warns of the dangers of vengeful memorialization.[23] Similarly, the

[17] Examples include works of fiction such as the television series *Derry Girls*, which gave Irish and British teenagers a better understanding of the conflict in the north of the island, and the television miniseries *Holocaust*, which has resonated around the world since 1978.

[18] Salvioli, Fabián, "La justice transitionnelle aujourd'hui", in Julián Fernández and Olivier de Frouville (eds.), *L'hirondelle et la tortue. Quatrièmes journées de la justice pénale internationale*, pp. 109–114, Paris, Pedone, 2020.

[19] "Principles on Public Policies on Memory in the Americas", resolution 3/2019, adopted on 9 November 2019.

[20] Sachs, Albie, *The Soft Vengeance of a Freedom Fighter*, Berkeley, University of California Press, 2000.

[21] Ibid.

[22] Ignatieff, Michael, "Articles of faith", *Index on Censorship* 5, 1996, p. 111, available at https://journals.sagepub.com/doi/pdf/10.1177/030642209602500522.

[23] www.ohchr.org/Documents/Countries/CD/DRC_MAPPING_REPORT_FINAL_EN.pdf, para. 111.

Working Group on Enforced or Involuntary Disappearances concluded, in the report on its mission to Bosnia and Herzegovina, that the inability of minorities in different parts of the country to build memorials has caused much controversy and unhappiness in the country.[24]

41. Memory work can also lead to abuse or even to the so-called "tyranny of memory"[25] when the message conveyed has the aim of confining people to their status as victims in the name of past violence in order to justify and incite new acts of violence. In societies in conflict, irresponsible political leaders often construct narratives out of past defeats, in some cases inflicted many centuries ago, in order to stir up the emotions of their fellow citizens and awaken a desire for revenge based on the memory of these humiliations. Shedding light on past events, acknowledging responsibility and bringing the perpetrators to justice are the best antidotes to the manipulation of the past and the glorification of violence. Such measures also serve as the basis for genuine and lasting peace with no impunity.

V. Memorialization in times of conflict

A. Temporality

42. Over the past 30 years, dozens of truth commissions and commissions for investigating and establishing the facts of mass violations of human rights and international humanitarian law have been established and numerous criminal tribunals have been set up to try war crimes and other international crimes. These instruments are of recognized educational importance and exemplary value in relation to crimes that humanity "can neither punish nor forgive"[26] because of their magnitude, although justice can, and must, be done in respect of them. The role that these bodies play in preventing the recurrence of such crimes must also be highlighted.

43. The issue of memory is one of the main reasons for the existence of these transitional justice mechanisms. This dimension of memory forms part of a medium- and long-term process, since, in the wake of mass violence, the task of democratically rebuilding a community can take decades or even generations.

B. Limits of transitional justice

44. Notwithstanding the foregoing, experience shows that immediate action is hardly ever taken to approach crimes through the prism of education and to identify them as examples of conduct to be repudiated. Many obstacles prevent this from happening: for example, truth commissions and special criminal courts are sometimes set up while the conflict is ongoing, international crimes continue to be committed, and warring groups continue to disseminate their warmongering propaganda. In such conditions, memorialization is extremely difficult.

45. In recent years, in places such as the Central African Republic, Mali and the Syrian Arab Republic, a number of criminal and non-criminal transitional justice mechanisms have been established in very complex circumstances. During ongoing conflicts, States are unable to exercise their authority throughout their territories and, in many cases, are themselves responsible for the commission of serious violations of human rights and/or international humanitarian law.

46. Investigation and documentation processes that take place during conflicts are very valuable because they involve the collection of evidence and testimonies that will subsequently prove to be highly important. New technologies, in particular satellites, have

[24] A/HRC/16/48/Add.1, para. 48.

[25] Todorov, Tzvetan, *Les abus de la mémoire*, Paris, Arléa, 1995.

[26] Hannah Arendt–Karl Jaspers, *Correspondence, 1926–1969*, letter of 17 August 1946, quoted by Claudia Hilb, "Des crimes que l'on ne peut ni punir ni pardonner. Penser avec Arendt, dans le débat sur le passé récent en Argentine", University of Paris-Diderot, available at http://lcsp.univ-paris-diderot.fr/Arendt/pdf/hilb.pdf.

shed light on certain events, making it possible to identify mass graves following the massacres in Srebrenica and, more recently, to uncover serious violations of human rights and international humanitarian law committed in Myanmar, the Syrian Arab Republic and the Sudan.

47. However, these documentation processes are complex and dangerous. In different parts of the world, human rights defenders, journalists and other persons who document violations have been attacked and killed. In some cases, there have even been "preventive" killings of such persons by assailants seeking to prevent the documentation of future crimes.

48. Efforts to ensure prevention and non-recurrence through education are even more difficult while conflicts are still ongoing, but this work is of great importance once the weapons have been laid down.

C. Managing victims' expectations

49. It is now possible to establish and document serious violations of international humanitarian and human rights law more immediately and effectively than ever before. However, this essential work may paradoxically aggravate the victims' feelings of abandonment and impotence by highlighting the international community's ineffectiveness in putting an end to such violations. During a conflict, transitional justice mechanisms must be sure-footed in their dealings with victims.

50. In times of conflict, transitional justice mechanisms must deal as best they can with the fact that they are unable, at least temporarily, to meet the unsatisfied expectations of the victims and communities on whose behalf they were created. An example of innovation in this regard is the International, Impartial and Independent Mechanism to Assist in the Investigation and Prosecution of Persons Responsible for the Most Serious Crimes under International Law Committed in the Syrian Arab Republic since March 2011,[27] which has taken a number of measures to respond adequately to victims' needs and has also cooperated with national jurisdictions prosecuting the perpetrators of international crimes,[28] established procedures for regularly informing victims' representatives about investigations, conducted studies on expectations and how best to meet them, and ensured that victims who testify have given their prior consent and agreement and that precautions are taken to guarantee their safety.

VI. Memory work in situations of transition

A. The challenge of ownership

51. When peace and/or democracy are finally restored, the educational goal of memorialization is not always achieved through transitional justice mechanisms. Although the act of prosecuting the perpetrators has enormous value for memory processes, the judgments handed down by an international or hybrid criminal court are not in themselves sufficient to change perceptions within societies. Decisions often run to hundreds of pages and are written in legal language that is not easily accessible to the general public. It has sometimes taken years to have such judgments translated into national languages.

52. For example, during its 25 years of existence (1993–2017), the International Tribunal for the Former Yugoslavia succeeded in apprehending and prosecuting many individuals, including heads of State, ministers, generals and other prominent political and military leaders of various parties. The case law of this Tribunal and of the International Criminal Tribunal for Rwanda has played an absolutely vital role in raising awareness of gender-based violence[29] and of other aberrant acts.

[27] A/73/741.

[28] As of January 2020, about a dozen States had submitted 41 requests to the Mechanism.

[29] See International Tribunal for the Former Yugoslavia, *Mucić et al.*, *Kunarac et al.*, *Šainović et al.* and *Đorđević*.

53. Despite the undeniable legal successes of the International Tribunal for the Former Yugoslavia, which were supplemented by the punitive measures taken by the War Crimes Chamber in Bosnia and Herzegovina and other national courts, it has not been possible to change the narrative established by the propaganda machines set up during the war in the societies of the former Yugoslavia or to curb denialism and hate speech, all of which are being vigorously echoed today.

54. One of the main lessons learned from the functioning of the Tribunal was that "the idea that simply flooding the public with technical information on the transitional justice mechanism's mandate, procedures and activities is sufficient to ... create reservoirs of popular support is sheer fantasy." [30] It was not until six years after the Tribunal's establishment that an outreach office was set up, and it would take even longer for that office to have a permanent presence on the ground from which to carry out its work in the republics of the former Yugoslavia. The toxic political culture there is still resistant to change, which is why truth commissions and courts must not isolate themselves from other mechanisms required to engage meaningfully with society.

55. The Truth and Reconciliation Commission in South Africa was established when the democratization process was already under way in that country. Its immense merit lay in its ability to project and imagine a different future, making the act of addressing the crimes of apartheid an indispensable step in transforming race relations within South African society. The Commission's approach was not technical but political, in the best sense of the word, and this enabled it to rally a sufficiently broad range of supporters around it, including victims' groups, the media, politicians, academics, trade unionists and others, to the point where this positive dynamic attracted and held everyone's attention. However, the Commission did not tackle head-on the issue of structural violence linked to the policy of apartheid, and its work was not accompanied by the prosecution and conviction of the perpetrators of atrocity crimes, leaving the victims without justice.

56. Justice alone, like the absence of justice, is not sufficient for the requirements of memory. These two examples show that memorialization must be part of a comprehensive transitional justice process in which the participants effectively address all components without losing sight of the goal of establishing democracy and a culture of peace. Those who lead transitional justice processes must form alliances with different civil society actors to help change a toxic political culture of violence, confrontation and marginalization. In order to make a useful contribution to the ownership of memory work, transitional justice processes must move away from a purely technocratic approach and forge bonds with civil society.

57. The Nuremberg trials held immediately after the Second World War did not transform German society on their own. That purpose could not have been accomplished without the additional trials held by the German courts from the 1960s onward and, subsequently, the thousands of books that were published, the thousands of student visits to concentration camps, and the dozens of documentaries and television drama series that were produced about the Holocaust. All this was essential to the task of recognizing the crimes committed by the Nazis and of democratically transforming society.

B. Good practices

58. Memorialization is a long-term process to which other tools of transitional justice can contribute. Its success partly depends on whether the authorities in charge of the public space adopt and implement policies on memory that represent different points of view and foster good collaboration with civil society, whose actions mobilize groups of people, launch initiatives and debates and facilitate the taking of ownership by the public.

59. One very fruitful approach to memorialization is to focus on understanding the mechanisms of oppression and dehumanization that always precede large-scale violence,

[30] Institute for Integrated Transitions, "Changing the Narrative: The Role of Communications in Transitional Justice", 2019, available at https://www.ifit-transitions.org/publications/major-publications-briefings/changing-the-narrative-the-role-of-communications-in-transitional-justice/changing-the-narrative-en.pdf/view.

opening up a broad debate on the causes and consequences of past violence and on the need to build a different future. Society must be given the opportunity to acquire a clear idea of the context that made it possible for mass violations of human rights and/or international humanitarian law to occur.

60. The examples given below are not exhaustive. It is not possible to list all the positive experiences in the area of memorialization, which include literature, the arts, academia, museums and other forums, and can make use of either physical or online means of dissemination. Other examples include the catalytic work of truth commissions, the observance of days to commemorate disappeared persons, and school textbooks.

61. The Truth and Reconciliation Commission of Canada,[31] after establishing the facts about persons who were directly or indirectly affected by the legacy of the Indian Residential Schools, devoted much of its work to the promotion of reflection on this past within society. In Liberia, one of the recommendations of the Truth and Reconciliation Commission was to launch a "memoryscape" that would examine forms of reparation and work on neo-traditional dispute settlement mechanisms. In Sierra Leone, the Truth and Reconciliation Commission launched a national cross-disciplinary project that triggered a broad reflection on the country's vision for the future. In Argentina, the work of the Truth Commission (the National Commission on Enforced Disappearance of Persons) and criminal prosecutions have helped to forge a common understanding of State terrorism under the military dictatorship.

62. In different countries, works that portray the history of victims and the circumstances surrounding their disappearance or death have served to remind the public of the lives lost to political violence.[32] Books such as *The Northern Ireland Book of the Dead* have had a broad impact, including on the Catholic and Protestant Churches of Ireland, and have made it possible for both communities to share their suffering.

63. The writing of collective history also addresses present and future issues, which is why history books are important for new generations. In addressing inter-State conflicts, historians from opposing countries have in some cases managed to produce a single narrative, while in other cases they have set out a range of mutually irreconcilable views. It is then up to the reader to develop his or her own interpretation of the facts, having had the benefit of access to a range of informed sources. A textbook on Franco-German history by authors from both States was published under the title *Histoire/Geschichte*[33] at the start of the 2006/07 school year. Another reference book worth mentioning is the Israeli-Palestinian work *Histoire de l'autre*, produced by the Peace Research Institute in the Middle East,[34] in which the text is set out in two columns, the first expressing the Palestinian perspective and the second putting forward the Israeli view of the same historical events; a space in the middle is left blank so that students can write their own narrative. A third example is a textbook that describes the wars that took place in the former Yugoslavia during the 1990s, placing them in the context of regional events and providing access to documents on highly controversial historical episodes.[35]

64. Civil society plays an important role in public memorialization activities. In 2019, voices in Lebanon were raised to express the need for dialogue, debate and the reappropriation of memory in the public arena in relation to the conflict that tore the country apart between 1975 and 1990. Walking tours along the route of the "green line" that once separated the communities, photo exhibitions on the civil war, film screenings and countless debates were organized. This swirl of activity has had the effect of transcending traditional community divisions.

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[31] https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525.

[32] For example, *The Kosovo Memory Book*, https://www.kosovskaknjigapamcenja.org/?page_id=29&lang=de, and *The Northern Ireland Book of the Dead*, https://www.hotpress.com/opinion/the-northern-ireland-book-of-the-dead-417032.

[33] https://www.klett.de/produkt/isbn/978-3-12-416510-7.

[34] Vidal-Naquet, Pierre and others, *Histoire de l'autre*, Liana Levi, Piccolo collection, No. 55 (February 2008).

[35] www.cdrsee.org/publications/education/volume-2-wars-divisions-integration-1990-2008, and www.balcanicaucaso.org/eng/Areas/Balkans/The-Balkans-rethinking-history-text-books-177099.

65. Culture in all its forms plays a key role in memory work, as it often allows mechanisms of oppression, confrontation and violence to be deconstructed. The aim is to replace toxic and negative political cultures whose legacies of violence and discrimination persist for decades. In Argentina, civil society and the authorities have carried out numerous activities in the arts, the media and public spaces that have helped successive generations to acquire critical knowledge of the violent past.

66. All these processes must observe the limits on memory practices described in paragraph 16 above.

C. Follow-up and ownership of the recommendations of truth-seeking mechanisms

67. All too often, the recommendations contained in the final reports of truth commissions are not implemented or disclosed by States. This prevents society from effectively taking ownership of them and leaves gaps in the narratives of the past that can be exploited by political actors who are oblivious to the suffering of victims and the requirements of a peaceful society. Transitional justice mechanisms should not be established for purely cosmetic reasons or as a cover that enables States to avoid carrying out the reforms needed to fulfil their obligations to victims and improve the quality of democracy.

68. During his visit to El Salvador, the Special Rapporteur expressed concern about the long-term consequences of a policy of impunity that has been in place for more than 30 years. Although the Truth Commission recommended that the perpetrators of the most serious crimes committed during the armed conflict should be prosecuted, thereby raising victims' hopes of obtaining justice, the opposite has happened.

> This mechanism for impunity was accompanied by an institutional and widespread system to deny and forget the past violations that gouged deep rifts in the social fabric and collective narrative of the Salvadoran people. In this process, the victims of the abhorrent crimes of the past were forgotten and rendered invisible.[36]

69. Unfortunately, this example is far from being unique in the world.

D. Access to archives

70. Memorialization is linked to the ability to obtain access to archives. The most obvious risk is that some warring groups might deliberately seek to destroy documents that may be compromising or be used as evidence of serious violations of human rights and international humanitarian law. This desire to hide is not new: more than a century ago, King Leopold II of Belgium ordered the destruction of archives[37] documenting the terrible violence committed under his authority in the Congo Free State. Since then, many Governments have tried to eradicate the traces of their crimes. The Special Rapporteur considers the protection of archives to be essential for enabling societies to learn the truth and regain ownership of their history.[38]

71. It is not enough to protect archives. All too often, State bodies linked to security structures refuse to cooperate fully with transitional justice mechanisms or to make their archives available. This has occurred in Morocco, where the Equity and Reconciliation Commission was denied access to certain archives belonging to the security services. In some countries, such as El Salvador, it is still practically impossible to obtain access to military archives related to specific crimes, over 30 years after they occurred, owing to the

[36] Preliminary observations of the Special Rapporteur following his official visit, available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24557&LangID=E.

[37] Van Grieken, E. and Madeleine van Grieken-Tavernier, *Les archives inventoriées au Ministère des Colonies*, 21 May 1957, available at www.kaowarsom.be/en/memoir_156.

[38] As a positive example, Switzerland and organizations such as Swisspeace have undertaken to protect endangered archives in several countries.

lack of cooperation by the authorities who hold them.[39] This contrasts with the exemplary attitude of the German authorities, who have opened the archives of the Stasi (the Ministry of State Security of the former German Democratic Republic).[40]

72. The development of new technologies has created additional difficulties. The mechanism for the Syrian Arab Republic alone has collected over 2 million documents, including videos and testimonies related to violations of the laws of war, representing 41 terabytes of information. Managing this volume of information requires an adequate budget and specific expertise. Procedural standards for processing such voluminous archives should be developed within the United Nations.

E. Role of the United Nations

73. The United Nations can play a very important role in memory work. Since its establishment, its agencies and organs have built up extensive and valuable archives in the countries where they have operated. These documents can provide a unique insight into violations of human rights and international humanitarian law and contribute to the historiography of different countries.

74. Within the institution itself, other actors, including the special procedure mandate holders of the Human Rights Council, do not always have access to these archives. In theory, all documents, except those considered to be highly confidential, are made accessible to the public after 20 years. In practice, however, this does not always occur for technical and budgetary reasons and because the resources required to process and digitize them are lacking.[41] The rules should be revised: in some cases, the importance of shedding light on past events may take precedence over the time limit, provided that the circumstances so permit and that mechanisms can be established to protect the identities of vulnerable persons mentioned in the documents concerned.

75. The report of the United Nations and the Economic Community of West African States on the deaths of 50 Ghanaian citizens and migrants in the Gambia under the dictatorship of Yahya Jammeh has never been published, even though five United Nations special procedure mandate holders have requested it and its release is hugely important for the societies of two countries.[42]

76. Given the importance of issues related to memory for societies seeking to recover from serious conflicts or periods of repression in which human rights and/or international humanitarian law were violated, the United Nations must uphold these societies' right to the truth by establishing a useful methodology for granting access to its archives. The Organization cannot neglect a principle and an obligation that it has itself identified and with which it calls on States to comply.

VII. Weaponization of memory through social networks

A. Balance between the right to information and the prohibition of incitement to hatred

77. Historically, information and memory have been critical political issues. The media play a vital role in documenting crucial events and reporting on them in real time: the

[39] https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=24557&LangID=E.

[40] See Federal Commissioner for the Archives of the Ministry of State Security of the German Democratic Republic, www.bstu.de/en/.

[41] By way of example, it is difficult in practice to obtain access to the archives of the El Salvador Truth Commission, which are held by the United Nations.

[42] See https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=24138 and https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=24141.

presence of four journalists in Guernica[43] during the Spanish Civil War made it possible to report on the first aerial bombing and destruction of a city, establishing the truth about the attack carried out by the German and Italian air forces while Franco's propaganda machine was blaming communist or anarchist "dynamiters". The articles by Roy Gutman published in *New York Newsday*[44] in July 1992 informed the world about the existence of the infamous prison camps in Bosnia and Herzegovina. The Rwandan genocide was also documented in real time by the press in 1994.[45] More recently, journalists working for the Reuters news agency spent over 500 days in prison for reporting on the atrocities committed against the Rohingya in Myanmar.[46]

78. The Special Rapporteur is deeply concerned about the possible dangerous manipulation of information and memory to the detriment of human rights, the stigmatization of certain communities and hate speech that encourages the commission of violent acts and even mass violence.

79. Discriminatory, racist, ultra-nationalist and hate-filled speech abounds in the world. Incitement to violence also proliferates on social networks, fuelling the polarization and radicalization of social behaviour, including violent acts. Specific State actions are needed to respond to these challenges.

80. The Rabat Plan of Action on the prohibition of advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence[47] provides valuable guidance to ensure the indispensable right to freedom of expression[48] and the fulfilment of States' obligation to prohibit any expression that constitutes hate speech or incitement to discrimination, hostility or violence.[49] The Rabat Plan of Action identifies six criteria for defining acts that constitute incitement to hatred and are therefore offences that must be prohibited. These are:

(a) The context, which has a direct bearing on causation or intent;

(b) The speaker's position;

(c) The object or intent, which requires the activation of a triangular relationship between the object and subject of the speech act as well as the audience;

(d) The content of the speech act;

(e) The extent of the speech act, such as its public or non-public nature and the media used to disseminate it;

(f) The likelihood, including the imminence, of a direct causal link between the hate speech and specific acts of violence.

81. The Special Rapporteur stresses that the right to information or any other human right may not be used as a pretext to justify acceptance of the advocacy of hatred.

B. Criminal responsibility of ideologues and propagandists

82. The responsibility of ideologues and propagandists was clearly established as early as 1946 by the International Military Tribunal in Nuremberg, which convicted Julius

[43] Four journalists went to Guernica on the same day: George Steer (*The Times* (London) and *The New York Times*), Noel Monks (*The London Daily Express*), Christopher Holme (Reuters) and Mathieu Corman (*Ce Soir*).

[44] Roy Gutman, *New York Newsday*, "Hidden Horror", 19 July 1992; "Witness tells of Serbian Death Camp", 19 July 1992; "For Muslims, Misery", 21 July 1992.

[45] See in particular the French media in 1994, Marc Le Pape, "Des journalistes au Rwanda. L'histoire immédiate d'un génocide", in Claudine Vidal and Marc Le Pape (eds.), "Les politiques de la haine: Rwanda, Burundi, 1994–1995", *Les Temps Modernes*, No. 583, July–August 1995, pp. 161–180.

[46] www.voanews.com/world-press-freedom/profiles-reuters-journalists-who-exposed-myanmar-atrocities.

[47] A/HRC/22/17/Add.4.

[48] International Covenant on Civil and Political Rights, art. 19.

[49] Ibid., art. 20; International Convention on the Elimination of All Forms of Racial Discrimination, art. 4.

Streicher, the founder of the anti-Semitic newspaper *Der Stürmer*. The Tribunal ruled that Streicher's incitement to murder and extermination at the time when Jews were being killed under the most horrible conditions clearly constituted persecution on political and racial grounds in connection with war crimes, as defined by the Charter, and constituted a crime against humanity.

83. The International Criminal Tribunal for Rwanda also imposed severe penalties on two officials of Radio-Télévision Libre des Mille Collines[50] and the presenters employed by that station for direct and public incitement to commit genocide and for persecution as a crime against humanity on the grounds that hate media had played a key role in the instigation of genocide. The Tribunal found a direct link between hate media and the killing of hundreds of thousands of Tutsis.

84. The impunity of ideologues and spreaders of hateful and discriminatory speech facilitates the construction of a false memory that is morally repugnant and that contributes to and encourages violence.

C. Responsibility of the media and the need to adapt laws

85. National and international law must be able to respond adequately to the development of information technology. Social media that transcend borders pose unprecedented challenges, as technology companies may be based thousands of miles from the places where hate speech originates and where civilian populations suffer its violent consequences.

86. The final report of the independent international fact-finding mission on Myanmar established that incitement to hatred through social networks and other non-electronic media was correlated with violence against the Rohingya:

> The Mission received information suggesting that the linkage between offline and online hate speech and real world acts of discrimination and violence is more than circumstantial. Patterns are emerging of hate speech sermons and rhetoric in specific locations that have subsequently experienced violence, and so are indications of peaks of online hate speech around outbreaks of violence. Such patterns and indications need to be comprehensively examined.[51]

87. The Special Rapporteur believes that, even when technology companies do not intend to engage in criminal acts, they cannot be absolved of responsibility for providing tools for the transmission of messages that may cause acts of violence to be inflicted on tens or even hundreds of thousands of people. There can be no justification for allowing social media companies to escape responsibility when they are found to have acted negligently and to have facilitated and/or permitted the dissemination of hate speech on their networks, inciting acts of violence that constitute international crimes.

D. Fake news

88. Equally worrying is the mass dissemination of fake news that can create an atmosphere in which people are at risk of becoming dangerously radicalized, making coexistence difficult. False information is not an exception or hiccup in the democratic process; it reveals and exacerbates the collapse of values and the dissolution of societies. Its appearance in the public sphere must therefore be treated with concern because, as history shows, it has previously been a harbinger of tragedies, bloodshed and pogroms.

89. The situation is particularly serious in fragile States, where institutions are often weak and politicians use sectarian discourse – based on affiliation with an ethnic group, religion, community or clan – and fake news to manipulate identities with the aim of stirring up emotions and setting the stage for violent conflict. In this way, memory and information can easily be weaponized.

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[50] *Nahimana et al. (Media case)* (ICTR-99-52), International Residual Mechanism for Criminal Tribunals, available at https://unictr.irmct.org/en/cases/ictr-99-52.

[51] A/HRC/39/CRP.2, para. 1326.

90. Serious media outlets have systems for monitoring information at the source, with regard to their own output. For example, *The New Yorker*, since its establishment in the 1920s, has been known for the rigour and discipline of its fact checkers. These days, however, the media are not generally known for such qualities. In recent years, the issue has taken on a new dimension with the erosion of media credibility, the emergence of 24-hour news channels, the rise of the Internet and the power of social networks that are rife with rumours and conspiracy theories, all of which increases the need for information to be checked. Such fact checking as there is has been unable to change the beliefs and behaviour of persons who consume and spread fake news.

91. Some States have enacted – or tried to enact – rules to regulate the Internet, particularly with a view to curbing hate speech and fake news. In 2018, the Act to Improve Enforcement of the Law in Social Networks (NetzDG),[52] which provides for heavy fines for platforms that do not remove hate speech, came into force in Germany. In late 2020, the German Government is expected to conduct a study of the Act's impact. In late 2018, France promulgated a law prohibiting the manipulation of information,[53] but there are doubts about its effectiveness.

E. Media education

92. Media and information education in schools is essential to counteract the harm and havoc caused by fake news, to address the credibility crisis affecting media outlets – which should be more rigorous – and to prevent the State from intervening more than it should in regulating information. Through education, students are taught to decipher information and images, sharpen their critical thinking skills and form their own opinions. These abilities are essential for the exercise of enlightened and responsible citizenship in a democracy where freedom of expression is upheld.[54] One of the priorities of the previous European Commission was media literacy, along with the adoption of codes of conduct by major digital platforms.

F. The moral climate of an age

93. The dissemination of hate speech and fake news is part of a broader trend marked by attacks on multilateralism and human rights and the rise of exclusionary and xenophobic ideologies based on nationalistic self-interest. In 1942, Stefan Zweig finished writing *The World of Yesterday*, in which he critically described the moral climate of the age as the suicide of Europe caused by "the most terrible defeat of reason". The moral climate of an age, when it is pernicious, allows the manifestation of ideas and behaviour that were hitherto considered repugnant because they were unacceptable to democracy and human ethics.

94. In the foreword to the United Nations Strategy and Plan of Action on Hate Speech, the Secretary-General, in addition to denouncing the rise of xenophobia, racism, intolerance, antisemitism, Islamophobia and the persecution of Christians, makes a disturbing observation:

> Social media and other forms of communication are being exploited as platforms for bigotry. Neo-Nazi and white supremacy movements are on the march. Public discourse is being weaponized for political gain with incendiary rhetoric that stigmatizes and dehumanizes minorities, migrants, refugees and any so-called "other". This is not an isolated phenomenon or the loud voices of a few people on the fringe of society. Hate is moving into the mainstream – in liberal democracies

[52] See www.lemonde.fr/pixels/article/2019/07/04/lutte-contre-la-haine-en-ligne-l-impossible-bilan-de-la-loi-allemande_5485218_4408996.html.

[53] Available at www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000037847559&dateTexte=&categorieLien=id.

[54] For example, at the Centre for Media and Information Literacy in France, www.clemi.fr/.

and authoritarian systems alike. And with each broken norm, the pillars of our common humanity are weakened.[55]

95. In places where there are ongoing conflicts – particularly the Syrian Arab Republic and Yemen – the United Nations, the International Committee of the Red Cross, other humanitarian and human rights organizations, independent media outlets and even private individuals have documented the bombings of numerous hospitals, schools and other protected sites in total disregard of international law. However, the reporting of these atrocities and the subsequent protests have neither changed the behaviour of the warring groups[56] nor led the Security Council to intervene appropriately.

VIII. Progressive development of memory and non-regression

96. Progressivity is a principle that informs international human rights law from a pro personae perspective.[57] Memorialization processes must also be progressively developed: progress must be made in the search for the truth and in the active establishment of policies on memory with regard to serious violations of human rights and grave breaches of international humanitarian law that have occurred. Such policies require the establishment of programmes at all levels of formal and informal education, both as a human rights obligation and with a view to preventing future violations by moving towards a culture of peace. It is also essential to encourage new memory processes reflecting contemporary human rights perspectives, such as the gender perspective, and to review memory processes that have not taken account of it in order to ensure that it is properly incorporated.

97. There can be no regression or reversal: the denial of extermination policies such as the Holocaust, genocides and other crimes against humanity committed in the past, as well as the whitewashing or praise of the regimes that carried them out, must be fully repudiated and deemed unacceptable. Governments and other public authorities must refrain from giving voice to such ideas, which are unethical and revictimize victims, offend the international community and violate States' international obligations. The Special Rapporteur has expressed his deep concern about statements made by the President of Brazil vindicating the military dictatorship that ravaged that country and calling the Truth Commission's report into question.[58]

98. In this regard, any memorialization policy that is designed and implemented must be bound by the obligation not to distort or diminish the conclusions of legitimate mechanisms established to shed light on the events – truth commissions – and/or of any tribunals that have tried and convicted those responsible for them.

IX. Conclusion and recommendations

99. **The obligation to adopt memorialization processes in societies that have suffered gross violations of human rights and serious violations of international humanitarian law derives from both primary and secondary sources of international human rights law and therefore cannot be circumvented by Governments on the basis of budgetary, political or structural arguments or claims that efforts should be focused on other areas of transitional justice.**

[55] https://www.un.org/en/genocideprevention/documents/advising-and-mobilizing/Action_plan_on_hate_speech_EN.pdf.

[56] www.icrc.org/en/document/yemen-attacks-health-care-facilities-must-stop.

[57] Salvioli, Fabián, "La perspectiva pro persona como método hermenéutico para la aplicación del derecho internacional de los derechos humanos", in Jon-Mirena Landa Gorostiza (ed.), *Retos emergentes de los derechos humanos: ¿garantías en peligro?*, pp. 31–41, Valencia, ed. Tirant lo Blanch, 2019.

[58] President Jair Bolsonaro attacked the work carried out by the Truth Commission, which had shed light on 443 murders and enforced disappearances committed by the military dictatorship. See the Special Rapporteur's press release at www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24431&LangID=E, and Naiara Galarraga Gortázar, "El presidente Bolsonaro cuestiona la verdad oficial sobre la dictadura de Brasil", *El País*, 31 July 2019, elpais.com/internacional/2019/07/30/actualidad/1564516182_689279.html.

100. **Transitional justice systems require vigorous and active memory policies based on human rights approaches in order to adequately address past crimes committed by dictatorial or authoritarian regimes or crimes perpetrated in the context of an armed conflict. Without memory, the rights to truth, justice and full reparation cannot be fully realized and there can be no guarantees of non-recurrence.**

101. **Memory processes related to gross violations of human rights and serious violations of international humanitarian law constitute the fifth pillar of transitional justice.**

102. **Memory processes complement but do not replace mechanisms for truth, justice, reparation and guarantees of non-recurrence. Memory mechanisms should never serve as a pretext for granting de jure or de facto impunity to the perpetrators of gross violations of human rights or serious violations of international humanitarian law.**

103. **Progressivity is a principle that informs international human rights law from a pro personae perspective. Memorialization processes must also be progressively developed so as to move forward in the search for truth and in effectively establishing memory policies concerning past violations, while considering different groups of victims and duly reflecting a gender perspective. The principle of non-regression in relation to memory processes places a limit on denialist or revisionist theories that seek to deny the extent of past violations and the harm caused to victims.**

104. **Memorialization is a long-term process in which the State must play an active and decisive role. The authorities that adopt and implement memory policies should ensure that such policies properly represent the views of the victims and are established in collaboration with civil society, especially human rights organizations.**

105. **Public policy on memory should be multidimensional and include measures related to public spaces (memorials, parks, squares, etc.), artistic expressions (museums, plays, concerts, pictorial exhibits, etc.), media initiatives, and State-sponsored public events and activities held on significant dates. In the area of education, programmes under such policies should be established at all levels of formal and informal education and steps should be taken to build a culture of peace.**

106. **Memory processes cut across all aspects of full reparation – especially the dimensions of satisfaction and guarantees of non-recurrence – as a new obligation for States arising from the violations committed.**

107. **The memorialization of past times defined by violations of human rights and international humanitarian law provides an opportunity to reflect on the present and identify contemporary problems related to exclusion, discrimination, marginalization and abuses of power, which are often linked to toxic political cultures. Memorialization promotes the development of a culture of democracy and respect for human rights.**

108. **The purpose of the proper use of memory is to establish a "dialogic truth", that is, to create the conditions for a debate within society on the causes and consequences of past crimes and violence and on the attribution of direct and indirect responsibility. Memory processes cannot, under any circumstances, deny or attempt to detract from violations and crimes that have been verified by truth commissions and/or legal proceedings. Such a deceptive exploitation of memory is unacceptable and contrary to international human rights obligations.**

109. **The voices of victims of human rights violations must play a key role in the construction of memory. This will also help to counteract attempts at denialism, revisionism and manipulation by the perpetrators of violations and by political groups or interests that seek to rekindle violence. The public authorities must refrain from making denialist statements that whitewash violations and revictimize victims.**

110. **The purpose of memory processes in post-conflict situations is to allow victimized populations to make sense of a brutal past, avoid vengefulness, come to terms with past divisions, repudiate the crimes committed, support justice mechanisms and, through the lessons learned, alleviate existing tensions, allowing society to live peacefully going forward.**

111. **Although memorialization and, in particular, the documentation of crimes and human rights violations in times of conflict are essential, they require that victims be treated appropriately. Victims should play a leading role in the process, be kept regularly informed and have their expectations met as far as possible for as long as the violence continues.**

112. **In transitional contexts, memorialization processes can be effective only if they pursue the political goal of establishing democracy and a culture of peace. Advocates of transitional justice mechanisms should form alliances with different civil society actors and help to change a toxic culture of political violence, confrontation and marginalization.**

113. **In order for memorialization processes to be effective, it is essential to protect the archives of State agencies and civil society organizations, especially those that work in the area of human rights. Archives should be accessible in accordance with established standards, and Governments should remove obstacles to such access.**

114. **The United Nations should establish procedures for sharing its own archives, which are important for shedding light on the past for many societies, thereby helping to uphold the right to the truth. Specifically, it should set up an efficient access methodology, with priorities defined in accordance with the purpose of investigations, in order to allow societies to learn more about their own history.**

115. **National legislation should be adapted to reflect technological developments. Hate speech that leads to violence cannot be accepted on the pretext that social networks are the entities that spread such statements. While freedom of expression must be guaranteed, criminal acts that constitute incitement to hatred must be banned and persons responsible for acts of discrimination, hostility or violence must be punished in accordance with international standards. Formal education in schools, colleges and universities should incorporate media and information literacy content that enables students to analyse information, sharpen their critical faculties and develop informed opinions, while ensuring full respect for human rights.**

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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence, Pablo de Greiff*,**

Summary

In the present report, the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence presents the key activities undertaken by him between July 2014 and June 2015.

The Special Rapporteur elaborates on the main elements of a framework for designing State policies regarding "guarantees of non-recurrence". Offering conceptual clarity to the term "guarantees of non-recurrence", the Special Rapporteur suggests structuring such policies around three main spheres of intervention. At the level of official State institutions, the report begins with a reminder of some basic conditions, including security and legal identity, and proceeds to offer a range of initiatives, including the ratification of relevant treaties; justice and security sector reforms; changes in security legislation; and constitutional reforms, incorporating the separation of powers principle, removing discriminatory provisions and incorporating a bill of rights. The Special Rapporteur then draws attention to two spheres of intervention, the potential of which has not been frequently examined as part of guarantees of non-recurrence, namely, civil society and the spheres of culture and personal dispositions. In these sections, the Special Rapporteur mentions the importance of legal empowerment and the creation of an enabling environment in order for civil society to discharge its crucial role. Finally, the Special Rapporteur emphasizes the preventive potential of education reform, arts and culture, and trauma counselling.

* Late submission.
** The annex to the present report is circulated as received, in the language of submission only.

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In conclusion, the Special Rapporteur emphasizes that "guarantees of non-recurrence" should be considered not as a rhetorical device but as an object of policymaking. The Special Rapporteur highlights that, in order to develop an effective preventive State policy, interventions in all three areas are necessary.

The Special Rapporteur's set of general recommendations for truth commissions and archives is presented in an annex to the present report.

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I. Introduction

1. The present report is submitted by the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence pursuant to Human Rights Council resolution 27/3. In it, the Special Rapporteur presents the key activities undertaken from July 2014 to June 2015, and addresses the topic of establishing a policy on guarantees of non-recurrence in the aftermath of mass violations.

II. Activities of the Special Rapporteur

A. Country visits and regional consultations

2. The Special Rapporteur undertook a country visit to Burundi (see A/HRC/30/42/Add.1; A/HRC/30/CRP.1) and an advisory visit to Sri Lanka.[1] He thanks both Governments for their invitations and cooperation.

3. The Special Rapporteur is pleased to announce he will undertake a country visit to the United Kingdom of Great Britain and Northern Ireland in November 2015. A further invitation was extended by the Government of Côte d'Ivoire. Other pending visit requests concern Brazil, Cambodia, the Democratic Republic of the Congo, Guatemala, Guinea, Indonesia, Kenya, Nepal, Rwanda and Sri Lanka.

4. The Special Rapporteur will undertake a regional consultation on transitional justice for the Asia-Pacific region in December 2015. As with previous consultations, the results will form part of the study requested in paragraph 1 (f) of Human Rights Council resolution 18/7.

B. Communications and press releases

5. From July 2014 to June 2015, the Special Rapporteur sent communications to Chile, Egypt, Guatemala, Italy, Morocco, Nepal, Pakistan, the Philippines, Portugal, Serbia, Spain and the Russian Federation;[2] prepared an open letter to the United States of America; and issued press releases on Argentina, Bosnia and Herzegovina, Burundi, Colombia, Nepal, Spain and the United States.

C. Other activities

6. In August 2014, the Special Rapporteur participated as panellist in a national forum on victims, organized in Cali, Colombia, at the request of the peace negotiation representatives of the Government of Columbia and the Revolutionary Armed Forces of Colombia – People's Army (FARC-EP).[3]

7. During the period in question, the Special Rapporteur presented his report (A/HRC/27/56) addressing the topic of prosecutorial strategies in the aftermath of mass atrocities and his visit reports on Spain and Uruguay (A/HRC/27/56/Add.1 and A/HRC/27/56/Add. 2, respectively). In addition, he was a panellist in the Human

[1] See www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15820&LangID=E.

[2] See A/HRC/28/85, A/HRC/29/50 and A/HRC/30/27.

[3] See www.hchr.org.co/publico/pronunciamientos/ponencias/PDeGreiff_Cali_Agosto_2014.pdf.

Rights Council panel debate on history teaching and memorialization processes, and participated in side events on gender and transitional justice and experiences on the implementation of transitional justice measures. He met with representatives of Armenia, Cambodia, Colombia, Côte d'Ivoire, Guatemala, Japan, Nepal, the Netherlands, the Republic of Korea, Spain, Sweden, Switzerland, the United States and Uruguay, as well as several non-governmental organizations.

8. In September 2014, the Special Rapporteur, the International Committee of the Red Cross and the organization Swisspeace organized in Geneva an expert workshop entitled "Archives in the Context of the Right to Know".

9. Furthermore, in September 2014, the Special Rapporteur attended a regional conference in Guatemala on the role of the judiciary in the fight against impunity for international crimes.

10. In October, the Special Rapporteur, with the founding office of the Nuremberg Principles Academy, conducted an expert workshop on guarantees of non-recurrence, held in Nuremberg, Germany.

11. Also in October, he presented to the General Assembly his report (A/69/518) addressing reparations for victims in the aftermath of mass violations of human rights and of international humanitarian law.

12. In January 2015, the Special Rapporteur held meetings in Addis Ababa on the draft African Union Transitional Justice Framework, including with the African Union Commissioner for Political Affairs, the African Union Chairperson's Special Envoy on Women, Peace and Security, and donors agencies and non-governmental organizations.

13. In February 2015, the Special Rapporteur presented a keynote speech at the conference entitled "Truth Commissions and Peace Processes: International Experiences and Challenges for Colombia", organized by the Kofi Annan Foundation and the International Centre for Transitional Justice in Bogota.

III. Guarantees of non-recurrence as part of a comprehensive transitional justice strategy

14. In the present report, the Special Rapporteur addresses the topic of developing a State policy on guarantees of non-recurrence in the aftermath of mass violations, understood as part of a comprehensive transitional justice strategy. It is to be read in conjunction with the 2015 report of the Special Rapporteur, to be presented to the General Assembly at its seventieth session, in which the Special Rapporteur elaborates on the topic of transitional justice and security sector reform.

A. Legal foundation

15. International standards on guarantees of non-recurrence have grown significantly since 1993, when the term was first used in a United Nations report.[4] This is demonstrated, inter alia, by the explicit reference to "guarantees of non-repetition" in the International Convention for the Protection of All Persons from Enforced Disappearance.

[4] See E/CN.4/Sub.2/1993/8, paras. 47 and 48, and 55; and section IX, principle 11.

16. In 2004, the Human Rights Committee held that the purposes of the International Covenant on Civil and Political Rights "would be defeated without an obligation integral to article 2 to take measures to prevent a recurrence of a violation of the Covenant. Accordingly, it has been a frequent practice of the Committee ... to include ... the need for measures, beyond a victim-specific remedy, to be taken to avoid recurrence of the type of violation in question".[5]

17. The first jurisprudence by the Committee regarding right-to-life cases requiring States to "take steps to ensure that similar violations did not occur in the future" dates back to the 1980s.[6] The former Special Rapporteur, Theo van Boven, argued on that basis that "there exists a definite link between effective remedies to which the victim(s) is (are) entitled, remedies aimed at the prevention of the recurrence of similar violations and the issue of the follow-up given by the State party".[7]

18. The general commitment to adhere to a right involves making efforts to ensure that its violation ceases and is not repeated. The duty to prevent recurrence is hence closely linked to the obligation of cessation of an ongoing violation. On this basis, "guarantees serve a preventive function and may be described as a positive reinforcement of future performance".[8]

19. Regional human rights courts and human rights treaty bodies have, with increasing frequency, issued orders related to guaranteeing non-recurrence. For example, the Inter-American Court of Human Rights has interpreted its remedial powers broadly and ordered remedies directed not only at victims, but also at communities and towards society at large. Significant progress by the Court includes a practice of requiring States to take measures to preserve the victim's memory or making relevant parts of its ruling public for educational purposes.[9] On legislative reform, the Court held that laws that place civilians under military court jurisdiction are a violation of the American Convention on Human Rights; consequently, it ordered the State to change the legislation.[10] Such orders are not uncommon in Court decisions. As the Court argued in its landmark *Velásquez Rodríguez* decision, States are obliged "to organize the governmental apparatus and, in general, all the structures through which public power is exercised, so that they are capable of juridically ensuring the free and full enjoyment of human rights".[11]

B. Conceptual issues

20. Despite the significant growth of the relevant international standards, the term "guarantees of non-recurrence" requires elaboration regarding the following conceptual questions:

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[5] See CCPR/C/21/Rev.1/Add.13, para. 17.

[6] See communications No. 88/1981, *Larrosa v. Uruguay*, Views adopted on 29 March 1983, para. 13; No. 124/1982, *Muteba v. Zaire*, decision on admissibility dated 25 March 1983, para. 13; and No. 176/1984, *Peñarrieta et al. v. Bolivia*, Views adopted on 2 November 1987, para. 18.

[7] E/CN.4/Sub.2/1993/8, para. 55.

[8] See Draft Articles on State Responsibility, article 30.

[9] See Arturo J. Carrillo, *Justice in Context: The Relevance of Inter-American Human Rights Law and Practice to Repairing the Past* (Oxford University Press, 2008).

[10] Ibid. See also *Castillo Petruzzi et al. v. Peru*, Judgement of 30 May 1999, Inter-American Court of Human Rights, Ser. C, No. 52. para. 222.

[11] See *Velásquez Rodríguez v. Honduras*, Judgement of 29 July 1988, Inter-American Court of Human Rights, Ser. C, No. 4, para. 166.

(a) The "offer", as it is not clear what is meant by a "guarantee";

(b) The "object", as the reference in the foundational texts[12] to the non-recurrence of gross violation of human rights by States has widened to include the non-recurrence of "international crimes" committed by State and non-State actors, the non-recurrence of atrocities and even of the non-recurrence of violent conflict;[13]

(c) The "subject", or who the beneficiaries of the guarantees are supposed to be, i.e., the victims, a wider group of "potential" victims or society at large;

(d) The "duty bearers", i.e., those supposed to fulfil their obligation to provide said guarantees.

21. In the present report, the Special Rapporteur aims at contributing conceptual clarity about "guarantees of non-recurrence"; acknowledging the breadth of the field, yet giving it some structure, without being necessarily comprehensive; and highlighting areas that have not received appropriate attention.

22. Furthermore, the main interests underlying the report are practical, and aim to show that the topic can be concretely acted upon; demonstrate that it is a fit object of rational policymaking, including planning, budgeting and monitoring; and offer a general framework for designing an actionable non-recurrence policy.

23. Conceptually, there is a difference between guarantees of non-recurrence and the remaining three core elements of a comprehensive transitional justice approach, namely, truth, justice and reparation. While those three elements refer to measures, guarantees of non-recurrence is a function that can be satisfied by a broad variety of measures. The foundational texts already demonstrate this variety, pointing to, inter alia, reforming institutions, disbanding unofficial armed groups, repealing emergency legislation incompatible with basic rights, vetting the security forces and the judiciary, protecting human rights defenders and training security forces in human rights.

24. The core function of guarantees of non-recurrence is preventive in nature. It is one to which truth, justice and reparation are themselves supposed to contribute: criminal justice mainly through deterrence; truth commissions through disclosure, clarification and the formulation of recommendations with a preventive intent; and reparations by strengthening the hand of victims to claim redress for the past and future violations and to enforce their rights more assertively.

25. The preventive intent is the unifying thread in the foundational texts. Framing an indicative reply to the aforementioned conceptual questions, the "offer" of guarantees of non-recurrence relates to a combination of deliberate, diverse interventions that contribute to a reduction in the likelihood of recurring violations. The "object" is not the prevention of isolated violations, but of gross human rights violations and serious violations of international humanitarian law. Such violations presuppose systemic abuses of (State) power that have a specific pattern and rest on a degree of organizational set-up.

26. The present report is written on the understanding that the "subject" of the guarantees is the previously victimized society, seen at large, thus not limited to the

[12] E/CN.4/Sub.2/1997/20/Rev.1; E/CN.4/2004/88; General Assembly resolution 60/147; and E/CN.4/2005/102/Add.1.

[13] See S/2004/616.

direct or indirect victims.[14] Given the Special Rapporteur's interest in exploring the development of preventive policies, State institutions will be the main "duty bearers". Nonetheless, considering the diversity of the potential elements of a comprehensive policy, those bearers are ultimately manifold.

27. Guarantees of non-recurrence are a function that can be satisfied by diverse measures. Thus, there is no such thing as a general non-recurrence policy. An effective policy designed to prevent systemic violations will need to adjust form to function and choose the proper instruments.

C. Framing considerations

28. Three general considerations are relevant. First, transitional justice programmes have not taken into account sufficiently the significant differences between the post-authoritarian contexts, where the model of transitional justice originally took shape, and the situations of (post-)conflict and fragility in which it is now predominantly implemented. Two important differences relate to degrees of (State) institutionalization and the types of violations, abuses and harms requiring redress.

29. These differences play out as follows: criminal trials, truth commissions and reparations programmes all rest upon certain institutional preconditions that are not satisfied in all settings. Furthermore, those measures are effective instruments for redressing certain kinds of violations and not others. The transfer of the model from the post-authoritarian context to the (post-)conflict setting has taken place with virtually no functional analysis.

30. The same applies to guarantees of non-recurrence: the institutional context, its characteristics, capacities and history all matter, as do the cultural circumstances and individual dispositions. Preventing mass violations does not call for the same specific measures regardless of those factors. Similarly, the (risk of) prevalence of some (patterns of) violations should naturally shape a prevention policy for a given country.

31. In addition, transitional processes are dynamic. Therefore, besides allowing for functional adequacy between means and ends and suitability to context, the design of the policies to implement transitional justice elements should take into account fittingness to a certain stage in a process. Thus, what is necessary and feasible for prevention changes over time, not only as institutional characteristics change, but also as the horizon of possibilities shifts.

32. Furthermore, the sort of transformations that are called for in order to approximate anything resembling guarantees of non-recurrence following mass violations cannot be achieved through "institutional engineering" or institutional reforms alone. The challenge of achieving justice retrospectively and prospectively is not merely a technical one. Lasting societal transformations require interventions not only in the institutional sphere but also in the cultural sphere and at the level of personal, individual dispositions. While culture and "character" play a stabilizing function in social relations, and as such are by nature relatively immune to deliberate change, they are not immutable altogether. Hence, in the present report, the Special

[14] See Juan E. Méndez, "Accountability for Past Abuses", *Human Rights Quarterly*, Vol. 19, No. 2, p. 261 (May 1997).

Rapporteur pays attention to interventions in the cultural and the personal domains that have received comparatively less attention.

33. Economic conditions and their relation to non-recurrence with a view to meaningful transformation is a topic that does not receive sufficient focus. As argued in previous reports, transitional justice cannot be thought to exhaust the agenda of thorough political, social and economic transformation that is called for in the aftermath of mass violations.

34. Although the causes of violence or violations of rights cannot be reduced to inequality or poverty, singly or jointly, or to any straightforward combination of social indicators, it is well known that both inequality and poverty correlate robustly with violence and the violations of various rights, including civil and political, and economic, social and cultural.[15] Most of the violent conflicts in the world take place in countries that are or have been deeply afflicted by large inequalities, poverty, and often both.

35. There are forms of economic exclusion that, if entrenched over time, may be particularly detrimental to the enjoyment of rights. Persistent and durable inequalities, but also some of the inequalities associated with rapid but highly uneven economic growth, have been argued to be associated with both social discontent and increases in criminal activities, violence and civil conflict.[16]

36. The continuation in power of an abusive regime makes it impossible to guarantee that violations will not be repeated. In some of these contexts, lack of economic opportunities outside government-paid posts raises decisively the stakes of losing power. This motivates the entrenchment of abusive regimes, increasingly also observed through the subversion of democratic processes, and consequently undermines the possibility of offering effective guarantees of non-recurrence. These cases provide a compelling illustration of the economic and developmental dimension to prevention, which must no longer be ignored and should be more thoroughly analysed.

37. In the present report, the Special Rapporteur presents a range of interventions from easily actionable to more ambitious, demanding interventions. This is not a causal sequence. No intervention, large or small, on its own, in any of the three spheres, is likely to offer sufficiently strong guarantees. The multidimensional character of conflict and of rights violations needs to be matched by multidimensional responses. The Special Rapporteur also demonstrates that there is always something that can be done in order to diminish the likelihood of repeated violations. Therefore, neither cost nor complexity of interventions is a legitimate excuse for inaction.

[15] See A/HRC/29/31. See also World Bank, *World Development Report 2011: Conflict, Security and Development* (Washington, D.C., 2011).

[16] See P. Justino, *Shared Societies and Armed Conflict: Costs, Inequality and the Benefits of Peace*, Institute of Development Studies (London, 2012).

IV. Institutional interventions

A. Basic preconditions

1. Security for all

38. Much reflection about redressing rights violations simply makes assumptions about what is missing in the majority of the cases at hand, namely, functional State institutions. In their original intent, human rights instruments were designed to address — and in fact to redress and correct — abuses of State power. A great deal of abuses, however, today takes place in areas of limited governance and by non-State actors. Moreover, it should be highlighted that it is usually the most marginalized who bear the brunt of the violations; the better-off have always more exit options and can translate economic power into some degree of security. Non-recurrence policies need to pay attention to the provision of effective security for all in full compliance with all relevant rights-related standards including equality and fairness.

2. Legal identity

39. Proof of legal identity is crucial for the exercise of rights and for gaining access to State services. It is generally a precondition for, inter alia, participating in most administrative and judicial proceedings, including those related to the violation of fundamental rights; settling questions relating to civil status; voting or standing for election and being appointed to office; obtaining a nationality and a passport; gaining access to social security or other forms of State support; taking part in commercial transactions, including entering contracts; opening bank accounts; and acquiring a title to property.

40. International and regional human rights law recognize the right to legal identity[17] in time of peace and conflict. According to the United Nations Children's Fund (UNICEF), approximately one third of all children under five worldwide have never been registered.[18] Statelessness, which affects more than 10 million people, according to the Office of the United Nations High Commissioner for Refugees (UNHCR), compounds the problem.[19] Conflict negatively affects legal identity through: (a) the absence or weakening of State presence and services; (b) migration and displacement, often involving the loss of documents and the impossibility of obtaining new ones; (c) fear and intimidation, for example, children being relocated and forcibly conscripted; and (d) the deliberate destruction of registries, as has happened during conflicts at least in Guatemala, Peru, Bosnia and Herzegovina and Timor-Leste. In Cambodia, during the Khmer Rouge regime in the 1970s, all documents relevant to civil status were destroyed. In Sierra Leone, where thousands of children were abducted and forced to fight during the 10-year conflict, many had

[17] See International Covenant on Civil and Political Rights, art. 24; Convention on the Rights of the Child, arts. 7 and 8; International Convention for the Protection of All Persons from Enforced Disappearance, art.25; African Charter, art. 6; and American Convention on Human Rights, arts. 3 and 18.

[18] See UNICEF, "Every Child's Birth Right: inequalities and trends in birth registration" (New York, 2013), available from www.unicef.org/media/files/Embargoed_11_Dec_Birth_Registration_report_low_res.pdf.

[19] See UNHCR, *2013 Statistical Yearbook* (Geneva, 2013), available from www.unhcr.org/54cf99f29.html.

no registration of their birth and lacked the means to trace their identity and identify their families or communities.[20]

41. Officially recognized identity, substantiated through birth certificates or identity documents, is a gateway for the realization of most fundamental rights. Legal identity is important for the purpose of having rights respected, for claiming them and for obtaining redress when they are violated. Addressing the challenges of legal registration in the aftermath of conflict or repression provides an opportunity to establish, restore or strengthen the foundations of a national registry that is compulsory, universal, permanent and continuous, which secures the confidentiality of personal data and is sensitive to cultural circumstances, including of minorities and religious or indigenous groups. By facilitating statistical data, legal registration can assist a Government to better plan, implement and monitor its service provision and efforts towards the realization of the rights of the individuals and development objectives. Addressing legal identity concerns in post-conflict or post-authoritarian contexts provides a way for transitional justice mechanisms to have an impact beyond their direct sphere of influence.

B. Ratification of treaties

42. While legal identity is a precondition for the exercise of rights, there are measures that can proactively promote rights, both retrospectively, by redressing their violation, and prospectively, by trying to prevent the violations. Some of these tools have received legal expression in international treaties. A basic step in the articulation of a non-recurrence policy, therefore, consists in the ratification of relevant treaties concerning gross human rights violations and serious violations of international humanitarian law.[21] States should avoid, or withdraw, any reservation that could raise doubts as to their compatibility with the object and purpose of the treaty.

43. Because no law is self-executing, ratification alone can at best be taken as a signalling device, which has the potential for misuse as "window dressing", in which case ratification can be followed by a worse human rights performance.[22] Nevertheless, ratification, exemplifying what has been called "the paradox of empty promises",[23] can lead to greater compliance if accompanied by various forms of advocacy.[24]

44. Except for pure "monist" legal systems, ratification can lead to greater compliance only if accompanied by the incorporation of treaty obligations into domestic legislation. In such systems, therefore, a basic element of a non-recurrence policy will require, in addition to ratification, a strategy of incorporation (and desirably of monitoring and enforcement).

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[20] Ibid.

[21] See key international instruments, available from www.ohchr.org/EN/Issues/TruthJusticeReparation/Pages/InternationalInstruments.aspx.

[22] See Oona A. Hathaway, "Do Human Rights Treaties Make a Difference?", *Yale Law Journal*, Vol. 111, No. 8 (2002).

[23] See Emilie M. Hafner-Burton and Kiyoteru Tsutsui, "Human Rights in a Globalizing World: The Paradox of Empty Promises", *American Journal of Sociology*, Vol. 110, No. 5 (2005).

[24] See Tomas Risse et al, *The Persistent Power of Human Rights* (Cambridge University Press, 2013).

C. Legal reforms

45. The incorporation of international legal obligations should at least cover the following basic issues: the typification of relevant crimes; statutes of limitations and retroactivity questions; and the introduction of reforms leading to de-incentivizing violations, including regarding anti-terrorism legislation.

1. Criminal types, statutes of limitation and retroactivity issues

46. The focus here is placed on the inclusion of measures that enable judicial and non-judicial remedies for redressing gross human rights violations and serious international humanitarian law violations.

47. The incorporation of criminal types (offences) on the basis of international law has the advantage not only of accurately reflecting international obligations, but also of solving two problems that have increasingly become an excuse for inaction in the face of systematic or widespread violations, namely, prescription and retroactivity issues.

48. Common crimes in domestic jurisdictions are generally accompanied by prescription regimes. The reasons to make "atrocity crimes" imprescriptible are, first, that atrocity crimes raise particular investigatory and prosecutorial challenges that usually cannot be met on the same schedule as common crimes; and second, that imprescriptibility helps signal that such crimes constitute an affront to humanity, communicating that, in theory, neither space nor time will provide escape from responsibility.

49. The Convention on the Non-Applicability of Statutory Limitations to War Crimes and Crimes Against Humanity,[25] which also covers crimes of genocide and those associated with apartheid, states that the relevant crimes are imprescriptible "irrespective of the date of their commission". International jurisprudence has frequently reiterated that the Convention does not create new rights or obligations, but that it is declarative in nature, and that the principle of imprescriptibility of war crimes, crimes against humanity and genocide is a matter of *jus cogens*.[26]

50. This helps to address claims regarding the retroactive application of criminal law or violations of the principle of legality, in particular, of the principle that no one should be punished for an act that was not proscribed by a law in force at the time of commission.[27] Jurisprudence from various courts shows the ways in which different countries have confronted some of these challenges. Some countries have carried out judicial processes for gross human rights violations using criminal types current in their penal codes at the time of their commission, but, judging the offences to be crimes against humanity in accordance with *jus cogens*, they have attributed to those violations some of the characteristics and consequences of international crimes, such

[25] General assembly resolution 2391 (XXIII), 1968.

[26] See, for example, *The Prosecutor v. Klaus Barbie* (Supreme Court, France); *Kolk and Kislyiy v. Estonia* (European Court of Human Rights); *Priebke*, and *Arancibia Clavel* (Supreme Court, Argentina); *Molco* (Supreme Court, Chile); *Barrios Altos*, and *Gelman* (Inter-American Court of Human Rights).

[27] See Universal Declaration of Human Rights, art. 11 (2); International Covenant on Civil and Political Rights, art. 15; Convention for the Protection of Human Rights and Fundamental Freedoms, art. 7; American Convention on Human Rights, art. 9.

as imprescriptibility.[28] Other courts have carried out judicial processes using criminal types that may have not been present in national codes when the acts were committed, arguing that this does not violate the principle of legality if international law already declared the acts in question to be illegal when they were committed.[29] Indeed, domestic and international courts have found ways to guarantee simultaneously respect to the principle of legality as well as due process and fair trial standards for the defendants, and to the rights of victims to see the perpetrators of violations brought to justice.[30]

2. Emergency, security and counter-terrorism legislation

51. Another crucial legislative reform that is not particularly onerous in terms of expenses or complexity is to ensure that emergency, anti-terrorism or other security-related legislation is fully compatible with human rights standards, so that it does not incentivize violations of rights. Authoritarian regimes, regimes mired in conflict and, for years now, States involved in so-called "wars on terrorism" almost invariably adopt legislation that goes well beyond the objective security needs that purportedly motivate it.[31] Such laws have been seriously misused to justify gross human rights violations. For example, in addition to allowing for prolonged periods of "preventive" detention, constraining access to defence lawyers, the absence of the review of the legality of detention by a court, among other limitations of rights, these laws either directly or indirectly promote, even instigate, the violation of rights. This is the case, for example, with the singly objectionable, jointly pernicious, removal of bars on the use of evidence that may have been obtained illegally, frequently by coercion, and the weakening of the safeguards under which "confessions" can be given by detainees.

D. Judicial reforms

52. Given the importance of an independent and effective judiciary in securing rights — but also of acknowledging the dubious role some judiciaries have played in pre-transitional periods in some countries — it is somewhat surprising that judicial reform has not played a more prominent role in discussions about guarantees of non-recurrence. This is in spite of recommendations made by many truth commissions in relation to judicial reform and the fact that many transitional countries have reformed their justice systems.[32] This serves as a good illustration of the lack of focus and strategy in discussions about guarantees of non-recurrence, and of the disconnect between transitional justice and other policy interventions with which it coexists but rarely interacts.

53. In the aftermath of mass violations, committed sometimes with the collaboration of the judiciary, or in any case having shown itself an insufficient bulwark against the violations, there are three important issues that should be tackled in order to help prevent future violations: (a) screening judicial personnel; (b)

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[28] See *Arancibia Clavel* and *Simón* (Supreme Court, Argentina); and *Fujimori* (Specialized Criminal Law Chamber, Peru).

[29] See Special Tribunal for Lebanon, Appeals Chamber, *STL-11-01/I*, paras.132 and 133; *Pérez García* (Colombia).

[30] See *Scilingo* and *Pinochet* (National High Criminal Court, Spain); *Gelman*.

[31] See A/HRC/16/51/Add.2; and A/HRC/25/59/Add.2.

[32] See Linn A. Hammergren, *Justice Reform and Development: Rethinking Donor Assistance to Developing and Transitional Countries* (Routledge, Oxford, 2014).

strengthening judicial independence; and (c) strengthening judicial competencies in areas specifically important for preventive purposes.

54. If judiciaries virtually everywhere can at times be subjects of mistrust, in contexts of past mass violations, some are so tainted with complicity that it is virtually impossible for them to gain trust without a major vetting or screening of their personnel, from the top down. Particularly in places in which higher court judges have responsibilities for the administration of courts, including case allotment, judicial career and disciplinary procedures, as well as a voice in decisions about judicial reforms, a judiciary entirely appointed by a predecessor regime, seen as complicit in past mass violation, will stand in need of major personnel review.

55. The vetting of judges poses particular challenges because procedures need to respect the separation of powers, judicial autonomy, due process guarantees and, if it exists, the general principle of the irremovability of judges, which may only be transgressed in exceptional cases.[33] Furthermore, even a judiciary dependent on the executive power is, in most cases, far from being a powerless branch. Some countries under quite difficult circumstances have managed to vet the judiciary, showing respect for the relevant principles, including due process. The latest country to embark in such a project has been Kenya.[34]

56. Continuing judicial training should include information about the role of the judiciary in past violations; the capacity to self-criticize needs to be exemplified by the judiciary above all branches of government.

57. Changes in personnel are insufficient to turn ineffective or complicit judiciaries into trustworthy arbiters and reliable guarantors of rights. Prospectively, structural changes are necessary, including means to strengthen judicial independence, as many truth commissions have recommended.[35] Without such reforms, the likelihood that courts will (at least) dare to check executive powers will not increase significantly, and will be entirely dependent on the virtue of particular individuals.

58. There is no single reform that can guarantee that judges will act independently. However, opportunities for individuals to exercise judgement independently are increased if they are offered certain protections, including recruitment on the basis of merit and objective criteria; security of tenure; adequate terms of service, for example, remuneration and predictable conditions of retirement; and transparent, reliable disciplinary processes, for example, fair procedures, proportionate sanctions, promotions, dismissals and transfers, so that the fears of losing their jobs, not being promoted or being arbitrarily transferred to an undesirable location do not influence their opinions.

59. Guaranteeing the physical safety of judges is a decisive condition of the exercise of independent judgement.

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[33] See Updated Set of principles for the protection and promotion of human rights through action to combat impunity, principle 30.

[34] For an overview of the vetting structures and procedures, see International Commission of Jurists, Kenya Section, available from www.icj-kenya.org/index.php/resources/publications/papers-dl.

[35] For El Salvador, S/25500 (1993), pp. 172ff; Guatemala see www.derechoshumanos.net/lesahumanidad/informes/guatemala/informeCEH.htm, vol. 3, ch.16; for Chile, see www.usip.org/sites/default/files/resources/collections/truth_commissions/Chile90-Report/Chile90-Report.pdf; and for Sierra Leone, see www.sierraleonetrc.org/index.php/view-the-final-report/table-of-contents, vol. 2, chap. 3, paras. 39, 104-106 and 132-163.

60. In addition to guaranteeing the individual independence of judges, it is also important to strengthen the institutional independence of the judiciary. This can be accomplished by enshrining the separation of powers in constitutional texts and/or practices; using methods for appointing judges and magistrates that signal a valuation of competence and independence rather than political affiliation; endowing the judiciary with sufficient resources and providing it with budgetary and administrative autonomy; ensuring that cases are assigned on the basis of objective criteria; and respecting and enforcing the decisions of courts, even when they are contrary to the interests of the executive or its supporters, including regarding significant issues for the Government, such as electoral questions.

61. For the adjudication of cases involving mass violations, judicial systems need to build and further develop specialized capacities regarding the widespread and systemic nature of violations and the identification of respective patterns and nodes in networks of systemic crimes, as they require a change in investigative, prosecutorial and adjudication techniques and practices.[36] In many jurisdictions, familiarity with international human rights and humanitarian law is weak to non-existent. Familiarity with the peculiarities of "structure crimes",[37] such as genocide, crimes against humanity and war crimes, which rest upon a network of actors, is even scarcer. Dismantling networks of such criminality, some of which are ensconced in State institutions, i.e. in torture cases, through the implementation of an appropriate strategy ably pursued by prosecutors and competently adjudicated by judges is one of the most effective contributions a judicial system can make to preventing the recurrence of violations. Such capacities are sometimes best expressed and built in the establishment of specialized (pre-)investigatory offices, courts or tribunals.

E. Constitutional reform

62. The following is a set of constitutional issues, presented in a rough ascending order of complexity, that transitioning countries could make part of their non-recurrence policy.

1. Removing discriminatory provisions, introducing mechanisms of inclusion

63. The removal from constitutions and other laws or by-laws of any provisions that may fuel discrimination, a well-known source of social strife, is likely to contribute to the prevention of violations. Several truth commissions and peace agreements have made recommendations to this effect. For instance, the Sierra Leonean Truth and Reconciliation Commission recommended removing racist and sexist provisions governing citizenship, arguing that citizenship should be acquired by birth, descent or naturalization. In Morocco, the *Instance équité et réconciliation* argued for a constitutional prohibition on all forms of internationally prohibited discrimination and any incitation to racism, hatred or violence. The Arusha Peace and Reconciliation Accord (2000), which aimed at settling the conflict in Burundi, banned all political or other associations that advocated ethnic, religious or gender discrimination, and laid the basis for the consociational power-sharing agreement,

[36] See A/HRC/27/56, paras. 88-91.

[37] Ibid., para. 71.

which the 2005 Constitution set in place, and on which peace in Burundi still hinges.[38]

64. Truth commissions and peace agreements have advocated for introducing mechanisms of inclusion into constitutional texts. The Guatemalan Peace Accord, for example, emphasized the need to define the country as multi-ethnic, multicultural, and multilingual at the constitutional level. The Guatemalan Commission on Historical Clarification elaborated recommendations on inclusion and the protection of indigenous rights, calling for modes of governance that enable individual and collective rights of the indigenous population and encourage their social and political participation.

2. Incorporating a bill of rights

65. A good part of the effectiveness of bills of rights depends on the strength of the courts that interpret them and on how deeply other State powers feel bound by courts' decisions. However, introducing a bill of rights that publically enumerates the most fundamental rights a country seeks to safeguard is a powerful way of drawing a line between an abusive past and a different future, especially in the aftermath of mass violations. The design of a bill of rights and enshrining the basic principles of governance signals to institutions and individuals where minimum standards of acceptable behaviour lie. Bills of rights are a sort of a "pre-commitment" strategy that works on the basis of publicity and takes some issues out of the give-and-take of political expediency.[39]

66. In many countries with past mass violations, minorities were predominantly targeted. Articulating clear and enforceable guarantees for minorities in bills of rights may offer some protection and de-incentivize both attacks on them and the taking by them of preemptive action in ways that are characteristic of "security dilemmas".

67. Where Governments have a history of committing or condoning human rights violations, a bill of rights enables courts to identify legislation and governmental practices that have the potential to lead to recurrence of violations before they take place.

3. Security sector reform

68. Crucial elements in the area of security sector reform aiming at the prevention of violations in the future pertain to: (a) defining the different roles of the police, the military and the intelligence services; (b) strengthening civilian control over the armed forces; (c) the elimination of military "prerogatives"; and (d) the vetting of the security forces. In the light of the complexity of these areas, the Special Rapporteur has dedicated a separate report to these reform undertakings.[40]

4. Separation of powers

69. Abuses of power by security forces and lack of judicial independence are often manifestations of the same phenomenon, namely, a bloated and unrestrained executive power uninterested in accountability. Following mass violations, some

[38] See A/HRC/30/42/Add.1.

[39] See Stephen Holmes, "Precommitment and the paradox of democracy", in *Constitutionalism and Democracy* (Cambridge University Press, 1993).

[40] Report to be presented to the General Assembly at its seventieth session.

countries reconsider issues such as the separation of powers and endeavour to limit executive powers. The 2010 Constitution of Kenya, for example, curbs some of the powers given to the President by the 1963 Constitution and successive amendments, which had increased the powers of the President while weakening the legislature and the judiciary. Most recently, the authorities in Sri Lanka presented to parliament the XIX Amendment, ending the era of the so-called "executive presidency", devolving to parliament some of the powers that the office of the President had accumulated over time to the detriment of the remaining State powers.

5. Limiting the scope of military justice

70. Militaries in most countries operate their own courts because the military relies on distinct regulations, laws and codes of conduct, and the enforcement of those codes, including disciplinary procedures, requires special mechanisms. International law, however, is clear that the jurisdiction of military courts is restricted to trying members of the military for military offenses, to the exclusion of human rights violations and serious violations of international humanitarian law.[41] Trying civilians in military courts or trying members of the military for crimes other than military crimes contravenes international law. Circumventing this key principle is one of the most prevalent ways of shielding violations committed by the military from accountability.

6. Establishing a constitutional court

71. Many transitioning countries, including virtually all the countries in the "third wave" of democratization,[42] have introduced a separate constitutional court, largely following the lead of Germany after the Second World War.[43] The establishment of such courts distinguishes the adjudication of routine, ordinary matters from crucial decisions on fundamental rights. This distinction provides an elegant way out of a dilemma faced by countries that do not trust judges appointed by a predecessor regime to be the last arbiters of the most fundamental rights-related questions, but that cannot afford to vet the judiciary.

72. There is no court, however, that can be entirely responsible for the protection of rights if other branches of power are determined to commit violations, or if non-State actors are determined to commit abuses. Similarly, no court, on its own, can sustain the rule of law in the face of attacks from other powers or indifference from citizens.[44] Membership in constitutional courts can be manipulated, judges coerced[45] or corrupted, and new ways of subverting legal order, which constitutional courts were not designed to counter, have emerged.[46]

73. Notably, for a constitutional court to be effective in protecting individuals' rights and preventing violations, it needs to be vested with an individual complaints

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[41] See Updated Set of principles for the protection and promotion of human rights through action to combat impunity, principle 29.

[42] See Samuel P. Huntington, *The Third Wave: Democratization in the Late Twentieth Century* (University of Oklahoma Press, 1993).

[43] See Samuel Issacharoff, *Fragile Democracies: Contested Power in the Era of Constitutional Courts* (Cambridge University Press, 2015).

[44] See Bojan Bugaric, "A crisis of constitutional democracy in post-Communist Europe: 'Lands in-between' democracy and authoritarianism", *International Journal of Constitutional Law*, vol. 13, Iss. 1, pp. 219-245 (2015).

[45] See, for example, the recent allegations against one member of the Burundi Constitutional Court.

[46] See David Landau, "Abusive Constitutionalism", *UC David Law Review* (2013).

procedure, whereby an individual can challenge the infringement of his or her rights by any public act or omission.

7. Adopting a new constitution

74. Many countries are tempted to adopt a new constitution immediately after a transition. Some countries have succeeded in such an effort, including Spain in 1978 and, more recently, Kenya in 2010 and Tunisia in 2014, in a display of maturity and self-restraint on the part of Assembly members that did the country proud. There can hardly be a more powerful way to mark a line between the present and the past and to introduce guarantees and protections that were missing or ineffective before. Provided the country can complete the constitution-making exercise and that the new provisions are in fact observed, a new constitution enshrining a bill of rights and principles of governance is likely to be the central part of a non-recurrence policy.

75. However, constitutions are, regretfully, more often breached than observed. It might be that engaging in the far-reaching "existential" questions characteristic of constitutional debates proves to be a distraction in the early days of a transition, in a context in which State institutions might be required to urgently establish their capacity to meet more immediate needs. The first phase of a transition might not be the most conducive context for guaranteeing that the constitution will indeed be inclusive enough; it may be that political actors are insufficiently representative or that, in the absence of previous opportunities in countries lacking the required political traditions, actors at the table on the cusp of the transition are insufficiently versed in the complicated type of judgement that is called for if a sufficiently inclusive, sustainable constitution is to be articulated. Some of these factors might invite participants in constitutional debates to adopt a zero-sum attitude thinking that this is their (only) chance. All of these elements put obstacles in the process expected to produce a foundation that is good for all and for a long time.

76. Therefore, it may be advisable for countries to expand their repertoire of options for constitutional reform to include, for instance, the adoption of transitional or interim constitutional arrangements, as South Africa did, or incremental processes of constitutional renewal, as in Hungary and Poland after 1989.[47] More gradual processes of constitution-making are likely to lower the stakes for all stakeholders. This might open the possibility of achieving a greater degree of consensus over issues of critical importance.

V. Societal interventions

77. Prevention is not merely a matter of making changes in texts; prevention calls for changes in practice. Hence, legal reforms need to be accompanied by initiatives that can change "factor endowments", including available resources and, importantly, human capacity.

78. Most discussions of guarantees of non-recurrence have focused on the reform of official State institutions. However, in contexts of past mass violations, State institutions are often weak, inefficient and/or corrupt. Even if they are honest and relatively competent, they may have very limited reach, as in some countries the majority of conflicts are settled through informal mechanisms.

[47] See Vicki C. Jackson, "What's in a Name? Reflections on Timing, Naming and Constitution-Making", *Willliam and Mary Law Review*, vol. 49, iss. 4 (2008).

79. The contribution of civil society organizations to transitional processes has been analysed is various ways, including regarding their advocacy function, their crucial role in collecting and preserving evidence, their monitoring functions and their reconciliation initiatives. All of these are crucial. However, in the present report, the Special Rapporteur concentrates on a more prevention-specific argument. He presents a series of initiatives that may enhance the preventive potential of civil society, ordered by degree of ambitiousness and complexity, showing how this potential, in many ways, is a manifestation of a "power of aggregation" that counteracts the "disarticulating power" of terror and that works by lowering the costs of raising claims.

A. Ceasing attacks and threats and removing obstacles

80. One of the simplest ways of enabling civil society to contribute to preventive work is simply to refrain from persecuting, intimidating and harassing civil society representatives, including human rights defenders.[48]

81. Another step is to remove many of the legal and practical barriers that have been placed on civil society with increased frequency in the recent past. According to one report, "between 2004 and 2010, more than 50 countries considered or enacted measures restricting civil society. Since 2012, more than 90 laws constraining the freedoms of association or assembly have been proposed or enacted."[49] These laws introduce obstacles of various types, such as barriers to operational activity, free speech and advocacy, contact and communication, peaceful assembly and access to funding.

82. Such strong governmental interest in hampering the work of civil society confirms yet again the importance of the latter. This consolation, however, does not make up for the different kinds of risks and privations that these obstacles generate, including violations of the right to physical integrity and the weakening of monitoring and advocacy capacities to prevent violations.

B. Legal empowerment

83. A more proactive way of strengthening civil society is to establish programmes targeted at the community level, focusing on those who have traditionally been excluded from the protection of the law, particularly women, with the specific aim of facilitating the use of the law, the legal system and legal services to advance their own rights, promote government accountability and resolve local disputes.

84. Legal empowerment can contribute to restoring the sense of agency of control over one's life that mass violations erode. These initiatives have also acted as a catalyst for social organizations and led to the enhanced ability, confidence and willingness of individuals and communities to participate in sociopolitical processes, including transitional justice mechanisms. This empowerment typically also brings with it a more assertive attitude of civil society actors to prevent violations in the future by enforcing their rights more confidently.

[48] See A/HRC/25/55.

[49] See Douglas Rutzen, "Aid barriers and the rise of philanthropic protectionism", *International Journal of Not-for-Profit Law*. vol. 17, no. 1, p. 7 (March 2015).

C. Creating enabling environments

85. In the present report, the Special Rapporteur encourages further reflection and study on the ways in which the strengthening of civil society can contribute to prevention. In earlier reports, observations were made about the fact that, without civil society participation, little progress would have been made in the domains of truth, justice and reparations. It is overwhelmingly thanks to the unrelenting advocacy of civil society organizations that accountability remains on the political agenda in countries with past mass violations. It is difficult to think of the efforts of Argentina to achieve justice without the contribution of the organizations Madres de la Plaza de Mayo and the centre for legal and social studies (CELS); those of Chile without the contribution of the Vicaría de la Solidaridad; or those of Guatemala without the persistence of the centre for human rights legal action (CALDH), to name only a few examples.

86. Because "civil society" should not be reduced to "non-governmental organizations", it is important to recall that, in all transitional processes, a variety of stakeholders, including trade unions and religious organizations, have made essential contributions. To illustrate, although the role of the Catholic Church during the dictatorships in Argentina and Spain and during the genocide in Rwanda has been questioned, its contributions to the search for accountability in Chile, Uruguay and to this day in Burundi are notable. Similarly, trade unions have made crucial contributions to many transitional processes, including in South Africa, Poland and, recently, in Tunisia.

87. Because most transitional processes have been "liberalizing" and therefore, over time, both trade union and church affiliations decline, the contribution of these groups tends to be overlooked. In the present report, the Special Rapporteur emphasizes the significance of their contribution not only for the sake of historical accuracy, but also because it gives an important indication about the type of civil society that we should aim at if we are interested in prevention.

88. Authoritarianism has not disappeared as a threat to human rights, and other threats have been added. Despite significant differences among them, systematic threats to rights share a common element: violence or threats of violence undermine civic trust, a phenomenon that creates a negative feedback loop and becomes both a condition and a consequence of the continuation of violence.

89. Hence the importance of strengthening civil society. In past reports, more concerned with issues of redress, the point to emphasize was that a strong civil society diminishes the costs and risks of raising claims, both for individuals and groups. In the context of a discussion about prevention, the point to emphasize is that in a strong civil society, in which individuals and groups are empowered to exercise their rights, the violation of rights is less likely.

90. Because civil society cannot be reduced to formal institutions, it would be a mistake to conceive the project of strengthening civil society on the model of an institutional reform process. Civil society by its very nature is not part of the State and therefore does not respond to State initiatives as if it were.

91. The strengthening and enhancing of the preventive potential of civil society are likely to come from such contributing factors as (a) the active promotion of the fundamental freedoms of expression and opinion, of peaceful assembly and association and of religion; (b) the establishment of an education system that provides opportunities to develop not just marketable skills but critical thinking; and (c) the preservation of traditions of openness, transparency and consultation, more

than from the mere removal of obstacles to the operation of non-governmental organizations.

VI. Interventions in the cultural and the individual spheres

92. In addition to interventions in the domains of official State institutions and in civil society, those in the domain of culture and individual spheres are required for long-lasting transformations, including non-recurrence. Culture and personality structures are, generally speaking, sources of stability and continuity in social relations, hence, neither one is open to direct and immediate change by legal fiat. However, this does not imply that they are immune to any change.

A. Education

93. In transitional contexts, education has the potential to act as a powerful tool for non-recurrence. Because of its formative potential, education can contribute to shaping new norms, mediating between contending narratives of the past and nurturing a culture of dialogue and democratic citizenship across generations. A transitional justice approach to education can greatly contribute to contextualizing the aims of educational reform after conflict and/or repression, with an eye to strengthening its potential for preventing the recurrence of violations, for example, by identifying the patterns that fuelled conflict, especially in relation to exclusionary and authoritarian practices in school systems.[50]

94. Of significant relevance is the teaching of history: if approached as a system of research rather than a mechanism for simply preserving and remembering data, it can train citizens in habits of analysis and critical reasoning.[51] In transitional contexts, historical facts are often manipulated to serve political and ideological aims through the propagation of one-sided narratives that leave no room for alternative perspectives. Different groups in society, particularly in ethnically divided ones, may learn different versions of a shared history that clash significantly with each other.[52] Similarly, the suppression of historical events, as practised in some contexts, reinforces the social identities of those who fought against each other.[53] Such practices risk perpetuating divisions and conflicts rather than preventing their recurrence.

B. Arts and culture

95. Cultural interventions, such as museums, exhibitions, monuments and theatre performances, have the capacity to affect not only victims but also the population at large.[54] In addition to the capacity to engage empathy, there are artistic and cultural interventions that are ideally suited to "make visible" both victims and the effects of

[50] See Clara Ramírez Barat and Roger Duthie, *Education and Transitional Justice. Opportunities and Challenges for Peace Building* (International Centre for Transitional Justice and UNICEF, forthcoming).

[51] See A/HRC/27/56/Add.1, para. 34.

[52] See A/68/296.

[53] See Harvey M. Weinstein et al., "School voices: challenges facing education systems after identity-based conflicts", *Education, Citizenship and Social Justice*, vol. 2 no. 1, p. 66 (March 2007).

[54] See A/HRC/25/49.

victimization, to account for the very complex ways in which violations affect the lives of individuals and of communities, especially over time. Furthermore, some artistic media provide space for victims to articulate their experiences and even, emphasizing the interventions' enabling potential, to try out new identities, including the identity of a rights claimant.

C. Archives

96. Archives containing records of mass violations can contribute to prevention. Access to well-preserved and protected archives is an educational tool against denial and revisionism, ensuring that future generations have access to primary sources, which is of direct relevance to history teaching. One notable example in this regard are the Stasi files opened up by Germany after 1989. Opening files contributes directly to the process of societal reform.

97. However, there is a lack of consistency in the disposition of archives of transitional justice mechanisms, including truth commissions.[55] To address this gap, as a first step and as a result of a series of consultations with experts, the Special Rapporteur developed a set of general recommendations that builds on the right to know. This set of general recommendations (see annex) is meant to provide guidance for truth commissions and other relevant stakeholders in their future archival work.

D. Trauma counselling and psychosocial support

98. Psychosocial support or trauma counselling has been rather marginally identified as a component of a comprehensive strategy of non-recurrence. Gross violations are likely to lead to health problems,[56] implying troubles for individuals and society, which call for adjustments on a more fundamental psychological level. Challenges may include identity problems for individuals and society, which hamper the transformation of societies. Moreover, unaddressed specific traumatic events may lock countries in repeated cycles of violence.

99. Post-authoritarian and/or post-conflict settings face low levels of trust both vertically — between the State and its people — and horizontally — between individuals and between communities. However, trust is the foundation for the development of a rule of law culture, an environment that fosters reconciliation and a necessary precondition for effective communication between the victims and the authorities, as well as within society.

100. Where structural abuse or recurrent patterns of violence and unresolved trauma intersect, high levels of conflict and further violence are likely to develop. Furthermore, amid high levels of inequality, poverty and unemployment, where people's sense of dignity and self-worth are severely compromised on a daily basis, violent behaviour can become a simple means of taking back the control people are denied in their life.

101. Trauma counselling can be used to overcome and transform victim/perpetrator identities, as an important step towards reaching a conclusion. For the victim, this

[55] Ibid.

[56] For example, for Peru, see Lisa J. Laplante, "Linking Peacebuilding and health in post-conflict settings", available from www.frient.de/publikationen/dokumente/library/linking-peacebuilding-and-health-in-post-conflict-settings.html.

can mean once more taking part fully in society; for the perpetrator, it can mean acknowledging and assuming responsibility. This transformation can help to avoid cycles whereby "victims become perpetrators", which perpetuate cycles of mass violations.[57]

102. While arguing for the anchoring of trauma counselling as a crucial element of a State policy aimed at guaranteeing non-recurrence, the Special Rapporteur warns against using psychosocial support to "water down" the importance of institutional reform. Instead, trauma counselling and civil society efforts should be considered as a "trigger-down mechanism" to ensure that institutional reform becomes truly effective at the individual level.

VII. Observations and recommendations

103. **The Special Rapporteur calls for more focused attention to the challenges arising in areas of weak governance for the effective satisfaction of rights and in particular to the challenges for protecting the rights of marginalized groups and individuals. Significantly more work needs to be done normatively and practically in order to protect the rights of individuals in such situations, including civilians trapped in the cross-fire of a conflict.**

Institutional level

104. **The Special Rapporteur calls upon States to take the necessary measures, in the aftermath of conflict and/or repression, to enable the registration of births and give access to all to gain or regain their legal identity; and to increase access to registration mechanisms, including through mobile registration units, accessible at the local and community levels, with simplified procedures that are reflective of the circumstances people face, for instance after displacement and the fragmentation of families. Measures need to be taken to ensure access for all, without discrimination, to a fully functional civil registration system that is universal, compulsory, permanent, continuous and cost-free, that ensures the confidentiality of personal data and is culturally sensitive, especially in relation to religious or cultural circumstances regarding minorities and indigenous groups.**

105. **He also calls upon States to adopt a non-recurrence policy that should include the ratification of relevant treaties, avoiding or withdrawing reservations that may defeat the purpose of the treaty. Ratification should be followed by a strategy for incorporating the provisions effectively into domestic law and their implementation. States should consider prioritizing the ratification of targeted treaties that pertain to gross human rights violations and serious violations of international humanitarian law, including torture, sexual and gender-based violence, extrajudicial executions, arbitrary detentions, enforced disappearances, institutionalized discrimination, forced displacement and exile, and crimes amounting to crimes against humanity, war crimes and**

[57] See S. Servaes and N. Birtsch, "Engaging with victims and perpetrators in transitional justice and peace building processes", workshop report published by Working Group on Development and Peace (FriEnt) and the Centre for Peacebuilding (KOFF) (October 2008). Available from www.frient.de/nc/en/publications-service/documents/library/engaging-with-victims-and-perpetrators-in-transitional-justice-and-peace-building-processes.html.

genocide. The Special Rapporteur urges all States to ratify the Convention on the Non-Applicability of Statutory Limitations to War Crimes and Crimes against Humanity.

106. **States should promote reforms to ensure full compliance of emergency, security or anti-terrorism legislation with international human rights standards. Reforms should include explicit reference to non-derogable rights and enshrine elements for suitability, necessity and proportionality tests. Legislation must be in conformity with international standards, in particular the principle of legality, due process and fair trial. Furthermore, the criminalization of terrorist activity must be formulated in explicit and precise terms that enable individuals to regulate their behaviour, and the definitions of terrorist crimes should be confined exclusively to activities that entail or are directly related to the use of deadly or serious violence against civilians.**

107. **States should also consider methods of vetting judicial personnel that are compatible with the separation of powers, the independence of the judiciary and due-process guarantees. A judiciary that is not trusted by citizens either for reasons of complicity or ineffectiveness will find it impossible to fulfil its corrective and preventive roles. Since self-reflection about the judiciary's own role in violations is both trust-inducing and potentially preventive, the training of judicial personnel, and judicial reform in itself, should address the judiciary's role in past violations.**

108. **The Special Rapporteur calls upon States to include in their policies initiatives geared towards strengthening internal (individual) and external (institutional) judicial independence. He urges them to ensure that their judicial systems comply with relevant standards, including the Basic Principles on the Independence of the Judiciary. Judiciaries can crucially help to prevent violations by checking executive powers and by adjudicating conflicts impartially and independently.**

109. **He also calls upon States to endow their judiciaries with specialized competencies required to address mass atrocities strategically to dismantle networks of criminality. Implementing such strategies is one of the most significant contributions judiciaries can make to the prevention of violations. Similarly, he urges them to acquire competencies in the detection and prevention of other gross violations, which are routine in many places, including torture. While specialized judicial capacities are sometimes best expressed through the creation of specialized entities, no special jurisdiction — military or not — should weaken the power to guarantee and enforce basic rights.**

110. **States should consider, in transitional contexts, constitutional amendments or reforms to lay down a catalogue of rights and structures of governance as the foundation of the "new" State. This is possible through an incremental, interim or fully fledged constitutional drafting process. Enshrining the principles of the separation of powers, the independence of the judiciary, the non-partisan role of the security forces and a bill of rights is indicative of a new beginning. Special attention should be paid to providing for oversight, accountability and strong human rights protection mechanisms, including through the establishment of a constitutional court or chamber with an individual complaints procedure.**

111. **The jurisdiction of military tribunals should be limited solely to military personnel charged exclusively with military offences, to the exclusion of human rights violations and serious violations of international humanitarian law.**

Civil Society

112. **The Special Rapporteur calls upon States to prevent any persecution, attacks, threats, intimidation and harassment of civil society representatives. States should ensure protection mechanisms for civil society at risk, including early warning systems, physical protection measures, as well as accountability and prompt and impartial investigations in cases of violations. This requires clear and decisive messages from the highest authorities on zero-tolerance policy for such attacks and intimidation against civil society actors and on public recognition of their essential role in building just, inclusive and tolerant democracies.**

113. **He also calls upon States to withdraw or reform provisions that impose an excessive burden or disproportional heavy bureaucratic and costly procedures, which severely hamper civil society participation. This includes (a) amending registration mechanisms thereby excluding the possibility to deny registration on vague grounds; (b) reforming excessive procedural requirements; (c) withdrawing prior-authorization requirements, allowing spontaneous peaceful assembly and, if prior-notification mechanisms exist, their rationale should be grounded by ensuring the exercise of the right to peaceful assembly, protection of public safety and order, and the rights and freedoms of others; (d) providing for precise regulations defining illegal activities; (e) preventing arbitrary interpretation of regulatory provisions; (f) reforming legislation that prevents organizations from receiving support from certain donors, including foreign funding; (g) reforming legislation that imposes undue restrictions on freedom of expression and criminalizes dissenting and critical opinions; (h) preventing arbitrary or unlawful surveillance; (i) ensuring effective access to encryption and anonymity tools in online communications; and (j) protecting the confidentiality of sources.**

114. **States should create the economic, political, legal, social and cultural conditions that actively support the ability and capacity of persons, individually or in association, to engage in social and civil activities, promoting the principles of participation, non-discrimination, dignity, transparency and accountability. Key conditions include: (a) a conducive political and public environment, through a supportive legal and practical regulatory framework in line with international human rights standards; (b) access to international and regional human rights mechanisms and effective cooperation with independent national human rights institutions; (c) access to information; (d) special measures and resources targeting the most marginalized groups to ensure their integration and participation and the consideration of their voice among civil society actors; (e) opportunities for civil society to participate in decision-making processes; and (f) the provision of financial resources and stability, including through public subsidies.**

115. **States should also support legal empowerment programmes, ensuring their broad participation among a sufficiently large section of the population and their long-term impact, in order to have a transformative effect on attitudes and behaviour. This may include: (a) building partnerships among various actors, including (international) donors, government focal points and community leaders; (b) sustained financial and capacity support; and (c) the creation of mutually reinforcing networks among individuals and groups at the local, national and international levels.**

Cultural and the individual spheres

116. **The Special Rapporteur calls upon States to conceive educational reforms, cultural interventions, including memorialization, and archives as part of their non-recurrence policies. He urges States to focus more attention on these areas, and intends to pay more attention to them in the future, in cooperation with other special procedures.**

117. **He also calls upon States to consider the annexed set of general recommendations for truth commissions and archives as an important component of the work of the Human Rights Council on transitional justice.**

118. **States should ensure that history teaching aims at fostering critical thought, analytic learning and debate, in order to enable a comparative and multi-perspective approach, as well as a better understanding of the contemporary challenges of exclusion and violence.**

119. **States should also ensure that psychosocial support and trauma counselling are addressed as core components of transitional justice, emphasizing their central importance for repairing the social contract — i.e., the relationship between the State and the individual — and social cohesion — i.e., relationships of individuals with one another — after periods of protracted violence and/or oppression. The Special Rapporteur underscores that these twin goals are essential to offering victims and society the highest possible guarantees available that violations will not reoccur.**

120. **The Special Rapporteur calls upon States to build a sustainable culture of non-recurrence by ensuring that trauma counselling in transitional contexts not only focuses on assisting individuals and families with "daily problems", but also includes interventions to build on and strengthen the resilience and coping mechanisms of the communities and society at large. In this connection, trauma work should be linked to educational reform and education itself, for children, adolescents and adults.**

121. **He also calls upon States to develop further work on and support for psychosocial initiatives, both to relieve the immense suffering of victims and to help to put an end to cycles of violence. He highlights that to think that the burden of prevention can be carried by punitive measures alone is both to overestimate the capacities of criminal justice systems and to underestimate the importance of other types of intervention.**

Annex

[English only]

Set of general recommendations for truth commissions and archives

Introduction

1. Many post-authoritarian and post-conflict societies are faced with enormous challenges in the preservation and disposition of records containing information on gross human rights violations and serious violations of international humanitarian law. In many cases, secrecy, national security concerns, and poor archival practice stand in the way of guaranteeing the right to know the truth.

2. Archivists have, over time, developed sophisticated technical expertise and knowledge on all relevant issues regarding archives, including preservation, accessibility, and management. However, there is a striking gap between technical archival expertise and practice. Policies and practices that fall short of international standards risk the loss of records containing an important part of a society's heritage and hence hamper the possibility of accessing documentary evidence and support for efforts to achieve truth and justice.

3. Indeed, archives are relevant and can make significant contributions to each of the pillars of transitional justice, not merely truth and justice. At the same time, transitional justice measures can contribute to a country's archival system. Beyond the fact that transitional justice measures generate records themselves, truth commissions, trials, reparations programs and other transitional justice initiatives can contribute to improving archival practice both by the way they implement relevant standards with respect to their own documents, and because some of them, particularly truth commissions, are in a good position to make comments and recommendations about archival reform in general.

4. That potential, however, has not been consistently realized. Even truth commissions, both in post-authoritarian and post-conflict settings, manifest a significant gap between expertise and actual practice. There is little consistency in the disposition of truth commission archives, in the regimes that govern subsequent access to them, and in the recommendations that truth commissions make concerning archival systems.

5. In the conviction that these gaps need to be addressed, the Special Rapporteur on the promotion of truth, justice, reparation and guarantees of non-recurrence in his 2013 report to UN Human Rights Council on truth commissions (A/HRC/24/42) "calls for the development of international standards on archiving" for truth commissions. What follows is intended to contribute to the development of such standards. Part I contains recommendations *for* truth commissions pertaining to their own operations and the disposition of their archives, and Part II comprises recommendations that truth commissions *can make* regarding the establishment of national archival policies concerning

records that contain information about gross human rights violations and serious violations of international humanitarian law.[a]

6. As a general point, the Special Rapporteur would like to take the opportunity to reiterate the call on States to provide full support to truth-seeking mechanisms throughout their whole life-cycle, which includes access to records containing information on gross human rights violations and serious violations of international humanitarian law, in order for them to be able to effectively and independently implement their mandate.

I. Recommendations for truth commissions

In the context of their operations, truth commissions are encouraged to:

7. *Build* provisions for the eventual disposition of their records, guaranteeing both their safety and accessibility. This needs to be done in the early stages of planning their operations; a commission needs to decide who will be responsible for managing the records, where they will be stored in the short and long term, and how access to them will be controlled.

8. *Engage* archival expertise in making and implementing those provisions during the life of the truth commission, and in this context take advantage of national (National Archives and Archival Associations) and international assistance and advice (e.g. International Council on Archives, Archivists without Borders);

9. *Plan* to deposit their archives in the country where the violations occurred and the commission operates, preferably in existing national archives, duly taking into account considerations of the security, integrity and accessibility of the archives. New and specialized archives may need to be created until such time as the national archives are able to adequately handle records of truth commissions. In the event of the possible loss, mutilation, poor preservation or destruction of the records in the country of origin, truth commissions should keep a complete, scanned and/or digitalized copy of the records in a secure facility outside the country or consider temporary preservation in a secure repository in a second jurisdiction or with an international institution;

10. *Consider* criteria having to do with preservation, accessibility, and trustworthiness of the host institution in deciding on the adequate repository.[b]

11. *Stipulate* that the access policy of truth commission archives should maximize public accessibility, while respecting applicable privacy concerns, including in particular assurances of confidentiality provided to victims and other witnesses as a precondition of their testimony. Access to truth commission archives may not be denied on grounds of national security or other grounds unless the restriction is in full compliance with international human rights law;

12. *Note* that maximizing future accessibility has an impact on many operations of a commission throughout its lifetime, including, for example, on the process of taking statements and other contact with victims and witnesses who should be advised that their

[a] Both sets of recommendations build on well-established definitions on the "right to know" and on "archives" as stipulated in, among other places, the Updated Set of principles for the protection and promotion of human rights through action to combat impunity; see report of the independent expert Diane Orentlicher to update the Set of principles to combat impunity, E/CN.4/2005/102/Add.1, 8 February 2005.

[b] For example, ISO 16363 defines a practice for assessing the trustworthiness of digital repositories.

contributions to the commissions may be accessible in the future under specified conditions;

13. *Establish* guidelines for access to truth commission records, which shall take into account:

(a) General access rules, such as what was previously public should remain public; victims, families, investigative and prosecutorial authorities, as well as legal defense teams, should have unhindered access to information on their specific case; there should be a presumption of public access to all State information with only limited exceptions; a procedure to make effective the right of access should be established; whatever access rules are determined for various categories of potential users (for example, victims, legal representatives, journalists, academics, and members of the general public) should apply to all members of the given category without discrimination;

(b) Categorization of records enabling familiar distinctions between types of documents (e.g. reports of own investigations, records of own meetings, victims' testimonies, documents obtained from other institutions, organizations, or private persons etc.) that will allow for a differentiated approach in facilitating access, in accordance with general access rules, to each type of document/collection;

(c) The need for effective mechanisms of reference services, as well as new technological advances in managing archives;

14. *Develop*, with the support of national and international expertise and assistance, provisions and measures to secure and preserve national archives, including by building effective and sustainable record management and archival systems, which includes, i.a., secure and adequate premises and clear appraisal policies;

15. *Elaborate* policies concerning relevant records and archives of non-State actors, including private businesses, so as to maximize effective management and access of these records by the truth commission.

II. Possible recommendations by truth commissions

16. Regarding their recommendations on archives and the establishment of national archival policies that concern records containing information on gross human rights violations and serious violations of international humanitarian law, truth commissions are encouraged to:

17. *Address* the issue of reform of national archival legislation and institutions to encourage the establishment of modern, accessible, and reliable archives which are essential for the long-term preservation and use of records containing information on gross human rights violations and serious violations of international humanitarian law. Recommendations should include that reform efforts ought to be conducted with the participation of public institutions, civil society, and archival experts;

18. *Make* recommendations to preserve and actively use national archives, including archives of security services;

19. *Call for* independent oversight over the archives, including of archives of formerly repressive regimes;

20. *Recommend* the creation of archival laws, freedom of information legislation, data protection legislation and transparency requirements within other laws, which take into account the right to information, the right to know the truth, and the specificity of the records dealing with human rights violations and violations of international humanitarian law;

21. *Recommend* to the responsible authorities that they increase the capacity and where necessary the resources of State and local archival actors;

22. *Recommend* the provision by the State of information to the public on legal and practical requirements for access to archives;

23. *Promote* the establishment of comprehensive National Archival systems, including non-governmental records, especially those that are relevant to gross human rights violations and serious violations of international humanitarian law. Improvements in the regulation, disposition, protection and access to non-governmental archives (which does not involve the centralization of *all* records) will contribute to the establishment of such comprehensive systems, in accordance with international standards;

24. *Recommend* to the responsible authorities that they facilitate the work of civil society in the area of archives and ensure an enabling environment in this respect, in accordance with international standards;

25. *Reiterate* that access to archives, containing records with information on gross human rights violations and serious violations of international humanitarian law, may not be denied to the public on grounds of national security unless the restriction is in full compliance with international human rights law.

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Sixty-first session
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PROMOTION AND PROTECTION OF HUMAN RIGHTS

Impunity

Report of the independent expert to update the Set of principles to combat impunity, Diane Orentlicher*

Addendum

Updated Set of principles for the protection and promotion of human rights through action to combat impunity

* The report was submitted after the deadline in order to take into account replies of all respondents as well as the results of the expert workshop held in November 2004.

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SET OF PRINCIPLES FOR THE PROTECTION AND PROMOTION OF HUMAN RIGHTS THROUGH ACTION TO COMBAT IMPUNITY

Preamble

Recalling the Preamble to the Universal Declaration of Human Rights, which recognizes that disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind,

Aware that there is an ever-present risk that such acts may again occur,

Reaffirming the commitment made by Member States under Article 56 of the Charter of the United Nations to take joint and separate action, giving full importance to developing effective international cooperation for the achievement of the purposes set forth in Article 55 of the Charter concerning universal respect for, and observance of, human rights and fundamental freedoms for all,

Considering that the duty of every State under international law to respect and to secure respect for human rights requires that effective measures should be taken to combat impunity,

Aware that there can be no just and lasting reconciliation unless the need for justice is effectively satisfied,

Equally aware that forgiveness, which may be an important element of reconciliation, implies, insofar as it is a private act, that the victim or the victim's beneficiaries know the perpetrator of the violations and that the latter has acknowledged his or her deeds,

Recalling the recommendation set forth in paragraph 91 of Part II of the Vienna Declaration and Programme of Action, wherein the World Conference on Human Rights (June 1993) expressed its concern about the impunity of perpetrators of human rights violations and encouraged the efforts of the Commission on Human Rights to examine all aspects of the issue,

Convinced, therefore, that national and international measures must be taken for that purpose with a view to securing jointly, in the interests of the victims of violations, observance of the right to know and, by implication, the right to the truth, the right to justice and the right to reparation, without which there can be no effective remedy against the pernicious effects of impunity,

Pursuant to the Vienna Declaration and Programme of Action, the following principles are intended as guidelines to assist States in developing effective measures for combating impunity.

Definitions

A. Impunity

"Impunity" means the impossibility, de jure or de facto, of bringing the perpetrators of violations to account - whether in criminal, civil, administrative or disciplinary proceedings - since they are not subject to any inquiry that might lead to their being accused, arrested, tried and, if found guilty, sentenced to appropriate penalties, and to making reparations to their victims.

B. Serious crimes under international law

As used in these principles, the phrase "serious crimes under international law" encompasses grave breaches of the Geneva Conventions of 12 August 1949 and of Additional Protocol I thereto of 1977 and other violations of international humanitarian law that are crimes under international law, genocide, crimes against humanity, and other violations of internationally protected human rights that are crimes under international law and/or which international law requires States to penalize, such as torture, enforced disappearance, extrajudicial execution, and slavery.

C. Restoration of or transition to democracy and/or peace

This expression, as used in these principles, refers to situations leading, within the framework of a national movement towards democracy or peace negotiations aimed at ending an armed conflict, to an agreement, in whatever form, by which the actors or parties concerned agree to take measures against impunity and the recurrence of human rights violations.

D. Truth commissions

As used in these principles, the phrase "truth commissions" refers to official, temporary, non-judicial fact-finding bodies that investigate a pattern of abuses of human rights or humanitarian law, usually committed over a number of years.

E. Archives

As used in these principles, the word "archives" refers to collections of documents pertaining to violations of human rights and humanitarian law from sources including (a) national governmental agencies, particularly those that played significant roles in relation to human rights violations; (b) local agencies, such as police stations, that were involved in human rights violations; (c) State agencies, including the office of the prosecutor and the judiciary, that are involved in the protection of human rights; and (d) materials collected by truth commissions and other investigative bodies.

I. COMBATING IMPUNITY: GENERAL OBLIGATIONS

PRINCIPLE 1. GENERAL OBLIGATIONS OF STATES TO TAKE EFFECTIVE ACTION TO COMBAT IMPUNITY

Impunity arises from a failure by States to meet their obligations to investigate violations; to take appropriate measures in respect of the perpetrators, particularly in the area of justice, by ensuring that those suspected of criminal responsibility are prosecuted, tried and duly punished; to provide victims with effective remedies and to ensure that they receive reparation for the injuries suffered; to ensure the inalienable right to know the truth about violations; and to take other necessary steps to prevent a recurrence of violations.

II. THE RIGHT TO KNOW

A. General principles

PRINCIPLE 2. THE INALIENABLE RIGHT TO THE TRUTH

Every people has the inalienable right to know the truth about past events concerning the perpetration of heinous crimes and about the circumstances and reasons that led, through massive or systematic violations, to the perpetration of those crimes. Full and effective exercise of the right to the truth provides a vital safeguard against the recurrence of violations.

PRINCIPLE 3. THE DUTY TO PRESERVE MEMORY

A people's knowledge of the history of its oppression is part of its heritage and, as such, must be ensured by appropriate measures in fulfilment of the State's duty to preserve archives and other evidence concerning violations of human rights and humanitarian law and to facilitate knowledge of those violations. Such measures shall be aimed at preserving the collective memory from extinction and, in particular, at guarding against the development of revisionist and negationist arguments.

PRINCIPLE 4. THE VICTIMS' RIGHT TO KNOW

Irrespective of any legal proceedings, victims and their families have the imprescriptible right to know the truth about the circumstances in which violations took place and, in the event of death or disappearance, the victims' fate.

PRINCIPLE 5. GUARANTEES TO GIVE EFFECT TO THE RIGHT TO KNOW

States must take appropriate action, including measures necessary to ensure the independent and effective operation of the judiciary, to give effect to the right to know. Appropriate measures to ensure this right may include non-judicial processes that complement the role of the judiciary. Societies that have experienced heinous crimes perpetrated on a massive or systematic basis may benefit in particular from the creation of a truth commission or

other commission of inquiry to establish the facts surrounding those violations so that the truth may be ascertained and to prevent the disappearance of evidence. Regardless of whether a State establishes such a body, it must ensure the preservation of, and access to, archives concerning violations of human rights and humanitarian law.

B. Commissions of inquiry

PRINCIPLE 6. THE ESTABLISHMENT AND ROLE OF TRUTH COMMISSIONS

To the greatest extent possible, decisions to establish a truth commission, define its terms of reference and determine its composition should be based upon broad public consultations in which the views of victims and survivors especially are sought. Special efforts should be made to ensure that men and women participate in these deliberations on a basis of equality.

In recognition of the dignity of victims and their families, investigations undertaken by truth commissions should be conducted with the object in particular of securing recognition of such parts of the truth as were formerly denied.

PRINCIPLE 7. GUARANTEES OF INDEPENDENCE, IMPARTIALITY AND COMPETENCE

Commissions of inquiry, including truth commissions, must be established through procedures that ensure their independence, impartiality and competence. To this end, the terms of reference of commissions of inquiry, including commissions that are international in character, should respect the following guidelines:

(a) They shall be constituted in accordance with criteria making clear to the public the competence and impartiality of their members, including expertise within their membership in the field of human rights and, if relevant, of humanitarian law. They shall also be constituted in accordance with conditions ensuring their independence, in particular by the irremovability of their members during their terms of office except on grounds of incapacity or behaviour rendering them unfit to discharge their duties and pursuant to procedures ensuring fair, impartial and independent determinations;

(b) Their members shall enjoy whatever privileges and immunities are necessary for their protection, including in the period following their mission, especially in respect of any defamation proceedings or other civil or criminal action brought against them on the basis of facts or opinions contained in the commissions' reports;

(c) In determining membership, concerted efforts should be made to ensure adequate representation of women as well as of other appropriate groups whose members have been especially vulnerable to human rights violations.

PRINCIPLE 8. DEFINITION OF A COMMISSION'S TERMS OF REFERENCE

To avoid conflicts of jurisdiction, the commission's terms of reference must be clearly defined and must be consistent with the principle that commissions of inquiry are not intended to

act as substitutes for the civil, administrative or criminal courts. In particular, criminal courts alone have jurisdiction to establish individual criminal responsibility, with a view as appropriate to passing judgement and imposing a sentence.

In addition to the guidelines set forth in principles 12 and 13, the terms of reference of a commission of inquiry should incorporate or reflect the following stipulations:

(a) The commission's terms of reference may reaffirm its right: to seek the assistance of law enforcement authorities, if required, including for the purpose, subject to the terms of principle 10 (a), of calling for testimonies; to inspect any places concerned in its investigations; and/or to call for the delivery of relevant documents;

(b) If the commission has reason to believe that the life, health or safety of a person concerned by its inquiry is threatened or that there is a risk of losing an element of proof, it may seek court action under an emergency procedure or take other appropriate measures to end such threat or risk;

(c) Investigations undertaken by a commission of inquiry may relate to all persons alleged to have been responsible for violations of human rights and/or humanitarian law, whether they ordered them or actually committed them, acting as perpetrators or accomplices, and whether they are public officials or members of quasi-governmental or private armed groups with any kind of link to the State, or of non-governmental armed movements. Commissions of inquiry may also consider the role of other actors in facilitating violations of human rights and humanitarian law;

(d) Commissions of inquiry may have jurisdiction to consider all forms of violations of human rights and humanitarian law. Their investigations should focus as a matter of priority on violations constituting serious crimes under international law, including in particular violations of the fundamental rights of women and of other vulnerable groups;

(e) Commissions of inquiry shall endeavour to safeguard evidence for later use in the administration of justice;

(f) The terms of reference of commissions of inquiry should highlight the importance of preserving the commission's archives. At the outset of their work, commissions should clarify the conditions that will govern access to their documents, including conditions aimed at preventing disclosure of confidential information while facilitating public access to their archives.

PRINCIPLE 9. GUARANTEES FOR PERSONS IMPLICATED

Before a commission identifies perpetrators in its report, the individuals concerned shall be entitled to the following guarantees:

(a) The commission must try to corroborate information implicating individuals before they are named publicly;

(b) The individuals implicated shall be afforded an opportunity to provide a statement setting forth their version of the facts either at a hearing convened by the commission while conducting its investigation or through submission of a document equivalent to a right of reply for inclusion in the commission's file.

PRINCIPLE 10. GUARANTEES FOR VICTIMS AND WITNESSES TESTIFYING ON THEIR BEHALF

Effective measures shall be taken to ensure the security, physical and psychological well-being, and, where requested, the privacy of victims and witnesses who provide information to the commission.

(a) Victims and witnesses testifying on their behalf may be called upon to testify before the commission only on a strictly voluntary basis;

(b) Social workers and/or mental health-care practitioners should be authorized to assist victims, preferably in their own language, both during and after their testimony, especially in cases of sexual assault;

(c) All expenses incurred by those giving testimony shall be borne by the State;

(d) Information that might identify a witness who provided testimony pursuant to a promise of confidentially must be protected from disclosure. Victims providing testimony and other witnesses should in any event be informed of rules that will govern disclosure of information provided by them to the commission. Requests to provide information to the commission anonymously should be given serious consideration, especially in cases of sexual assault, and the commission should establish procedures to guarantee anonymity in appropriate cases, while allowing corroboration of the information provided, as necessary.

PRINCIPLE 11. ADEQUATE RESOURCES FOR COMMISSIONS

The commission shall be provided with:

(a) Transparent funding to ensure that its independence is never in doubt;

(b) Sufficient material and human resources to ensure that its credibility is never in doubt.

PRINCIPLE 12. ADVISORY FUNCTIONS OF THE COMMISSIONS

The commission's terms of reference should include provisions calling for it to include in its final report recommendations concerning legislative and other action to combat impunity. The terms of reference should ensure that the commission incorporates women's experiences in its work, including its recommendations. When establishing a commission of inquiry, the Government should undertake to give due consideration to the commission's recommendations.

PRINCIPLE 13. PUBLICIZING THE COMMISSION'S REPORTS

For security reasons or to avoid pressure on witnesses and commission members, the commission's terms of reference may stipulate that relevant portions of its inquiry shall be kept confidential. The commission's final report, on the other hand, shall be made public in full and shall be disseminated as widely as possible.

C. Preservation of and access to archives bearing witness to violations

PRINCIPLE 14. MEASURES FOR THE PRESERVATION OF ARCHIVES

The right to know implies that archives must be preserved. Technical measures and penalties should be applied to prevent any removal, destruction, concealment or falsification of archives, especially for the purpose of ensuring the impunity of perpetrators of violations of human rights and/or humanitarian law.

PRINCIPLE 15. MEASURES FOR FACILITATING ACCESS TO ARCHIVES

Access to archives shall be facilitated in order to enable victims and their relatives to claim their rights.

Access shall be facilitated, as necessary, for persons implicated, who request it for their defence.

Access to archives should also be facilitated in the interest of historical research, subject to reasonable restrictions aimed at safeguarding the privacy and security of victims and other individuals. Formal requirements governing access may not be used for purposes of censorship.

PRINCIPLE 16. COOPERATION BETWEEN ARCHIVE DEPARTMENTS AND THE COURTS AND NON-JUDICIAL COMMISSIONS OF INQUIRY

Courts and non-judicial commissions of inquiry, as well as investigators reporting to them, must have access to relevant archives. This principle must be implemented in a manner that respects applicable privacy concerns, including in particular assurances of confidentiality provided to victims and other witnesses as a precondition of their testimony. Access may not be denied on grounds of national security unless, in exceptional circumstances, the restriction has been prescribed by law; the Government has demonstrated that the restriction is necessary in a democratic society to protect a legitimate national security interest; and the denial is subject to independent judicial review.

PRINCIPLE 17. SPECIFIC MEASURES RELATING TO ARCHIVES CONTAINING NAMES

(a) For the purposes of this principle, archives containing names shall be understood to be those archives containing information that makes it possible, directly or indirectly, to identify the individuals to whom they relate;

(b) All persons shall be entitled to know whether their name appears in State archives and, if it does, by virtue of their right of access, to challenge the validity of the information concerning them by exercising a right of reply. The challenged document should include a cross-reference to the document challenging its validity and both must be made available together whenever the former is requested. Access to the files of commissions of inquiry must be balanced against the legitimate expectations of confidentiality of victims and other witnesses testifying on their behalf in accordance with principles 8 (f) and 10 (d).

PRINCIPLE 18. SPECIFIC MEASURES RELATED TO THE RESTORATION OF OR TRANSITION TO DEMOCRACY AND/OR PEACE

(a) Measures should be taken to place each archive centre under the responsibility of a specifically designated office;

(b) When inventorying and assessing the reliability of stored archives, special attention should be given to archives relating to places of detention and other sites of serious violations of human rights and/or humanitarian law such as torture, in particular when the existence of such places was not officially recognized;

(c) Third countries shall be expected to cooperate with a view to communicating or restituting archives for the purpose of establishing the truth.

III. THE RIGHT TO JUSTICE

A. General principles

PRINCIPLE 19. DUTIES OF STATES WITH REGARD TO THE ADMINISTRATION OF JUSTICE

States shall undertake prompt, thorough, independent and impartial investigations of violations of human rights and international humanitarian law and take appropriate measures in respect of the perpetrators, particularly in the area of criminal justice, by ensuring that those responsible for serious crimes under international law are prosecuted, tried and duly punished.

Although the decision to prosecute lies primarily within the competence of the State, victims, their families and heirs should be able to institute proceedings, on either an individual or a collective basis, particularly as *parties civiles* or as persons conducting private prosecutions in States whose law of criminal procedure recognizes these procedures. States should guarantee broad legal standing in the judicial process to any wronged party and to any person or non-governmental organization having a legitimate interest therein.

B. Distribution of jurisdiction between national, foreign, international and internationalized courts

PRINCIPLE 20. JURISDICTION OF INTERNATIONAL AND INTERNATIONALIZED CRIMINAL TRIBUNALS

It remains the rule that States have primary responsibility to exercise jurisdiction over serious crimes under international law. In accordance with the terms of their statutes, international and internationalized criminal tribunals may exercise concurrent jurisdiction when national courts cannot offer satisfactory guarantees of independence and impartiality or are materially unable or unwilling to conduct effective investigations or prosecutions.

States must ensure that they fully satisfy their legal obligations in respect of international and internationalized criminal tribunals, including where necessary through the enactment of domestic legislation that enables States to fulfil obligations that arise through their adherence to the Rome Statute of the International Criminal Court or under other binding instruments, and through implementation of applicable obligations to apprehend and surrender suspects and to cooperate in respect of evidence.

PRINCIPLE 21. MEASURES FOR STRENGTHENING THE EFFECTIVENESS OF INTERNATIONAL LEGAL PRINCIPLES CONCERNING UNIVERSAL AND INTERNATIONAL JURISDICTION

States should undertake effective measures, including the adoption or amendment of internal legislation, that are necessary to enable their courts to exercise universal jurisdiction over serious crimes under international law in accordance with applicable principles of customary and treaty law.

States must ensure that they fully implement any legal obligations they have assumed to institute criminal proceedings against persons with respect to whom there is credible evidence of individual responsibility for serious crimes under international law if they do not extradite the suspects or transfer them for prosecution before an international or internationalized tribunal.

C. Restrictions on rules of law justified by action to combat impunity

PRINCIPLE 22. NATURE OF RESTRICTIVE MEASURES

States should adopt and enforce safeguards against any abuse of rules such as those pertaining to prescription, amnesty, right to asylum, refusal to extradite, *non bis in idem*, due obedience, official immunities, repentance, the jurisdiction of military courts and the irremovability of judges that fosters or contributes to impunity.

PRINCIPLE 23. RESTRICTIONS ON PRESCRIPTION

Prescription - of prosecution or penalty - in criminal cases shall not run for such period as no effective remedy is available.

Prescription shall not apply to crimes under international law that are by their nature imprescriptible.

When it does apply, prescription shall not be effective against civil or administrative actions brought by victims seeking reparation for their injuries.

PRINCIPLE 24. RESTRICTIONS AND OTHER MEASURES RELATING TO AMNESTY

Even when intended to establish conditions conducive to a peace agreement or to foster national reconciliation, amnesty and other measures of clemency shall be kept within the following bounds:

(a) The perpetrators of serious crimes under international law may not benefit from such measures until such time as the State has met the obligations to which principle 19 refers or the perpetrators have been prosecuted before a court with jurisdiction - whether international, internationalized or national - outside the State in question;

(b) Amnesties and other measures of clemency shall be without effect with respect to the victims' right to reparation, to which principles 31 through 34 refer, and shall not prejudice the right to know;

(c) Insofar as it may be interpreted as an admission of guilt, amnesty cannot be imposed on individuals prosecuted or sentenced for acts connected with the peaceful exercise of their right to freedom of opinion and expression. When they have merely exercised this legitimate right, as guaranteed by articles 18 to 20 of the Universal Declaration of Human Rights and 18, 19, 21 and 22 of the International Covenant on Civil and Political Rights, the law shall consider any judicial or other decision concerning them to be null and void; their detention shall be ended unconditionally and without delay;

(d) Any individual convicted of offences other than those to which paragraph (c) of this principle refers who comes within the scope of an amnesty is entitled to refuse it and request a retrial, if he or she has been tried without benefit of the right to a fair hearing guaranteed by articles 10 and 11 of the Universal Declaration of Human Rights and articles 9, 14 and 15 of the International Covenant on Civil and Political Rights, or if he or she was convicted on the basis of a statement established to have been made as a result of inhuman or degrading interrogation, especially under torture.

PRINCIPLE 25. RESTRICTIONS ON THE RIGHT OF ASYLUM

Under article 1, paragraph 2, of the Declaration on Territorial Asylum, adopted by the General Assembly on 14 December 1967, and article 1 F of the Convention relating to the Status of Refugees of 28 July 1951, States may not extend such protective status, including diplomatic asylum, to persons with respect to whom there are serious reasons to believe that they have committed a serious crime under international law.

PRINCIPLE 26. RESTRICTIONS ON EXTRADITION/*NON BIS IN IDEM*

(a) Persons who have committed serious crimes under international law may not, in order to avoid extradition, avail themselves of the favourable provisions generally relating to political offences or of the principle of non-extradition of nationals. Extradition should always be denied, however, especially by abolitionist countries, if the individual concerned risks the death penalty in the requesting country. Extradition should also be denied where there are substantial grounds for believing that the suspect would be in danger of being subjected to gross violations of human rights such as torture; enforced disappearance; or extra-legal, arbitrary or summary execution. If extradition is denied on these grounds, the requested State shall submit the case to its competent authorities for the purpose of prosecution;

(b) The fact that an individual has previously been tried in connection with a serious crime under international law shall not prevent his or her prosecution with respect to the same conduct if the purpose of the previous proceedings was to shield the person concerned from criminal responsibility, or if those proceedings otherwise were not conducted independently or impartially in accordance with the norms of due process recognized by international law and were conducted in a manner that, in the circumstances, was inconsistent with an intent to bring the person concerned to justice.

PRINCIPLE 27. RESTRICTIONS ON JUSTIFICATIONS RELATED TO DUE OBEDIENCE, SUPERIOR RESPONSIBILITY, AND OFFICIAL STATUS

(a) The fact that the perpetrator of violations acted on the orders of his or her Government or of a superior does not exempt him or her from responsibility, in particular criminal, but may be regarded as grounds for reducing the sentence, in conformity with principles of justice;

(b) The fact that violations have been committed by a subordinate does not exempt that subordinate's superiors from responsibility, in particular criminal, if they knew or had at the time reason to know that the subordinate was committing or about to commit such a crime and they did not take all the necessary measures within their power to prevent or punish the crime;

(c) The official status of the perpetrator of a crime under international law - even if acting as head of State or Government - does not exempt him or her from criminal or other responsibility and is not grounds for a reduction of sentence.

PRINCIPLE 28. RESTRICTIONS ON THE EFFECTS OF LEGISLATION ON DISCLOSURE OR REPENTANCE

The fact that a perpetrator discloses the violations that he, she or others have committed in order to benefit from the favourable provisions of legislation on disclosure or repentance cannot exempt him or her from criminal or other responsibility. The disclosure may only provide grounds for a reduction of sentence in order to encourage revelation of the truth.

When disclosures may subject a perpetrator to persecution, principle 25 notwithstanding, the person making the disclosure may be granted asylum - not refugee status - in order to facilitate revelation of the truth.

PRINCIPLE 29. RESTRICTIONS ON THE JURISDICTION OF MILITARY COURTS

The jurisdiction of military tribunals must be restricted solely to specifically military offences committed by military personnel, to the exclusion of human rights violations, which shall come under the jurisdiction of the ordinary domestic courts or, where appropriate, in the case of serious crimes under international law, of an international or internationalized criminal court.

PRINCIPLE 30. RESTRICTIONS ON THE PRINCIPLE OF THE IRREMOVABILITY OF JUDGES

The principle of irremovability, as the basic guarantee of the independence of judges, must be observed in respect of judges who have been appointed in conformity with the requirements of the rule of law. Conversely, judges unlawfully appointed or who derive their judicial power from an act of allegiance may be relieved of their functions by law in accordance with the principle of parallelism. They must be provided an opportunity to challenge their dismissal in proceedings that meet the criteria of independence and impartiality with a view toward seeking reinstatement.

IV. THE RIGHT TO REPARATION/GUARANTEES OF NON-RECURRENCE

A. The right to reparation

PRINCIPLE 31. RIGHTS AND DUTIES ARISING OUT OF THE OBLIGATION TO MAKE REPARATION

Any human rights violation gives rise to a right to reparation on the part of the victim or his or her beneficiaries, implying a duty on the part of the State to make reparation and the possibility for the victim to seek redress from the perpetrator.

PRINCIPLE 32. REPARATION PROCEDURES

All victims shall have access to a readily available, prompt and effective remedy in the form of criminal, civil, administrative or disciplinary proceedings subject to the restrictions on prescription set forth in principle 23. In exercising this right, they shall be afforded protection against intimidation and reprisals.

Reparations may also be provided through programmes, based upon legislative or administrative measures, funded by national or international sources, addressed to individuals and to communities. Victims and other sectors of civil society should play a meaningful role in the design and implementation of such programmes. Concerted efforts should be made to ensure that women and minority groups participate in public consultations aimed at developing, implementing, and assessing reparations programmes.

Exercise of the right to reparation includes access to applicable international and regional procedures.

PRINCIPLE 33. PUBLICIZING REPARATION PROCEDURES

Ad hoc procedures enabling victims to exercise their right to reparation should be given the widest possible publicity by private as well as public communication media. Such dissemination should take place both within and outside the country, including through consular services, particularly in countries to which large numbers of victims have been forced into exile.

PRINCIPLE 34. SCOPE OF THE RIGHT TO REPARATION

The right to reparation shall cover all injuries suffered by victims; it shall include measures of restitution, compensation, rehabilitation, and satisfaction as provided by international law.

In the case of forced disappearance, the family of the direct victim has an imprescriptible right to be informed of the fate and/or whereabouts of the disappeared person and, in the event of decease, that person's body must be returned to the family as soon as it has been identified, regardless of whether the perpetrators have been identified or prosecuted.

B. Guarantees of non-recurrence of violations

PRINCIPLE 35. GENERAL PRINCIPLES

States shall ensure that victims do not again have to endure violations of their rights. To this end, States must undertake institutional reforms and other measures necessary to ensure respect for the rule of law, foster and sustain a culture of respect for human rights, and restore or establish public trust in government institutions. Adequate representation of women and minority groups in public institutions is essential to the achievement of these aims. Institutional reforms aimed at preventing a recurrence of violations should be developed through a process of broad public consultations, including the participation of victims and other sectors of civil society.

Such reforms should advance the following objectives:

(a) Consistent adherence by public institutions to the rule of law;

(b) The repeal of laws that contribute to or authorize violations of human rights and/or humanitarian law and enactment of legislative and other measures necessary to ensure respect for human rights and humanitarian law, including measures that safeguard democratic institutions and processes;

(c) Civilian control of military and security forces and intelligence services and disbandment of parastatal armed forces;

(d) Reintegration of children involved in armed conflict into society.

PRINCIPLE 36. REFORM OF STATE INSTITUTIONS

States must take all necessary measures, including legislative and administrative reforms, to ensure that public institutions are organized in a manner that ensures respect for the rule of law and protection of human rights. At a minimum, States should undertake the following measures:

(a) Public officials and employees who are personally responsible for gross violations of human rights, in particular those involved in military, security, police, intelligence and judicial sectors, shall not continue to serve in State institutions. Their removal shall comply with the requirements of due process of law and the principle of non-discrimination. Persons formally charged with individual responsibility for serious crimes under international law shall be suspended from official duties during the criminal or disciplinary proceedings;

(b) With respect to the judiciary, States must undertake all other measures necessary to assure the independent, impartial and effective operation of courts in accordance with international standards of due process. Habeas corpus, by whatever name it may be known, must be considered a non-derogable right;

(c) Civilian control of military and security forces as well as of intelligence agencies must be ensured and, where necessary, established or restored. To this end, States should establish effective institutions of civilian oversight over military and security forces and intelligence agencies, including legislative oversight bodies;

(d) Civil complaint procedures should be established and their effective operation assured;

(e) Public officials and employees, in particular those involved in military, security, police, intelligence and judicial sectors, should receive comprehensive and ongoing training in human rights and, where applicable, humanitarian law standards and in implementation of those standards.

PRINCIPLE 37. DISBANDMENT OF PARASTATAL ARMED FORCES/DEMOBILIZATION AND SOCIAL REINTEGRATION OF CHILDREN

Parastatal or unofficial armed groups shall be demobilized and disbanded. Their position in or links with State institutions, including in particular the army, police, intelligence and security forces, should be thoroughly investigated and the information thus acquired made public. States should draw up a reconversion plan to ensure the social reintegration of the members of such groups.

Measures should be taken to secure the cooperation of third countries that might have contributed to the creation and development of such groups, particularly through financial or logistical support.

Children who have been recruited or used in hostilities shall be demobilized or otherwise released from service. States shall, when necessary, accord these children all appropriate assistance for their physical and psychological recovery and their social integration.

PRINCIPLE 38. REFORM OF LAWS AND INSTITUTIONS CONTRIBUTING TO IMPUNITY

Legislation and administrative regulations and institutions that contribute to or legitimize human rights violations must be repealed or abolished. In particular, emergency legislation and courts of any kind must be repealed or abolished insofar as they infringe the fundamental rights and freedoms guaranteed in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. Legislative measures necessary to ensure protection of human rights and to safeguard democratic institutions and processes must be enacted.

As a basis for such reforms, during periods of restoration of or transition to democracy and/or peace States should undertake a comprehensive review of legislation and administrative regulations.

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30 July 2021

By email

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Our ref 10162979

Dear Deputy Funchion

MOTHER & BABY HOMES COMMISSION REPORT

As we believe you will be aware, this firm is acting on behalf of Adoption Rights Alliance ("ARA") and JFM Research ("JFMR") in connection with The Clann Project which was set up to assist anyone who wished to submit their evidence, in the form of witness statements, to the Mother & Baby Homes Commission of Investigation ("the Commission").

In doing so, the Clann Project spoke to 164 witnesses and submitted 82 statements to the Commission of which 34 were supported by the sworn affidavit confirming their truth required by the Commission if they were to be taken into account as evidence. Based on these statements and the work of a large number of academics and lawyers, including more than 20 members of the Bar of Ireland, the Clann Project made a substantial submission to the Commission setting out its own findings as regards the treatment of mothers, children and adopted people in the institutions under investigation and the adoption system as a whole and also made a number of recommendations that it believed the Commission should make to the Irish Government in its report.

We understand that your Committee is interested in meeting with various groups to discuss the suggestion that the Commission's Report be repudiated based on its content and findings together with concerns expressed about the Commission's methodology as described in the Report but also in subsequent comments by one of the Commissioners at an online seminar hosted by Oxford University.

The Clann Project co-directors Claire McGettrick and Dr Maeve O'Rourke attended before you on 29 June 2021 in relation to the Birth Information and Tracing General Scheme of Bill and are also available to appear in relation to the Commission Report. We will leave them to make their detailed position clear if invited to appear. In the meantime, however, they have asked us to provide you with any comments that we have about the Commission's approach and methodology arising out of our own interaction with the Commission over the course of its investigation.

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THE ESTABLISHMENT OF THE COMMISSION OF INVESTIGATION

ARA and JFMR were pleased when in 2014 the Government stated its intention to establish an investigation into Ireland's Mother & Baby Homes and related issues. Both organisations had long felt that there needed to be a comprehensive investigation into adoption, forced family separation and connected institutional abuses.

The Clann Project was established to help anyone who wanted to give evidence to the Commission by providing such assistance as they required. This started by providing practical information about how those who wanted to interact with the Commission could do so and moved on to the preparation of witness statements. As well as assisting those individuals who approached us, we also believed that the Clann Project would assist the Commission as it would receive professionally drafted statements that cross referred to relevant documentation. Indeed, at one point *Ref: MBHCOI letter to HL dated 21 July 2016* the Commission said that it was pleased we were providing this Pro Bono service to affected individuals.

Against this backdrop, it is fair to say that we were disappointed by the reaction we got from the Commission in response to our correspondence with them (which was principally directed to obtaining a greater understanding of the Commission's procedures and the extent to which Clann Project witnesses could give evidence and make submissions to the Commission in public hearings) which, at times, seemed to be unnecessarily defensive and unduly focussed on maintaining the secrecy of the investigation.

CORRESPONDENCE WITH, AND SUBMISSIONS MADE TO, THE COMMISSION

Procedure for giving evidence and responding to the evidence of others

At the very outset, we wrote to the Commission with a number of questions relating to the procedures by which individuals could give evidence to the Commission and how they could be involved in the cross examination of witnesses whose evidence affected them (*Ref: HL letter to MBHCOI dated 12 November 2015*).

The Commission's response (*Ref MBHCOI letter to HL dated 14 December 2015*) contained the following statements:

- *The Commission will disclose the evidence of a witness and ask that witness to attend in person… for the purposes of cross examination by the representative of an affected party in circumstances where the Commission considers that fair procedures require such an attendance. The decision will obviously be to a significant extent based on the nature of the evidence given but will also depend on the other evidence available to the Commission and the degree to which a person is considered to be affected by that evidence.*

- *Unless the Commission directs that evidence will be heard in public…[it] is not anticipated at this stage that other interested parties or their legal representatives will be invited to attend the private hearings of the Commission.*

- *The conduct of the investigation is a matter for the Commission and should it at any stage require commentary on relevant evidence from survivors, arrangements will be made in this regard.*

Making procedural submissions in public

On 11 February 2016, a request was made to the Commission that when the Clann Project made its procedural submissions to the Commission on 9 May 2016, that hearing be heard in public [*Ref: letter from CM to MBHCOI dated 11 February 2016*. On 19 February 2016, the Commission asked why a public hearing would be appropriate. Reasons were subsequently provided [*Ref: letter from ARA/JFMR to MBHCOI dated 3 May 2016*] and again and in further detail at the hearing on 9 May

2016. Those reasons included the fact that the submissions were on the scope of the investigation, no personal evidence was being given, that the Clann Project was acting in a quasi-representative capacity and it was in the interest of fairness and transparency that the hearing be in public. The request was declined so we asked for the reasons why [*Ref: letter from HL to MBHCOI dated 27 May 2016*]. The Commission responded by referring us to S11(1) of the Commission of Investigations Act 2004 and by saying that it "*was not satisfied that it was desirable in the interests of both the investigation and fair procedures to hear all or part of your clients' evidence in public*" [*Ref: letter from MBHCOI to HL dated 1 June 2016*]. We responded [*Ref: letter from HL to MBHCOI dated 1 July 2016*] pointing out that S11(1)(a) allows the Commission to hold a hearing in public if it is requested by a witness and, in these circumstances, it was incumbent on the Commission to give reasons for its decision to refuse such a request.

Giving evidence to the Investigation Committee

On 9 August 2016, we wrote to the Commission [*Ref: letter from HL to MBHCOI dated 9 August 2016*] noting that the Commission website gave the impression that the only way individuals could give evidence was via the Confidential Committee and that there was no indication of how witnesses could give evidence to the Commission itself. The Commission responded [*Ref: letter from MBHCOI to HL dated 23 August 2016*] stating that the Investigation Committee will invite witnesses to give evidence which "*will add to its body of knowledge of the issues under investigation. Not everyone who expresses an interest in giving evidence to the Investigation Committee will be invited for hearing*".

On 23 February 2017, we wrote to the Commission [*Ref: letter from HL to MBHCOI dated 23 February 2017*] passing on a request from Philomena Lee that she be able to give her evidence to the Investigation Committee and that her hearing be held in public. The Commission said that it would consider the request [*Ref: letter from MBHCOI to HL dated 21 March 2017*]. We repeated the request on 1 March 2017 [*Ref: letter from HL to MBHCOI dated 1 March 2017*].

REACTION OF SURVIVORS, ADOPTED PEOPLE AND MOTHERS TO THE COMMISSION OF INVESTIGATION'S FINAL REPORT

As your Committee will be well aware, the Commission's Final Report has been criticised by survivors, adopted people, mothers and other relatives.

The criticisms range from inaccuracies in the reporting of individual cases including in the main report of the Commission, to the making of various findings—for example that there is very little evidence that children were forcibly taken from their mothers, that there is no evidence that women were forced to enter mother and baby homes by the Church or State authorities, that women were not incarcerated in the institutions, that the women's unpaid labour was generally work which they would have had to do if they were living at home, and that non-consensual vaccine trials disclosed no evidence of injury—and the extent to which the evidence of witnesses given to the Confidential Committee was considered by the Commission and included in its Report.

STATEMENTS BY THE COMMISSIONERS

The criticism as to the extent to which the evidence of survivors, adopted people and mothers was considered by the Commission was fuelled recently by the statements made by Professor Daly at an Oxford University seminar on 2 June 2021 in relation to the testimony reflected in the Confidential Committee Report [*Ref: http://clannproject.org/commission-report/oxfordtranscript/*]. During that seminar, Professor Daly said:

> *"Anything in the main report had to meet robust legal standards of evidence".*
>
> *"If we wrote something that was adverse, critical about an individual or an entity, an institution, we had to write a draft report where we made these critical observations and*

supply them with the accompanying documentation…. And they had a chance to read that and they had a chance to come back…. They came back with a vengeance."

"I have spoken to my colleagues about how we could have integrated the Confidential inquiry into the Report? Well, first of all, it would have taken us… it would have taken a lot of time, additional time…".

"I think basically we've done a job and I think let it stand and nobody ever suggested this was going to be the last word on it. We never knew it could be or should be the last word and my view is, by all means, let others go and work with this topic and with taking statements from people, particularly people who spoke to the Confidential inquiry, from anyone who has got evidence. So my view is we've done a job and basically, you know, let others go and take it further."

Following a request that the Commissioners appear before your Committee to answer questions about their Report and its methodology, Judge Murphy wrote a letter dated 11 June 2021 [*Ref: Letter from Judge Murphy to Joint Committee on Children, Disability, Equality, Integration and Youth dated 11 June 2021]* In that letter, Judge Murphy said:

"The Commission… was required to work within the 2004 Act and its Terms of Reference."

"During the Investigation, the Commission investigated critical witnesses on oath, testing the evidence where appropriate and always on the express understanding that those affected by it would be given the opportunity to cross examine."

"It must be noted that the number of mothers who spoke to the Confidential Committee is a tiny proportion of the total number of mothers in the institutions under investigation. 304 mothers gave testimony to the Confidential Committee… in the period 1960-1998 inclusive, there were 24,207 mothers in the institutions investigated – the experiences of 1 per cent of those are reflected in the Confidential Committee Report."

"In the absence of evidence that would withstand scrutiny and cross examination, the Commission was unable to reach factual conclusions that many people wished that it had reached".

REFLECTIONS ON THE COMMISSION'S METHODOLOGY AND APPROACH

We can readily understand that the Irish government wished to avoid the time and expense of undertaking a public inquiry with all the expense of large legal teams and hence set up the Commission in the way that it did. That said, the approach taken by the Commission, which was to hold every hearing in private and apparently feel unable to make even general factual findings based on the testimony given to the Confidential Committee has left many of those most acutely affected lacking confidence in the Report.

This lack of confidence is, at least in part, based on the following elements of the Commission's approach to its investigation:

- Article 6 of the Commission's Terms of Reference contained the express option for the Commission to revert to the relevant Minister to request a variation. Indeed, in July 2016 Minister Zappone expressly confirmed that she was willing to entertain any such request [referred to in the Commission's second interim report at https://assets.gov.ie/26424/d934467e5b0e46a5b4217e4a997afd48.pdf]. Thus, had the Commission felt as constrained by its Terms of reference as is now suggested it had the option to seek a variation.

- The Commission of Investigation Act 2004 does not require that every hearing be held in private. S11(3) of the Act expressly allows evidence to be heard in public at the request of

a witness. The Commission's refusal to hold any hearings in public, or give any reasons for its position, gives an unnecessary impression of secrecy.

- Neither the Terms of Reference nor the Commission of Investigation Act 2004 require that anything in the main report has to meet robust legal standards of evidence. There was nothing to stop the Commission drawing conclusions from a preponderance of evidence available to it, including evidence given to the Confidential Committee (see Article 4 of its Terms of Reference), while stating any caveats as to the nature of that evidence.

- Judge Murphy has stated that the testimony of the 550 witnesses who gave evidence to the Confidential Committee is only a tiny fraction of those who passed through the Homes. This, of course, is true but, in that case, why were witnesses encouraged to attend the Confidential Committee by virtue of the Commission not including on its website details of the other route to give formal evidence? Why did the Investigation Committee only call 64 of those witnesses to give evidence? Why did the Commission not call any of the Clann Project witnesses (even those who had submitted sworn affidavits) to give evidence? Why did the Commission not even reply to the request of Philomena Lee that she be able to give her evidence to the Commission?

- Notwithstanding the various statements made about, and statutory provisions (not least Section 12 of the Commissions of Investigations Act 2004 and Articles 2 and 3 of the European Convention of Human Rights), relating to individuals being affected by other persons' evidence, the Clann Project is unaware of any affected person being shown any evidence from any of the relevant institutions or being called for cross examination or being invited to cross examine another witness.

- It is clear from the comments of Professor Daly that various institutions have been given the opportunity to comment on draft findings and to make submissions on them. The Commission Report (Chapter 18) also indicates that individual nuns have had the opportunity to comment on draft findings. The Clann Project is unaware of any affected person being offered the same opportunity.

All of the above have contributed to the feeling amongst many adopted people, survivors and mothers that the Commission's Report has been prepared about them but with insufficient involvement of them.

HOW SHOULD THE REPORT BE TREATED?

We do not for one second criticise the integrity or hard work of the Commissioners. Indeed, much excellent work has been done to accumulate and pull together all the various sources of oral and written evidence.

Unfortunately, the manner in which the Commission has operated has resulted in conclusions being drawn that simply do not reflect the actual experiences of the very people most affected by the Commission's report. As a result, it would be disappointing if this report were accepted by the Irish Government as the definitive word on the operation of the Mother & Baby Homes. We would refer to the statement of Professor Daly that the Report should not be regarded as the last word on this subject and nor was it intended to be.

We note the suggestion by ARA and JFMR that the Government should affix to the Report's cover a notice to the effect that the Government has concerns about the Commission's methodology and as a result has not accepted the Commission's findings in full. Given our own misgivings about the Commission's procedures, as discussed in this letter, we see this proposal as a sensible one. In these circumstances, your Committee might therefore consider recommending to the Government the attachment of such a note to the Report.

Yours sincerely

Yasmin Waljee

Pp Yasmin Waljee OBE

Faye Jarvis
Partner

CC All members of the Committee on Children, Disability, Equality, Integration and Youth