An Garda Síochána Homicide Review

Assessment of Implementation of Recommendations

PCSA

Údarás Póilíneachta & Sábháilteachta Pobail

Policing & Community Safety Authority

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Executive Summary

The Policing and Community Safety Authority was established on 2 April 2025 as an independent, statutory agency responsible for the oversight of An Garda Síochána. Its core objective is to oversee and assess the performance of An Garda Síochána in providing policing services to communities across Ireland and its work with partner organisations to ensure the safety of those communities. It is a successor organisation to the Policing Authority and Garda Síochána Inspectorate.

The Garda Síochána Inspectorate report on Crime Investigation published in 2014 and the Commission on the Future of Policing in Ireland both recommended an urgent and thorough overhaul of the crime investigation function of An Garda Síochána. This report deals specifically with one aspect of the crime investigation function – the investigation of suspicious deaths and homicides and more specifically with the degree to which the recommendations of the review of homicide carried out by An Garda Síochána have been implemented.

The Homicide Review was carried out by An Garda Síochána at the request of the Policing Authority during 2018 and 2019. It arose from oversight into a number of issues that arose concerning the classification of sudden deaths and homicides in 2017. The Policing Authority sought assurance from An Garda Síochána that the classification and data quality issues identified and reported to the Policing Authority relating to a number of deaths, had not impacted on the quality of the investigation of these deaths.

The review was performed by a dedicated team, the Homicide Investigation Review Team, established specifically for this purpose. The review team identified a range of data quality and investigative issues across 41 cases it examined. It is important to note that the review found that none of the issues identified, had impacted on the outcomes of the investigations. Six reports were presented to the Policing Authority during the period of review and were discussed at public and private meetings with the then Garda Commissioner.

The sixth (final report) identified twenty-one recommendations which in the view of the HIRT required implementation in order to ensure no recurrence of the issues identified.

The Policing Authority's focus then shifted to oversight of the implementation of the recommendations by An Garda Síochána. In 2025, the Policing and Community Safety Authority included the assessment of the progress made in the implementation of the recommendations as a specific piece of work in its business plan. This work commenced in late 2025 and included significant engagement with key stakeholders both inside and outside of An Garda Síochána who are involved in the classification and investigation of suspicious deaths and homicides. This report is a presentation of an assessment based on the outcomes of this work.

This assessment has found clear improvements evident in relevant policy, training and practice in the area of the investigation and classification of homicides and suspicious deaths. Data quality has improved and there are clear means by which each case or investigation is managed and supervised. This is particularly evident in Divisions in which the Investigative Management System has been rolled out. These improvements have been highlighted by key stakeholders both inside and outside of An Garda Síochána including the Director of Public Prosecutions on the quality of files received on the investigation of homicides.

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The decision as to whether a death is suspicious is a critical juncture that determines the direction of policing focus and the consequent resourcing of that focus. Once a death is regarded as suspicious, the subsequent investigation is provided with significant resources with supervision and governance structures that guide its progression, and is undertaken by investigators trained to an identified standard.

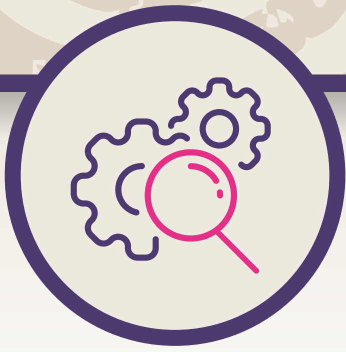
The numbers of cases being referred to the Office of the State Pathologist has also increased significantly since the Homicide Review, reflecting what was described as a preference for a 'belt and braces' approach to making the important determination as to the nature of a death.

Fifteen of the twenty-one recommendations have been assessed as implemented while six recommendations have yet to be implemented fully. The non-implemented recommendations relate to significant guiding policy on the categories of death, how non-crime deaths are to be recorded and governed, arrangements for data exchange with the courts system and the recording and storage of evidence in Garda Divisions.

The policy issues can be resolved by An Garda Síochána in the short term and the Authority understands that the required policy has been drafted but awaits finalisation. It will be clearer once this policy is finalised the degree to which it addresses the recommendations made by the Homicide Review.

The outstanding recommendations regarding the sharing of information with the courts system and the progression of suitable Property Exhibit Management System (PEMS) facilities are very important but are both contingent on the work of bodies and agencies external to An Garda Síochána.

While thematic areas identified to the PCSA by victims regarding the investigation of the death of a loved one informed this report, it is important to note that this report does not comment on or assess any specific, individual investigations or cases.



A. Background and Context

1 Homicide Review and its Oversight by the Policing Authority

The 'Homicide Review' was undertaken over a two-year period by a multi-disciplinary team within An Garda Síochána, the Homicide Investigation Review Team (HIRT).

The context for the establishment of the HIRT and its work was oversight activities conducted by the Policing Authority into a number of issues that arose concerning the classification of sudden deaths and homicides in 2017. These issues first came to light during work initiated by the Garda National Protective Services Bureau (GNPSB). This work saw the Garda Statistical Analysis Service (GSAS) conduct analysis in relation to homicide incidents with a domestic abuse motive. The methodology used involved comparing records on the PULSE system with the records held in the Office of the State Pathologist (OSP) in relation to each death. The issues were initially presented by An Garda Síochána as being data quality issues. Public assurance as to the quality and standard of investigations into deaths was considered significant by the Policing Authority in terms of public confidence.

The Policing Authority sought assurance from the Garda Commissioner that any misclassification of a death on PULSE had not impacted on the quality of the investigations carried out into that death. It also sought assurance that each investigation was of the standard required by Article 2 of the European Convention on Human Rights (ECHR). Consequently, the Policing Authority requested An Garda Síochána undertake a detailed review - utilising independent peer review - focusing on the quality of investigations in 41 specific cases.

The HIRT was led by a Chief Superintendent and drew its membership from experienced Senior Investigating Officers (SIOs) at a variety of ranks. Members of the HIRT examined cases in which they had no previous involvement. It also included senior personnel from the Garda Síochána Analysis Service (GSAS) and gardaí from Roads Policing. The team was based in Crumlin Garda Station and its terms of reference is provided in Appendix 1.

During the two years of the Homicide Review, independent peer review of the quality of the investigations was carried out in respect of each of the 41 case files. HIRT members travelled around the country and conducted interviews with the original Senior Investigating Officer and the Investigating member in each case. The HIRT produced six reports for the Policing Authority between the period June 2018 to December 2019, each dealing with a number of the 41 cases. The HIRT's work uncovered disparities regarding classification and data quality in respect of 41 specific incidents which occurred between 2013 and 2015. Of note, at the time of the publication of the final report, HIRT had completed its review of 40 files with one unable to be completed at the time of publication due to its nature as a live investigation.

The HIRT concluded that 28 of the 41 investigations had at least one investigative issue identified, ranging from minor issues to others which were a greater cause for concern. Arising from the Homicide Review, 12 deaths from the 41 cases were reclassified on PULSE. Of note, the HIRT concluded that the issues identified did not impact on the outcome of investigations in each of the cases reviewed.

A total of 21 recommendations were set out in the final report. The recommendations were outlined in the order in which they were identified in the review process and not ranked in order of importance or priority for implementation. The HIRT was clear in the final report that until such time as the recommendations were implemented, the risk of a recurrence of the issues identified could not be ruled out.

The Homicide Review featured prominently in the work of the Policing Authority during 2017-2019. This included engagement with the Garda Commissioner and members of the Policing Authority executive attending at a number of the HIRT meetings as observers. The Homicide Review was an agenda item consistently discussed in public and private with the Garda Commissioner. Following completion of the Review, the Authority's oversight focused on the implementation of the recommendations.

The Policing Authority in December 2019 expressed satisfaction that the review carried out by the HIRT represented a thorough piece of work and commended the candour of the final report. It sought the swift and full implementation of the recommendations and engaged with An Garda Síochána regularly on the progress being made. Prior to the work, throughout 2025 and 2026, undertaken for the production of this report, the last such engagement was at a meeting of the Policing Authority with the Garda Commissioner in February 2023. At this time, An Garda Síochána informed the Policing Authority that 17 recommendations had been implemented with 4 outstanding.[1]

2 Overview of the Investigation of Sudden, Unexpected or Suspicious Deaths

2.1 The Role of Coroner and An Garda Síochána

This section provides a concise overview of the initial process for investigation of sudden, unexpected or suspicious deaths in particular the role of An Garda Síochána, the Coroner and OSP. When a body is discovered following a sudden, unexpected or suspicious death, the Emergency Services including paramedics and An Garda Síochána are generally alerted. Members of An Garda Síochána attend the scene and inform the Coroner of the circumstances and scene findings.

Following the discovery of a deceased person, An Garda Síochána, in practice, acts as an agent of the Coroner, who is responsible for directing investigation into all deaths covered in the Coroners Act 1962-2020 as amended.

1. Recommendations 8, 18, 19, and 21.

The Coroner, in short, seeks to establish whether the death was due to natural causes or is a 'reportable death'.[2] Reportable deaths for the purposes of the Coroner's Act are where the death of a person which occurred, or may have occurred, either directly or indirectly;

- in a violent or unnatural manner;
- by unfair means;
- by misadventure;
- from unknown causes;
- in an unexplained manner as a result of negligence, misconduct or malpractice on the part of others;
- or in such circumstances as may, in the public interest, require investigation;
- either directly or indirectly, from any cause other than natural illness or disease for which the person had been seen and treated by a registered medical practitioner within one month before his or her death; and
- a death which occurred, or may have occurred, at a place or in circumstances which require that an inquest should be held.[3]

The specific functions and duties for An Garda Síochána in the context of a coronial death investigation[4] include:

- the identification of the body;
- the taking of witness statements and/or gathering of evidence;
- communication with families and next of kin;
- preparation of a report for the coroner; and
- giving evidence at inquests.[5]

Section 17 of the Coroners Act sets out a general duty to hold an inquest in relation to the death of that person if he or she 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 the behalf contained in any other enactment, require that an inquest should be held.[6]

The purpose of the inquest is to establish the identity of the persons, how, when and where the death occurred, and 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 (or "findings") and return a verdict.[7]

2. Section 16B of the amended act places an obligation on a member of AGS to report the death to the coroner. Section 16B, Coroners Act 1962 as amended.
3. Section 16A, Coroners Act 1962 as amended.
4. Department of Justice, 2024. Report on the Public Consultation on the Reform of the Coroner Service, report-on-the-public-consultation-on-the-reform-of-the-coroner-service-oct-2024.pdf
5. Section 16A, Coroners Act 1962 as amended. There is also an obligation on behalf of medical practitioner, nurse or midwife who had responsibility for, or involvement in, the treatment or care of the woman concerned in the period immediately before or after the delivery of the stillborn child, or who was present at the delivery, is required to report, or cause to be reported to the Coroner in the case of reportable death is that of a stillborn child or a death intrapartum. See section 16B.
6. Ibid, section 17.
7. Ibid, section 18A.

Medical and technical reports are required for the function of the coronial process as well as critical witnesses.[8] This can take time to realise. Where a death is under investigation by An Garda Síochána an inquest may be opened to hear basic information as to the identity of the deceased and then subsequently adjourned pending its conclusion.

An inquest therefore will not proceed during criminal proceedings so as not to prejudice a trial. A member of An Garda Síochána not below the rank of Inspector can request for an inquest to be adjourned on the basis that criminal proceedings in relation to the death are being considered. In such circumstances, the coroner shall adjourn the inquest for a period as he or she thinks proper or for a period the member of An Garda Síochána so requests.[9] The Trial Clerk of the Court is also required to inform the Coroner of a guilty verdict where relevant.

However, it is not obligatory for the Coroner to resume the inquest unless he or she thinks there are "special reasons" to do so.[10] Despite this, some families may seek an inquest to find out further information on the death even in the case of criminal convictions.

2.2 Office of the State Pathologist and State Forensic Cases

When An Garda Síochána informs the Coroner of the occurrence and circumstances of a death, they make a decision as to whether the circumstances suggest that they should make request that a post-mortem examination be carried out by the OSP to determine the cause of death.

The main activity of the OSP is the performance of postmortem examinations in cases of sudden, unexplained deaths where a criminal or suspicious element is present (commonly referred to as 'State' forensic cases)[11], which usually involves an investigation by An Garda Síochána.

While An Garda Síochána is the primary contact in most cases, it is the Coroner who directs the work of the OSP to perform the post mortem examination, via verbal or written consent.[12] In practice the decision to have a State forensic case is usually taken by the Coroner following discussions with investigating gardaí. Consequently, a crime scene may be attended by scenes of crime gardaí and the State Pathologist.[13] Due to advancements in technology and evidence gathering techniques, the OSP is now attending fewer crime scenes.[14]

8. Section to 26 (1), a coroner may, at any time before the conclusion of an inquest held by him, cause a summons in the prescribed form to attend and give evidence at the inquest to be served on any person (including in particular any registered medical practitioner) whose evidence would, in the opinion of the coroner, be of assistance at the inquest. Section 26 Coroners Act 1962, as amended.
9. Section 25 Coroners Act 1962, as amended. 'Adjournment of inquest where criminal proceedings are being considered or have been instituted'
10. Section 25(2)(c), Coroners Act 1962, as amended.
11. Post mortems are generally carried out by hospital pathologists and not the OSP in non suspicious or non State cases.
12. The OSP deals with homicides as well as a wide range of natural and unnatural deaths for example: road traffic and other accidents, drug-related and prison deaths as instructed by the Coroner.
13. For a State forensic case, the body is moved to a local hospital from the crime scene (throughout the country) or to the Dublin District Mortuary in Whitehall (if the death occurs in Dublin) where the post mortem examination is performed by one of the State Pathologists with the assistance of an anatomical pathology technician, a Garda photographer and the exhibits officer. Following the post mortem examination histological samples are processed and reviewed in the OSP Laboratory and toxicological samples are analysed at the State Laboratory.
14. OSP, Office of the State Pathologist

In State forensic cases, families or next of kin are not allowed to touch the deceased until after the post-mortem examination is complete. The Coroner directs that a post-mortem examination can proceed once the body is identified to the pathologist, usually by An Garda Síochána, as that from the scene. A member of An Garda Síochána remains with the body, to ensure no unauthorised access occurs, until the post-mortem examination is complete. This is to ensure the maintenance of forensic integrity and the preservation of 'the chain' of relevant forensic evidence, and to ensure that it is not contaminated in any way.[15]

Once all the further investigations have been undertaken and reports have been received, the the findings are added to the post mortem report in which conclusions regarding the death are made. The report is peer reviewed by at least one other forensic pathologist(s) before being finalised and sent to the Coroner.[16] A notification of the issuing of the final report is sent to the investigating gardaí by the OSP and the report can then be obtained from the Coroner by formal request.

2.3 An Garda Síochána and Homicide and Suspicious Death Investigations

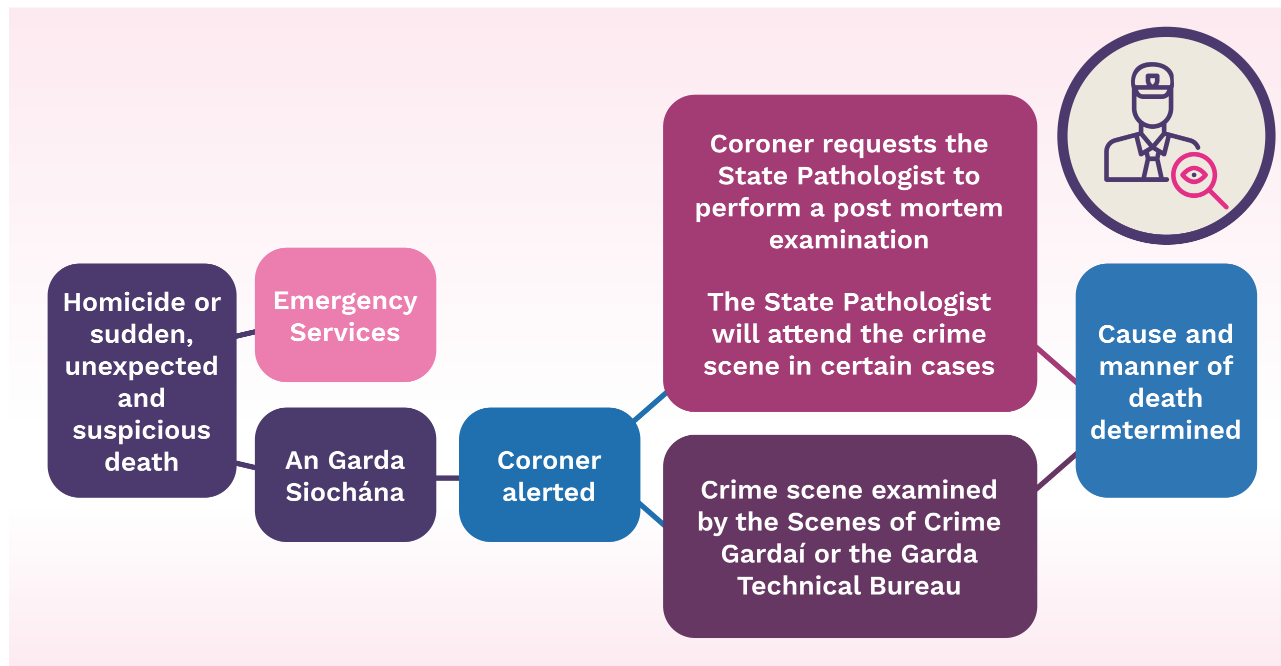
An Garda Síochána carry out a formal investigation into a suspicious death or homicide. A formal investigation proceeds under the overall supervision of the Crime Superintendent within the Garda Division. The decision to commence an investigation (or not) is dependent on the suspected cause of death which may involve consideration by An Garda Síochána, the Coroner and the OSP. The decision as to whether a death is suspicious is a critical juncture that determines the direction of policing focus and the consequent resourcing of that focus. Once a death is regarded as suspicious, the subsequent investigation is provided with significant resources with supervision and governance structures that guide its progression and is undertaken by investigators trained to an identified standard. Initially, a death is entered on PULSE as informed by the immediate circumstances, this may include personal misadventure or sudden death in ambiguous cases. This categorisation may and can change over the course of the investigation following post-mortem or other relevant enquiries. Therefore, it is important to note that this is not a linear process and An Garda Síochána can commence the activities associated with a homicide investigation while awaiting the outcomes of the Coroner or OSP examination.

15. Study on Familicide Domestic and Family Violence Death Reviews, study-on-familicide-domestic-and-family-violence-death-reviews.pdf

16. OSP, Office of the State Pathologist Office of the State Pathologist

See figure 1 below for a concise overview process of death investigations by different State agencies including An Garda Síochána.[17]

Figure 1: Overview of the process of death investigations



In the case of an incident with a potentially criminal element, the scene is first declared a crime scene by a member of An Garda Síochána not below the rank of Superintendent in accordance with Section 5 of the Criminal Justice Act, 2006.

In short, Section 5 empowers a member of An Garda Síochána to designate a place a crime scene, if he or she reasonably believes an arrestable offence has been committed there, or there is or may be evidence of or relating to an offence which was committed elsewhere to preserve any evidence of, or relating to, the commission of the offence.[18] Following a direction from a member not below the rank of Superintendent[19] a member is authorised to take steps, as considered necessary, to preserve, search and collect evidence at the scene to which the direction relates. These steps include:

- delineating and segregating the area of the crime scene by means of notices, markings or barriers;
- preventing a person from removing anything which is, or may be, evidence or otherwise interfering with the crime scene or anything at the scene;
- securing the crime scene from any unauthorised intrusion or disturbance;
- searching the crime scene and examining the scene and anything at the scene; and
- photographing or otherwise recording the crime scene or anything at the scene.[20]

17. Source Office of State Pathologist Office of the State Pathologist
18. Section 5(1) Criminal Justice Act 2006
19. Section 5(3) Criminal Justice Act 2006
20. Section 5(4) Criminal Justice Act 2006

An extensive examination of the scene(s) is typically conducted by the Garda National Technical Bureau with assistance from the Divisional Crime Scene Investigation Unit particularly with the preservation of evidence in situ. As part of the initial stages of the investigation, efforts are made to identify all witnesses and any potential suspects in or close to the crime scene. House to house enquiries are conducted based on a questionnaire provided by the Incident Room overseen by the Serious Incident Canvass Coordinator. A serious incident report is also submitted to inform senior management within the Division and Region of the incident.

An incident room and investigation team are established. A Senior Investigating Officer (SIO) is appointed while assistance may be sought from different national units such as specialist interviewers and cyber forensic experts as necessary. Examples of other roles which may be assigned to members of the investigation team include Family Liaison Officer (FLO)[21], Crime Scene Manager, Exhibits Officers, Incident Room Coordinator (IRC), and Telephone Liaison Officer.

3 Human Rights Obligations

This section sets outs an overview of relevant human rights considerations in the investigation of homicides and suspicious deaths.

These investigations engage a range of human rights obligations for the State, including under the European Convention on Human Rights (ECHR).

Article 2(1) ECHR, for example, provides that: *"[e]veryone'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".*[22]

When read in conjunction with Article 1[23], Article 2 initially placed a procedural obligation on the State to conduct an effective investigation into an unlawful use of force by someone acting on behalf of the State, for example a police officer or member of the military forces.

This duty has been extended to include any suspicious death or instances of a loss of life whether perpetrated by State or non-State actors including suspicious deaths, Domestic Sexual and Gender-Based Violence, and disappearances.[24]

21. FLOs are Members of An Garda Síochána who have received training in relation to family liaison. FLOs are assigned by the Functional Area Officer to keep a family or victim updated on the progress of an investigation in line with HQ Directive 01/2014. Under the current Victims' Policy and Procedures introduced by HQ Directive 061/2025 on 14 November 2025, the FLO is responsible for updating the victim engagement screen on PULSE with details of contact with a victim.

22. Article 2(2) ECHR provides that: "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 escape of a person lawfully detained; (c) In action lawfully taken for the purpose of quelling a riot."

23. Article 1 ECHR also places States under a general duty to "secure to everyone within their jurisdiction the rights and freedoms defined in the Convention."

24. See for example, ECtHR, *Paul and Audrey Edwards v. United Kingdom,* App no. 46477/99 [14 March 2002]; ECtHR, *Opuz v. Turkey*, App no. 33401/02 [9 June 2009]; ECtHR, *Iorga v. Moldova*, App no. 12219/05 [23 March 2010].

The procedural obligation to conduct an effective investigation into a suspicious death is triggered once an agent of the State becomes aware of the death. In *Ergi v. Turkey*, for example, the European Court of Human Rights (ECtHR) held that: *"The obligation is not confined to cases where it has been established that the killing was caused by an agent of the State. Nor is it decisive whether members of the deceased's family or others have lodged a formal complaint about the killing with the relevant investigatory authority. In the case under consideration, the mere knowledge of the killing on the part of the authorities gave rise ipso facto to an obligation under Article 2 of the Convention to carry out an effective investigation into the circumstances surrounding the death."* [25]

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/employees or bodies, to ensure their accountability for deaths occurring under their responsibility. This obligation requires by implication that there should be some form of effective official investigation when there is a reason to believe that an individual has life-threatening injuries in suspicious circumstances, even where the presumed perpetrator of the fatal attack is not an actor or employee of the State.[26]

In short, investigations should be thorough, impartial and careful with conclusions based on thorough, objective and impartial analysis.[27]

In summary, there are four key areas in which the ECtHR has assessed the effectiveness of investigations, namely:

- The independence of the persons responsible for the investigation;
- The adequacy of the investigation or whether it was capable of leading to the establishment of the facts and, where appropriate, the identification and punishment of those responsible;
- Whether the investigation proceeded promptly and/or with reasonable expedition; and
- Whether the investigation was subject to sufficient public scrutiny, including by allowing the deceased's next of kin to participate.[28]

However, the ECtHR has held that the question of whether an investigation is effective and in compliance with obligations under Article 2 depends on the particular circumstances of each case and must be assessed on the basis of all relevant facts and with regard to the practical realities of investigative work. The nature and degree of scrutiny which satisfy the minimum threshold of the investigation's effectiveness also depends on the circumstances of the particular case.[29]

25. ECtHR, *Ergi v Turkey*, App no. 23818/94 [28 July 1998] at para 82.

26. ECtHR, *Mustafa Tunc and Fecire Tunc v. Turkey, App no. 24014/05 [14 April 2015]*; ECtHR, *Rod v. Croatia*, App no. 47024/06 [18 September 2008].

27. ECtHR, *Mustafa Tunc and Fecire Tunc v. Turkey, App no. 24014/05 [14 April 2015]*;

28. See, for example, ECtHR, *Brecknell v. United Kingdom* App no. 32457/04 [27 November 2007].

29. Ibid, at para. 68.

The obligation, moreover, is one of means not outcome. The investigation therefore must only be "capable" of leading to the establishment of the facts and, where appropriate, the identification and punishment of those responsible.[30] However, the requirement of adequacy includes whether there was any deficiency in the investigation, which undermined its ability to identify the perpetrators. Consequently, the State should adhere to its procedural obligations irrespective of the outcome of an investigation. An inadequate investigation, therefore, *may* constitute a breach of the procedural obligation under Article 2, irrespective of any resulting conviction.

4 Victim's Rights and Obligations

An Garda Síochána and other criminal justice agencies have specific obligations to victims under the Criminal Justice (Victims of Crime) Act 2017 or Victim's Act.[31]

The Victim's Act transposed into Irish law Directive 2012/29/EU ("Victims Directive") which established minimum standards on the rights, support and protection of victims of crime and replaced (European Union) EU Council Framework Decision 2001/220/JHA.

The definition of victim as a *"natural person who has suffered harm, including physical, mental or emotional harm or economic loss, which was directly caused by an offence" is transposed from the Directive.*[32]

The Victim's Act introduced a number of statutory rights for victims of crime including:

- The right to comprehensive information on the criminal justice system;
- The right to information on victim support services (section 7);
- The right to be kept informed on the progress of the investigation and any court proceedings (section 8);
- The right to an individual assessment of their protection needs and measures to safeguard them from further victimisation and intimidation (sections 15 and 16);
- The right to be informed of a decision not to proceed with a prosecution and the right to request a review of that decision (sections 9 and 10); and
- The right to receive information in clear and concise language and to interpretation and translation where necessary (section 22).

Of significance to the investigation of homicides and suspicious deaths, section 2 provides for the inclusion of family members of a person who died as a direct result of a crime in the definition of a victim.[33] According to section 3, moreover, the affected family can nominate a member or members to avail of the rights under the Victim's Act.[34]

30. ECtHR, *Olewnik-Cieplińska and Olewnik v. Poland*, App no. 20147/15 [5 December 2019], para. *136*.

31. The legislation was enacted on 5 November 2017 and commenced on 27 November 2017.

32. Criminal Justice (Victims of Crime) Act 2017, s.2(1).

33. Criminal Justice (Victims of Crime) Act 2017, s.2.

34. Ibid, s.3(a)(b)

An Garda Síochána introduced new policy and procedures for victims on 14 November 2025. A 'Victims of Crime' Procedure Document was developed to provide practical direction to gardaí in meeting their obligations under the Victim's Act.

According to the procedures, it is the responsibility of the reporting member, where a victim is deceased or the victim is unable to communicate, to identify and engage with a member of their family who can fulfil the 'Family Victim Role' and obtain their details; and complete an individual victim assessment with regard to the person(s) who is recorded in respect of the Family Victim role.

Family Liaison Officers (FLOs) and Scenes of Crime Examiners are also considered 'specialist services' under the new procedures. Where an investigating or other member organises the provision of a specialist service, they are responsible for recording relevant information on PULSE. The Superintendent who directs the deployment of a specialist service to victims assumes responsibility for recording the relevant decision (or Performance Accountability Framework (PAF) administrator on their behalf) on PULSE and informing the specific An Garda Síochána service. Members assigned to specialist positions, moreover, are personally responsible for recording on PULSE any contact or attempted contact made and any services they offer to victims of crime, including whether the service was accepted or declined.

5 Homicide Offences in Ireland Statistics and Classification

This section provides some recent data on the number of reported homicides, detections, and cases referred to the OSP by the Coroner. The Irish Crime Classification System (ICCS) published by the Central Statistics Office (CSO) for the purposes of crime statistics includes five offences under the category Homicide Offences Crime Category 1. These are the offences of Murder, Manslaughter, Infanticide, Manslaughter (for Traffic Fatalities) and Dangerous Driving Leading to Death.[35]

Of particular relevance to the Homicide Review is that fact that reclassifications of a sudden death on the PULSE system may occur a number of times from the time of reporting of the incident through the investigation and as a result of a court outcome. Reclassification can include, for example, a murder is reclassified to manslaughter when a charge of manslaughter commences or when a murder charge results in a conviction for manslaughter. A reclassification to a homicide offence (murder, manslaughter or infanticide) occurs when, for example, a serious assault has been recorded and, sometime later, the victim dies as a consequence of the assault.[36] Classifications therefore may change over time.

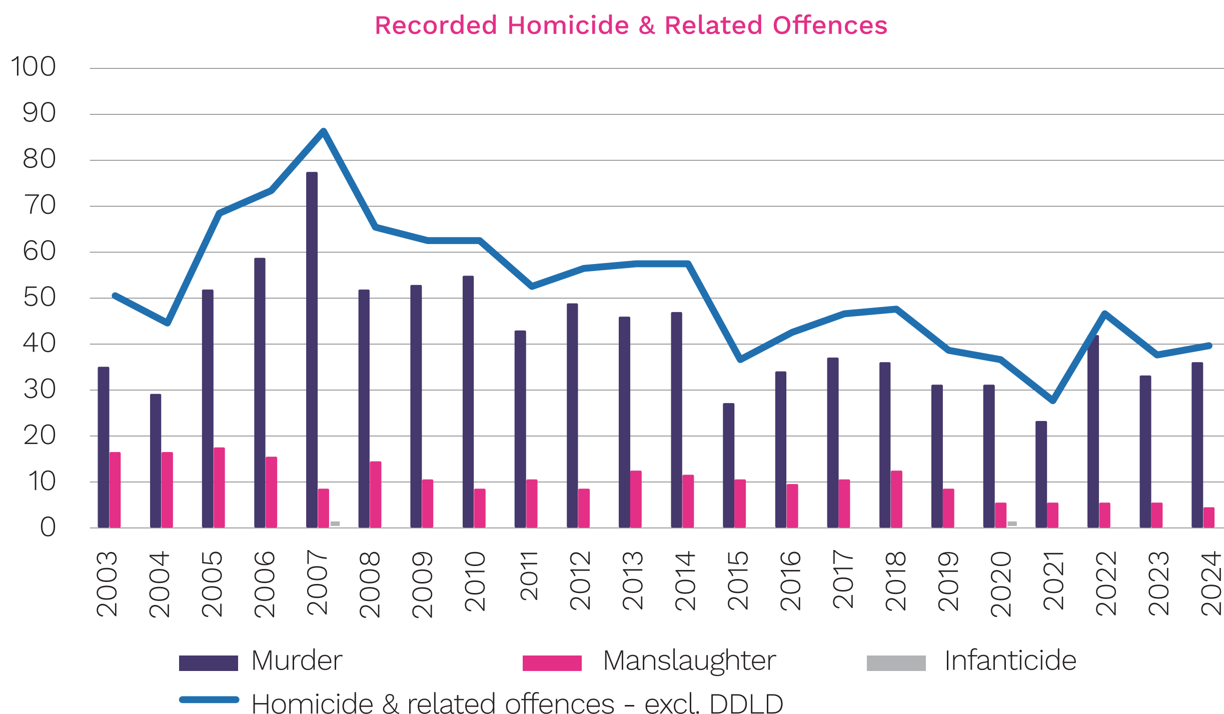
During the period 2003-2024 – the period covered by available CSO data[37] – there have been an average of 99 homicide and related offences recorded per year in Ireland. Of these, over the period, 49% were offences recorded as 'Dangerous Driving Leading to Death' (DDLD). The chart below (figure 2) shows the individual and cumulative total of all other homicide offences (murder, manslaughter and infanticide), by year.

35.Central Statistics Office, 2008. Irish Crime Classification System (ICCS). Microsoft Word - crimeclassification.doc

36.AGS, 2020, Guide to How Crime Is Counted and Recorded by An Garda Síochána, p. 20

37. As of 11 November 2025.

Figure 2: Recorded Homicide & Related Offences



During the 2003-2024 period there have been an average of 52 offences per year, predominantly murders. As per the chart above, the long-term trend is one of decline since 2007 – a peak which aligns with the height of the so-called Limerick Feud. There was also an increase in the period 2016-2018, which covers the period of the 'Hutch-Kinahan Feud'[38].

Recent data in the public domain also confirms the decline in the prevalence of shootings and killings related to organised crime or 'gangland' killings. As of 30 December 2025, there were no gun killings in the State, for the first time since 1968. The last murder of someone directly targeted in an organised crime related attack was in December 2023, it was reported.[39]

Homicide offences have a comparatively high detection rate, relative to other offence types. The percentage of offences marked as detected at 27 November 2025 are set out in table 2:

Table 2: Detection Rate of Homicide Offences 2018 - 2024							
Year	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Detected	75%	69%	86%	79%	79%	79%	73%

In line with other offence types the detection rate tends to be lowest in the most recent years, rising in subsequent releases as investigation and supporting processes have longer to run – i.e. the rate of detection in respect of 2023 offences was at 70% when first reported on in November 2024 but had risen to 79% when reported on in November 2025.

38. While it is unlikely that the comparatively high levels of murders in these years are solely attributable to these feuds, both have had approximately 20 murders attributed to them.

39. Conor Feehan, "No gun killings in the country for first time in nearly 60 years as 30 people die in suspicious circumstances in 2025", Irish Independent, 30 December 2025

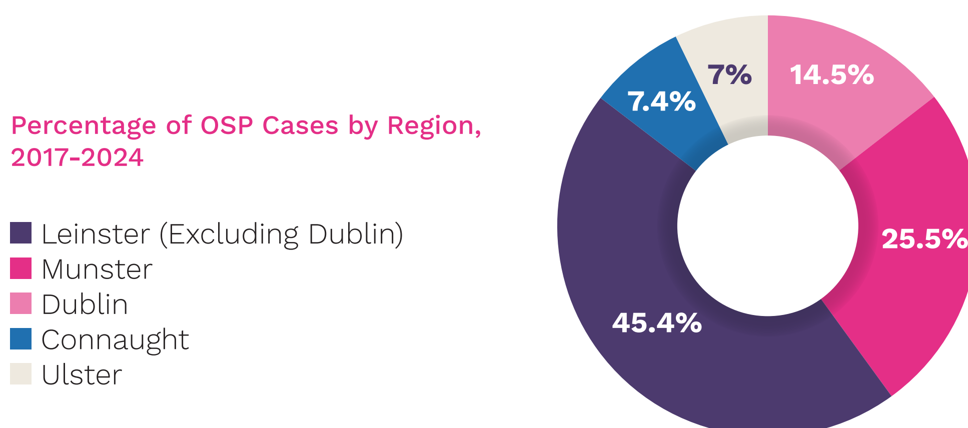
The OSP publishes figures on the number of State forensic cases in which foul play is suspected and there is a formal investigation by An Garda Síochána. Naturally, not all these cases examined would conclude that there was foul play and this data is distinct from official crime statistics. A regional distribution of State cases at the OSP is provided in table 3 below. It should be noted that the State cases are not the entirety of the OSP's caseload. However, it is the majority of cases dealt with by the office and reflects the geographic spread of forensic workload within the country. It should also be noted that cases can be examined across these regional lines depending on availability of local mortuary facilities and staff.

Table 3: Number of State Cases at the OSP by Region and Year

Year	Leinster (excluding Dublin)	Munster	Dublin	Connaught	Ulster	Total
2017	32	44	57	16	17	**167**
2018	46	46	78	13	13	**196**
2019	26	54	92	10	6	**188**
2020	4	55	109	11	9	**188**
2021	19	46	88	15	14	**182**
2022	37	48	93	14	21	**213**
2023	29	55	78	18	12	**192**
2024	30	44	104	17	19	**214**

Between 2010 and 2024, thirteen homicides of children and young people in care or known to child protection services were also notified to the National Review Panel (NRP).[40] This accounts for almost 4 per cent of the total deaths (13 out of 334). The cause of death was classified as unknown in a further 9 percent of all cases (30 out of 334). Unknown is when the Coroner or a post-mortem has failed to identify a cause of death.[41]

Figure 3: Percentage of OSP Cases by Region, 2017-2024



40.The National Review Panel (NRP) was established in 2010, following a recommendation of the Ryan Implementation Report by the Office of the Minister for Children in 2009, to undertake reviews of serious incidents including deaths of children in care or known to Tusla (Child and Family Agency). Although commissioned by Tusla, it is an independent entity. The overarching objective of the NPR is to promote learning and best practice from the review of specific cases with a view to assisting the child welfare and protection system in improving the services provided and minimising the possibility of similar deaths and/or serious incidents to children and young people using such services. Department of Children, Equality, Disability, Integration and Youth, 2021. Interim Guidance for Tusla on the Operation of the National Review Panel.

41. Natural causes accounted for 44 percent (or 147), Suicide 22 percent (or 74), Accidents 16 percent (or 53) with Drug Overdoses accounting for a further 5 percent (or 17 deaths). See National Review Panel, Annual Report 2024, p.11.

B. Assessment of Implementation of Recommendations

1 Activities and Engagement to Inform Assessment

The PCSA executive carried out a range of activities to inform the assessment of the implementation of each recommendation. These activities included desk-based research, a review of relevant data and relevant An Garda Síochána policy and procedures, and direct engagement with key An Garda Síochána members and external stakeholders. (see table 4 for a list of all engagements conducted).

Table 4: List of engagements undertaken to inform the review

Table 4: Engagement		
Assistant Commissioner, Organised and Serious Crime	Garda Information Services Centre	Senior Investigating Officers
Homicide Investigation Review Team	Director Garda Síochána Analysis Service	Office of the State Pathologist
An Garda Síochána National Interview Advisor	Chief Superintendent, Garda Training College Templemore	Dublin District Coroner
Serious Crime Review Team[42] and Criminal Investigation Department (National Criminal Bureau of Investigation)	An Garda Síochána Operational Support Service	AdVIC (organisation for families of victims of homicide)
Director of Public Prosecutions	Irish Association of Funeral Directors	Coroners Society of Ireland

The Authority is aware that there are families – some of whom have contacted the Policing Authority and the PCSA over the years - that are dissatisfied with the service they received from An Garda Síochána in relation to the death of a family member. The issues raised vary and include the quality of the investigation, the classification of the death and the level and quality of victim contact support received from An Garda Síochána. This assessment has been cognisant of these issues, perspectives and insights raised from a thematic perspective. However, the focus of this assessment is on the progress made at an organisational rather than specific case level. Individual cases are not the subject of this report and the PCSA does not have a remit over individual cases or the investigation of complaints concerning Garda conduct.

42. The Serious Crime Review Team was established in 2007 under the direction of Detective Chief Superintendent, Garda National Bureau of Criminal Investigation. Its primary purpose is to assist Senior Investigating Officers in the investigation of serious crime by identifying new and investigative opportunities which require consideration of progression.

2 Assessment of Status of Implementation of Recommendations

Of the twenty-one recommendations made by An Garda Síochána, fifteen have been implemented while six remain to be implemented fully. The non-implemented recommendations relate to significant guiding policy on the categories of death, how non-crime deaths are to be recorded and governed, arrangements for data exchange with the courts system and the recording and storage of evidence in Garda Divisions.

The reason as to why each of the twenty-one recommendations was made is not repeated in this assessment, but this information is available in the original HIRT Reports. While not a neat delineation, the recommendations centre around a number of key areas namely:

- Changes to the PULSE system;
- Policy change and updating;
- The need to ensure greater consistency in investigative practice;
- The need for enhanced supervision and governance of investigations;
- Improvements in training;
- The need for improvement in classification and data quality; and
- The use of peer review for investigations.

The recommendations marked implemented in each of the tables below give assurance that the issues identified have been addressed. For example in terms of PULSE changes, training curricula and delivery, policy change, or establishment of new supervisory systems and governance. However, this assessment cannot attest to how these are or have been used in the investigations of specific cases of suspicious deaths or homicides.

It is also important to understand that recommendations marked not implemented does not mean that considerable work has not been undertaken, but rather that this work, in the view of the Authority, has not as yet implemented the recommendation in full. A variety of reasons may exist for non-implementation. For example, in some cases policy awaits finalisation by senior leadership of An Garda Síochána's, or instances where there are dependencies on agencies external to An Garda Síochána.

The Authority can in future decide to do an updated assessment of the implementation of the outstanding recommendations, or perform an inspection of the quality of sudden death and homicide investigations.

HIRT Recommendation 1

PULSE to be updated to include a Date Field(s) to record the Date of Death of a person, which is different to the Date on which The Incident occurred.

IMPLEMENTED

Assessment: Pulse Revision 7.5.1 incorporated a Date Field into PULSE that allowed for the recording of the date of death distinct from the date on which the incident involving the victim occurred. This addressed issues that had arisen in the capture of data in incidents where the injured party dies subsequently to an assault. The existence of this change on the PULSE system has been confirmed.

HIRT Recommendation 2

The HIRT recommends that organisational policy is issued providing guidance relating to the creation and classification of incidents on PULSE involving the death of a person (and other incidents). It is recommended that existing policy is consolidated, but also expanded to include the classification of Non-Crime incidents.

NOT IMPLEMENTED

Assessment: This recommendation identified the need for new organisational policy to give guidance on the creation and classification of incidents on PULSE involving the death of a person (and other incidents). It recommended the consolidation of existing categories and the expansion of existing policy to include the classification of non-crime incidents – for example, incidents of suicide or cot death.

The central tenet of any new policy, according to the HIRT, should be the 'Crime Counting Rules' (then HQ Directive 139/2003). The HIRT further recommended a PULSE upgrade to allow for the rationale for decisions made concerning the categorisation/classification of incidents (particularly deaths) to be recorded.

An Garda Síochána published "A Guide to how Crime is Recorded and counted by An Garda Síochána" in July 2020, with internal briefing sessions organised by the Garda College. This was to enable users of crime statistics to understand how crime is recorded. At that time no change was made to the existing 16 categories of incidents involving the death of a person.

The launch of IMS is put forward as a key means by which this recommendation has been addressed. The IMS requires that each incident is classified and recorded and necessary updates are made to the PULSE incident throughout its lifecycle. This does require that decisions regarding changes to classification or categorisation are recorded and explained as they happen throughout an investigation. The IMS is not yet rolled out in every Division and will not begin roll out in the Dublin Metropolitan Region (DMR) until 2027.

While this recommendation is considered closed by An Garda Síochána, in the Authority's view, its full implementation is dependent on the status of recommendations 8 and 12. Recommendation 8 aims to establish more appropriate recording categories for deaths on PULSE. Recommendation 12 dealt with the recording of deaths that, on the basis of reasonable probability, are suicides.

From 2020 to 2022, a number of meetings were held, led by An Garda Síochána's Chief Information Officer (CIO) with internal and external stakeholders including the CSO Suicide Mortality Group. There was also consultation with the Coroners Group, the National Suicide Prevention Office and the National Suicide Research Foundation. In 2022, An Garda Síochána reported that consensus had been reached in support of a change to the PULSE suicide category to self-inflicted death. This in conjunction with decisions regarding the number of categories by which a death could be reported on the system was to steer and inform a revised policy. The Policing Authority was informed in 2022 that policy development had commenced regarding the proposed new categories to record a death. The recording of non-crime death incidents would also be included in both the revised policy on the classification of deaths and an updated HQ Directive.

In late 2025, it was anticipated that this policy and associated HQ Directive would be approved and finalised in early 2026. While significant work has been undertaken on the policy, it has yet to be finalised, approved and published. In its absence, the 16 categories remain in place and the anticipated changes relating to non-crime deaths are not in effect.

HIRT Recommendation 3

Some of the jobs allocated in Jobs Book in Incident Rooms were not marked completed and closed. The HIRT recommends this issue is addressed on all future relevant training and developments programmes (in particular IRC and SIO programmes).

IMPLEMENTED

Assessment: Two key actions were undertaken to implement this recommendation. The first is that training in the Garda College for probationers was revised to ensure increased emphasis was put on the importance of closing jobs in the Jobs Book. This inclusion of the Homicide Review recommendations as a module on the Senior Investigative Training Course also ensured it was addressed with this key cohort.

The second significant change is the movement – for most of the organisation – to an online Jobs Book. At the time of the Homicide Review, a traditional manual Jobs Book was utilised – or large leather-bound books in which each job is allocated pages, and as each job is progressed and completed, details of the work undertaken and by whom is included and signed.

A significant development since the Homicide Review has been the introduction of IMS. This is, at time of writing, available in most of Divisions, with a number of divisions due to go live with the system in 2026. The DMR will not get the system until 2027. The significance of the system to this recommendation is that now all the jobs associated with an investigation are online. The system highlights to the investigator jobs that remain to be closed on each specific investigation and the number and nature of the jobs remaining to be closed is apparent to supervisors at any time. Jobs that remain to be done, remain on the screen to be closed.

HIRT Recommendation 4	
PULSE merge function should be re-established to allow PULSE IDs to be merged.	**IMPLEMENTED**

Assessment: A significant data quality issue highlighted in the Homicide Review and previously by the Garda Síochána Inspectorate concerns the existence of duplicate person records on the PULSE system. The Homicide Review identified that there is considerable risk associated with the existence of duplicate records, as well risks if PULSE records are merged incorrectly. In the absence of a unique identifier, the existence of multiple identities (IDs) for individuals on the PULSE system occurs as a result of people having similar names, persons living at the same address, having given or had their date of birth recorded incorrectly or the use of nicknames or names given at different times in Irish and English.

In 2020, A working group under direction of the CIO was working on the re-establishment of Merge teams within the Operating Model organisational process with a pilot subsequently established in the Mayo division.

An Garda Síochána, it was reported, has completed analysis of years 2020, 2021, and 2022 with update year to date figures to the end of May 2023. A 'Masterclass' workshop for training on merging commenced in 2022 and they have continued. Further merge training in the Garda College, based on the learning arising from the masterclass is reported as scheduled for 2026. According to An Garda Síochána, in 2023, merge rates in Divisions were tracked at the Deputy Commissioner, Policing and Security monthly PAF meeting. In 2023, An Garda Síochána reported that approximately 12,000 merges were done, with 17,500 in 2024 and 20,500 in 2025.

The merge function is in operation. Rectifying this issue is labour intensive and while work is undertaken to tackle existing records, it does not necessarily prevent new duplicate records from being created. The current Programme for Government commits to the introduction of a common identification number for individuals in the criminal justice system. Until such time the challenge of duplicate person records on PULSE endures for An Garda Síochána.

HIRT Recommendation 5

The HIRT recommends the Courts Service assume responsibility for the recording of convictions from the Higher Courts. In the short-term it is recommended that the Chief Data Officer examines the issue and implements an interim-solution in order to ensure accuracy, timeliness and consistency in the recording of convictions from the Higher Courts. The HIRT recommends that the Courts Service (Higher Courts) creates Court Outcomes on the PULSE Incident for each Charge Sheet. The HIRT also recommends that AGS updates the process for recording incidents on PULSE for which a 'life-sentence' is imposed, by the Higher Courts, on conviction.

NOT IMPLEMENTED

Assessment: Recommendation 5 relates to the recording of convictions from the Higher Courts. The HIRT advised that the Courts Service (Higher Courts) should create Court Outcomes on the PULSE Incident for each Charge Sheet and that An Garda Síochána update the process for recording incidents on PULSE for which a life-sentence is imposed, by the Higher Courts, on conviction. This was in light of inconsistencies in practice in the recording of Court Outcomes from the Higher Courts, on PULSE. Issues concerning timeliness and accuracy were identified by the HIRT and, prior to this, by GSAS.

In addition, the HIRT found variation in the term of imprisonment recorded on PULSE incidents for 'life' sentences, resulting in inconsistent and inaccurate data being recorded. The HIRT recommended that the recording process for the recording of 'life' sentences imposed by the Higher Courts on conviction for certain offences be updated on PULSE, with the removal of the requirement to record the number of years imposed.

This recommendation was closed by An Garda Síochána in 2022. However, the Higher Courts Outcome process under the Criminal Justice Operational Hub Project (CJOH) has not been realised. As of 2022, the CJOH Board on behalf of the Court Services, An Garda Síochána, DPP and Department of Justice had taken responsibility for the delivery and monitoring of the project.

The Higher Court Outcome project formally ceased in January 2023. According to An Garda Síochána, this was due to the need to safeguard data quality, i.e. reliable outcomes data linked back to the original crime incident(s) could not be sourced from existing courts systems. The Court Services consequently decided to replace its Integrated Case Management System (ICMS) and, as part of that project, to put measures in place with a view to supporting access to linked outcomes data by An Garda Síochána. As of August 2025, this project was then approved for scoping by the CJOH and work has continued on this project through 2025 and 2026 with roll-out expected to commence in 2027.

In this context, the Authority questions the extent to which the provision of timely, accurate information to An Garda Síochána has improved. In practice, it appears An Garda Síochána is currently relying primarily on the relevant Garda member in court accurately recording and then updating the information based on what is said in court by a Judge. While Garda member can take down take what it is said in Court, this may not be practical if the Judge speeds through the information too quickly for accurate record taking. Moreover, there can be delays in An Garda Síochána receiving a court order. An Garda Síochána identified this area as an ongoing risk if the initial charge sheet doesn't align with the indictment, or any subsequent report from the Judge.

This recommendation remains unimplemented but the Authority acknowledges that the ownership of the recommendation has transferred at this point to the CJOH.

HIRT Recommendation 6

A PULSE upgrade (or IT fix) is required to ensure that no further data can be 'associated' with a Deceased Person without the appropriate rationale and governance of the new data entry.

IMPLEMENTED

Assessment: PULSE upgrade 7.5.1 was deployed in May 2020. This prevented inappropriate data updates to be applied to a deceased person's record on PULSE.

HIRT Recommendation 7

A PULSE update (or IT fix) is required to ensure that a PULSE 'prisoner log' cannot be created / attached to a 'Sudden Death' or Non-Crime incident. The HIRT recommends that an additional category (or categories) is created on PULSE in order to 'log' persons or children who are held in Garda Stations as 'detained' persons or other reason to be in 'Garda care', such as the Mental Health Act, 2001, Child Care Act, 1991, Court Order or other reason.

IMPLEMENTED

Assessment: At the time of the Homicide Review, a person detained in a Garda station could only be entered on PULSE as detained as a result of an arrest. On PULSE this could only be associated with a crime incident. This had potential implications for vetting. PULSE release 7.6.1 changed the 'prisoner log' functionality into 'detained person' log. This meant that persons detained for their own safety, searches etc., are now prevented from being associated on PULSE with incidents other than those which are non-crime incidents. This PULSE update 7.6.1 has addressed the recommendation.

HIRT Recommendation 8

The number of 'death' classification types on PULSE should be examined, with the possibility of introducing sub-categories to reduce the number of primary categories (Category), with sub-categories (Type) providing specific information concerning the death. This process should be done in consultation with GISC and the CSO.

NOT IMPLEMENTED

Assessment: Recommendation 8 on death classification types is at present outstanding. There are currently 16 'death' classification types (with 15 active) on PULSE, which according to HIRT, was leading to confusion and inaccuracies in the recording and classification of incidents involving the death of a person.[43] Examples of these categories include manslaughter, infanticide and murder. The HIRT also noted at the time that the most appropriate category to record a miscarriage or still birth was as an 'Attention and Complaint' incident on PULSE, which it found to be inappropriate.[44]

43. HIRT also recommended that the number of 'death' classification categories and types on PULSE should be dovetailed with revised policy concerning the recording of deaths (as outlined in Recommendation No. 2).

44. HIRT also recommends that the foetus should not be recorded with a unique [PULSE] Person Identification Number and that it is more appropriate to associate the mother on the incident which may be required for an autopsy.

A second HIRT team was established by An Garda Síochána in 2022 with new terms of reference. This recommendation was assigned to the second team and a dedicated subgroup. New categories have been developed by the sub-group with proposals for existing categories to be removed (e.g. abortion). The review process undertaken to develop the categories included external engagement with stakeholders particularly around the recording of suicide. For example, the HIRT met with the CSO Suicide Liaison Group in January 2023 where it was agreed that the National Suicide Prevention Office would review policy on suicide classification and provide advice. According to An Garda Síochána, the revised number of categories will remain the same but will be clearer and more accurate. Associated guidelines have also been drafted. Both the policy and guidance awaits finalisation by An Garda Síochána's Senior Leadership Team. This was expected in Quarter 1 2026.

Once the new categories are agreed, their implementation will require technical amendments to the PULSE system. Engagement is reported as ongoing with the Office of Information and Communications Technology (ICT) for a 2026 release. However, Ireland's Presidency of the Council of the EU from July to December of 2026 and its associated resource implications for An Garda Síochána has been identified as a potential barrier to implementation in 2026.

Given that the indicative timeline for completion of the policy and guidance on the categories of death has passed, it is not clear when this will be finalised.

HIRT Recommendation 9

Policy renewal and training modules are required to provide clarity across the Organisation in relation to the distinction between classifying someone as 'witness', 'suspect', 'suspected offender' and 'questioned in relation to' regarding a crime incident. This has implications in relation to General Data Protection Regulation (GDPR), the Garda Vetting Bureau and is an organisational risk.

IMPLEMENTED

Assessment: The risks associated with the issues identified in recommendation 9 had also been identified by the Garda Síochána Inspectorate and Commission on the Future of Policing in Ireland. These include the consequence of an incorrect role being assigned against a person on PULSE, which may affect a person's human rights, or in terms of vetting their employment or travel opportunities.

In 2020, An Garda Síochána published HQ Directive 45/20 regarding the classification of incidents and recording of crime within PULSE. This sought to clarify the respective roles and how they are applied and categorised. Internal communications to support the directive was provided.

HIRT Recommendation 10

The HIRT recommends that key witness statements should be prioritised and taken as soon as possible following an incident. Key witness statements should also be corroborated and verified by other evidence

IMPLEMENTED

Assessment: An Garda Síochána included the requirements of this recommendation in its review of all training courses relevant to the investigation of suspicious death to include training for Incident Room Coordinators (IRC), Detective Sergeants and Detective Gardaí, and Senior Investigating Officer Training. A second significant development relevant to this recommendation is the rollout of the IMS.

The taking of key witness statements is an identified 'job' within the IMS for each case of suspicious death. Any delay in the taking of a statement within a division that has the IMS would be apparent to both the relevant garda and his or her supervisor and remain on screen as a job to be done. In divisions which have yet to receive the IMS, the timeliness of taking statements is a matter for the SIO to manage within each investigation.

HIRT Recommendation 11

The HIRT recommends that revised policy is issued concerning the 'casing' and 'association' of incidents, with the role of the Investigating Member, District Officer, GISC and the Chief Data Officer specifically outlined. The revised policy should be supported by additional training across the Organisation on the casing of incidents.

IMPLEMENTED

Assessment: The quality of crime data and its importance in crime prevention, investigation, public policy and garda deployment had been highlighted by the Policing Authority, Garda Síochána Inspectorate, Commission on the Future of Policing in Ireland and the CSO. In 2018, the CSO and An Garda Síochána began work on a Quality Improvement Plan to develop a stronger data governance framework which would underpin a more strategic and systematic approach to data collection. Garda Information Services Centre (GISC) has responsibility for incident creation on PULSE in order to create consistency in how incidents were recorded. GISC has also established a data quality review team to review incidents.

GISC is an An Garda Síochána call centre based in Castlebar, Co. Mayo staffed by Garda personnel. An Garda Síochána's policy requires Garda members to contact GISC and speak with an operator to record each incident on the PULSE system. This is to ensure that the content, motive and any other required data fields and information are recorded correctly and consistently. This system relies on garda members using GISC to record incidents rather than recording incidents themselves on the system within stations.

In terms of the casing of incidents, following a review by the CSO in 2022, metrics regarding the quality of casing began to be published monthly. The CSO placed a reservation on Garda PULSE data in 2014. The CSO in recognition of the fact that the deferral of crime statistics would result in a significant information gap, resumed the publication of recorded crime statistics under a category of 'under reservation'. This categorisation indicated that the quality of these statistics did not meet the standards required of official statistics published by the CSO.

The progress made in improving the metrics and in enhancing and improving the process for checking adherence to the crime counting rules was a contributory factor for the CSO removing the 'under reservation' status of PULSE data in late 2023, following a fifth review of data quality by the CSO in October relating to garda data from Quarter 1 2023 onwards.

HIRT Recommendation 12

The HIRT has identified inconsistencies concerning the recording of deaths, which on the basis of 'reasonable probability' are (or are not) suicides. The HIRT believes AGS should not be the sole providers of data relating to suicide incidents and that such data collection requires a multi-agency approach. New PULSE categorisations for the classification of deaths (Recommendation 2) should incorporate a more appropriate category for death resulting from self-inflicted injuries. The HIRT recommends the Department of Justice and Equality examines the issue of the recording of incidents of suicide. The HIRT recommends new policy in relation to the recording of Non-Crime incidents on PULSE. The HIRT recommends a PULSE upgrade (IT fix) to provide for Form 104 to be printed directly from Pulse incidents, which will ensure a consistent set of data within, and disseminated by AGS. This will ensure consistency between Pulse data (categorisation) and Form 104 regarding sudden deaths and self-inflicted injury deaths recorded by AGS.

NOT IMPLEMENTED

Assessment: Recommendation 12 related to identified inconsistencies concerning the recording of deaths, which on the basis of 'reasonable probability' are (or are not) suicides. In this context, HIRT made a number of recommendations for example, that An Garda Síochána should not be the sole providers of data relating to suicide incidents. It believed that such data collection necessitates a multi-agency approach and examination by the Department of Justice of the recording of suicides.

HIRT also recommended new policy in relation to the recording of non-crime incidents on PULSE, a PULSE upgrade (ICT fix) to provide for 'Form 104' to be printed directly from PULSE incidents.

Form 104 is a document issued by the CSO to An Garda Síochána in respect of most inquest cases. This is sent to the Divisional Inspector of the relevant location where the death occurred and is then redirected to the garda member that attended the scene of the death. Form 104 collects additional information on the circumstances/location of the death and the information returned on this form is strictly confidential under the Statistics Act 1993.

The Garda member completing Form 104 provides his/her opinion as to whether the death was an accident, homicide, suicide or undetermined. That information is taken into account when the CSO assigns a statistical code for cause of death.

This, according to HIRT, would ensure a consistent set of data within, and disseminated by, An Garda Síochána and consistency between the categorisation of PULSE data and Form 104 in respect of sudden deaths and self-inflicted injury deaths recorded by the organisation.

HIRT has been working with the CSO regarding new guidance on the submission of Form 104 with current guidance from the CSO being that Form 104 is only required when prompted by the CSO.

As outlined, the implementation of recommendation 12 is connected to recommendations 2 and 8. For example, HIRT recommended the revised PULSE categorisations for the classification of deaths (recommendation 2) should incorporate a more appropriate category for death resulting from self-inflicted injuries. However, recommendations 2 and 8 have not been fully implemented and require that the policy and guidance around the categorisation of death is finalised as outlined in the update provided on recommendation 8.

HIRT Recommendation 13

The HIRT recommends that a Garda member should always accompany the injured / deceased person in the ambulance to hospital to ensure best evidence is available for continuity of exhibits/evidence and where the death is considered suspicious all clothing and evidence should be seized and retained in the hospital.

IMPLEMENTED

Assessment: Policy clarifying the requirement for a Garda member to accompany the injured or deceased person in the ambulance was already in place prior to the Homicide Review. This was contained in Section 9.2.7 of the Crime Investigation Techniques Manual and HQ Directive 10/2018. During September and October 2019, a communications strategy was undertaken to highlight the existing policy. This included a corporate notice on the Garda Portal and a national desktop screen saver outlining the key objectives of the policy. In addition, it was mandated that all gardaí on relevant training courses receive training on the directive and relevant section of the manual. This included student/probationer training.

This is one of the recommendations that does not require new policy or additional actions. However, it does require ongoing supervision to ensure Garda members' adherence in all relevant incidents.

HIRT Recommendation 14

The HIRT recommends that when taking key cautioned memorandum of interview and key witness statements (e.g. vulnerable witnesses), consideration is given to the recording of cautioned interviews using audio/visual recording equipment to ensure best evidence is available.

IMPLEMENTED

Assessment: Training for SIOs, IRCs and Level 3 and Level 4 Interviewers as well as courses for Detective Sergeants and garda training programmes were updated to implement this recommendation. The recording of cautioned interviews is now recorded as normal practice within stations.

HIRT Recommendation 15

The HIRT recommends that where houses or premises are identified for house to house enquiries, that call-backs must be conducted to unanswered houses/premises, and if not, a written decision rationale for not conducting callbacks must be documented by the investigating member or SIO.

IMPLEMENTED

Assessment: Training programmes for SICCs, SIOs, IRCs were updated to emphasise this requirement. In Divisions with the IMS, an investigating officer confirms when this job is completed and if not completed requires a rationale before the job can be closed.

HIRT Recommendation 16

The HIRT recommend revised policy in relation to recording the 'motive' of a crime or incident, to include further categories (such as 'hate crime'). This policy should be supported by an update to Pulse in relation to recording the 'motive' and 'modus operandi' of a crime or incident.

IMPLEMENTED

Assessment: The suspected motivations for, and certain characteristics of, crime incidents are recorded on PULSE by making use of the modus operandi (MO) data field. The MO data field is used to record a discriminatory motive or domestic violence, for example. It is also used to record other characteristics of crime such as the use of weapons.[45]

As part of the crime recording procedure, it is also mandatory to consider whether a discriminatory motive is present in respect of all crime victims, and to record if necessary.[46]

The HIRT found, a lack of clarity behind the recording of the motive for crimes or incidents, resulting in an under reporting of the motive behind such crimes or incidents. HIRT also noted that a discriminatory motive may be recorded incorrectly.

45.CSO, 2018. Review of the Quality of Recorded Crime Statistics Based on 2017 data provided by An Garda Síochána, p.23.

46.It must also be recorded that 'no known discriminatory motives' were identified where none of the above were identified as being relevant. CSO, 2018. Review of the Quality of Recorded Crime Statistics Based on 2017 data provided by An Garda Síochána, p.23.

This recommendation was completed in March 2022. This followed PULSE release 7.6 introduced in October 2020. There were two relevant changes arising from this release. The release updated the nine discriminatory motives to include the word 'anti' i.e. anti religion or anti age. This was done to improve the quality of data entry. The addition of a discriminatory motive to a Hate Crime incident, indicated the presence of hostility or prejudice against the characteristic, as opposed to the mere presence of the characteristic. So rather than just recording that a victim of a crime had a particular characteristic e.g. was of a particular religion, this now identified that their membership of the religion was itself the motive for the attack. This improved the reporting and recording of hate crime and non-crime hate incidents on PULSE. In 2017 the CSO had published a report in which it indicated that statistics with a discriminatory motive were - based on the MO data field - understating the number of recorded incidents where such a motive is known or suspected. The CSO also indicated that there may also be crime incidents for which a discriminatory motive is incorrectly recorded. The PULSE update included the introduction of a Hate related tick box and the mandatory selection of discriminatory motives (aligned with the An Garda Síochána Hate Crime definition).

The PULSE 'Motive' and MO functionality was previously grouped together in the PULSE Incident MO tab. The change to PULSE separated these into 2 distinct screen areas and the tab was renamed 'MO' and 'motive' to reflect the separation. The distinction between motive and MO of a crime or incident was now more clearly distinguished with both required to be filled out.

Data Quality checks undertaken in GISC include checks to ensure that motives relevant to an incident are correctly recorded. This now includes an enhanced process for key motives.

HIRT Recommendation 17

The HIRT recommends priority is given to the roll-out of PEMS 3 and that PEMS should incorporate the storage of all property and exhibits (custody records, notebooks, etc.).	**NOT IMPLEMENTED**

Assessment: Recommendation 17 related to giving priority to the roll-out of the Property and Exhibits Management System (PEMS). PEMS is an ICT system designed to electronically manage and track all property and exhibits coming into the possession of An Garda Síochána. PEMS Part 1 was introduced through HQ Directive 18/2016 and came into effect on 30 March 2016. PEMS Part 1 was introduced as an interim project and the first of an intended three stage approach to the implementation of an overall property and exhibits management and storage strategy within An Garda Síochána.

PEMS Part 2 introduced in 2017 was focused on the ICT system and implementing a comprehensive electronic tracking system to manage all objects coming into the possession of An Garda Síochána and is designed to provide a property and exhibits management system to manage, store and dispose of objects in a secure, effective, efficient and professional manner.

The HIRT found instances of exhibits being misplaced during investigations under its review. The HIRT advised that greater care should be taken with exhibits coming into the possession of An Garda Síochána during the course of an investigation, recommending that all exhibits be retained in a secure place in a timely manner until they have been submitted to the exhibits officer or PEMS storage.

As PEMS, according to HIRT, was having a positive impact on the tracking and secure storage of property/exhibits, it was recommended that PEMS Part 3 be prioritised and further progressed to provide a 24-hour property/exhibit, drop and collect facility.

The Garda Internal Audit Service published an audit report into property and exhibit management in July 2023 indicating an 'unsatisfactory' assurance level and identifying five high-priority matters requiring attention: PEMS policy governance; Divisional property stores capacity; the Garda National Repository; items being stored outside of divisional property stores; and PEMS training.

The 2024 Post Implementation Review (PIR) of recommendation 9.16 of the Crime Investigation Report published by the Garda Síochána Inspectorate in 2014 found that in the roll out of a national system was not operating to its full potential. The PIR as a result made a number of recommendations including the identification of a single PEMS store in each division, comprehensive in-person training for PEMS managers and staff, and the inclusion of property and exhibit management as a key performance indicator to be monitored as part of the Performance and Accountability Framework or PAF.

An Garda Síochána marked this recommendation as implemented, as the roll out of PEMS 3 has been approved and is being implemented according to the National PEMS 3 Implementation Plan. However, building works are still to be completed in five Garda Divisions and the PIR conducted suggests that there is still work to be done to achieve the spirit of the recommendation.

HIRT Recommendation 18

The HIRT recommends the implementation of a mechanism to review non-crime investigations (surrounding deaths, other unusual or particular circumstances, or investigations of public importance), which should be supported by policy.

NOT IMPLEMENTED

Assessment: Recommendation 18 is outstanding. This recommendation reflected the HIRT's finding that investigation files were submitted to the DPP in a number of instances where the investigation established no crime had occurred (e.g. sudden death incident). These instances generally related to deaths where there were particularly unusual circumstances. HIRT also recommended that an internal mechanism to review particular investigations (both crime and non-crime) is implemented.

The Authority understands that the Assistant Commissioner for Organised and Serious Crime circulated new draft Serious Crime Review Guidelines to all members of An Garda Síochána's Senior Leadership Team (SLT) in June 2025. A draft was subsequently submitted to the Policy Governance and Coordination Unit on the 1 October 2025. These guidelines await finalisation and SLT approval. On 2 May 2025, the Assistant Commissioner for Organised and Serious Crime issued an instruction relating to suspicious sudden infant deaths and a requirement for engagement with the relevant Coroner.

The recommendation sought that processes would exist that gave assurance regarding the oversight and governance of the investigation of non-crime incidents. The ability for a death to erroneously be entered as a criminal incident is possible but so too is the possibility of a criminal incident to be entered as a non-crime incident. The daily PAF processes whereby all incidents that occurred in the previous 24 hours are reviewed by the relevant sergeant provides one mechanism to review non-crime investigations. The Daily PAF Incident Report with all incidents created on PULSE in the previous 24-hour period (7a.m. to 7a.m.) is produced and reviewed at this daily PAF. While incidents recorded as a crime, go into the IMS with significant visibility for supervisors and gardaí, it is unclear at present if the impending policy will include a requirement for periodic dip sampling of non-crime death related incidents on PULSE. Policy finalisation is currently preventing this recommendation from being assessed as fully implemented.

HIRT Recommendation 19

The HIRT recommends joint protocols are established between emergency services regarding the notification of other agencies surrounding particular emergency calls.	**IMPLEMENTED**

Assessment: This recommendation was closed by An Garda Síochána following the establishment of joint protocols between An Garda Síochána and the National Directorate for Fire and Emergency Management, signed in March 2025 and published under HQ Directive 24/2025. The agreement of the Memorandum of Understanding followed engagement since 2020 between both organisations as well as key external stakeholders including local authorities.

HIRT Recommendation 20

The HIRT recommend that taking of contemporaneous notes and documentation of the rationale for decision-making is emphasised on Garda trainee and other relevant training and development courses.	**IMPLEMENTED**

Assessment: Contemporaneous note taking and the documenting of the rationale for decision making were embedded as core subjects in a number of An Garda Síochána training and development courses. In addition, internal communications using a "Corporate Notice" on the Garda Portal and National Desktop Screen Saver were developed and disseminated. In terms of the recording of the rationale for decisions, the IMS has an Electronic Decision Log that is used by all SIOs during SIO led investigations.

HIRT Recommendation 21

The HIRT recommends the status of missing persons on PULSE is reviewed as part of the annual anniversary review of missing persons (as outlined in the "Guidance on the Recording Investigation and Management of Missing Persons"), with consideration given to updating the status of the missing person to 'deceased' and 'dead' on PULSE.

IMPLEMENTED

Assessment: HIRT focused on a number of areas within this recommendation. These are: that the status of missing persons on PULSE is reviewed as part of the annual anniversary review of missing persons, with consideration given to updating the status of the missing person to 'deceased' and 'dead' on PULSE.

- That the threshold for recording a person as 'deceased' and 'dead' should meet higher criteria and standard of proof, with careful consideration, and that the updated missing persons policy should reflect this and provide guidance on the criteria, standard of proof and considerations to be given prior to marking a person 'deceased/dead' on PULSE.
- That an updated missing persons policy should also give some guidance regarding the categorisation of persons as 'deceased/dead' following the finding of particular body part(s), and the 'association' of relevant incidents and;
- That the revised policy should review the 'association' and 'casing' of incidents relating to missing persons and review PULSE rule 38 regarding connecting missing persons to other incidents.

A revised Missing Persons Policy Management, Recording and Investigation of Missing Persons was introduced in March 2026 through HQ Directive 015/2026 and the recommendation is now implemented.

C. Themes Arising and Potential Areas for Improvement

This section sets out some key themes arising from the engagement and work carried out for the assessment of the implementation of recommendations as well as potential areas for improvement.

1 Themes Arising

1.1 Governance and Supervision

The work undertaken for this assessment - including engagement with external stakeholders and An Garda Síochána - has identified evidence of enhanced supervision and governance in homicide investigations. There are more checks and balances and increased organisational infrastructure in place, including a range of supports from national units and bureaus.

At national level, the Garda National Bureau of Criminal Investigation (GNBCI) is available to provide support and advice, when needed, to local SIOs. The GNBCI is of the view that engagement with Divisions has improved and that there is a greater likelihood of short-term support being sought. The GNBCI highlighted increased engagement with local Divisions to provide advice, guidance or in some cases resources for investigations such as Level 4 interviewers to assist with interview strategy planning.

The work of the Serious Crime Review Team (SCRT) is aimed primarily at finding new investigative lead opportunities within investigations, to catch good and weak practices and disseminate learning arising from cases throughout An Garda Síochána. This can further improve practice and reassure both An Garda Síochána and victims/families about the quality of the investigation. The Serious Crime Review Team is active, and a number of cases in local Divisions are taken on each year.

The National Interview Advisor, moreover, conducts reviews of a sample of interviews each year conducted by level 3 and 4 interviewers[47] in local investigations to identify any serious issues with interviewing approach or content. The position of National Interview Advisor is also a mechanism by which the consistency and quality of interviewing is assessed.

As is discussed further in a subsequent section, interviewing is a key element of the investigation into a suspicious death and homicide and there are four levels of interviewing qualification and skill within An Garda Síochána aligned to the Garda Síochána Interviewing Model. These are aligned to the Garda Síochána Interview Model. The Advisor is also available to support investigations.

47. Level 1 is covered with students in the Garda College. Level 2 interviewing is typically undertaken in relation to volume crime. Level 3 interviewing is an advanced level for more serious, complex crime, while level 4 is supervisory level.

The reestablishment of a HIRT by An Garda Síochána in 2022 is an interesting and commendable development. It is an example of a proactive initiative by the organisation in response to concerns around the classification of deaths on PULSE, which came to light during analysis conducted by GSAS for the publication 'Domestic Sexual and Gender Based Violence A Report on Crime Levels and Garda Operational Responses'.

The new HIRT was tasked to look at cases from 2016 onwards, with a five-step approach taken to each case depending on the nature of the concerns identified. The work of the team ranges from a 'tabletop review' with data quality issues addressed, to an onsite review similar to that conducted by the original HIRT, in instances where serious investigative concerns exist.

It was also charged with drawing on this learning to review the PULSE categories to record deaths working with the CSO and external stakeholders and providing feedback on the work to revise the missing persons policy and the "Crime Counting Rules".

HIRT provided data on suspected or potential issues it has examined on cases between 2016 and 2020 where there were investigative concerns, misclassification of deaths and data quality concerns.

It is not certain at the time of publication if the HIRT will continue in its current form. It is resource intensive and the multi-disciplinary team members take on the HIRT responsibilities on top of other permanent roles and duties. However, it has provided a proactive mechanism by which the key issues which arose during the Homicide Review are kept under review on a consistent basis.

In terms of local supervision of investigations, this is undertaken by Sergeants, Inspectors, Superintendents and Chief Superintendents. Daily, biweekly and monthly PAF meetings take place at local, divisional and regional level which support the supervision and oversight of investigations.

The IMS was introduced as a key response to the findings of the HIRT review. The introduction of the system is initially resource intensive and constitutes a significant change from manual processes to a digital one.

Specifically, IMS was identified as a means by which there could be better governance and supervision that all the required tasks (known as 'jobs') within an investigation were completed within a suitable timeframe. The system is prepopulated with the relevant tasks pertaining to the investigation. The relevant documentation – for example witness statements – can be uploaded to the file.

The system addresses the issue of consistency in that every investigation lists out the jobs required to be completed, and these must be signed off as completed or a rationale provided to the supervisor. The ability for close supervision is provided in that there is access for the supervisor to an overview and the detail of the work completed by the garda member, in the investigation at any time. Arguably, enhanced supervision and governance of each investigation is enabled, in real time, by IMS.

In terms of supervision, another key change made since the Homicide Review is change to SIO Policy and Procedures, which has now formally segregated SIO responsibility into two types of role: a leading or supervising role. The SIO position therefore now has more of a governance element, which is considered positive for the workload of SIOs in that they are not now required to lead all investigations depending on the circumstances of the case.

1.2 Data Quality

Data quality has increased in importance within An Garda Síochána in the period since the Homicide Review. The issue of data quality in relation to the recording of deaths was addressed through the changes made to the PULSE system and through the establishment of a quality review function in the Garda Information Services Centre (GISC) in Castlebar, Co. Mayo in 2017.

The quality assurance of the recording of crime data in An Garda Síochána is now built around the following three main pillars:

- The primary collection of incident data carried out by Incident Creation Representatives at GISC;
- GISC Reviewers who assess the quality of created incidents, highlighting issues requiring clarification or updates required by placing the incident on 'Reviewed Clarification' on PULSE; and
- The PAF which includes PULSE crime incidents forming the basis for regular (at least weekly) operational performance reviews by local Garda management.

Following the publication of the fifth *Review of the Quality of Crime Statistics* in October 2023, the CSO lifted the 'Under Reservation' categorisation around Recorded Crime Statistics. The CSO concluded that PULSE data was fit for official statistical purposes, while also noting the improved data for operational policing purposes. This followed An Garda Síochána meeting requirements set out in the *Quality Improvement Proposal* agreed with the CSO in 2018 and in the CSO Quality Reviews.[48]

An Garda Síochána is now also undertaking regular data quality checks on PULSE data and crime Incidents for specific quarters of the year which are published periodically.[49] A review for Q4 2024, for example, reported that homicide incidents in which the injured party is associated with an incident was recorded, and that the injured party's gender and date of birth were correctly input in 100 per cent of incidents.[50]

GISC has undertaken a data coherency check of Sudden Death PULSE incidents (non-crime incidents) searching for keywords potentially indicating that an incident may need to be reclassified to a crime category. While PULSE incidents created from January 2023 to July 2025 have been reviewed, according to An Garda Síochána, for operational reasons, it is not possible to publish detailed data relating to this coherency check.[51]

48.CSO, Review of Quality of Recorded Crime Statistics 2023 Review of the Quality of Recorded Crime Statistics 2023 - Central Statistics Office

49.For example, see AGS, Review of Quality of Recorded PULSE Crime Data for Q3 2024. Available here.

50.For example, see AGS, Review of Quality of Recorded PULSE Crime Data for Q3 2024. Available here.

51. An Garda Síochána, AGS Crime Incident Data Quality Metrics – September 2025 Update p.12.

In addition, as part of the drafting and publication of the report 'Domestic Sexual and Gender Based Violence A Report on Crime Levels and Garda Operational Responses', GSAS and other sections of An Garda Síochána engaged in an extensive review of data relating to homicide and other offences in the context of gender-based violence. This work included reconciling relevant data with HIRT and determining the underlying motivations of offences in domestic violence and in the case of homicide, organised crime.

Finally, An Garda Síochána in collaboration with the OSP also engaged in data coherency checks in 2022 to further ensure the timely and accurate recording of suspicious death investigations.

Arguably, there has been a significant commendable shift in the view of data within the organisation, and it is now regarded as a key asset. The above work also coincided with a move within the organisation to combine data and technology into one organisational strategy which aimed to increase the accuracy, availability and usage of data by front line gardaí. This is evidence of a specific organisational drive to build better governance around data across the organisation generally and not just in terms of the homicide category.

1.3 Training

The area of training was one of the first to be addressed following the Homicide Review. Revisions were made to a range of courses - from garda trainees to SIOs. The immediate focus was to ensure that the specific issues arising in the Homicide Review - in particular issues that were already contained in training curricula – received greater emphasis. This resulted in a specific HIRT module on the SIO course while a presentation on the outcomes and recommendations also now featured at the annual SIO Conference.

A further key development has been the re-establishment in 2023 of the Crime Training Management Board. The main function of the Board – which meets four times a year - is to support and advise in relation to crime investigation courses which are delivered by the Crime Training Faculty in the Garda College. Board members at present are the Assistant Commissioner for Crime, the Chief Superintendent from the NBCI, the Superintendent for Crime Training in the Garda College, and an Operational Chief Superintendent.

The terms of reference of the Board are:

- appraising the effectiveness of crime training/development in at least one specific area each year[52];
- liaising with the relevant policy owner where updates in policy have been identified which require attention;
- reporting to the Deputy Commissioner, Policing Operations, on any significant risks identified in crime training that require executive support to progress; and
- supporting the Director of Training in endeavouring to mitigate any risks.

52. The Board can also appoint a sub - committee with expertise in the relevant area to assist with this work and make observations surrounding improvements for consideration.

In terms of the key role of SIO, there has been 172 SIOs trained since 2020 over 9 training courses. The SIO training course, which is accompanied by revised SIO policy and procedures, is now considered a "flagship" in the Garda College. The course takes approximately two years to complete, and the final qualification is a 'Level 9' post graduate diploma accredited by the University of Limerick (UL).[53] This training is now a pass/fail course and includes a dedicated module on HIRT and its findings. Twenty members graduate at present each year which is considered adequate for the organisation without leading to oversaturation or dilution in the standard of graduates.

The quality of the training and resulting skills and professionalism of SIOs was highlighted many times. Within An Garda Síochána, the SIO course is seen as high-quality training, a tough qualification to achieve but one which equips gardaí well to undertake the key SIO role.

The existence of an annual conference for SIOs, moreover, has provided a useful forum at which the findings of the HIRT can be presented and discussed by HIRT members. The annual conference speakers include senior, experienced SIOs who can speak credibly to the type of investigative issues found in the 41 cases examined. This annual conference as well as in person training is also widely regarded as a key means to develop relationships with colleagues and as an engine of knowledge sharing and seeking assistance from colleagues from different Divisions during investigations as required.

Interviewing is a key element of the investigation into a suspicious death and homicide. There are four levels of interviewing qualification and skill. These are aligned to the Garda Síochána Interview Model. Level 1 is covered with trainees in the Garda College. Level 2 interviewing is typically undertaken in relation to volume crime. Level 3 interviewing is an advanced level for more serious, complex crime, while level 4 is supervisory level.

The number of courses for the Garda Síochána Interview Model in the Garda College increased to eight in 2025 up from two annually before the COVID-19 pandemic. As of 9 December 2025, according to An Garda Síochána, there are 528 Level 3 trained Interviewers with 359 available to conduct interviews. Those not available may have been promoted to other roles. There are 98 Level 4 trained Interview Advisors with 76 currently available to develop advanced interview strategies and advise SIOs. This is considered by An Garda Síochána as striking the right balance between maintaining quality but providing an increase in quantity of level 3 interviewers within An Garda Síochána with an increase of 50 available members expected over five years.

The current National Interview Advisor is of the view that there is now, with increased skills across the organisation, a greater emphasis on planning and preparing interviews that there had been, in particular for dealing with vulnerable suspects and witnesses.

Peer Review Training has been reintroduced in the form of a three-day course developed and delivered under the direction of Detective Superintendent of the SCRT. The programme is designed to equip participants with the skills and confidence needed to conduct effective reviews. In 2025, two such courses were delivered at the Garda Training College, with a total of 38 participants taking part. In 2026, another Peer Review Training Course has been run with a second due to run in July.

53. SIOs can also undertake a subsequent Masters course in UL in Serious Crime Investigation following completion of the SIO course.

The Family Liaison Officers (FLO) Seminar was also reintroduced in November 2025. A seminar took place in Tipperary on 25 November 2025 hosted by a Superintendent in Crime Specialist & Operational Skills and brought together operational FLOs of both Garda and Sergeant rank to provide current and relevant updates in the area. The initial seminar was attended by 120 FLOs. Topics included the expectations of an FLO in a major investigation, Organ Retention Procedures, Disaster Victim Identification, Trauma Awareness and Employee Welfare. Similar changes were made to the training for Incident Room Coordinators (IRCs) who play a pivotal role in the management of an investigation.

In summary, there have been significant developments in the area of training that support the investigation of suspicious deaths and homicides, which has enhanced organisational capacity.

1.4 Role of the Senior Investigating Officer

As outlined, the new SIO policy has formally segregated responsibility into a leading and supervising role depending on the type of investigation. Prior to this, SIOs were assigned as lead on all relevant investigations. This is seen as positive for the workload of SIOs, while still facilitating their input and expertise in their supervision of cases. The role of SIO, it was argued, has professionalised AGS in terms of serious crime investigation and is hugely respected in Court.

With regards to the initial recording of incidents, a cultural shift in members was described, with a greater willingness of SIOs to consult with colleagues, seek additional support and external agency expertise. Increased caution when dealing with suspicious deaths and investigating homicides was also reported by SIOs.

The Chief Superintendents in the HIRT, the SCRT and the National Interview Advisor, for example, all described a greater willingness from colleagues in Divisions to seek formal and informal guidance from their offices during investigations.

1.5 Policy Related Recommendations

There are a number of the recommendations which were identified as needing policy revision to give them effect. Homicide and suspicious death are governed by a number of HQ Directives and associated policies. This includes those relating to crime classification, investigative policy and procedures, and missing persons. A number of these policies while revised versions have been drafted, have not been finalised and disseminated. In their absence, it is not possible to regard those relevant recommendations as implemented.

The issue of the pace of policy development and prioritisation of policies for revision is one that has arisen across many parts of the organisation, and it is an issue on which the PCSA has engaged with the Garda Commissioner. There is not currently a timeframe within which it is expected that the policies relevant to this review will be completed.

1.6 Increased Referrals of Deaths to the Office of the State Pathologist

In a previous section, the number of State cases were provided. During the course of this review, it was repeated by Garda members and other stakeholders that the number of cases being referred to the OSP has risen. When questioned as to why this is the case the view was reiterated by gardaí, the OSP and coroners that gardaí are now – post homicide review - more risk averse and will not take a chance with a death if there is any suspicion. This is reinforced by hospital based histopathologists being more reluctant to perform autopsies in general, but in particular where there is trauma or complexities involved, it was reported.

The Dublin District Coroner also reported that there is now a greater willingness to refer cases to the OSP on ambiguous cases due to increased caution and awareness of the possible benefits of a more 'belt and braces' approach. The interaction between gardaí and Coroner, it was reported, is often one of reassurance in deaths in which it is not possible to make a definitive judgment right away at the scene.

2 Potential Areas for Improvement

While significant progress has been made, a number of areas for improvement were identified during this review by both members of An Garda Síochána and external stakeholders. These are not all pertinent to the recommendations but are captured here as relevant to the investigation of suspicious deaths.

2.1 Selection Process for Senior Investigating Officer Training

In terms of the training of SIOs, a number of points were raised by current SIOs in relation to the selection mechanism for the SIO training course. At present, the initial applicants are selected by Regional Assistant Commissioners, by relevant role and experience, and then sent to the Garda College where the Director of Training hold final decision as to the suitability of candidates. There was an expressed desire for greater transparency to the process to ensure the right members of Garda personnel are selected and ultimately participate on the course. The fact that there is a failure rate was seen as a good thing indicative of the high standards of the course.

2.2 Content and Format of Information provided by An Garda Síochána to the Coroner and Office of the State Pathologist

In general, the communication between An Garda Síochána and Coroners including in Dublin is considered good. The OSP also reported improvement in the engagement of An Garda Síochána since the Homicide Review including increased formal and informal communication for advice on cases and incidents.

The Dublin District Coroner and OSP did however report some areas for improvement and of concern – namely the quality and completeness of information provided by An Garda Síochána on the required C71 (record of death) form.[54]

54. The C71 is a form completed by An Garda Síochána to notify a sudden, unexplained, violent or unnatural death to the Coroner's Office.

The OSP, for example, requires as much information as possible prior to the postmortem to inform its work including the deceased's medical and social history, prescribed medications, smoking history, and any alcohol or substance misuse. This is to rule out possible homicides or foul play. Any General Practitioner, Paramedic or recent hospital notes should also be provided.

Problems cited included:

- No medical history for the deceased provided;
- Name of the deceased's General Practitioner omitted;
- No information on history of alcohol or substance misuse; and
- Forms completed but lacking appropriately detailed information or containing inaccuracies.

While the Coroner can also supplement the C71 form with additional information, if the information is not provided by An Garda Síochána, the Coroner or a member of his or her office staff will have to contact the bereaved for it at an already difficult time.

The OSP would also like to receive information - including an aide memoire for gardaí on mobility devices - to improve An Garda Síochána practice and the information provided to the OSP prior to the examination of a body. It was also suggested that An Garda Síochána could make greater use of forensic archaeology in incidents where remains are concealed and forensic anthropology with skeletal remains.

There is also some delay in the presentation of files to coroners by An Garda Síochána. Coroners are often reliant on An Garda Síochána to make progress on cases. Files are required to schedule inquests but there is a considerable back log in Dublin.

While the relevant Coroner is the decision maker in the decision to hold an inquest, An Garda Síochána's members could, it was argued, have a greater awareness of cases which will likely require an inquest and send such files more expeditiously. The delays can be due to issues outside the Garda member's control such as medical information, but not always. At present, there is a lack of proactive supervision and governance within An Garda Síochána as to what information due to the Coroner remains outstanding on the part of individual gardaí at any point in time and how long this information is outstanding. This should be considered in terms of An Garda Síochána's obligations to victims, with any undue delays affecting not just the system but the families awaiting an inquest.

2.3 Non-criminal Cases

As outlined, An Garda Síochána has various obligations and commitments to victims of crime. According to An Garda Síochána, a revision of HQ Directive 10/2018 (Sudden Unexplained & Suspicious Deaths) is currently being undertaken which makes provision for a clear governance / review mechanism for the governance of non-crime incidents.

In the absence of the relevant finalised policy, however, it is not yet clear what mechanisms will be put in place to ensure that all cases of death classified as non-crime have been classified correctly. In engagement with the HIRT, it was suggested that the policy will contain a requirement for routine 'dip' sampling of non-crime incidents as a means of providing governance and reassurance in this area.

2.4 Training

Both the OSP and coroners stated that gardaí - in particular young and more inexperienced members - could benefit from training on the death investigation process involving the Coroner and pathology requirements. A Coroner used to provide in person training for garda trainees in the Garda College, but this is no longer carried out. Some local initiatives have taken place over the years. For example, the Dublin Coroner has had a number of engagements with groups of probationers in Store Street regarding the coronial process, the importance of the inquest for families and the role of gardaí in the Coroner's Court.

2.5 Learning from the Outcomes of Court Proceedings

It was suggested by some SIOs and those involved in the supervision of interviews that the dissemination of learning - arising from court judgements that have a potential impact on the approach to investigation - needs to be more timely. It was reported that this is the role of An Garda Síochána's Crime Legal Section. The National Interview Advisor spoke of an initiative undertaken by his office whereby a PhD student from Dublin City University analysed court judgements in the context of the interviews of suspects. This learning will be made available throughout An Garda Síochána.

2.6 Peer Review

Prior to the conclusion of the original HIRT process, An Garda Síochána invested in the training of circa 200 gardaí in peer review. There were mechanisms in place for the review of individual investigations through the SCRT and Domestic Homicide Review process. However, what was envisaged at that time was a process whereby peer review became a routine occurrence in investigations after either a certain period of time or when requested by investigators. At the time there was some concern within An Garda Síochána as to the 'cultural shift' required whereby investigators from outside divisions not previously involved in the investigation would review an investigation file, to hopefully assist in progressing the investigation. The process of peer review is a common practice for police other jurisdictions.

While the policy awaits finalisation, from engagement with senior gardaí it would appear that it is not the intention to proceed with a peer review process as initially envisaged. This view has, it was stated, been influenced by consideration of the resources required, but also a view that there is sufficient resources available at national level to provide assistance. It is not clear whether the HIRT is to have a continued role in reviewing cases where issues have been identified, or whether it will be disbanded. In the absence of clear policy, the question perhaps remains whether the support and governance provided by both the GNBCI and GSAS (in terms of classification) and the current mechanisms by which a peer review can be initiated will be sufficient; to take on what is currently being done by the HIRT and what was envisaged would be achieved through peer review.

Appendices

Appendix 1 – Terms of Reference: Garda Síochána Homicide Review Team

1. Independent Peer Review of the quality of the investigations carried out in respect of the 41 cases between 2013-2015: That each investigation is in compliance with the positive obligations under Article 2, European Convention on Human Rights and Section 7(1)(c), Garda Síochána Act, 2005, as amended.
2. Examine the degree to which PULSE is updated with outcomes from the Higher Courts in relation to Homicide incidents between 2013 and 2017.
3. All PULSE data relating to Homicide incidents from 2013 to 2017 to be reviewed, including fatal road traffic collisions. Where, following a preliminary Data Review, concerns relating to investigative issues are identified, Peer Reviews, at local level, are to be conducted.
4. Monitor PULSE, from 1st January 2018, to identify any deaths referred to the Office of the State Pathologist, to ensure they are correctly classified.

2 Appendix 2 – Glossary of Terms

An Garda Síochána (AGS)

Central Statistics Office (CSO)

Chief Information Officer (CIO)

Covert Human Intelligence Sources (CHIS)

Criminal Justice Operational Hub (CJOH)

Dangerous Driving Leading to Death (DDLD)

Dublin Metropolitan Region (DMR)

European Convention on Human Rights (ECHR)

European Court of Human Rights (ECtHR)

Family Liaison Officer (FLO)

Garda Information Services Centre (GISC)

Garda National Bureau of Criminal Investigation (GNBCI)

Garda National Protective Services Bureau (GNSPB)

Garda Síochána Analysis Service (GSAS)

General Data Protection Regulation (GDPR)

Incident Room Coordinator (IRC)

Information and Communications Technology (ICT)

Integrated Case Management System (ICMS)

Investigative Management System (IMS)

Irish Crime Classification System (ICCS)

Homicide Investigation Review Team (HIRT)

National Review Panel (NRP)

Modus Operandi (MO)

Office of the State Pathologist (OSP)

Performance Accountability Framework (PAF)

Policing and Community Safety Authority (PCSA or Authority)

Post Implementation Review (PIR)

Property Exhibit Management System (PEMS)

Senior Investigating Officer (SIO)

Senior Leadership Team (SLT)

Serious Crime Review Team (SCRT)

University of Limerick (UL)

PCSA

Údarás Póilíneachta
& Sábháilteachta Pobail

Policing & Community
Safety Authority