

Application of International Convention on Human Rights in British Colonial System As An Example for Malaysia

NOORFAJRI ISMAIL

ABSTRACT

Coroner's inquest or deaths investigation have always been regarded as a domestic law of the respective country. Therefore the local procedural legal framework on death enquiry is considered as a primary source of law. However investigation relating to who, how, where and on what manner the deceased came into his death are crucial issues pertaining to 'right to life' which is a salient feature of human right, a right that is internationally recognized via international convention. By virtue of Article 2 of European Convention on Human Rights (ECHR), everyone's right to life shall be protected by law. This obligation vested upon the State to protect the right to life so as to form an effective official investigation whenever there are cases of individual unlawful killed or died as a result of the use of force by, inter alia agents of the State. Any deprivation of life must be subjected to the most careful scrutiny. For example inquiry into deaths in custody e.g. under the control of police or prison officers, the State is under an obligation to provide plausible explanation as to the cause of death. The issue is whether ECHR can be regarded as universal standard hence being referred to and applied for the local coroners in holding inquest proceeding particularly in investigating to death cases beyond term of reference provided by domestic law. Thus broadening the scope of coroner's enquiry and compatible with the Convention right under Article 2. This paper will discuss the application of ECHR in UK colonial legal system by analyzing latest reported cases and the possibilities of Malaysian coroner to adopt the principle enunciated by the Convention in making the death investigation more effective.

Keywords: *Coroner's Inquest, Coroner, Human Rights, European Convention on Human Right, Domestic Law*

ABSTRAK

Inkues atau siasatan kematian oleh koroner lazimnya dikaitkan dengan perundangan domestik sesebuah negara. Dengan demikian skop perundangan tempatan berkaitan inkuiri kematian merupakan sumber perundangan utama. Bagaimanapun penyiasatan berkaitan dengan siapa, bagaimana, di mana dan dengan apa cara si mati menemui ajalnya adalah isu-isu penting yang berkait rapat dengan 'hak untuk hidup' yang

merupakan ciri utama dalam hak asasi manusia, hak yang dijamin oleh konvensyen antarabangsa. Artikel 2 Konvensyen Hak Asasi Manusia Eropah (ECHR) menyatakan bahawa hak untuk hidup bagi seseorang adalah dilindungi di bawah undang-undang. Obligasi ini terletak pada pemerintah atau kerajaan sesebuah negara untuk melindungi hak untuk hidup ini dengan menubuhkan satu badan penyiasatan rasmi yang berkesan jika wujud kes-kes kematian individu yang dibunuh tanpa lunas undang-undang atau mati akibat tindakan kekerasan oleh agen pemerintah. Setiap pencabulan pada hak untuk hidup mestilah tertakluk kepada penyiasatan menyeluruh, bebas dan berwibawa. Seperti kes kematian dalam tahanan polis atau penjara yang mana pihak kerajaan perlu berupaya untuk memberikan penjelasan berkaitan sebab kematian tahanan tersebut. Persoalannya adakah ECHR garis panduan sejagat yang boleh dirujuk dan di aplikasi oleh koroner tempatan dalam prosiding inkues mengatasi skop kerangka perundangan tempatan sedia ada. Sekali gus memperluaskan skop penyiasatan kematian dan bertepatan dengan kehendak Artikel 2, ECHR tersebut. Artikel ini akan membincangkan berkaitan aplikasi Artikel 2 dalam sistem inkues oleh koroner di UK dengan menganalisa kes-kes terkini serta kemungkinan mengadaptasi prinsip yang ada pada peruntukan tersebut oleh Koroner di negara ini bagi membolehkan sesuatu penyiasatan kematian atau inkues lebih efektif dan berkesan.

Kata kunci: *Inkues, Penyiasatan Kematian oleh Koroner, Koroner, Hak Asasi Manusia, Konvensyen Hak Asasi Manusia Eropah, Perundangan Tempatan/Domestik*

INTRODUCTION

INQUEST AND HUMAN RIGHT IN UK

The main function of holding an inquest on a dead body is to determine certain facts about the deceased, the cause of death, and the circumstances surrounding both the death and the cause. As a fact-finding inquiry by a coroner, four important questions need to be answered but they are limited to factual questions by a coroner i.e. the identity of the deceased, place of his death, time of death and how the deceased came to his death.¹ Lord Lane C.J. in summary stated that "The function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires".²

¹ *R. v North Humberside Coroner, ex.p. Jamieson* [1995] 1 Q.B 1 (CA).

² *R. v South London Coroner, ex.p. Thompson* (1982) 126 S.J. 625, D.C.

The *Brodrick Report*³ 1971 concluded that in modern society today coroner's inquest should serve on the basis of public interest i.e. not just to determine the medical cause of death but to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths; to allay the rumours or suspicion; and to advance medical knowledge within the medical fraternity. In consideration of public interest, the coroner should also preserve the legal interest of the deceased's person's family, heirs or other interested parties concerned.

Coroner's inquest or death investigation has always been regarded as a domestic law of the respective country. Therefore the local procedural legal framework on death enquiry, for example, Coroners and Justice Act 2009 (UK) and Coroners Rules 1984 (UK) are considered as primary sources of law. However, investigation relating to who, how, where and on what manner the deceased came into his death are crucial issues pertaining to 'right to life' which is a salient feature of human rights, a right that is internationally recognized via international convention.

The Human Rights Act 1998 (HRA), which came fully into effect on 2 October, 2000 gave effect in UK law to the European Convention on Human Rights (ECHR). The ECHR is a treaty of the Council of Europe, drafted in the late 1940s and passed in 1950 as a setback of Second World War to avoid a repetition of the abuses of human rights. It is intended by legislature that HRA 1998 is to give more direct effect to a number of rights guaranteed by ECHR in domestic UK law. Other implications of HRA are as follows:

1. the aggrieved party will be able to petition the European Court of Human Rights at Strasbourg for any act by local public authority that is incompatible with Convention rights;
2. the aggrieved party can sought a declaration of incompatibility from the European Court of Human Rights that the primary local legislation is incompatible with a Convention rights;⁴
3. illegality for a public authority⁵ e.g. Court of tribunal, Government Agencies such as Police Department, Prison Service, etc. to act in a way which is incompatible with the Convention rights;⁶
4. courts are now required to take account of decision of the European Court of Human Rights and this includes other sources e.g. declarations and

³ Report of the Committee of Death Certification and Coroner, Cmnd. No.4810 dated September 22, 1971 chaired by Mr. Norman Brodrick Q.C (later Judge).

⁴ s. 2(1) of HRA.

⁵ s. 6(3) of HRA.

⁶ s. 6 of HRA.

- advisory opinions decided by the Court when determining questions in relation to Convention rights;⁷ and
5. courts must interpret existing legislation in a manner compatible with the Convention rights.⁸

Convention rights may be relevant in coronial legal procedure and practice in a number of areas. In reference to ECHR and HRA, the rights that are most likely be raised in this context are as follows:

1. the right to life (Article 2);
2. the right to a fair hearing (Article 6(1));
3. the right to respect for private and family life (Article 8(1)); and
4. the right to freedom of religion (Article 9).

Courts in exercising its judicial authority have to ensure that primary legislation must be construed and interpreted together with subordinate legislation to give effect in a way which is compatible with the Convention rights. Christopher Dorries⁹ commented that in interpretation of coroner's law today requires extra step upon coming into effect of HRA i.e. according to ordinary principles, the Court will have to ask whether the result produced is compatible with Convention rights. If not, it will be necessary to try to re-interpret it to achieve compatibility. This will apply to the exercise of administrative powers under the Coroners Act and Rules e.g. in decisions such as the requirement for post-mortem examination, etc just as much as any judgment made in court during an inquest.

The author will discuss and examine briefly the relevant Articles enunciated by ECHR in the context of coroner's inquiry.

The Right to Life

Article 2 of ECHR relates to right of life which ranks as the most fundamental provision from which no derogation is permitted, even in times of national emergency. The Article states that "Everyone's right to life shall be protected by law and no one shall be deprived of his life intentionally save in execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

⁷ s. 2(1) of HRA.

⁸ s. 3 of HRA.

⁹ C. Dorries, *Coroners Court: A Guide to Law and Practice*, Oxford University Press, 2004, p 106.

This provision is crucial as the state's duty under Article 2 requires it not only to refrain from the 'intentional' or unlawful taking of life by state agents but also to establish appropriate measures to protect life and to take active steps to preserve a citizen's life where it is in danger from a third party and the authorities know or ought to have known of the risk.¹⁰

House of Lord in *Regina (Amin) v. Secretary of State for the Home Department*¹¹ discussed further as the State's duty in engagement of Article 2 as follows:

The state is under a duty to carry out an effective investigation, not only where there has been a killing by state agents, but also where there has, arguably, been a failure to protect life in breach of article 2(1). The duty to investigate is not "adjectival", i.e. subordinate or secondary to the duty to protect life, but is implicit in it. The Strasbourg jurisprudence gives member states a margin of appreciation as to how its investigative duty should be fulfilled... The domestic court is, however, obliged to act consistently with principles declared in the Strasbourg jurisprudence which set minimum standards... To be effective the investigation must be independent of hierarchical or institutional connection, be reasonably prompt, and have a sufficient element of public scrutiny to ensure practical accountability and an appropriate level of involvement of the next of kin.

However in the case of *Re McKerr*¹², House of Lord has laid down the limitation on the scope in domestic law of the procedural obligation to inquire under Article 2 in deciding that the duty to investigate under the said Article did not arise in domestic law in respect of deaths before the coming into force of the HRA i.e. 2 October 2000.

In summary, the obligation to protect the right to life also requires that there should be some form of effective official investigation when individuals have been killed; died whether due to natural or unnatural cause; or as result of the failure, negligence, neglect or omission by any public authority. Any deprivation of life must be subjected to 'the most careful scrutiny' and this will include cases involving deaths which occurred in custody. The state is under an obligation to provide a plausible explanation as to the cause of death.

¹⁰ *McCann Savage and Farrel v UK* (1995) 21 EHRR 97; *Osman v United Kingdom* (1998) 29 EHRR 245; *Edwards v UK* 35 EHRR 487; *Salman v Turkey* 34 EHRR 425; *Menson v UK* (Application No47916/99), 6 May 2003; *Sacker v West Yorkshire Coroner* [2003] 2 All ER 278 and *In Re Rapier, dec'd* [1988] QB 26.

¹¹ [2004] 1 AC 653.

¹² [2004] UKHL 12 (HL).

The Right to a Fair Hearing

The right to a fair hearing can be found under Article 6 of ECHR that states:

In the determination of his civil rights or obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within reasonable time by an independent and impartial tribunal established by law.

In discussing the right under Article 6, it is noteworthy that Professor Paul Matthews¹³ commented that this Article relates to the principle of 'equality of arms' in inquest proceeding. Based on the said principle, the author submitted that in cases where this provision is engaged, it gives several rights to the parties involved such as:

1. having the same access to records and documents of a case which play a part in the Court's opinion;
2. opportunity to present their case under conditions not putting them at a disadvantage;
3. a right to know and to comment about the documents or other evidence produce; and
4. the opportunity to be involved actively and right to examine the witnesses during the inquest proceeding.

In regard to the right of disclosure, the Article confers a right of disclosure from the other party's relevant material in possession although not being produced to the court provided that the other party is the state or public authority itself. Otherwise, as a general rule, there will be no right of disclosure towards documents or materials to the parties individually.¹⁴

The Right to Private and Family Life

Everyone has the right to respect and shall not be interfered in his private and family life, his home and his correspondence except in accordance with the law. This is the third human right feature that relates to death investigation under Article 8 of ECHR. Some author feels that the impact of this Article on the Coroner is difficult to discern.¹⁵ But author is in the opinion that this right gave a great impact to the right of the family members of the deceased to the death

¹³ Paul Matthews, *Jervis on the Office and Duties of Coroners*, Twelfth Edition, Thompson Sweet and Maxwell, 2002.

¹⁴ *McGinley and Egan v UK* (1998) 27 E.H.R.C 421.

¹⁵ C. Dorries, *Coroners Court : A Guide to Law and Practice*.

investigation of their relative. While Christopher Dorries states that the list of persons entitled to participate in the inquest under Rule 20 of Coroners Rules 1984 (UK)¹⁶ will almost certainly be considered as having been extended, the position in Malaysia regarding to the rights of the deceased's family in inquest is silent. For instance, a family member has no 'Right of Audience'¹⁷ and 'Right to Disclosure' of any document or report and other relevant information under statutory procedural law.¹⁸

In UK, the right to have a family life extends beyond the formal relationships created by marriage, and includes relationships between siblings, uncle and nephew. Whereas in Islam, this right is only being recognized through proper marriage according to Syariah Law. The issue is whether the family members have certain rights and entitlement:

1. to be informed about the death investigation conducted by public authority e.g. Police Department, Prison Service, etc.;
2. to take part in inquest proceeding or 'Right of Audience' particularly in examining witnesses;
3. right of disclosure of documents whether being referred to the court or otherwise and this will include post-mortem report, investigation finding, witness statement etc.;
4. right in final arrangement of the body which include right to object to the post-mortem;
5. right to apply for a second post-mortem;
6. right to be legally represented by legal practitioner and right to receive legal aid.

The Right to Freedom of Religion

Right to freedom of thought, conscience and religion are guaranteed and absolutely protected under Article 9 of ECHR. This right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance but shall be subjected only to such limitations as are prescribed by law.

It is in the author's view, that the freedom of religion in relation to Article 9 is closely connected to several issues surrounding post-mortems and death rites of religion or cultures in final arrangement of the body, or retention of the

¹⁶ Relates to 'Entitlement to Examine Witnesses'.

¹⁷ Right to participate in legal proceeding or represented by legal practitioner.

¹⁸ Criminal Procedure Code (Malaysia).

body etc. Beliefs and practices with regard to the dead vary quite markedly amongst cultures, and at the time of a death, cultural and religious practices are profoundly important to the family concerned.

Objection to post-mortem on the ground of religion would likewise fail as the British law authorises the coroner to instruct the pathologist to perform invasive autopsy towards the body of the deceased. An invasive post-mortem will be justified even against religious belief where it contributes to the aim of inquest in promoting and protecting public safety and public health.¹⁹ Furthermore, it was held that Article 9 do not require that one should be allowed to manifest one's religion at any time and place of one's own choice. Common civility also has a place in the religion life.²⁰

LATEST DEVELOPMENT IN UK

The British coronial law has been reformed by introducing the new legislation known as Coroners and Justice Act 2009 (CJA) which received royal assent on 12 November 2009. The CJA replaced the framework for the investigation of deaths by coroners which was previously governed by the Coroners Act 1988 that was in consolidation with the existing coroner legislation, dating back to the early 1900s.

After series of consultation²¹, public debate²² and taking into consideration latest decided cases²³ from European Court of Human Rights, the British government acknowledged the need to revamp the existing coronial legal framework so as make it inconformity with the European standard of human rights laid down by ECHR. These legislative changes are considered as an overall package of reform aimed at addressing the weaknesses in the previous coroner and death investigation system.

¹⁹ *R. (Begum) v Denbigh High School Headteacher and Governors* [2006] UKHL 15 (HL).

²⁰ *R. (Begum) v Denbigh High School Headteacher and Governors* [2006] UKHL 15 (HL).

²¹ Fundamental Review on Death Certification and Investigation; and the 'Shipman Inquiry' (2003), Consultation Paper on the Introduction of a Statutory Duty for Medical Practitioners to Report Deaths to Coroners (2008) and Consultation Paper Regarding Sensitive Reporting in Coroner's Court (2008).

²² Public Consultation on a draft Coroners Bill published in 2006 and Consultation on a draft Charter for bereaved people who come into contact with the coroner service (2008).

²³ [2004] 1 AC 653.

Some of the key reforms are as follows:-

1. the institutionalisation of coroner's hierarchy for effective governance;
2. broadening the scope of coroner's investigation in line with Article 2 of ECHR;
3. improving the service bereaved families receive from a reformed coronial system by giving them access to public funding for representation in inquest proceeding;
4. giving those who are suddenly or unexpectedly bereaved, opportunities to participate in coroners' investigation, including rights to information and access to a straightforward appeals system; and
5. independent scrutiny and confirmation of the causes of death hence putting in place a unified system of mandatory death reporting and certification mechanism.

The institutionalisation of coroner's hierarchy can be seen by the creation of Chief Coroner²⁴ who will lead the coroners service, with powers to intervene in cases in specified circumstances, including presiding over an appeal process²⁵ designed specifically for the coroner system. Whereas the Senior Coroner²⁶ will take in-charge of each area (previously known as coroner districts) with the possibility of appointing Area Coroners²⁷ or Assistant Coroners to assist the senior coroner of the area. By having exclusive coroner's institution and the new route of appeal, author feels that it will serve as an independent body in investigating deaths which is different from the ordinary function of the judiciary in UK.

The scope of coroners inquest has been broadened by the amendment of section 5(2) of CJA that requires the scope of the coroners investigation to be widened to include an investigation of broader circumstances of the deaths, including events leading up to the death in question. This wider investigation is necessary to ensure compliance with the ECHR, in particular Article 2.

Other reform involved is the introduction of the public funding for advocacy in certain inquest proceedings²⁸ for the family members. In other words, for those family members who are involved in an inquest into the death of the person while in custody of the State, or deaths of British service personnel who die while in active service, the Legal Services Commission (UK) will be authorised to fund advocacy to the family members to be represented at such

²⁴ s. 35 of CJA.

²⁵ s. 40 of CJA.

²⁶ s. 23 of CJA.

²⁷ s. 22 of CJA.

²⁸ s. 51 of CJA.

inquest but subject to the funding criteria in the Funding Code enumerated under section 8 of Access to Justice Act 1999 (UK) and the means test. It is noteworthy that this fund is not accessible to those who are not an 'interested person' within the list provided pursuant to section 47(2) of the CJA. In other words, two limitations are provided by this provision i.e. firstly, the person seeking the access to these public fund must be involved directly in an inquest case into the death of person while in custody or in an active national service. Secondly, that person must be within the list of an 'interested person' so as to make him have a locus to be represented before the coroner's inquest.

CJA also provides the list of 'interested person' i.e. the person or group of person or government agencies that having beneficial interest in the inquest proceeding, to be able to participate and having access to all records as well as having the right to appeal against certain decision made during the course of investigations and inquests. By virtue of section 47 of CJA, the law recognises 13 classes of 'interested person', in relation to a deceased person or inquest into a person's death. Among them are the family members of the deceased, personal representative of the deceased, medical examiner and etc.

The death reporting mechanism introduced by CJA, will put all deaths reporting and certification under scrutiny, and this for author, aims to improve the practical accountability to the current and future coronial system itself compared to the previous coroners' practices. Under the new coroners legal regime, the medical examiner will scrutinise the attending practitioner's report and certificate, as well as other related information regarding the death of the deceased, either to confirm the cause of death reported or to refer the death to the senior coroner. If the medical examiner finds that the attending practitioner's report is either insufficient or incorrect, he will discuss with the attending practitioner to issue a fresh certificate of death. If in exceptional situations where the attending practitioner and medical examiner are unable to agree on the cause of death, the medical examiner will refer the case to the senior coroner.²⁹ The senior coroner will then assign other medical practitioner as medical examiner for the purpose of ascertaining the cause of death and this is considered as the third expert report. It must be noted that section 18 of CJA that is read together with the regulations made under the said provision had changed the practice of medical practitioners to refer deaths to a senior coroner from just a duty under common law into a statutory duty. During the making of this article, there was no latest decided cases that relates to practical application of the CJA and these provisions are yet to be tested by the parties concerned.

²⁹ S. 20 of CJA.

ECHR AS A UNIVERSAL STANDARD FOR MALAYSIAN CORONERS

It has been suggested by Crown Prince Raja Dr. Nazrin Shah³⁰ of Perak that Malaysia's judiciary should look beyond the national borders and adopt more international human rights thinking and standards in arriving at legal decisions.³¹ His Highness then elaborate further that it was not about imitating others but it is about seeking solutions to local problems by consulting universally accepted standards therefore drawing on the experience of others who have faced similar problems.

Substantive procedure in conducting inquiries of death in Malaysia can be found in Criminal Procedure Code (the "CPC")³² which came into force on 10 January 1976 throughout the country. Unfortunately, until today there is no major amendment to the said procedural provision that relates to inquest except in the late 2001 when the law was amended to insert the role of the Institute of Medical Research³³ in conducting the forensic laboratory tests and preparing expert reports for the investigation officers with regards to the tests that were conducted by the Institute. As the legislation on death investigation in other jurisdictions such as in the UK and Australia are being recently revised and amended, the author is of the opinion that our domestic law relating to inquest can be considered as outdated, outmoded, archaic and in dire need of revision.

Inquest is not compulsory under the CPC and since an option is given to the magistrate (Coroner) to record the cause of death without holding an inquiry provided he is satisfied as to the cause of death, in most cases the magistrate will resort to it. What the magistrate does is to study the sudden death report and if the evidence attached therein indicates that a certain verdict is appropriate, he or she would record that verdict. Only in doubtful cases would he or she conduct a full scale open inquiry in court.³⁴

Based on the author's observation, in many cases, inquests were initiated either by family persuasion or the direction from the Public Prosecutor as a result of the public outcry. Only in a few cases were inquests initiated by the Magistrate himself. In Malaysia, the Magistrate of first class will preside as the

³⁰ The Regent of Perak.

³¹ His Highness in delivering key note address when opening Judicial Colloquium on Human Rights, jointly organized by Malaysian Commission of Human Right and Malaysian Judiciary. Reported at News Straits Time, 24 October 2009.

³² Chapter XXXII, Act 593.

³³ Criminal Procedure Code (Amendment) Act 2001 (Act A1132) w.e.f 27th September 2001.

³⁴ 'Professorial Inaugural Lecture on Inquiries of Death' by Professor. Dr. Mimi Kamariah Majid. 29 November 1995 at University of Malaya. Published in *A Collection of Socio-Legal Essays*, by University of Malaya Press.

coroner in conducting the inquest proceeding. Though it is mandatory to hold an inquest, especially in cases of deaths of persons in police detention, in reality only a few inquest proceedings were held.

In 2004, the Royal Commission to Enhance the Operation and Management of the Royal Malaysian Police (the "Royal Commission") has been formed by the government as an outlet of public outcry towards the inefficiency, mismanagement, bureaucracy and negative perception of Royal Malaysian Police Force. In relation to death investigation, the Royal Commission in its final report stated that the public, NGOs and international organisations have voiced their concern that there are too many deaths in police custody and the failure of the police to investigate and hold inquests into these deaths effectively.

The Royal Commission found that the number of deaths in police custody for the period 2000-2004 is 80 deaths and only 6 cases where the inquiries were being held. Whereas in 22 other cases either the magistrate or the prosecutor had decided that an inquiry is not necessary which is contrary to section 334 of the CPC. This is because it is compulsory for the magistrate to hold an inquest for any cases of death in custody.

Others findings and recommendations from the Royal Commission pertaining to the above issues are as follow:

1. The law governing inquiry on death has to be amended to specify with greater clarity and specific duties of the police, the pathologist and the Magistrate within the specified time frame. In that regard, the Commission had proposed certain amendments to be made in the CPC;
2. The police had in certain cases, relied solely on the findings of the pathologist on the cause of death and stop their investigation. The pathologist duty is merely to establish the cause of death but whether the death is suicidal or homicidal can only be established by further gathering of evidence and investigation on the part of the police;
3. The Magistrate must be guided on the verdict that he can make after an inquiry. The circumstances under which a Magistrate may make an open verdict, a verdict of misadventure or a verdict of foul play after holding an inquiry should be set out clearly in the law.
4. The rules should be made to regulate the conduct of the hearing of an inquiry under Part VIII Chapter XXXII of the CPC. Under section 335(1) of the CPC, the Magistrate shall have all the powers which he would have in holding an "inquiry into an offence". In practice and under the law, Magistrates no longer conduct "inquiry into an offence". Therefore, the powers of a Magistrate when holding an inquiry under Chapter XXXII must be made clear in the CPC.

Non existence of any specific procedures as a guidance had caused uncertainty among the Coroners in conducting inquests. This can be seen in a few inquest cases that have been reviewed on various grounds e.g. uncertainty as to the 'right of audience' and difficulty in ascertaining the interested party to the proceeding;³⁵ erred in delivering verdict by specifically spelling out the penal offence committed by somebody who had directly caused the deceased to come to his death;³⁶ refusal in discovery of documents to the parties concerned;³⁷ being biased, superficial and failure to consider the evidence as a whole;³⁸ uncertainty as to the standard of proof in inquest; ambiguity in whether rules of evidence need to be strictly adhered to;³⁹ what type of evidence are relevant to the inquest (admissibility of evidence); etc.

The question remains whether the Malaysian coroner should adopt principles enunciated under ECHR as a guidance or guideline in holding an inquest. It is clear under CPC that criminal procedure for the time being in force in England shall be applicable by the local courts in the event of non-existence of special provision, provided that the importation of such legislation shall not be in conflict or be inconsistent with the CPC.⁴⁰ The local court is bound by the provisions of the existing rules and procedures. The judges should be careful and slow to adopt the decisions of the courts in other countries, even on the basis that it forms part of the common law.⁴¹ Thus the application of common law or English criminal procedural law is strictly on the ground that there is no provision which is made clearly by the CPC and if it is necessary based on the facts of the case.⁴² Cases shown below illustrate the application of English criminal procedure law by the local courts in criminal cases in situations where there is a lacuna in the CPC:

1. *Ong Lai Kim v Public Prosecutor*⁴³ where the court invoke section 5 of CPC to adopt English procedure in identification parade;

³⁵ *Sara Lily & Satu Lagi v PP* [2004] 7 CLJ 335.

³⁶ *Inquest Into The Death of Anthony Chang Kim Fook*, Malayan Unreported Judgments, High Court (Kota Kinabalu). Criminal Revision No. K43-05-2006. Judgment delivered by Sulong Matrajie J on 10 January 2007.

³⁷ *Retnarasa Annarasa v. PP* [2008] 4 CLJ 90.

³⁸ *Pendakwaraya v Shanmugam & 5 ors* [2002] 1 LNS 160.

³⁹ *Pendakwaraya v Shanmugam & 5 ors*.

⁴⁰ S. 5 of CPC (Laws of England, when applicable).

⁴¹ Per Abdul Hamid Mohammad FCJ in *Raphael Pura v Insas Bhd & Anor* [2003] 1 MLJ 513, 536, cited with approval in *Public Prosecutor v Mohd. Fazil bin Awaludin* [2009] 7 MLJ 741 per. Mohd Zawawi JC (as hc then was) at p 752.

⁴² *Tan Boon Hock v Public Prosecutor* [1979] 1 MLJ 236 (FC).

⁴³ [1991] 3 MLJ 111.

2. *Justin Milroy Narakera v PP*⁴⁴ where section 33 of English Criminal Justice Act 1925 was invoked as to how a corporation is to plead to a criminal charge;
3. *Public Prosecutor v Misbah bin Saar*⁴⁵ which adopted the English principle regarding as to whether unsoundness on mind factors to be considered in making assessment towards an accused's mental condition before making any plea; and
4. *Tan Boon Hock v Public Prosecutor*⁴⁶ where the Federal Court adopted the English law in addressing the issue of whether the appellant's bail should be continued if the appellate court order for retrial to the court of first instance.

Death inquiry in Malaysia is one of the inquiries though inquisitorial in nature classified as one of the special criminal proceeding under the CPC. Therefore section 5 of the CPC is applicable in relation to the reception of English law for inquest proceeding although the inquiry is not a criminal proceeding in nature. As early as 1971, in the case of *Re Derek Selby Dec 'd*,⁴⁷ it has been decided that section 5 of the Settlements Code (which is now known as the CPC) allows the reception of English law to death enquiry cases in determination whether the High Court can exercise its revisionary jurisdiction against the finding of a magistrate. Sharma J. in his judgment found that the High Court had a revisionary jurisdiction and since there is no special provision at that time regarding to the power to revise in this case, section 5 allows the reception of English law regarding the revisionary jurisdiction of the superior court to be applied against the verdict delivered by the magistrate or coroner as he had failed to consider crucial evidence, and was in a state of uncertainty during the process of reasoning before delivering the verdict of suicide.

In *Sara Lily & Anor v PP*⁴⁸ application of revision has been lodged by Madam Sara Lily who claimed to be the mother of the deceased against the verdict of a magistrate in not allowing her to examine the witnesses during the inquest of Francis Udayappan. It was held that section 5 allow the reception of Coroners Rules (UK) 1984 in determining the issue of 'interested person' who can participate in inquest proceeding hence having a right to examine the witnesses during the inquiry process.

⁴⁴ [1990] 2 CLJ 226.

⁴⁵ [1997] 3 MLJ 495.

⁴⁶ [1979] 1 MLJ 236.

⁴⁷ [1971] 2 MLJ 277.

⁴⁸ [2004] 7 CLJ 335.

Looking into the decision in the above cases it is clear that there is a need to adopt the principle enunciated by ECHR particularly in the aspect of right to life for death inquiry proceeding. Although Malaysia is not one of the European countries, the right to life is considered as a fundamental right not just by ECHR but also under the Universal Declaration of Human Rights (UDHR). Furthermore, in the absence of specific legislation regarding to the rules and procedures in conducting inquest, the reception of English law is crucial to the inquiry itself. Cases decided in UK can be considered as a common law which is persuasive in nature and can be a guidance to set the parameters of death inquiry. For example, in determining the issue on how the deceased came to his death, the term 'how', the inquiry should not just focus on matters directly causative of death alone or 'by what means' but also 'by what means and in what circumstances' as decided by House of Lord in *R v Coroner for the Western District of Somerset; ex parte Middleton*.⁴⁹

In *Middleton* it was commented that the coroner's inquest constitutes the means by which the state may discharge its procedural obligation under Article 2 of ECHR, which prescribes that 'everyone's life shall be protected by law', save where a criminal prosecution intervenes. One of the results of this approach is to put all death cases under careful scrutiny such as the circumstances in which persons, e.g. prisoners die in custody as to preserve the sanctity of life.

The advantages of this approach will serve the purpose of coronial inquest i.e. lessons can be learned from the circumstances of the death occurred so that in future the risk of injuries to the health and safety arising from similar circumstances should be prevented or reduced. Thus broadening the scope of a coroner's investigation in ascertaining the cause of death.

In matters such as a death in custody, the obligation of the coroner has been said to involve interlocking aims;

- 1) to minimise the risk of future like deaths;
- 2) to give the beginning of justice to the bereaved; and
- 3) to assuage the anxieties of public.⁵⁰

Cause of death had been defined under the CPC as to include not only the apparent cause of death as ascertainable by inspection or post-mortem examination of the body of the deceased, but also all matters necessary to enable an opinion to be formed as to the manner in which the deceased came by his

⁴⁹ [2004] UKHL 10.

⁵⁰ *Amin and Middleton v Home Secretary* [2002] EWCA Civ 390 (CA) cited by Ian Freckelton & David Ranson in *Death Investigation and the Coroners Inquest*, Oxford Publication, 2006.

death and as to whether his death resulted in any way from, or was accelerated by, any unlawful act or omission on the part of any other person.⁵¹ While death inquiries to be made by magistrate shall inquire when, where, how and after what manner the deceased came by his death and also whether any person is criminally concerned in the cause of the death.⁵² It is in the writer's view that the term of reference for the magistrate provided above are not comprehensive, lacking in clarity and open to public debate. Cases from 1971 until 2008 showed no reference towards the issue of circumstances of which the deceased came to his death and the absent of verdict to prevent similar fatalities by the coroner.

In the case of inquest into the death of *Sujatha s/o Krishnan*,⁵³ evidence disclosed during the inquiry on the missing samples taken from the deceased and the failure to conduct a mandatory post-mortem although had been requested by the investigation officer were disturbing factors to the case. Coroner Mohd. Faizi Che Abu in his verdict stated as follows:

Missing Samples/No post mortem report

This is indeed the most disturbing evidence in this inquest. The urine samples of the deceased were missing. The doctors testified that this was normal in Kelang Hospital; but in my view that is not a reasonable excuse especially in medico-legal cases such as this case. Having said that, I must decide the consequence of the missing samples in this inquest. I come to a conclusion that the only implication is, it had deprived me of obtaining medical certainty as to whether the deceased had taken Paraquat. I am now left with the circumstantial evidence and oral testimony of the witnesses. It is equally comforting to know that after this case, the Kelang General Hospital had cleared any misunderstanding in respect of medico legal case. The position is now that; a post mortem is mandatory once the police have requested it to be done. This is regardless of whether the patient was diagnosed in the same hospital or that the cause of death is known or that the family members had refused the post mortem. In this case, the reason why the post mortem was not carried out was due to the fact that it was refused by the family members and the cause of death was known. Again, this lack of understanding of the correct procedure has deprived me from knowing the cause of death of the deceased from the medical point of view. (emphasis added)

The verdict acknowledged the crucial issues on the failure of the health authority ie. Kelang General Hospital (KGH) to preserve the samples taken from the deceased or patient; and neglect in duty to perform the post-mortem as

⁵¹ S. 328.

⁵² S. 337.

⁵³ [2009] 5 CLJ 783.

requested by the police. But there is no indication or remark by the coroner on measures to prevent similar failure of duty in the future by the health department in exercising its duty towards identifying the medical cause of death of the deceased.

The learned coroner in his verdict acknowledged the role of the coroner in United Kingdom and Australia in giving recommendations if he thinks that it is necessary to prevent future fatalities, but he refused to do so as it would run foul of section 339 of CPC.⁵⁴ The author is unable to agree with the learned coroner's verdict that he was unable to give recommendations as his hands are tied by section 339 of CPC. This is irrelevant because the said provision relates to the power of Public Prosecutor to require the coroner's enquiry to be held and did not restraint the coroner from making any verdict on prevention from such future fatalities. It is noteworthy that this inquest proceeding was initiated by the coroner's own initiative after the coroner was dissatisfied with the report from the investigation officer and without any direction from the Public Prosecutor.⁵⁵ Furthermore, though section 337 of CPC expressly states 5 important questions to be answered by coroner i.e. who, how, when, where and in what manner the deceased came to his death, the author humbly submits that the coroner's role is not only as a facts finder but stretches beyond the said term of reference.

Since the missing samples is crucial in his verdict regarding the exact cause of death of the deceased, the failure of KGH authorities to secure and to preserve the said samples had raised doubts as well as an anxieties not just to the bereaved family but also to the public. Failure of the attending practitioner to perform a post mortem examination though had been requested by the investigating officer to do so, reflected a system failure on the part of the forensic department of KGH in handling medico-legal cases in their institution.

System failure refers to the failure of the KGH personnel who were in-charge of the mortuary or forensic department to follow the standard operation procedure (SOP) in handling medico legal cases. It is not the author's intention to explain at length about the concept of this system, but based on the evidences tendered in Sujatha's case, the act of the attending practitioner who refused to conduct the autopsy on the deceased is not just against the hospital's SOP but in contravention with section 331 of CPC which is serious in nature. As discussed in Middleton's case, the obligation of a coroner is not revolved around the 3 interlocking aims as previously discussed but also to prevent similar fatalities by the medical practitioners in the future. Therefore the coroner is allowed to invoke

⁵⁴ [2009] 5 CLJ 783, 796 (para 33).

⁵⁵ Based on the interview between the learned Coroner and the author at Kuala Lumpur Magistrate Court.

section 5 of CPC to adopt section 32 of CJA in delivering a verdict about the prevention of future and similar fatalities at the end of the enquiry as an indication for the relevant authority i.e. the Health Department, to act upon it.

CONCLUSION

As one of the country that promotes human rights in the international arena, Malaysia should be abreast with the latest developments and must be ready to review the laws which are not in conformity with the international standard of human rights. Application of principles under international convention is important towards the legal framework of inquest in Malaysia. Although inquest is considered as a domestic law, international laws and conventions plays vital parts in enhancing and promoting the protection of human rights not just towards the deceased alone but to the family, next of kin and other parties concerned.

The related procedural law i.e. CPC needs to be revised and be amended in order to make it in line with the current wave relating to death investigations. Attorney General Chambers should look into possibilities of introducing the Malaysian Coroners Act and Coroners Rules as a legislative framework and guidance in practice and procedure for the coroners. The said Act and Rules must be able to address important issues e.g. issues on the right of bereaved family members, list of interested parties, coroner's roles, powers and guidance in giving verdict etc. Coroners jurisdiction in United Kingdom and Australia are the best model in analysing their laws for the purpose of drafting the Act and Rules. The amendments to the law will give clarity to the presiding coroner in exercising his duties in investigating the death.

The coroners law reform definitely will be time consuming and requires strenuous effort from the government. As the cases on inquest are on the rise, the author is in the opinion that for the time being, the coroners must be bold and innovative in making efforts to adopt international human rights concept in making their verdicts. Provided that, in situations where the non existence of local procedural provisions act as an obstacle from doing so, the reception of English law is vital so as to supplement and to fill in the lacunae in the law. This interim measures are crucial so as to protect the sanctity of life guaranteed under international laws and convention as well as to assuage the anxiety among the public at large.

The establishment of coroners court and the creation of the post of coroners such as in UK will provide an effective governance towards the institution that will ensure prompt and systematic death enquiries. Coroners court will

complement the overall judicial system of the country and serve the purpose of administration of justice for the society.

While the proceeding of coroners inquest is costly, the government must provide the public funding for the bereaved family. This fund will include the legal fees and disbursements as well as free legal representation for the family members of the deceased. Department of Legal Aid, the related agency under the Prime Minister's Department must be given the task in authorising this fund to be utilised for the said advocacy costs. The author however, feels that this public funding must be limited to those who are involved in cases of inquests into the death of the deceased while in State custody e.g. under police or prison detention. This will lessen the burden of the family members hence giving legal access and justice for them in seeking the truth behind the death of their loved ones.

Finally, the scope of inquest must be broadened so as not just to ascertain the medical cause of death and to ascertain the 5 questions pertaining to the death of the deceased, but must also include the surrounding circumstances that lead to his demise and making recommendations to avoid similar fatalities in the future. By taking into consideration circumstantial evidences but with strict compliance to the rules of evidence, the purpose of death investigations i.e. to give justice to the bereaved will be served.

Norfajri Ismail

Lecturer

Faculty of Law

Universiti Kebangsaan Malaysia

43600 UKM Bangi

Selangor

Malaysia

Email : fajri@ukm.my