

MANAGING CORONER'S COURT IN MALAYSIA:  
RECENT DEVELOPMENT OF INQUEST PROCEEDINGS

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ABSTRAK

Artikel ini menganalisa prosedur siasatan dan pengurusan kes kematian mengejut oleh koroner di Malaysia. Inkues bagi kes kematian mengejut seharusnya berupaya merungkai sebab sebenar di sebalik kematian di samping mengimbangi hak dan kepentingan ahli keluarga atau waris. Namun dengan kerangka perundangan semasa yang kompleks, siasatan koroner bagi kematian kes-kes kematian mengejut sering kali dilihat sebagai tidak efektif dan menimbulkan ketidaktentuan dalam aspek amalan prosedur. Artikel ini menggunakan kaedah analisa kes-kes perundangan dan mendapati terdapat beberapa kes telah melalui semakan kehakiman oleh mahkamah lebih tinggi atas permohonan ahli keluarga atau waris si mati terhadap keputusan pihak koroner atas sebab tidak berpuas hati dengan pengurusan siasatan kematian mahkamah koroner. Adakah ini suatu tindakan alternatif yang lebih efektif berbanding dengan siasatan koroner? Kajian mendapati siasatan koronial yang efektif bakal meredakan keresahan umum kerana setiap nyawa warganegara perlu dilindungi berasaskan konsep 'hak untuk hidup' yang dijamin dalam Perlembagaan Persekutuan.

**Kata kunci:** Inkues koroner, kematian mengejut, hak untuk hidup, sains forensik, undang-undang

ABSTRACT

*This article analyzing the related procedure and management of sudden death investigation by the coroner in Malaysia. The main purpose of inquest should be to identify the actual cause of death behind the death as to balance the interest between the rights and the interest of the deceased's family member. However, the current legal framework is complex, hence defeat the actual purpose and objective of such investigation by the coroner. It is also submitted that the current procedure has created non-uniformity in practice by the coroners. This article employs method of legal case analysis and found several decisions made by the coroners was reviewed by the higher court on the application of the deceased's family member. Such cases reviewed created a few questions on the effectiveness of the current management of coroner's court. The study shows that an effective coronial investigation will be able to assuage public grievance and concerns as the 'right to life' is guaranteed by the Federal Constitution.*

**Keywords :** coroner's inquest, sudden death, right to life, forensic science, law

1.0 INTRODUCTION

The Inquests proceeding under Malaysian law is contained in chapter XXXII of the Criminal Procedure Code (CPC). With reference to the CPC, the Inquest proceedings are conducted in the Magistrate Court and the code also explains the function of the inquest as well as the procedures that must be followed in the conduct of the inquest itself. It is contained in **sections 329 to 341** of the Code.

In conducting an inquest proceeding, a Coroner apart of following the provision under the CPC, must also comply with the Practice Direction No. 1 of 2007 'Guideline on Inquest'. This guideline was then, as in line with the establishment of the coroner's court was repealed and replaced by the Chief Registrar of the Federal Court's Practice Direction No. 2 of 2014 dated 8 April 2014 (The Practice Direction No.2 of 2014). The Practice Direction No. 2 of 2014 was later revoked by the Chief Justice and replaced with the Practice Direction No. 2 of 2019 'Handling of Sudden Death Reports and Inquest by the Coroner Sessions

Court’.

An inquest is not a trial that involves the prosecution of an accused and a defence counsel to represent him or herself. According to Black’s Law Dictionary, an inquest is an inquiry by a coroner or medical examiner, sometimes with the aid of jury, into the manner of the death of anyone who has been killed, or died suddenly under unusual or suspicious circumstances, or by violence, or while in prison.

Justice Mah Kweng Wai JCA (as he then was) in *Teoh Meng Kee v PP* (2014) 7 CLJ 1034

*“An inquiry of death is not like a criminal trial. There is no complaint, no prosecutor and there is no accused person on trial. It is only an inquiry by a magistrate as to the cause of death and the Deputy Public Prosecutor is there not to prosecute anyone but only to assist the court with the examination of witnesses for the purpose of receiving the evidence. Hence the officer “conducting” the inquiry is known as an assisting officer and not as prosecuting officer. Counsel present is there not to defend anyone but only to look after the interest of those who have appointed him. The procedure and rules of evidence which are suitable for the accusatorial process are unsuitable for an inquiry of death which essentially is an inquisitorial process. At the close of an inquiry there is no finding of guilt, conviction or punishment of anyone. The threshold for the standard of proof in an inquiry of death must thus be lower than that for a criminal trial.”*

## 2.0 THE DEVELOPMENT OF INQUEST PROCEEDING IN MALAYSIA

Prior to the establishment of the Special Coroner’s Court in 2014, the issues and laws regarding Inquests in the country are very limited and not much been discussed. As such, it is only once in a while that it becomes a hot topic among the community and netizens when there are cases of custodial death or sudden death involving public interest or human rights issues.

The deaths in custody often arouse suspicion among the public at large and the families of the deceased particularly. The suspicion may be real or misplaced or the death may be due to suicide, natural causes or foul play by certain parties. When a person is legally taken into custody, the law imposes an obligation on the custody officer to ensure the safety of the person in the custody. Therefore, there is always a need to be transparent and accountable and to provide satisfactory answers to grieving family members about the cause and circumstances of death. The family of the deceased should not be left in the dark to get the answers they deserve to know so that they can bear the loss and lie down to rest their loved ones.

As such, the failure to conduct a timely independent investigation into the deaths often raises suspicions among the public that the authorities have something to hide. This will then result in an increase in negative perceptions of custody rights authorities. However, the fact is that such an independent investigation will not be conducted immediately.

The lack of interest and speed in conducting investigations into the suspicious deaths i.e when the deaths occurred while the deceased was in police custody or imprisoned or detained in a hospital psychiatry is all the more worrisome when the law requires local Magistrates to conduct such investigations. This fact is clearly contrary to human rights as enshrined in Article 5 of the Federal Constitution.

Hence, with the cases involving the importance of human rights, then re-emerged ideas and suggestions from the public as well as legal practitioners about the need to expedite the establishment of a Special Coroner's Court that is fair and transparent in finding the cause of death. With this special court, the Coroners appointed to conduct the Inquest will be more focused and thorough in conducting the proceedings and not as previous Coroners of Magistrates as in the case of **Teoh Meng Kee v PP** (*Teoh Beng Hock*).

Although a Special Coroner's Court has been established and has come into force in 2014, is it because it is not a full trial as in criminal cases or is it because of these Inquest proceedings are rare and only conducted when there are high profile cases and involve public interest, therefore its legal provisions do

not need to be reviewed or improved?

It is very clear that until the **Practice Direction No. 2 of 2019 ‘Handling of Sudden Death Reports and Investigation of Death by the Coroner’s Sessions Court’**<sup>1</sup> (Practice Direction No. 2 of 2019) came into force, while part XXXII of the Criminal Procedure Code remains unchanged of even a single word.

Referring to **item 7 of the Practice Direction No. 2 of 2019** it states that all cases of Sudden Death Report and Death Inquiry shall be handled by a Sessions Court Judge called Coroner, whereby when we specifically referring **Section 337 of the CPC**, it has stated that a Magistrate holding an inquiry 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. There is no such specific instruction likewise **Practice Direction No. 2 of 2019** where all cases of Sudden Death Report and Death Inquiry shall be handled by a Session Court Judge. If any, as stated in **Section 335 (1)** a magistrate conducting an inquiry under this chapter has the same powers as at the time he conducts an inquiry into an offence.

Having referred to the above section, this is clearly contradicting each other because when we talk about a criminal case or offence then it must be bound by the procedure in the Evidence Act. While the Inquest, as we already knew is not bound by any provision in the Evidence Act 1950. In fact, when we referred to **Practice Direction No. 2 of 2019, Part 5 (Siasatan Kematian) Paragraph D; Kelonggaran Pemakaian Tatacara dan Kaedah Keterangan**, where it states “*tatacara dan kaedah keterangan yang sesuai untuk proses accusatorial adalah tidak sesuai bagi proses siasatan.*”

An Inquest proceeding is different from trial proceedings in court. Unlike criminal cases, an Inquest is not a trial process against any individual or accused of an offence, but the purpose is to identify and determine the cause of death. It is the Coroner who controls the course of the proceedings in giving instructions, calling witnesses to testify under oath, as well as authorizing any prosecuting officers or lawyers who wish to assist in the inquest proceeding. In an inquest proceeding as well, only interested parties can examine witnesses. However, it is subject to permission sought from the court in advance. Only the Coroner has the right to decide whether the party wishing to raise a question is an interested party or not depending on the facts of the case.

This can be seen in the case **Sara Lily & Other v PP**<sup>2</sup>. There was an application by the Applicant to make a review under s. 323 (1) of the Criminal Procedure Code on the correctness, legality or propriety of a coroner's ruling on the rights of counsel representing the applicant in an inquest of a body found in Sungai Kelang by the Royal Malaysian Police. The Coroner allowed the Counsel representing the Applicant to 'watch the brief' on the basis that the Applicant, the mother of a police detainee named Francis Udayappan who had escaped by diving into the Klang River, claimed and had physically identified that the body found was the body of her son namely Francis Udayappan.

Both the Applicant's lawyer and the Malaysian Bar Council have applied for the 'right of audience' but the Coroner has decided that both parties are only allowed to 'watch the brief'. The issue to be decided is whether the Applicant and the Malaysian Bar Council are 'interested persons' and have the right to question witnesses or examine exhibits presented as evidence. Applicant's counsel also requested that all evidence regarding the arrest, detention and fugitive of Francis Udayappan be quashed and removed from the inquest record and ordered the coroner to limit the investigation only to bodies found to be unidentified (John Doe).

The court held that since the Applicant had claimed the body of 'John Doe' as the body of his son named

<sup>1</sup> Arahan Amalan KHN Bin 2. 2019

<http://library.kehakiman.gov.my/digital/Arahan%20Amalan%20KHN/2019/Arahan%20Amalan%20KHN%20Bil%202%20Tahun%202019.pdf>

<sup>2</sup> [2004] 7 CLJ 335

Francis Udayappan, the evidence of Francis Udayappan's arrest, detention and fugitives was important and relevant to the Coroner in this John Doe inquest. As a Coroner, he has a heavy duty and extensive powers in taking evidence before come to a decision. No one shall restrict the Coroner from taking such evidence as he deems necessary unless it is found that the Coroner has violated or is not in accordance with the principles of law.

The court subsequently added that the parties must show that they have a 'real, substantial and reasonable' interest before they have the right to question witnesses and examine documents or exhibits in the inquest. As a biological mother (no argument of denial by the deputy public prosecutor), it is certain that the applicant has a 'real, substantial and reasonable right' to any evidence about her biological son called Francis Udayappan. In the event of an inquest into the death of John Doe, the Applicant has no right to question witnesses and examine the exhibits; but in the inquest, evidence about her child is presented and it is certain that as a principle of justice, the Applicant as a mother has a 'real, substantial and reasonable' right to know; therefore, Counsel representing the applicant is allowed to examine the witnesses and exhibits presented during the inquest proceeding.

In Malaysian Judicial System, the Special Coroner's Court is practising 'inquisitorial' system where the Coroner will gather evidence either through witnesses or through documents that will assisting him in determining the cause of death of the deceased. In contrast to the court that conduct criminal cases, trial proceedings practising an 'adversarial' system where the role of a magistrate or judge is limited to acting as a judge controlling the course of the trial. The parties involved, namely lawyers and the prosecution play an active role in conducting the trial, besides the duty to decide how the evidence of the case is to be tendered, who should be called as a witness during the trial, the burden lies on the prosecutor itself.

The court has decided in the case **R v South London Coroner, Ex Parte Thompson**<sup>3</sup> where;

*'In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.'*

Thus, when we are saying the Coroner is whom the controller of the Inquest proceedings like giving instructions, calling witnesses to testify under oath, to decide what documents to be received as evidence or not as well as authorizing any prosecuting officers or lawyers who wish to assist in the inquest proceeding, what is actually the boundaries that he or she must be bear in mind while deciding any matters that raises as regards to the manner of the proceeding? Back to our CPC, definitely it does not state as details as practice direction do. Hence CPC is such not a complete and comprehensive legal statutory to be referred for in terms of Inquest proceeding.

From the above view, the Coroner must always remind him or herself that an Inquest is not a criminal trial and therefore they are not bound by the straight jacket rules of evidence as applied in criminal trial. The Coroner has also been minded that they should distinguish their role and function when they are at the same time presiding over criminal trials. If they failed to do so would frustrate the very purpose of an Inquest and the flexibility of procedures it possesses.

### 3.0 THE NEEDS FOR CRIMINAL JUSTICE REFORM IN INQUEST

In Malaysia, the Special Coroner's Court is a court that conducts Inquest proceedings to determine the cause of death of a person through a provision under Section 337 of the Criminal Procedure Code. A Coroner has to decide whether there is a criminal element in the case of the death. Judge Mohamed Dzaidin

<sup>3</sup> [1982] 126 SJ 625 DC

in the case of **Re Loh Kah Kheng**<sup>4</sup> had ruled that:

*“... it is the primary duty of the learned Magistrate conducting the inquiry to satisfy himself that there is sufficient evidence in whatever form or manner elicited and whether admissible or not, which could assist him in establishing the cause of death of the deceased, he is perfectly entitled to know and take cognizance of it...”*

Referring to **Section 334 of the CPC**, when any person dies while in the custody of police or in a psychiatric hospital or prison, the officer who had the custody of that person or was in charge of that psychiatric hospital or prison, as the case may be, shall immediately give intimation of such death to the nearest Magistrate, and the Magistrate or some other Magistrate shall, in the case of a death in the custody of the police, and in other case may, if he think expedient, hold an inquiry into the cause of death.

While in **section 329(5) of the CPC**, it only mentions the word magistrate in a statement such as *“the Officer in Chief of Police District (OCPD) shall immediately submit the report to the magistrate who is within the area of local jurisdiction where the body was found”*. Hence there is no special appointment or statement in the form of statutory duty stating that all sudden death cases and inquest shall be handled by a Magistrate.

According to **Section 333 (2)** of the CPC it states that “Magistrates shall conduct an inquiry as soon as possible in accordance with the provisions of this Chapter”, the practice previously applicable is that all death inquest cases shall be heard in a magistrate's court where a magistrate is directed to conduct such inquiry where he or she is present or on duty.

At this time in accordance with the Practice Direction No. 2 of 2019, it states that the handling of sudden death reports and death investigations is handled by a Sessions Court Judge called as Coroner. Therefore, it seems that the provisions in the CPC and guideline in the Practice Direction No. 2 of 2019 are inconsistent.

Referring to **item 7 of the Practice Direction No. 2 of 2019**, it has mentions that any reference to the word ‘Coroner/Magistrate’ shall also be read as a Coroner Sessions Court Judge.

Again, there is no statutory power that allows a court officer with the rank of Session Court Judge to conduct inquest proceedings stated in the CPC as provided by the Practice Direction No. 2 of 2019. It is not impossible if sooner or later the Practice Direction No. 2 of 2019 might be challenged its validity and hence how should the power and discretion be exercised by the Coroner?

#### **4.0 Recent Issues on the Inquest Proceeding**

##### **a) Disclosure of Documents**

In the Inquest Mohd Fadzrin bin Zaidi (deceased), a revision against the Coroner’s finding been filed at the Penang High Court in the name of Applicant **Zaidi bin Mohdzain & Anor v PP**<sup>5</sup>. The deceased had passed away on 22.11.2019 at approximately 3.20am whilst in police custody at the lock up of the District Police Headquarters Seberang Perai Utara, Penang. The deceased was the son to the both Applicants. The issue arises where before the commencement of the inquest proceeding, the counsel in the capacity as lawyers appointed to watch brief the Inquest proceedings on behalf of the Applicants has applied to the Coroner for the disclosure and delivery of relevant documents that will enable the Applicants as interested persons to effectively observe the Inquest proceedings and assist the Court whenever possible.

<sup>4</sup> [1990] 2 MLJ 126

<sup>5</sup> [2021] MLJU 722

However, the application was opposed by the Deputy Public Prosecutor acting as assisting officer on the grounds that section 51A of the CPC did not apply to an inquest proceeding. The Coroner having heard the parties, decided that section 51A of the CPC did not apply to an inquest proceeding and consequently denied the Applicant's request for disclosure of documents. Dissatisfied with the decision, made the Applicant bring the application to the high court. The High Court Judge in exercising its revisionary powers setting aside the Coroner's decision and ordered the disclosure of the relevant documents to the Inquest.

The Judge further added that *“this court holds that section 51A of the CPC cannot be the statutory provision that gives the Coroner the power to exercise a discretion to order the disclosure of documents in an inquest and corollary to that an application for disclosure for documents cannot be made under that provision. To that extent, the Coroner's discretion that section 51A of the CPC does not apply to an inquest is correct. The court subsequently gave its view that the decision of the High Court in **Retnarasa Annarasa v PP [2008] 4 CLJ 90** referred to by Learned Counsel for the Applicants cannot longer be taken as good authority for the proposition that section 51A of the CPC can be read together with section 51 of the same Act to give the Coroner the power to order the disclosure of documents in an inquest. Both Court of Appeal and Federal Court in *PP v. Dato Seri Anwar Ibrahim & Anor (supra)* had clearly held that section 51A cannot be read as an extension to section 51 of the CPC and that they must read separately.....”*

Having read the above finding we can see that, in any situation in the Inquest proceeding, the Coroner even though he or she has the power to control the Inquest proceeding, it doesn't mean that he or she can apply his discretionary power without considering the facts and circumstances of the case before him/ her.

As decided in the case **Retnarasa a/l Annarasa**<sup>6</sup>, where the magistrate court was conducting an inquest into the death of the applicant's wife when counsel made an oral application for several reports to be supplied to the Applicant. The Magistrate refused and instead ordered that the reports be given to the Applicant after the relevant medical witnesses had given evidence. Dissatisfied the Applicant filed a notice of motion to set aside the magistrate's order and to be supplied with the relevant reports. The Counsel for the Applicant subsequently narrowed his application for disclosure to the post-mortem report on the Applicant's deceased wife.

The court held to vary the order of the Magistrate and ordering the supply of the post-mortem report to the Applicant. The Magistrates conducting an inquest are obliged to follow Practice Direction No 1 of 2007. The practice direction is a very comprehensive guideline for Magistrates to follow in an inquest. It confers upon a Magistrate a discretionary power with regard to the release of documents. This discretion ought to be exercised in favour of releasing documents. Refusals to release documents have therefore to be justified with reasons.

#### **b) The Practice Direction (Arahan Amalan) is Not an Enforced Law**

We can see that so far there have been 3 practice directions that have been issued by the Chief Registrar Office of the Federal Court as follows; **(1) Arahan Amalan No. 1 Tahun 2007 'Guideline on Inquest'**<sup>7</sup>; **(2) Arahan Amalan Ketua Pendaftar Mahkamah Persekutuan Bilangan 2 Tahun 2014 'Pengendalian Siasatan Kematian (Death Inquiry) Selaras Dengan Penubuhan Mahkamah Khas**

<sup>6</sup> [2008] 8 MLJ 608;

<sup>7</sup> Arahan Amalan Bil. 1 Tahun 2007;

<https://intranet.kehakiman.gov.my/EAA/arahanamalan/Practice%20Direction%20No%201%20of%202007.pdf>

**Koroner**<sup>8</sup>; and the latest (3) **Arahan Amalan Bilangan 2 Tahun 2019 ‘Pengendalian Laporan Mati Mengejut dan Siasatan Kematian oleh Mahkamah Sesyen Koroner**<sup>9</sup>.

Logically why has this practice direction undergone revision and improvement every few years? Have we ever thought this effort might be made because there is an urgent need in conducting Inquest proceedings where too many issues involving public interest have already occurred? Why is this happening? Where is the cause?

In the certain media, there are several parties who have voiced their concerns over the management and conducting of this Inquest case. Urge after urge on the government has led the Chief Registrar Office to take steps to upgrade this practice direction (*Arahan Amalan*) in line with the current needs. This is because to review and revise the Criminal Procedure Code requires a lot of efforts and a process that takes a long time to be approved by Parliament.

Hence, the Legislative Body from now on has needs to take steps to begin preparations to make improvements to this CPC as it is a law enforcement whose validity cannot be challenged. While the practice directions are merely in the form of administrative directive and can be challenged at any time.

In the recent case, **Zaidi bin Mohdzain v PP**<sup>10</sup>, where the Coroner denied the Applicant’s request for disclosure of documents, the Deputy Public Prosecutor argued that the source of that power must come from the *Arahan*. The High Court hasn’t agreed to that argument simply because the *Arahan* does not have the force of law. It is merely an administrative directive issued by the office of the Chief Registrar of the Federal Court. A practice direction only aids the Court in applying the provision of the CPC (see at page 6, **The Criminal Procedure Code, A Commentary by Srimurgan Alagan** and the decision of the High Court in **Re Teoh Beng Hock** [2010] 2 CLJ 192; [2010] 1 MLJ 715.

In **Teoh Meng Kee** (supra), Hamid Sultan JCA expressed the view: [157] The Learned Magistrate in the instant case had assumed the role of a coroner and proceeded to deliver an open verdict relying much on the erroneous Practice Direction No. 1 2007 relating to Guidelines on ‘Inquest’, which is inconsistent with the provisions of CPC. All relevant parties must be reminded when interpreting a statute, first consideration must be to determine what the statute says and its effect. When the statute is clear in its application, common law principles cannot be imported. (see **PP v Yuvaraj** [1968] 1 LNS 116). The failure to follow the relevant provisions of the law has resulted in erroneous result which has caused the need to appoint a Royal Commission and has also attracted undue condemnation by the public of our criminal justice system. This also led to a miscarriage of justice to the family members of the deceased.

Although the above view did not find approval in His Lordship’s fellow panel Mah Weng Kwai JCA where His Lordship opined that an ‘open verdict’ is applied under common law, the point here is that the *Arahan* cannot be taken as the legal source of the Coroner’s power to order the disclosure of documents. The source must come from a statutory provision and in this Court’s view that provision must be section 51 of the CPC. It is clear by words in section 334 and 337 of the CPC, an inquest is an inquiry and in inquiry comes within the scope of the section 51 of the CPC.

<sup>8</sup> Arahan Amalan Bil. 2 Tahun 2014;

<https://intranet.kehakiman.gov.my/EAA/arahanamalan/22.%20Arahan%20Amalan%20Bil%202%20Tahun%202014.pdf>

<sup>9</sup> Arahan Amalan Bil. 2 Tahun 2019;

<https://intranet.kehakiman.gov.my/EAA/arahanamalan/2.%20Arahan%20Amalan%20KHN%20Bil%202%20Tahun%202019.pdf>

<sup>10</sup> [2021] MLJU 722

Section 51 of the Criminal Procedure Code empowers any court to issue a summons to the person, either the accused or the prosecution requiring him to attend and produce the document or property at the time and place stated in the summons or order if it or he considers that the production of the property or document is necessary or desirable for the purposes of any investigation, inquiry, trial or other proceeding under the CPC. The such application may be made at any stage of the proceedings.

As stating in the **section 51**<sup>11</sup> that “necessary or desirable for the purpose of any investigation, inquiry, trial or other proceeding”, it makes itself available either before the commencement of a trial or in the course of a trial. As such, the court has to consider the justice of the case and at what stage of the proceeding the application is made.

If the stage is prior to the commencement of the trial, regard must be had to the requirements in sections 152, 153 and 154 CPC inclusive that is that a charge must contain sufficient particulars of the offence.

The entitlement of the accused to any document or other material in the possession of the prosecution is entirely at the discretion of the court having regard to the necessity, desirability, relevance to the case and justice of the case – **PP v Raymond Chia Kim Chwee & Anor; Zainal bin Hj All v Public Prosecutor**<sup>12</sup>

Therefore, in an Inquest, any application for disclosure of documents must be made pursuant to the section 51 of the CPC. How that power shall be exercised by the Coroner must then be guided by the *Arahan*.

As such, a Coroner must at all times unless otherwise, favour the disclosure of documents to the interested persons. This Court agrees with the Learned Counsel for the Applicants that the disclosure of relevant documents is not for the purpose of embarrassing any party but it is to bring forth to light information that could enable the interested persons to assist the Court through the questioning of witnesses the determination of all the matters as required under section 337 of the CPC.

### c) CPC is Silent About the Coroner’s Finding

We can see in the CPC, nothing in any section states the manner in which a Coroner should give his decision. Thus, what is the standard of proof that needs to be considered before the Coroner reaching its findings. Since the decisions of Inquest cases does not bind one another, therefore this matter is very crucial because it is a needed guide by a judge in making a conclusion or decision in a case. When there is no standard of proof to be followed, it opens the door to Coroners who do not have enough evidence to give an open verdict or confuse the public. When involving high profile cases, the open verdict will cause dissatisfaction among the family of the deceased or interested parties.

As the CPC does not mention what kind of decision should be given by the Coroner, in Practice Direction No. 2 of 2019, Part G, it is stated that the Coroner/ Magistrate who conducts the Death Inquiry must make a finding on: a) siapa simati; (b) bagaimana simati mati; (c) bila simati mati; (d) di mana simati mati; (e) sebab kematian simati; dan (f) mana-mana orang yang melakukan perbuatan atau melakukan peninggalan yang menyalahi undang-undang yang menyebabkan kematian, tanpa membuat apa-apa dapatan mengenai liabiliti jenayah orang itu.

When there is no specific guidance in decision making, resulting little error in the inquest verdict. For example, in the Inquest of **Muhammad Adib bin Mohd Kassim** (unreported), the Coroner in her decision found that the cause that had led to Muhammad Adib’s death after 21 days from the day of the incident was blunt chest trauma injury (BCT) which was not resulted by Muhammad Adib’s own actions or an accident. Instead, it was the result of a criminal act by at least 2 or more other unidentified persons who had pulled Muhammad Adib from his seat in the EMRS van, stripped the left front door of the EMRS

<sup>11</sup> Criminal Procedure Code

<sup>12</sup> [1985] 2 MLJ 436.



until it hit Muhammad Adib's right chest causing the BCT injury, slammed Muhammad Adib's left back into the end of the door leaf of the EMRS van and subsequently dragged Muhammad Adib to the side of the road on the night of the incident.

Muhammad Adib's death was also contributed by the failure of the PDRM and FRU teams to control the riot and provide proper protection to the fire brigade comprising Muhammad Adib who came to the location to put out the fire. The failure of the PDRM and FRU teams to use their powers under the provisions of the law that has been stated has also contributed to the death of the late Adib. With these findings and verdict, the Coroner has directed the Inspector General of Police and the Attorney General to do whatever is necessary to initiate any investigation under their authority as stipulated under the Criminal Procedure Code and the Federal Constitution of Malaysia and further prosecute if deemed reasonable.

Having read the Coroner's findings above, it is stated that the cause of Muhammad Adib's death was due to criminal conduct. However when at the end of the 'verdict' she instructed the Inspector General of Police of PDRM and the Attorney General to conduct further investigation and prosecute if deemed appropriate, this matter is clearly contrary to the guideline given by the Chief Registrar Office in the Practice Direction Bil. 2 tahun 2019. As far as we concern, the Coroner's duty is only to find the cause of death and not to determine who caused the death itself.

This matter has been previously discussed in the Inquest revision case viz **PP v. Shanmugam**<sup>13</sup>, where the Magistrate of Tumpat came to the conclusion that the action of the police team to shoot back towards the direction of the van was an act of self defence and that the retaliatory shots fired by the police were reasonable. The Magistrate further concluded that no criminal act had been committed emanating from the incident. The families of the six deceased persons filed the instant petition to review the outcome of the inquiry.

The court held that setting aside the verdict of the magistrate and substituting therefore a verdict of misadventure: (1) There was no reason why an opinion of the magistrate as to the manner in which the deceased came by his death may not be reviewed. So long as a miscarriage of justice had been committed by a magistrate, in that the correctness, legality or propriety of his findings were found wanting, a High Court judge was entitled to invoke his statutory revisionary powers (see p 571A-B). (2) The magistrate court had assumed the powers and duties of a coroner's court. A coroner's inquest was a court of law, though not a court of justice, because it was essentially set up to investigate and ascertain the cause of death. Apart from being shackled by a limited mandate, a coroner was also not bound to follow the usual procedure of law courts. The position of the magistrate in the instant case was no different to that of a coroner when holding an inquiry of death, and thus, the magistrate was similarly not bound by the usual procedure of courts of law and the normal rules of evidence. A magistrate who conducted an inquiry must however confine himself to the evidence made available to him, and decide on that evidence alone. If any verdict was based on probability and not on the established facts, that verdict must be quashed and an open verdict returned. (see pp 571D-E, 572A).

#### **4.0 The Challenges if The Inquest Provision in the CPC Remain Unreviewed and Unrevised**

Although the government has succeeded in creating a Special Coroner's Court run by a very experienced Sessions Judge, there are still endless issues and rumours. The matter has been raised by the Human Rights Body, Lawyers for Liberty (LFL) said, the establishment of coroner courts without enacting the Coroner Act or comprehensive structural changes does not remove the immunity of police officers involved in misconduct cases. Eric Paulsen noted that a Special Coroner's Court set up hastily without enforcing the Coroner's Act would result in most inquests ending in an 'open verdict'. Based on this issue, he is worried that it will be a normal situation where the police and the Attorney General's Chambers General's Chambers who previously neglected and protected members of the Police will continue and make severe

<sup>13</sup> [2002] 6 MLJ 562; [2002] 4 AMR 4019

accusations on the cause of death<sup>14</sup>.

Therefore, it is very necessary for the Legislature Body to review and revise the law provisions on Inquests in the CPC to be improved in accordance with the public interest and in line with the function of establishing a Special Coroner's Court that aimed at providing justice to interest persons in a suspicious case of death.

## 5.0 Conclusion

Based on this discussion, there is no doubt that the existence of the Special Coroner's Court can relieve the family members or interest persons of the deceased during the proceedings. It is because the proceedings handled by a Session Court Judge who has extensive experience in legal issues. Among the legal practitioners it is clear that the provisions contained in the Criminal Procedure Code regarding Inquest proceeding are incomplete as it does not touch on some important aspects in the conduct of a Coroner lead to the occurrence of lacuna. The Practice Direction No. 2 of 2019 which replaces the previous Practice Direction Bil. 2 Tahun 2014 although seen as more comprehensive but it is not a law in force.

Therefore, a Coroner shall ensure that the investigation and proceedings of the Inquest are carried out carefully, smoothly and without delay. The improvement to the existing system should be considered from time to time to ensure that the handling of Inquest proceedings can be done effectively and comply with all procedures that have been set.

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<sup>14</sup> Mahkamah Koroner tanpa penambahbaikan tak hilangkan kekebalan polis;  
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