

REEVALUATING THE ROLE OF CORONERS IN CUSTODIAL DEATHS IN MALAYSIA

REAVALIANDO O PAPEL DOS CORONEIS EM MORTES SOB CUSTÓDIA NA MALÁSIA

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Abstract

Deaths in custody continue to be a critical and sensitive issue in Malaysia, attracting significant attention from various stakeholders. Unlike countries such as the United Kingdom (specifically England and Wales), Australia and Canada, Malaysia lacks dedicated legislation for investigating deaths in custody. This study evaluates the adequacy of Malaysia's legal framework, focusing on the role of coroners. While coroners are key in determining the cause of death, their jurisdiction is limited by the Criminal Procedure Code and Practice Direction No. 2 of 2019, which restrict their authority to investigations without addressing systemic issues. Coroners in Malaysia depend on external reports and testimonies and do not independently visit death scenes. In contrast, coroners in other countries have greater independence and broader investigatory powers. The article recommends enhancing Malaysia's legal framework to grant coroners more authority for comprehensive investigations, improving accountability, and ensuring justice in custodial deaths.

Keywords: Death in Custody. Coroner. Coroner's Jurisdiction. Death Investigation. Legal Framework.

Resumo

As mortes sob custódia continuam sendo uma questão crítica e delicada na Malásia, atraindo atenção significativa de diversas partes interessadas. Ao contrário de países como o Reino Unido (especificamente Inglaterra e País de Gales), Austrália e Canadá, a Malásia não possui legislação específica para a investigação de mortes sob custódia. Este estudo avalia a adequação do arcabouço legal da Malásia, com foco no papel dos legistas. Embora os legistas sejam fundamentais para determinar a causa da morte, sua jurisdição é limitada pelo Código de Processo Penal e pela Diretriz Prática nº 2 de 2019, que restringem sua autoridade a investigações sem abordar questões sistêmicas. Os legistas na Malásia dependem de relatórios e depoimentos externos e não visitam os locais das mortes de forma independente. Em contraste, os legistas em outros países têm maior independência e poderes investigativos mais amplos. O artigo recomenda o aprimoramento do arcabouço legal da Malásia para conceder aos legistas mais autoridade para investigações abrangentes, melhorando a responsabilização e garantindo justiça em casos de mortes sob custódia.

Palavras-chave: Morte sob custódia. Legista. Jurisdição do legista. Investigação de morte. Arcabouço legal.



1 INTRODUCTION

In Malaysia, there is no specific legislation dedicated to the investigation of deaths, particularly those occurring in custody, unlike in countries such as the United Kingdom (specifically England and Wales), Australia, and Singapore, where specific statutes guide these investigations. In Malaysia, the legal framework for investigating deaths is found within Part VIII, Chapter XXXII of the Criminal Procedure Code (CPC), specifically in sections 328 to 341. While the title of the chapter refers to "death inquiry," it is important to note that the term encompasses not only inquest proceedings but also the process of investigating and reviewing death investigation files, as explained by Aminuddin Mustafa & Siti Nurul Aziera Moharani (2012) and Zulkifli (2020).

These provisions apply to a broad range of deaths, not limited to those occurring in custody. The determination of the cause of death in Malaysia involves more than just an apparent cause that can be identified through external examination or post-mortem. The investigation process, as stipulated in section 328 of the CPC, is comprehensive and takes into account any potential unlawful actions by others that may have contributed to the death. Additionally, under section 335(1) of the CPC, a magistrate conducting an inquiry has all the powers available to them in holding an inquiry into an offence, suggesting that coroners in Malaysia are not without authority, although their investigations remain dependent on information provided by others. This reflects the effort to ensure thorough investigations into all aspects of a death, particularly where foul play is suspected.

Further guiding the death investigation process is Practice Direction No. 2 of 2019, issued by the Office of the Chief Justice of the Federal Court of Malaysia, which outlines the handling of Sudden Death Reports (SDR) and procedures for death investigations within the Coroner's Court. This replaces the earlier Practice Direction No. 2 of 2014 and serves to clarify the procedural requirements for death-related matters (SUHAKAM, 2020).

The direction, particularly in Lampiran A, details the mandatory circumstances under which an inquest must be held, such as: (a) when a person dies in police custody (section 334 CPC); (b) when a person dies in care under suspicious circumstances; or (c) when the Public Prosecutor requests an inquest under sections 339, 328, and 329 of the Criminal Procedure Code.

While the role of the coroner in cases of deaths in custody is critical, it is important to note that the coroner's jurisdiction in Malaysia remains limited. The current provisions under the Criminal Procedure Code restrict the coroner's involvement primarily to conducting inquests and investigating causes of death, with little scope for oversight of pre-inquest investigations, which are managed by the police (McGowan, 2015; Rubenstein & Larkin, 2018). Although the coroner leads the inquest, the actual post-mortem is conducted by government medical officers, not by the police, which differs from perceptions that the police fully control all aspects of the investigation. Additionally, coroners in Malaysia are appointed from among Session Court judges, but their duties extend beyond death investigations to include other criminal cases. This dual role may raise concerns regarding the capacity of the coroner to focus exclusively on the significant matter of custodial deaths.

As Malaysia's legal framework is continually evolving, the effectiveness of the current provisions in addressing deaths in custody warrants reassessment. This study aims to examine the existing limitations and propose recommendations for expanding the coroner's role, enhancing transparency, and ensuring that the investigation of custodial deaths is both independent and thorough. The exploration of the jurisdiction of coroners and the examination of practices in other countries will be discussed in further sections.

2 METHODOLOGY

This study adopts a doctrinal legal research approach, focusing on the interpretation and analysis of legal frameworks to evaluate the adequacy of laws regarding deaths in custody in Malaysia. The main objective is to assess the effectiveness of current legal provisions, especially the Criminal Procedure Code (CPC) and Practice Directions, in investigating deaths that occur in state custody. Doctrinal research, as explained by Bryman (2016), involves analyzing laws, precedents, and statutes to understand their application and effectiveness in addressing specific legal issues. In this context, the study critically examines the jurisdiction of coroners and how their role is applied in custodial death cases.

To achieve this, content analysis be the primary methodology used. This qualitative approach involves systematically examining primary sources, including statutes, case law, and official reports, as well as secondary sources such as scholarly

articles and law journals (Silverman, 2013). The content analysis approach will help identify patterns and themes in legal texts that are directly relevant to investigating custodial deaths in Malaysia and compare these with legal practices in other countries.

The study also employs comparative legal methods to examine Malaysia's legal framework alongside those of countries with well-established custodial death investigation systems, such as the United Kingdom (specifically England, Wales), Australia, Canada, and New Zealand. This comparison is valuable in understanding Malaysia's strengths and weaknesses, and how it can learn from international practices to improve its system. For example, the UK's Coroners and Justice Act 2009 outlines comprehensive powers for coroners, mandating independent inquiries into deaths in police custody (Coroners and Justice Act 2009, UK). Similarly, Australia's Coroners Act 2009 (NSW) mandates that all deaths in custody, including those in police and prison custody, undergo a coroner's investigation (Coroners Act 2009, NSW). In comparison, Malaysia's system gives more discretion to the coroner, and inquests are only mandatory for deaths in police custody, while deaths in other detention facilities like prisons or immigration centers are not always subjected to inquests (Criminal Procedure Code, Malaysia).

The comparative analysis highlights gaps in Malaysia's legal framework, particularly in the limited powers of coroners. Countries like the United Kingdom (specifically England and Wales) and Australia have independent oversight mechanisms, ensuring impartial investigations and transparency, while Malaysia's system is more reliant on police-led investigations. This raises concerns about the independence of investigations when law enforcement agencies investigate deaths that occur within their own custody. International legal standards require independent and impartial investigations into deaths in custody (Freckelton & Ranson, 2006). In comparison, Malaysia's practice still faces challenges in achieving such independence and transparency, highlighting the need for reform.

Furthermore, the study investigates the procedural aspects of investigating custodial deaths in Malaysia. As stated by Noorfajri Ismail & Farah Nini Dusuki (2015), the inquest in Malaysia is a special inquiry process, and the coroner's role is inquisitorial. The coroner is tasked with gathering evidence, summoning witnesses, and examining the cause of death, but the investigation largely depends on the police's initial report. In other countries like Canada, Australia, and the United Kingdom (specifically England and

Wales), coroners have broader powers to conduct independent investigations, issue subpoenas, and even hold public hearings to ensure that the investigation is transparent and impartial (Rubenstein & Larkin, 2018). This difference in the role of coroners in Malaysia compared to other countries further underscores the need for reforms to increase the transparency and independence of death investigations in Malaysia.

By adopting a comparative legal approach supplemented by content analysis, this study aims to provide critical insights into the existing gaps in Malaysia's system and suggest reforms. These reforms should focus on enhancing the role of coroners, introducing mandatory inquests for all custodial deaths, and establishing independent oversight bodies. Such reforms are crucial in aligning Malaysia's death investigation system with international standards, ensuring that custodial deaths are investigated thoroughly, impartially, and transparently, thus restoring public trust in the justice system.

3 RESULTS AND DISCUSSION

To identify the gaps related to the research topic, the author has carried out an in-depth evaluation and review of several previous academic articles. Furthermore, the author has examined existing legal provisions both in Malaysia and internationally for comparison. The results derived from these analyses will be addressed in the subsequent sub-topics.

4 PRE-INQUEST INVESTIGATION INTO DEATHS IN CUSTODY

In Malaysia, the Criminal Procedure Code (CPC) serves as the primary legal instrument that governs the investigation of deaths, including those that occur in police or state custody. Section 329 of the CPC stipulates that it is the responsibility of the police to investigate any death that is reported as suspicious. This section mandates that upon receiving information about a death under suspicious circumstances, a police officer must carry out a preliminary investigation to ascertain the cause of death.

According to Section 329(5) of the CPC, after the preliminary investigation, the investigating officer is required to prepare a Sudden Death Report, which is then submitted to the coroner for further examination. The coroner has the discretion to decide whether an inquest is necessary based on the investigation findings. If the cause of death

is sufficiently clear, the coroner may decide that an inquest is unnecessary. If the cause is unclear or if there are signs of foul play, an inquest is ordered to further examine the circumstances surrounding the death. The findings of the inquest are then reported to the Public Prosecutor in accordance with Section 333(1) of the CPC.

A crucial aspect of the pre-inquest investigation is the role of the post-mortem examination. Section 330 of the CPC empowers the investigating officer to request an autopsy if they suspect the death was sudden or unusual. The officer must notify the nearest Government Medical Officer using Form Pol 61 to request the autopsy. The autopsy provides critical evidence regarding the cause of death and assists the coroner in determining whether further legal action is needed (Noorfajri et al., 2015).

The Practice Direction No. 2 of 2019 provides guidelines on the role of coroners in these investigations. Generally, coroners are not required to examine the body in cases of deaths in custody unless the police request it. This is a shift from Practice Direction No. 2 of 2014, which mandated coroner examinations in custodial deaths. Critics argue that this change reduces independent oversight and could allow suspicious deaths to go unchecked before an autopsy is conducted. The author suggests that the reintroduction of mandatory coroner examinations of bodies in custody deaths would enhance the independence of the investigative process and help identify injuries that may be significant before an autopsy is performed (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

For deaths occurring in police custody or other forms of detention, Section 334 of the Criminal Procedure Code provides specific provisions. For deaths in police custody, an inquest must be held as soon as possible to determine the cause of death. However, for deaths in other detention facilities such as prisons or hospitals, an inquest is not mandatory and only occurs if the coroner believes it is necessary. This raises concerns as it implies a disparity in the level of scrutiny between different forms of custodial death. Some experts have argued that all custodial deaths, regardless of the type of detention, should be subject to mandatory inquests to ensure fairness and transparency (Aminuddin Mustaffa et al., 2012).

Previously, pre-inquest investigations were conducted by the Officer-in-Charge of the Station (OCS) where the death occurred. However, in January 2022, responsibility for such investigations was transferred to the Death in Custody Crime Investigation Unit (USJKT) under the Integrity and Compliance Department (JIPS) of Bukit Aman. Despite

this organizational change, reports from Suara Rakyat Malaysia (SUARAM) have raised concerns about the effectiveness of USJKT in handling custodial deaths. Investigations have been slow, with no updates provided on several cases in the first quarter of 2022. Additionally, transparency regarding USJKT's internal procedures remains limited, with only the police knowing the details of their operational methods (FMT Reporters, 2022).

Concerns have also been raised about the independence and transparency of investigations, given that the police are investigating deaths that occur within their own custody. There is growing skepticism that police investigations may not be sufficiently impartial when conducted by the very institution involved in the incident. Sevan Doraisamy, the Executive Director of Suara Rakyat Malaysia (SUARAM), has called for an independent body, such as the Independent Police Conduct Commission (IPCC), to take over the investigation of custodial deaths. However, the IPCC is composed of both current and former police officers from the Royal Malaysian Police (PDRM), raising concerns that its ability to carry out independent investigations may still be compromised (Farah Marshita Abdul Patah, 2022).

The independence of investigations is vital to ensuring fairness and transparency, particularly in cases involving custodial deaths in Malaysia. High-profile cases such as *Re Teoh Beng Hock [2010] 1 MLJ 715* and *Nora Anne Quoirin [2021] 1 LNS 6* have raised concerns about the impartiality of the investigations. The cases of *Ho Kooi Sang v Universiti Malaya [2004] 2 MLJ 51* and *In Re Inquest into the Death of Sujatha Krishnan, Deceased [2009] 5 CLJ 783* stress the need for more thorough and independent investigations. A key issue identified in these cases is the over-reliance on autopsy reports without conducting further independent investigations, which has been recognized as a significant flaw in the justice system. These cases illustrate that relying solely on autopsy findings is insufficient to uncover the full truth, highlighting the necessity of a more comprehensive investigative process to ensure justice is achieved.

Moreover, investigations into deaths in police custody by the PDRM must be carried out with full transparency and integrity, adhering strictly to procedures and standard protocols without compromise. This is essential to ensure that the evidence gathered is reliable and can be properly considered by the court. For example, in *PP v Shanmugam and Ors [2002] 1 LNS 160*, the coroner ruled that an efficient investigation, supported by a comprehensive and well-documented investigation file, allowed for conclusions that protected human rights.

For investigations to be truly independent, they must be free from interference by authorities, particularly the police, who may have a vested interest in the outcome. Therefore, it is crucial to separate the roles of the police investigation from the coroner's inquest. International best practices support the distinction between the initial police investigation and the subsequent coroner's inquiry, as this helps maintain impartiality and thoroughness, ensuring that the truth is pursued without bias (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

Furthermore, the involvement of independent bodies like SUHAKAM is crucial in reinforcing the independence of investigations. These organizations help monitor and safeguard the integrity of the investigation process, ensuring that the proceedings are conducted impartially and transparently. Without an independent and transparent investigation process, public confidence in the justice system diminishes, especially in cases involving custodial deaths. Thus, the independence of investigations, as emphasized in the cases of Ho Kooi Sang and Sujatha Krishnan, is essential to preventing abuses and ensuring fairness in the system. These cases highlight the judiciary's growing awareness of the need for independent scrutiny of custodial deaths and the importance of ensuring that all aspects of the investigation, including the autopsy, are carried out impartially and comprehensively.

The United Kingdom (specifically England and Wales) has established a robust legal framework for investigating deaths in custody, ensuring independent oversight and transparency in the process. Under the Coroners and Justice Act 2009, coroners have a statutory duty to investigate all deaths that occur in police custody, particularly when the circumstances are suspicious or unnatural. However, Section 4 outlines the circumstances under which an investigation may be discontinued, rather than mandating an investigation in all cases. Sections 1–3 provide general definitions and the duty to investigate certain deaths, but the authority to mandate public inquests is subject to specific statutory criteria.

The United Kingdoms' (specifically England and Wales) legal framework prioritizes independent scrutiny and accountability, preventing conflicts of interest where law enforcement agencies might otherwise investigate their own conduct. Sections 1–3 of the Coroners and Justice Act 2009 provide definitions and outline the general duty of coroners to investigate certain types of deaths, such as those occurring in custody or involving violence. However, the specific powers to summon witnesses, request documents, and hold public hearings are found in other parts of the Act, including

Schedule 5 and Section 5C. This ensures that the investigation process remains free from political or institutional interference.

In addition to the role of coroners, the Independent Office for Police Conduct (IOPC) is responsible for investigating deaths related to police actions, ensuring that law enforcement agencies do not have direct control over their own investigations (IOPC, 2022). The IOPC operates as an external oversight body, reviewing cases involving police misconduct, use of force, or systemic failures that may have contributed to the death. The United Kingdoms' model, therefore, incorporates multiple layers of accountability, ensuring that pre-inquest investigations into custodial deaths are conducted fairly, transparently, and independently of law enforcement authorities.

This multi-tiered approach, involving both coroners and independent police watchdogs, offers a stronger guarantee of impartiality and transparency compared to systems where law enforcement retains primary investigative control. The United Kingdoms' model contrasts sharply with Malaysia's police-led pre-inquest investigation system, where the same institution responsible for detention also leads the investigation, creating a clear conflict of interest (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

Australia has developed a structured and transparent approach to investigating deaths in custody, particularly in light of historical injustices involving Indigenous Australians. The Coroners Act 2009 (NSW) mandates that all deaths in police or prison custody must be investigated by independent coroners, ensuring that each case is thoroughly examined. Section 27(1)(b) of the Coroners Act 2009 (NSW) is a key provision that mandates a formal investigation (an inquest) into any death that occurs while an individual is in police or prison custody. It ensures that deaths occurring in these contexts are subject to thorough, independent scrutiny, which is vital for transparency, accountability, and justice.

One of the defining moments in Australia's approach to custodial death investigations was the Royal Commission into Aboriginal Deaths in Custody (1991). This commission was established in response to the high number of deaths of Indigenous Australians in police custody and correctional facilities. The final report of the commission contained 339 recommendations, many of which emphasized mandatory inquests for all custodial deaths, greater transparency in investigations, and the need for external oversight to prevent institutional bias and cover-ups. The Law Enforcement

Conduct Commission (LECC) was established as an external oversight body to investigate deaths involving police officers. The LECC ensures that investigations into deaths in custody are conducted independently, thereby minimizing the risk of bias or institutional protection. Australia's model stands in contrast to Malaysia's, where police-led investigations remain the norm, and inquests are not automatically required for all custodial deaths (Aminuddin Mustaffa et al., 2012). The Australian system's emphasis on mandatory inquests and independent oversight ensures that the investigation process remains transparent, reducing opportunities for institutional bias.

Canada follows a dual-layered approach to investigating deaths in custody, combining coroner-led inquests with external oversight agencies to ensure accountability and transparency. The Coroners Act (Ontario) establishes the legal requirement for independent investigations into all deaths occurring in police custody or correctional facilities. Under Section 10(1) of the Coroners Act (Ontario), a coroner shall investigate a death that occurs in custody or under suspicious circumstances. Section 15(1) states that an inquest is mandatory when a person dies while detained in a correctional institution, secure facility, or police custody.

In addition to coroner-led inquiries, Canada has also established the Special Investigations Unit (SIU), which operates independently of law enforcement agencies. The SIU is responsible for investigating all deaths involving police officers, ensuring that police agencies do not control their own investigations.

The Canadian model is particularly noteworthy for its emphasis on forensic independence, with post-mortem examinations and forensic investigations being conducted separately from police departments (Noorfajri et al., 2015). However, in Malaysia, although post-mortem examinations are not conducted by police officers but by government medical officers, the pre-inquest process still relies heavily on police-led reports. This is significantly different from Malaysia's system, where the police maintain primary control over pre-inquest investigations, even when their own officers may be implicated in excessive use of force or negligence. By combining coroner-led inquiries with external oversight, Canada ensures that deaths in custody are thoroughly investigated in a way that protects public confidence in the legal system.

The United States operates under a decentralized system, where pre-inquest investigations into deaths in custody vary by state. Typically, state medical examiners or coroners are responsible for investigating custodial deaths, with some states requiring

mandatory inquests for deaths in police custody. However, in cases where a custodial death is high-profile or involves potential misconduct, federal agencies such as the FBI may intervene. The George Floyd case highlighted the role of federal oversight in cases of police-involved deaths, where the Department of Justice (DOJ) and the FBI conducted independent investigations to determine whether civil rights violations had occurred. Unlike Malaysia, where pre-inquest investigations are primarily controlled by the police, the U.S. model emphasizes forensic independence. In most states, coroners and medical examiners conduct autopsies, while law enforcement's role is restricted to gathering evidence without influencing forensic conclusions. This federal intervention model offers an additional check and balance on state-level investigations, ensuring that institutional bias does not compromise the credibility of custodial death inquiries.

In Malaysia, the legal framework for investigating deaths in custody is clearly defined under the Criminal Procedure Code, but the implementation has faced challenges related to transparency and independence. While the creation of the Death in Custody Crime Investigation Unit (USJKT) was a step towards specializing these investigations, there remain serious concerns about the effectiveness of the unit, especially regarding transparency and timeliness. The shift to an independent oversight body like the Independent Police Conduct Commission (IPCC) may offer a solution, but it needs careful evaluation to ensure true independence, considering the involvement of current and former police officers. It should also be clarified whether the IPCC is intended to function as a death investigation authority or as an external monitoring mechanism.

Internationally, countries such as the United Kingdom, Australia, and Canada provide examples of robust systems for investigating deaths in custody, ensuring that inquests are mandatory, and investigations are conducted independently. Malaysia could benefit from adopting certain practices from these jurisdictions, such as ensuring mandatory inquests for all custodial deaths and establishing independent external oversight bodies to handle such investigations.

The integration of best practices from these countries would promote greater accountability and transparency in the investigation of custodial deaths in Malaysia, which is crucial for maintaining public confidence in the legal and justice system.

5 THE PROCEEDINGS OF A DEATH INVESTIGATION AND DEATH INQUEST

The investigation into the cause of death is a critical process, particularly when the death occurs under suspicious circumstances, such as in custodial deaths. In Malaysia, the Criminal Procedure Code outlines the legal framework for conducting inquests into unnatural deaths, including those that occur in police custody, prisons, and immigration detention centers. According to Noorfajri Ismail & Farah Nini Dusuki (2015), an inquest is a special inquiry-based proceeding where a coroner investigates the cause of death to determine whether it was due to natural causes, external factors, or suspicion of foul play. However, despite its importance, the inquest process in Malaysia has been a source of ambiguity and inconsistency, leading to variations in the practice and execution of investigations across different cases.

The inquest system in Malaysia follows an inquisitorial approach, in which the coroner actively participates in investigating the facts of the case, rather than simply adjudicating disputes between two parties as is typical in an adversarial system (Noorfajri et al., 2015). In this regard, the coroner plays an active role in determining the cause of death and has the authority to gather evidence, summon witnesses, and direct investigations (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023). This approach is intended to ensure that the truth is uncovered in cases of suspicious deaths.

However, as emphasized by Noorfajri Ismail & Farah Nini Dusuki (2015), the inquest in Malaysia is governed by a system that exempts it from standard judicial practices and the rules of evidence applied in criminal trials. This is because the inquest is not intended to be a criminal trial; rather, it is an investigative proceeding designed to determine the cause of death and establish the circumstances surrounding the death. The coroner's role is to be inquisitive, meaning that the coroner can take a leading role in questioning witnesses and examining evidence, unlike in an adversarial trial where the burden of proof rests on the prosecution (Noorfajri et al., 2015). While this exemption provides flexibility for coroners to conduct thorough inquiries, it also creates concerns about consistency in the execution of these proceedings, as they are not bound by the same formalized judicial structures.

A major issue that has emerged in Malaysia's inquest proceedings is the standard of evidence. According to Noorfajri Ismail & Farah Nini Dusuki (2015), the coroner is

restricted to the evidence that is presented during the inquest. They must base their decision on proven facts, and only established facts, those supported by verified evidence such as witness testimony, forensic evidence and document should be considered. The coroner is explicitly not allowed to rely on assumptions, speculations, or unverified information about the circumstances surrounding the death. This means that if the evidence is insufficient or fails to provide clarity on key questions, the coroner may not be able to make a ruling on the cause of death.

An example of this principle being applied can be seen in the Shanmugam case, where the court examined the role of post-mortem examinations and additional evidence in determining the true cause of death. Facts successfully proven through additional evidence, such as expert testimony or documentary evidence, helped the coroner in reaching an accurate conclusion regarding the cause of death. In this case, if the evidence had been insufficient or contradictory, the coroner would have been unable to establish the cause of death with certainty, underlining the critical role of forensic analysis and witness testimony in these proceedings (*Public Prosecutor v. Shanmugam* [2002] 6 MLJ 563).

The role of the police in pre-inquest investigations is critical to ensuring that investigations are thorough, objective, and conducted in accordance with established procedures. As Noorfajri Ismail & Farah Nini Dusuki (2015) highlight, during an inquest, it is crucial for the police to conduct their investigation with complete transparency. The investigating officer is expected to gather all relevant evidence and report their findings in a way that allows the coroner to make a fully informed decision. This includes ensuring that no evidence is withheld, that the chain of custody is maintained, and that all evidence is documented and available to the coroner and the public.

This requirement for integrity in the police investigation is critical, particularly in custodial deaths where police involvement in the death may cause public skepticism. In the Shanmugam case, for example, the court ruled that for an inquest to be effective, the police must conduct a thorough and efficient investigation and submit a well-prepared and complete investigation paper to the coroner. Transparency in the investigation ensures that all parties involved, including the family of the deceased and the public, are confident that the death is being investigated impartially and without bias (*Kok Eng Kuan v. Public Prosecutor* [1998] 3 MLJ 193).

In the United Kingdom (specifically England and Wales), the Coroners and Justice Act 2009 ensures that deaths in police custody are investigated by an independent coroner. The Act authorizes coroners to conduct preliminary inquiries and inquests when deaths occur in police detention (Coroners and Justice Act 2009). Section 4 of the Act outlines circumstances under which an investigation may be discontinued, thereby providing discretion rather than mandatory inquiry. This system prioritizes transparency by granting coroners the power to summon witnesses, request documents, and even hold public hearings. The Independent Office for Police Conduct (IOPC) further ensures external oversight of police actions, investigating deaths that may involve police misconduct, thereby enhancing the independence and accountability of the process (IOPC, 2022).

Australia similarly mandates that all deaths in custody, whether in police or prison custody, be independently investigated by coroners under the Coroners Act 2009 (NSW). The Royal Commission into Aboriginal Deaths in Custody (1991) called for mandatory inquests for all custodial deaths, particularly focusing on Indigenous deaths, and ensuring independent oversight of the investigations. The Law Enforcement Conduct Commission (LECC) in Australia provides additional external scrutiny, ensuring that investigations involving police custody are not subject to institutional bias (Royal Commission into Aboriginal Deaths in Custody, 1991). This approach contrasts with Malaysia, where inquests are not mandatory for all custodial deaths, especially in prison or immigration detention settings.

Canada follows a similar approach with the Coroners Act (Ontario), which mandates mandatory inquests for deaths in custody and involves the Special Investigations Unit (SIU), an independent body that oversees police-involved deaths to ensure impartial investigations (Rubenstein & Larkin, 2018). The SIU ensures accountability and transparency, especially in cases where police officers are implicated, promoting public trust in the investigation process.

In Malaysia, although post-mortems are conducted by government medical officers rather than the police, the pre-inquest investigation process remains heavily reliant on police-led documentation and reporting. This limits the independence of the inquiry and underscores the need for greater coroner autonomy.

The inquest proceedings in Malaysia are a crucial aspect of investigating custodial deaths and determining the cause of death. However, the current system faces significant

challenges in terms of independence, transparency, and accountability. While coroners are responsible for conducting inquests, the pre-inquest investigation process remains largely police-driven, raising concerns about conflicts of interest, particularly in cases where police misconduct is involved.

By comparing Malaysia's approach with international practices in the United Kingdom (specifically England and Wales), Australia, and Canada, it is evident that Malaysia could benefit from incorporating independent oversight mechanisms.

Adopting mandatory inquests for all custodial deaths and establishing independent oversight bodies, similar to the IOPC in England and Wales or the SIU in Canada, would help ensure that every custodial death is investigated thoroughly and independently. This would significantly enhance public trust in the system and ensure that justice is served in custodial death cases.

For example, in England and Wales, following the inquest into the death of an individual in police custody, a coroner may recommend better training for officers, improved medical facilities in detention centers, or a change in policies regarding the use of force or restraint. These recommendations, if taken seriously, can have a profound impact on the overall reform of detention practices.

The current system in Malaysia could benefit greatly from a reform in which coroners are granted the authority to make recommendations for improvement in detention conditions, investigation procedures, and police practices following deaths in custody. A comparison with other jurisdictions reveals that making recommendations is an essential function of death inquest proceedings in many countries.

6 APPOINTMENT OF CORONER

The role of the coroner in Malaysia is crucial in the investigation of deaths, particularly those that occur in custody or under suspicious circumstances. The Criminal Procedure Code governs the procedures related to the appointment of coroners and the conduct of inquests in Malaysia. Historically, the concept of a coroner dates back to medieval England, where it emerged as part of the common law system under the Articles of Eyre 1194. During this time, three officers, typically knights, along with a clerk, were assigned to oversee judicial matters related to deaths and other criminal activities. Their role was to act as a form of government oversight on death investigations in regions

controlled by the monarchy, ensuring that no suspicious deaths were left unchecked (Aminuddin Mustaffa & Siti Nurul Aziera Moharani, 2012).

The modern system of coroner-led investigations in England and Wales was formalized with the Coroners Act of 1887, which was later updated to the Coroners and Justice Act 2009. This Act provided the legal framework for coroners in England and Wales to independently investigate deaths, particularly in police custody. The legislation has undergone several reforms over the years, culminating in the Coroners and Justice Act 2009, which emphasizes the importance of an independent coroner in ensuring the accountability and transparency of death investigations, particularly those involving state authorities. This reform was a direct response to concerns about police misconduct and negligence in custodial deaths, leading to public pressure for more independent oversight (Coroners and Justice Act, 2009, UK).

In Malaysia, the Criminal Procedure Code, Sections 328-341, outlines the role of coroners in investigating deaths. The coroner's role is not only to determine the cause of death but also to investigate the circumstances surrounding the death, particularly in cases of suspicious deaths. The CPC specifies that coroners are typically magistrates or Session Court Judges, who are appointed to conduct death investigations in their official capacity. However, unlike in other jurisdictions, where the coroner's role is separate and specific to death investigations, the coroner in Malaysia often handles other types of criminal cases as well. This system of shared duties has raised concerns about the specialization of coroners in death investigations (Noorfajri et al., 2015).

The establishment of Coroner's Courts in Malaysia in April 2014 was a significant step toward addressing the rising concerns about the number of deaths in custody (Gan Chee Keong, 2018). These courts were established in response to the public outcry following increasing custodial deaths and are designed to give more focus and attention to death inquiries. The coroner's court is presided over by Senior Session Court Judges, and the coroner's role is to conduct death investigations and decide whether an inquest should be ordered.

The creation of these specialized courts was a response to the demand for independent oversight in investigating custodial deaths. Prior to 2014, death inquiries were handled by magistrates, who were also responsible for a wide range of cases, including general criminal cases. As Noorfajri et al. (2015) pointed out, this overlap of duties was seen as ineffective in addressing the specific complexities of custodial deaths,

particularly in cases where institutional negligence or abuse by law enforcement may have contributed to the death.

Despite the establishment of Coroner's Courts in Malaysia, concerns persist about the prioritization of death inquiry cases, as coroners are still required to handle general criminal cases alongside death inquiries. This has led to delays in addressing custodial deaths, as these cases are typically scheduled only after all other cases have been dealt with, a practice that diminishes the priority given to death investigations (M Visvanathan, 2022). Shamshol Azwa Martadza & Muhamad Helmi Md Said (2023) argue that coroners should be dedicated to death investigations exclusively to expedite the investigation process and enhance the effectiveness of death inquiries.

In Malaysia, judicial decisions have reinforced the vital role of the coroner in investigating custodial deaths. Aminuddin Mustaffa & Siti Nurul Aziera Moharani (2012) highlight that coroners are granted wide-ranging powers to conduct death inquiries, which include the discretion to summon witnesses, request documents, and order autopsies. However, these powers are somewhat limited in their scope and effectiveness due to the overlap in the coroner's role and other judicial duties. As Noorfajri et al. (2015) note, while the coroner must resolve questions related to the cause of death, they lack the authority to assign criminal responsibility or identify the perpetrators, which limits the extent of their jurisdiction in cases where criminal conduct is suspected.

The lack of specialized training and focus for coroners is a significant issue in Malaysia. The fact that coroners also handle other criminal cases means they may lack the necessary expertise and dedication to thoroughly investigate complex custodial deaths. Shamshol Azwa Martadza & Muhamad Helmi Md Said (2023) propose that coroners should be appointed full-time and specialized in death investigations, as this would improve the speed and quality of death inquiries, ensuring that human rights are better protected.

In England and Wales, the process for appointing coroners is significantly different. Under the Coroners and Justice Act 2009, senior coroners are appointed by the Chief Coroner, and their primary role is to investigate deaths, especially those occurring in custody (Coroners and Justice Act 2009). England and Wales' system emphasizes specialization and independence, with coroners appointed specifically to investigate deaths, without being tasked with other criminal duties. Sections 1-3 of the Coroners and Justice Act grant coroners extensive powers, including the authority to summon

witnesses, request official documents, and conduct public hearings to ensure transparency and accountability. In England and Wales, coroners also operate independently of law enforcement agencies, ensuring that police misconduct and institutional failures can be properly scrutinized. This contrasts sharply with Malaysia's system, where coroners often juggle other criminal cases, leading to concerns about whether death inquiries are being prioritized appropriately.

In Australia, particularly in New South Wales, the Coroners Act 2009 (NSW) also mandates that all deaths in custody be investigated by an independent coroner. Australia's approach to investigating custodial deaths is influenced by the Royal Commission into Aboriginal Deaths in Custody (1991), which emphasized independent investigations and mandatory inquests for all custodial deaths (Royal Commission into Aboriginal Deaths in Custody, 1991). The Law Enforcement Conduct Commission (LECC) in Australia plays a pivotal role in ensuring that investigations involving police officers are independent, making the Australian model more robust in preventing institutional bias (Royal Commission into Aboriginal Deaths in Custody, 1991).

In Canada, the Coroners Act (Ontario) establishes a framework for investigating deaths in custody. Section 10 of the Act empowers coroners to conduct investigations into deaths in police or prison custody. Moreover, Section 15(1) mandates that a mandatory inquest be conducted if the death is unnatural. The establishment of independent bodies, like the Special Investigations Unit (SIU) in Ontario, ensures that police-related deaths are thoroughly investigated and remain free from institutional bias (Rubenstein & Larkin, 2018).

The appointment and role of coroners in Malaysia play a vital role in investigating deaths, especially custodial deaths, and ensuring justice and accountability. However, there are significant challenges with the current system, including lack of specialization, conflict of interest, and insufficient prioritization of death investigations. Unlike jurisdictions like England and Wales, Australia, and Canada, where coroners are specifically appointed for death investigations and have independent oversight bodies, Malaysia's system remains police-led and subject to potential bias.

The creation of Coroner's Courts in Malaysia is a step forward, but there is still a need for more specialization in the role of coroners and greater independence from the police. Malaysia could greatly benefit from adopting best practices from international jurisdictions, including mandatory inquests for all custodial deaths, and the establishment

of external oversight bodies like the Independent Police Conduct Commission (IPCC). These reforms would strengthen the investigation process, enhance accountability, and promote public confidence in Malaysia's criminal justice system, ultimately ensuring that justice is served in cases of custodial deaths.

7 CONCLUSION

This study analyzes Malaysia's legal framework for investigating deaths in custody, focusing on the Criminal Procedure Code (CPC) and Practice Directions No. 2 of 2019. The CPC mandates the police to conduct preliminary investigations into suspicious deaths and submit a Sudden Death Report (SDR) to the coroner, who decides whether an inquest is necessary. However, the powers of coroners in Malaysia are limited compared to other countries, as coroners only examine bodies upon the police's request, a shift from the previous mandate in 2014. Critics argue that this limits the independence of investigations and suggest reinstating mandatory coroner examinations (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

The CPC also requires inquests for deaths in police custody but allows discretion for deaths in other detention facilities, raising concerns about the consistency of investigations (Aminuddin Mustaffa et al., 2012). In contrast, countries like the United Kingdom (specifically England and Wales) and Australia have more robust systems, where coroners have greater independence and authority. The UK's Coroners and Justice Act 2009 mandates independent coroners to investigate all police custody deaths, and Australia's Coroners Act 2009 (NSW) ensures mandatory inquests for all custodial deaths (Coroners and Justice Act 2009, UK; Coroners Act 2009, NSW).

In Malaysia, investigations are largely police-led, which has led to concerns about impartiality, especially when the police investigate their own custodial deaths. The lack of independent oversight has raised calls for an external body like the Independent Police Conduct Commission (IPCC) to handle investigations (FMT Reporters, 2022). Judicial cases such as *Public Prosecutor v. Chia Chor Teong* [1989] 3 MLJ 457 highlight the importance of thorough and impartial investigations to restore public trust.

In conclusion, Malaysia's current legal framework for investigating custodial deaths faces significant challenges, including the lack of independence and transparency in pre-inquest investigations. A review of the system is needed to ensure that inquests for

all custodial deaths are mandatory, coroners are appointed with specialized expertise, and independent oversight bodies are established. Learning from the practices of the United Kingdom (specifically England and Wales), Australia, and Canada could significantly improve Malaysia's custodial death investigation system, enhancing transparency, accountability, and public confidence in the justice system.

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Authors' Contribution

Both authors contributed equally to the development of this article.

Data availability

All datasets relevant to this study's findings are fully available within the article.

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