

REFORMING MALAYSIA'S DEATH-INVESTIGATION SYSTEM: THE APPOINTMENT OF CORONERS AND THE ESTABLISHMENT OF THE CORONER'S COURT

REFORMA DO SISTEMA DE INVESTIGAÇÃO DE ÓBITOS DA MALÁSIA: A NOMEAÇÃO DE MÉDICOS LEGISTAS E A CRIAÇÃO DO TRIBUNAL DE MÉDICOS LEGISTAS

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Abstract

In Malaysia, Sessions Court judges perform coroner functions without dedicated training or institutional support, limiting the independence and effectiveness of death investigations. This article examines Malaysia's coroner appointment framework and the absence of specialised Coroner's Courts, contrasting it with the established systems in England and Wales, Australia, and Canada. Comparator jurisdictions appoint specialised coroners and operate purpose-built coronial courts with clear statutory mandates. The study identifies key structural gaps in Malaysia's model and highlights the need for legislative reform, professionalised appointments, and independent coronial institutions to enhance accountability and public confidence. The reform proposals outlined, which include separating the coroner role from judicial duties, setting up a National Coroner's Office, creating independent Coroner's Courts, modernising legal frameworks, instituting comprehensive training, and implementing robust audit mechanisms, collectively aim to transform Malaysia's coroner system into a world-class institution. These measures require legislative reform, institutional capacity building, dedicated funding, and political commitment despite possible resistance or initial costs.

Resumo

Na Malásia, os juízes dos tribunais de primeira instância desempenham funções de médico legista sem formação específica ou apoio institucional, o que limita a independência e a eficácia das investigações de mortes. Este artigo examina o quadro de nomeação de médicos legistas da Malásia e a ausência de tribunais especializados em medicina legal, comparando-o com os sistemas estabelecidos na Inglaterra e no País de Gales, na Austrália e no Canadá. Jurisdições comparativas nomeiam médicos legistas especializados e operam tribunais forenses específicos com mandatos legais claros. O estudo identifica lacunas estruturais importantes no modelo da Malásia e destaca a necessidade de reforma legislativa, nomeações profissionalizadas e instituições forenses independentes para aumentar a responsabilidade e a confiança do público. As propostas de reforma delineadas, que incluem a separação da função do médico legista das funções judiciais, a criação de um Gabinete Nacional de Médicos Legistas, a criação de tribunais médicos legistas independentes, a modernização dos quadros jurídicos, a instituição de formação abrangente e a implementação de mecanismos de auditoria robustos, visam coletivamente transformar o sistema médico-legal da Malásia numa



Keywords: Coroner System. Appointment. Death Investigation. Malaysia. Legal Reform. Comparative Study.

instituição de classe mundial. Estas medidas requerem uma reforma legislativa, o reforço das capacidades institucionais, financiamento específico e compromisso político, apesar da possível resistência ou dos custos iniciais.

Palavras-chave: Sistema de Investigação Forense. Nomeação. Investigação de Óbitos. Malásia. Reforma Jurídica. Estudo Comparativo.

1 INTRODUCTION

In modern judicial systems, the role of a coroner is one of the most crucial components in ensuring justice and transparency in investigating deaths whose cause is unclear. A coroner is a public officer whose main responsibility is to investigate the cause of death in certain cases, especially when the true cause of death is not yet known. Additionally, the coroner is also tasked with conducting or directing inquests as well as investigating the identity of individuals found dead (Noorfajri Ismail et al., 2024). The coroner institution has existed in various forms across different jurisdictions for centuries. The role has evolved significantly from its medieval origins in England, where it primarily served to protect royal interests, to the modern institution focused on serving public interest and ensuring justice for the deceased and their families (Wigmore, 1970). A coroner in the contemporary context is defined as a public officer who has the primary responsibility of investigating the cause of death in specific cases where the true cause of death is not yet known. This role is very critical in the judicial system because it ensures that each death is investigated thoroughly and fairly (Office of Chief Justice, 2019).

In Malaysia, the coroner system has been established for a long time under the legal framework of the Criminal Procedure Code (Act 593), but it has unique characteristics that distinguish it from systems practiced in other countries such as England & Wales, Australia, and Canada. These differences lie in organizational structure, methods of appointment and the legal framework that underlines coroner operations (Forsythe, 2009). The Malaysian system faces several challenges that have prompted calls for comprehensive reform to align with international best practices and improve the professionalism and effectiveness of death investigations. This article will provide an in-depth analysis of the Malaysian coroner system, examining its current

structure and legal framework, comparing it with proven effective international systems and presenting evidence-based reform proposals to improve the professionalism and effectiveness of the inquest system in Malaysia. By understanding both the strengths and weaknesses of the current system and learning from successful international models, Malaysia can develop strategies to enhance the quality and credibility of its death investigation processes.

2 METHODOLOGY

This study employs a doctrinal legal research methodology, which systematically analyzes legal doctrines, statutes, case law, and precedents to evaluate their interpretation, application, and effectiveness (Hutchinson, 2018). Unlike empirical approaches, doctrinal research focuses on synthesizing authoritative legal sources to identify gaps, inconsistencies, and reform needs within Malaysia's death investigation framework, particularly under the Criminal Procedure Code (Sections 329-341) and judicial Practice Directions (Chynoweth, 2008). The primary aim is to assess the adequacy of current provisions governing custodial death inquiries and coroner jurisdiction, highlighting areas requiring legislative enhancement to ensure justice and transparency (Majeed, 2023).

Content analysis serves as the core analytical tool, enabling systematic examination of primary sources, including statutes, judgments, official reports and secondary materials, including scholarly articles, law journals, and policy documents, to uncover patterns in legal application and procedural shortcomings (Silverman, 2013). This qualitative method facilitates critical evaluation of how Malaysian laws perform in practice, especially in high-stakes custodial death cases where independence and thoroughness are paramount (Creswell, 2014).

Complementing doctrinal analysis, a comparative legal approach contrasts Malaysia's framework with robust systems in the United Kingdom (specifically England and Wales), Australia and Canada. This method reveals strengths such as specialized coroner powers and institutional autonomy in comparator jurisdictions, offering actionable insights for Malaysian reforms while respecting contextual differences (Zweigert & Kötz, 1998).

The study employs extensive primary data, including official documents, legislative texts, and policy guidelines (Mohd Zamre Mohd Zahir et al., 2019a; Mohd

Zamre Mohd Zahir et al., 2019b). It entails the critical interpretation of legal texts, case law, and comparative statutory provisions, focusing on normative as opposed to empirical construction. Data collection is mandatory (Na'aim et al., 2025). This is a useful study and review stage (Rahman et al., 2023). Data collection relied on library-based research at UKM Law Library and Tun Sri Lanang Library, supplemented by online databases including Scopus, LexisNexis, HeinOnline, E-Law, and Westlaw for comprehensive access to Malaysian and international materials (Fink, 2014; Li & Zhou, 2021). This multi-source strategy ensures rigorous, evidence-based findings capable of informing policy recommendations for a professionalized Malaysian coroner system aligned with international best practices.

3 DISCUSSION AND FINDINGS

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.

3.1 Coroner appointment and establishment of coroner's court in Malaysia

The appointment and duties of coroners in Malaysia are regulated under the Criminal Procedure Code (Act 593), specifically Sections 329 to 341, which form the fundamental legal basis for coroner operations in the country (Criminal Procedure Code, Act 593, 329–341). Section 329 establishes the framework for appointing coroners, with subsequent sections detailing their powers, duties, and procedures. In addition, Practice Direction No. 2 Year 2019 provides operational guidance to ensure consistency and standardization in implementing coroner duties nationwide (Office of Chief Justice, 2019). Coroners are appointed to preside over inquests where death occurs under circumstances that require official investigation. An inquest is a legal process to determine the identity of the deceased, the time, place, cause, and circumstances of death. This process is crucial for maintaining public confidence in the judicial system and ensuring proper documentation of all deaths (Cross and Tain, 2010).

A defining characteristic of the Malaysian coroner system is the method of appointment. Unlike many countries with a dedicated corps of professional coroners, Malaysia appoints coroners primarily from among serving judges of the Sessions Court (Gan, 2018). Consequently, a Sessions Court judge may serve as a coroner while continuing their regular judicial duties. This dual role means the same individual performs as a trial judge and as a coroner responsible for conducting inquests, determining causes of death, and issuing findings with significant legal and social implications (Roberts and Anderson, 2012). These appointments are made by the Judicial and Legal Services Commission, which administers the judiciary according to the Federal Constitution and relevant legislation, with authority to appoint, promote, and discipline judicial officers, including coroners (Malaysian Bar Council, 2018).

The current structure of the Malaysian coroner system has been identified as having several significant weaknesses that affect its efficiency and professionalism, including:

3.1.1 Dual role conflict

The structure of the Malaysian coroner system has an issue of dual role where a Sessions Court judge is appointed as a coroner while continuing to perform regular judicial duties (Malaysian Bar Council, 2018). This creates a fundamental problem: one judge must perform two different and potentially conflicting roles simultaneously. As a judge in regular court proceedings, judges must maintain strict neutrality and impartiality. They must ensure that justice is administered fairly and that all parties receive equal treatment. However, as a coroner, judges need to conduct more investigative and proactive inquiries to uncover the truth about deaths (Noorfajri Ismail et al., 2024). These two roles place different demands on judicial temperament and approach, creating potential conflicts of interest.

3.1.2 Lack of specialized expertise

Coroner work requires specialized knowledge and skills that are distinct from general judicial administration. Because a coroner is a judge who undertakes this role as a side responsibility, they may not have specialized training or in-depth experience in the

field of forensic medicine or specific investigation procedures required for complex cases (Gan, 2018). This lack of specialization can result in inquests that are not conducted with the depth and technical understanding necessary to properly investigate complex deaths (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

3.1.3 Procedural delays

The second major weakness is the persistent delays in inquest proceedings that occur throughout Malaysia. Many inquest cases take years to be completed, with some cases remaining unresolved for a decade or more (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023). These delays cause significant suffering to the family of the deceased who are waiting for answers about the circumstances of their loved one's death. Such delays also reduce public confidence in the judicial system and undermine faith in the integrity of the inquest process. The causes of these delays are multifaceted, including the limited time judges can allocate to inquest work alongside their regular judicial duties, inadequate court resources, and the complexity of some cases requiring extensive investigation (Malaysian Bar Council, 2018).

3.1.4 Resource constraints

The current system operates with limited dedicated resources. There are no specialized coroner's offices, no dedicated investigative staff, and limited access to forensic facilities (Gan, 2018). These resource constraints mean that coroners often must rely on police investigations or seek assistance from other agencies, which can result in inconsistent quality of investigation and potential delays in obtaining necessary information.

3.1.5 Lack of institutional independence

The current system does not provide coroners with sufficient institutional independence. Coroners operate within the regular court system as judges, which means they are subject to the same administrative and procedural constraints as other judges (Noorfajri Ismail et al., 2024). This can limit their ability to conduct independent

investigations and may expose them to indirect pressure or influence from government or other stakeholders (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

Currently, Malaysia does not have dedicated Coroner's Courts with their own institutional identity. Instead, inquest proceedings are conducted in regular Sessions Courts by judges appointed as coroners (Malaysian Bar Council, 2018). The proceedings follow the Criminal Procedure Code rather than specialized inquest procedures (Criminal Procedure Code, Act 593, ss. 329–341). The absence of a dedicated Coroner's Court means that inquest work must compete for court time and resources with regular criminal and civil cases (Noorfajri Ismail et al., 2024). This competition for resources contributes to the delays in inquest proceedings that have become characteristic of the Malaysian system. Furthermore, the lack of specialized court facilities and support staff means that the inquest process is not optimized for the particular requirements of death investigations (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Gan, 2018).

The weaknesses identified in the current Malaysian coroner system have led to growing recognition among legal professionals, civil society organizations, and government agencies that institutional reforms are necessary. These reforms should address the fundamental structural issues while learning from the successful models that have been developed in other Commonwealth jurisdictions. The goal of reform should be to create a coroner system that is professional, independent, efficient, and capable of conducting thorough and impartial investigations into deaths that require official scrutiny.

3.2 Coroner appointment and establishment of coroner's court in United Kingdom (Specifically England and Wales), Australia and Canada

3.2.1 Coroner system in England & Wales

The office of coroner in England has a very long and distinguished history, dating back to the 12th century. Initially, the coroner played a role in protecting the interests of the King, particularly in securing crown pleas (results of the crown) from cases that could benefit the government. The position originated as a law enforcement officer whose duties included investigating suspicious deaths and collecting revenue for the crown. However, as society and the legal system developed over centuries, the role of the coroner evolved significantly. The focus gradually shifted from protecting royal interests to serving the

interests of justice and the public. This evolution reflects broader changes in the English legal system toward democracy, rule of law, and public accountability. Various reforms have been implemented to streamline and modernize the coroner system in England. The Registration of Births and Deaths Act 1836 was an early step to ensure more systematic death records and better coordination between the coroner system and vital statistics. Subsequently, the Coroners Act 1887 provided a more formal structure to the office of coroner and clarified their powers and responsibilities. However, the most significant modern reform was the Coroners and Justice Act 2009, which replaced older coroner laws with a comprehensive and modern framework designed for contemporary society. This legislation fundamentally restructured the coroner system to create a more professional and accountable institution (Coroners Society, 2012; Judiciary UK, 2025; Wigmore, 1970; Lord Chancellor's Department, 2005).

Current Structure and Organization In England & Wales, a coroner is a special and full-time position, unlike Malaysia. The coroner is a dedicated professional role held by individuals with specific expertise and training, not a side responsibility of judges (Chief Coroner's Guidance, 2019). This fundamental difference reflects a different approach to organizing the death investigation system. The system is led by the Chief Coroner, who provides leadership, oversight, and strategic direction to the entire coroner system in England & Wales. The Chief Coroner is appointed by the Lord Chief Justice and has responsibility for developing and maintaining standards across the coroner service, handling complaints, and implementing reforms (HM Courts & Tribunals Service, 2020). Under the Chief Coroner, there are Senior Coroners who lead specific geographical areas and are responsible for achieving coroner objectives within their regions. Senior Coroners have significant authority and responsibility for organizing coroner services in their areas, including the supervision of assistant coroners and the management of inquest cases. They also play an important role in quality assurance and ensuring that cases are handled in accordance with best practices (Lord Chancellor's Department, 2005). Assistant Coroners assist the Senior Coroner in carrying out daily functions and conducting inquests. Assistant Coroners are full-time or part-time professionals who have met the same professional standards as Senior Coroners. This hierarchical structure allows for effective management of workload and ensures that expertise is properly distributed throughout the system (HM Courts & Tribunals Service, 2020).

Appointment Process The appointment of coroners in England & Wales is handled through a rigorous and highly professional process that prioritizes qualifications and expertise. Coroners are appointed by local authorities following a structured selection process that is overseen by the Chief Coroner and approved by the Lord Chancellor (now effectively the Secretary of State for Justice), who is a senior official in the judicial system (Chief Coroner's Guidance, 2023). To be eligible to become a coroner, candidates must meet strict and clearly defined professional qualifications. These qualifications include at least five years of experience in law or medicine at a senior level. Candidates with a legal background must have experience as a qualified lawyer, while candidates with a medical background must have substantial experience in forensic medicine or pathology (Judiciary UK, 2025). Beyond professional qualifications, candidates must meet several other requirements. These include age requirements (typically between 30 and 70 years old), demonstrated good health sufficient to discharge the duties of office, high integrity and impartiality, and a clean moral background with no disqualifying criminal convictions or ethical violations (Chief Coroner's Guidance, 2023). The selection process is designed to ensure that only the most qualified and suitable individuals are appointed to this important position.

The independence of the coroner institution in England & Wales is one of the most important and carefully protected features of this system. This independence is guaranteed through a clear legal structure and deliberate separation of powers in various aspects of coroner operations (Coroners and Justice Act 2009). First, the separation of powers in appointment ensures that coroners cannot be influenced by government or political interests in receiving their positions. While coroners are appointed by local authorities, the involvement of the Chief Coroner and oversight by the Lord Chancellor's office provides safeguards against purely political appointments (Chief Coroner's Guidance, 2019). Second, the separation of powers in investigation allows coroners to conduct their investigations without interference or direction from other officials. Coroners have the authority to direct police investigations, summon witnesses, compel testimony, and access any evidence relevant to determining the cause of death. They are not subject to direction from police, prosecutors, or government officials regarding the scope or conduct of their investigations (HM Courts & Tribunals Service, 2020). Third, the separation of powers in making inquest decisions ensures that findings are made based on evidence and law, not external influence. Coroners have complete discretion to

determine how deaths occurred and the circumstances surrounding them, and they cannot be overruled or influenced by government or other authorities in making these determinations. This independence is essential for the legitimacy and credibility of the coroner system. The public must have confidence that coroner investigations and findings are based solely on evidence and the law, not on political pressure or other extraneous influences. The system has proven to be effective in maintaining this independence while still remaining accountable to the public through parliamentary oversight and published standards (Coroners and Justice Act 2009; Lord Chancellor's Department, 2005).

The English & Welsh coroner system has achieved several important successes that demonstrate the effectiveness of the professional, independent coroner model: -

3.2.2 Systematic investigation

Coroners conduct thorough and systematic investigations into deaths, ensuring that all relevant facts are discovered and properly documented (HM Courts & Tribunals Service, 2020).

3.2.3 Preventive function

Coroners have the authority to make recommendations aimed at preventing deaths in similar circumstances. These recommendations have led to significant safety improvements in various sectors (Chief Coroner's Guidance, 2019).

3.2.4 Public confidence

The system maintains high levels of public confidence due to its independence, professionalism, and transparency (Judiciary UK, 2025).

3.2.5 Accountability

Clear lines of accountability exist, with coroners required to maintain records, produce written findings, and be subject to oversight by the Chief Coroner (Chief Coroner's Guidance, 2019).

3.3 Coroner system in Australia

The coroner system in Australia developed separately according to each state following the formation of colonies in the 19th century (Australian Coroners Information Council, 2018). This is a result of Australia's federal structure where each state and territory has its own judicial powers and operates its own judicial system independently. As a result, each state in Australia has developed its own unique coroner laws and regulations, adapted to their local needs and circumstances. Despite these differences, there are also basic similarities in the coroner system across various Australian states. Most states have adopted a coroner model that is fundamentally similar to that in England & Wales, with a Coroner's Court having clear powers and jurisdiction over death investigations (Australian Coroners Information Council, 2018). This reflects both the common heritage of English law and the lessons learned from the experience of other coroner systems.

Victoria operates a centralized coroner system with the Coroners Court of Victoria as the principal institution. The system is led by the State Coroner who provides oversight and leadership. Multiple coroners work within the centralized court structure, handling inquests across the state. New South Wales operates the District Court (Coroner's Division) and also has the Office of the State Coroner. The system includes State Coroners and other coroners who conduct inquests throughout the state. South Australia maintains a centralized coroner system with a State Coroner and coroners who operate through the South Australian Coroner's Court. Western Australia and Tasmania operate more decentralized systems where coroners operate in different regions or districts, though with state-level oversight and guidance (Australian Coroners Information Council, 2018).

Coroners in Australia are formally appointed by the state Governor on the recommendation of the Minister of Justice or equivalent state minister. This appointment process ensures that coroners are selected based on their professional qualifications and expertise, not on the basis of nepotism or purely political choice (Coroners Act 2009 NSW; Coroners Act 2003 SA; Coroners Act 1996 WA). Candidates for the position of coroner must meet strict qualification requirements specified in state legislation; these typically include being a licensed attorney (solicitor or barrister) with substantial legal experience, or a qualified judicial officer with appropriate experience. Some jurisdictions

also allow appointments of medical examiners or forensic medical specialists, reflecting recognition that forensic medical expertise is valuable in coroner work (Coroners Act 2009 NSW; Australian Coroners Information Council, 2018).

Coroners in Australia enjoy substantial freedom to determine the cause of death based on available evidence and applicable law (Australian Coroners Information Council, 2018). They are not involved in determining guilt in criminal or civil cases; their task is solely to determine the cause of death and the circumstances surrounding it. This ensures that coroner investigations remain free from political influence or pressure from other interested parties. Australian coroner legislation typically includes provisions that protect coroner independence. These may include security of tenure provisions, protections against arbitrary removal from office, and legal provisions ensuring that coroners can conduct investigations without political interference or direction (Coroners Act 2009 NSW; Coroners Act 2003 SA; Coroners Act 1996 WA). The Coroner's Court in Australia also has the power to make recommendations aimed at preventing deaths in similar circumstances. These recommendations have often led to significant improvements in workplace safety, public health measures, and institutional practices (Australian Coroners Information Council, 2018). Australian coroner system demonstrates several important strengths: -

3.3.1 Professional specialization

Coroners are full-time professionals with specialized training and expertise (Australian Coroners Information Council, 2018).

3.3.2 State coordination

While each state operates independently, there is growing coordination and sharing of best practices through the Australian Coroners Information Council (Australian Coroners Information Council, 2018).

3.3.3 *Transparent processes*

Most Australian coroner courts operate with high levels of transparency, with inquests being open to the public and findings being published (Coroners Act 2009 NSW).

3.3.4 *Effectiveness in prevention*

Coroners' recommendations have been effective in identifying systemic issues and preventing deaths (Australian Coroners Information Council, 2018).

3.3.5 *Coroner system in Canada*

The Canadian coroner system is rooted in the British model that originated in the 12th century, but it has undergone significant changes over the centuries, particularly during the 20th and 21st centuries (Office of the Chief Coroner, 2019). The most meaningful and recent change is the establishment of the "Medical Examiner System" in various provinces, an approach inspired by the American model. This hybrid system combines elements of the traditional coroner model with modern science-oriented forensic practices (Chief Medical Examiner's Office, 2016). Different provinces and territories in Canada have chosen different approaches based on their particular needs and circumstances. This reflects the Canadian federal system where provinces and territories have significant autonomy in organizing their own judicial and legal systems (Coroners Act, R.S.O. 1990, c. C.37).

The appointment of coroners in Canada is handled according to different laws in each province and territory, reflecting the constitutional division of powers between provincial and federal governments. Generally, coroners are appointed by the Lieutenant Governor in Council (the provincial cabinet), which is a provincial government structure (Coroners Act, R.S.O. 1990, c. C.37). Coroners in Canada may be appointed from among medical practitioners, judicial officers, or other qualified professionals, depending on the laws of the relevant province or territory. Some provinces maintain traditional coroner systems where coroners are often drawn from the legal profession, while others operate "medical examiner" systems where full-time forensic medical specialists serve as the

chief medical examiner and are assisted by other medical examiners (Chief Medical Examiner's Office, 2016).

Ontario maintains a coroner system with a Chief Coroner and regional coroners. The province also has a forensic pathology service. Ontario uses a "Formal Inquest" system for certain deaths, which provides an opportunity for public inquiry into the circumstances of death (Office of the Chief Coroner, 2019). Some Canadian provinces such as Alberta and others have transitioned to a medical examiner system where deaths are investigated by specially trained forensic pathologists and medical examiners rather than judges or lawyers serving as coroners. Prince Edward Island maintains a smaller-scale coroner system but also incorporates medical examiner principles in its approach to death investigation.

Professional freedom of coroners in the Canadian system is a fundamental element to ensure integrity and justice in death investigations. Coroners are guaranteed the freedom to conduct their investigations without political interference or pressure from the administration. The appointment system is overseen by order-in-council at the provincial level, ensuring that this process is transparent and based on professional criteria rather than political patronage. Canadian coroner legislation typically includes provisions protecting the independence and impartiality of coroners. These provisions ensure that coroners can conduct investigations and make determinations based solely on evidence and professional judgment, without fear of repercussion or pressure from government or other authorities (Chief Medical Examiner's Office, 2016).

3.4 Comparative analysis

Comparing the coroner system in Malaysia with systems in England & Wales, Australia, and Canada reveals several important differences that have significant implications for effectiveness and professionalism:

3.4.1 Professionalization and full-time status

The Malaysian system uses a model where a Sessions Court judge is appointed as a coroner, making it a side position for judges. This dual role arrangement means that coroners in Malaysia carry out inquests alongside their regular judicial duties, which can

limit the time and specialized focus they can dedicate to death investigations. In contrast, in countries such as England & Wales, Australia, and Canada, the position of coroner is a full-time (or in some cases substantial part-time) dedicated role. Coroners in these jurisdictions undergo specialized training in death investigation, forensic medicine, and legal procedures relevant to coronial inquiries, which equips them with the skills and expertise necessary to conduct thorough and professional investigations (Chief Coroner's Guidance, 2019; Australian Coroners Information Council, 2018; Office of the Chief Coroner, 2019). Having coroners as dedicated professionals fosters an institutional identity that supports the development of expert knowledge, promotes consistency in handling complex cases, and enhances the overall effectiveness and credibility of the death investigation system (Matthews, 2007). This professionalization and full-time status of coroners in these jurisdictions stand in marked contrast to Malaysia's model and highlight a key area for potential reform to improve the specialization and quality of coronial investigations (Malaysian Bar Council, 2018; Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

3.4.2 Appointment and selection process

The appointment process in Malaysia for coroners is notably less transparent and fundamentally different compared to systems in countries such as England & Wales, Australia, and Canada. In these countries, candidates for the position of coroner must satisfy strict professional qualifications, typically including legal or medical expertise related to forensic and death investigations, and undergo a rigorous, competitive selection process subject to public and institutional scrutiny. These procedures are designed to ensure that only individuals with the necessary specialized knowledge and ethical integrity are appointed to this critical role (Chief Coroner's Guidance, 2023; Australian Coroners Information Council, 2018; Office of the Chief Coroner, 2019).

Conversely, Malaysia's appointment system selects coroners primarily from the existing pool of Sessions Court judges, emphasizing judicial experience rather than specialized death investigation expertise. This approach means that appointments often lack transparent criteria related to forensic knowledge or investigative skills and do not subject candidates to the same level of public or professional scrutiny as international counterparts. As a result, this system may limit the professional capacity of coroners in

Malaysia, restricting the development of specialized expertise essential for high-quality death investigations, and this has been a point of concern raised in scholarly critiques and reform recommendations (Malaysian Bar Council, 2018; Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Saner, 2010).

This divergence from international best practice invites calls for reform in Malaysia to adopt a more transparent, rigorous, and qualification-based appointment system, aligning with global standards that enhance the independence, professionalism, and accountability of the coroner system.

3.4.3 Freedom and autonomy

The system in other countries provides more extensive freedom and autonomy to coroners in carrying out their duties. In jurisdictions such as England & Wales, Australia, and Canada, coroners operate as specialized professionals with institutional independence that safeguards their capacity to make unbiased and thorough investigations. These coroners are free from undue influence by other branches of government or internal organizational pressures, enabling them to direct investigations, summon witnesses, and access all relevant evidence without obstruction (Chief Coroner's Guidance, 2019; Australian Coroners Information Council, 2018; Office of the Chief Coroner, 2019).

Conversely, in Malaysia, the dual role assigned to Sessions Court judges as coroners generates an inherent conflict of interest. Judges must balance the competing demands of managing a broad range of judicial responsibilities while simultaneously conducting inquests, often leading to limitations in the time, focus, and resources that can be dedicated to coroner functions (Malaysian Bar Council, 2018). This constraining duality reduces the autonomy coroners have over investigations and can impact the quality and depth of inquests. Scholarly critiques highlight that this structural weakness undermines the independence vital for a credible coroner system and calls for structural reforms to grant coroners full professional autonomy and dedicated resources akin to international best practices (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Saner, 2010).

3.4.4 Institutional infrastructure

Other countries provide dedicated institutional infrastructure for coroner work, including Coroner's Courts equipped with specialized staff, courtrooms, forensic facilities, and support services tailored to the unique needs of death investigations. These dedicated institutions facilitate more efficient, focused, and professional management of inquest proceedings and ensure that the complex legal and medical aspects of death investigations receive appropriate attention (Australian Coroners Information Council, 2018; Chief Coroner's Guidance, 2019). Furthermore, such infrastructure supports the training and specialization of personnel and enables the implementation of best practices and consistent quality assurance measures across jurisdictions (Matthews, 2007).

In contrast, Malaysia lacks dedicated institutional infrastructure for coroner work. Inquests are conducted within the existing regular Sessions Courts, sharing resources with civil and criminal cases and without specialized facilities or dedicated staff for coronial investigations (Malaysian Bar Council, 2018). This integration leads to competition for court time and resources, contributing to procedural delays and limiting the capacity to deploy specialized forensic and administrative support (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023). The absence of purpose-built coronial institutions also hinders the development of a distinct professional identity and culture necessary for advancing the efficiency and credibility of death investigations in Malaysia's legal system.

3.4.5 Professional standards and training

England & Wales, Australia, and Canada have developed comprehensive professional standards and mandatory training requirements for coroners. In England & Wales, coroners must undergo rigorous initial training and continuous professional development programs covering forensic medicine, death investigation techniques, legal procedures, and ethical standards, with oversight by the Chief Coroner (Chief Coroner's Guidance, 2023). Australia mandates specialized training through state coroner colleges and national standards established by the Australian Coroners Information Council, ensuring coroners possess both legal and medical competencies essential for complex investigations (Australian Coroners Information Council, 2018). Canada similarly

requires province-specific training programs that blend medical examiner expertise with legal training, particularly in jurisdictions operating hybrid coroner-medical examiner systems (Office of the Chief Coroner, 2019). These structured training regimes cultivate a professional coroner cadre equipped with specialized knowledge and skills.

Malaysia has no comparable system of specialized training for judge-coroners. Sessions Court judges appointed as coroners receive no mandatory forensic medicine, death investigation, or coronial procedure training beyond their general judicial education (Malaysian Bar Council, 2018). This absence of specialized professional development leaves judge-coroners reliant on ad hoc learning and general judicial experience, which often proves inadequate for the technical demands of modern death investigations involving complex forensic analysis and multi-agency coordination (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023). The lack of systematic training contributes significantly to inconsistencies in inquest quality and procedural delays characteristic of the Malaysian coroner system.

3.4.6 Specialized expertise

The international systems recognize that coroner work requires specialized knowledge distinct from general judicial administration. England & Wales, Australia, and Canada therefore recruit coroners from candidates with specific expertise in forensic medicine, pathology, or death investigation law. In England & Wales, coroner candidates must possess at least five years of senior-level experience as qualified lawyers or medical professionals with forensic pathology backgrounds (Chief Coroner's Guidance, 2023). Australian state coroner legislation mandates qualifications in legal practice or forensic medicine, with preference given to candidates demonstrating both competencies (Australian Coroners Information Council, 2018). Canadian provinces operating medical examiner systems appoint forensic pathologists as chief medical examiners, while traditional coroner jurisdictions select legally trained professionals with death investigation experience (Chief Medical Examiner's Office, 2016). This deliberate recruitment strategy ensures coroners possess the technical proficiency required for complex forensic analysis, multi-disciplinary case coordination, and authoritative interpretation of medical-legal evidence.

The Malaysian system does not apply this principle. Coroners are appointed exclusively from Sessions Court judges based on general judicial experience rather than death investigation or forensic expertise (Malaysian Bar Council, 2018). This approach assumes judicial competence automatically transfers to coronial work, overlooking the specialized skills required for forensic pathology interpretation, crime scene reconstruction, and medico-legal synthesis essential for credible inquest findings (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023). Consequently, Malaysian judge-coroners often lack the domain-specific knowledge that defines professional coronial practice internationally, compromising investigation quality and eroding public confidence in death inquiry outcomes.

The comparative analysis reveals several important lessons that can inform Malaysia's approach to coroner system reform:

3.4.7 Full-time specialization works

The experience of other countries demonstrates that full-time, specialized coroners who can devote their entire professional attention to death investigation are more effective than judges who serve as coroners alongside regular judicial duties. Specialization allows for deeper expertise, consistency, and improved investigative quality (Chief Coroner's Guidance, 2019; Australian Coroners Information Council, 2018).

3.4.8 Independence matters

Coroners operating as independent professionals or in independent bodies are more effective and earn greater public confidence than coroners within the judicial hierarchy. Independence reduces conflicts of interest and political influence, thus safeguarding public trust (Coroners and Justice Act 2009; Saner, 2010).

3.4.9 Expertise is essential

Recruiting coroners with expertise in forensic medicine, pathology, or death investigation law is critical. Jurisdictions prioritizing these qualifications yield higher

quality investigations and informed decisions compared to appointment of judges lacking specialized training (Chief Medical Examiner's Office, 2016; Matthews, 2007).

3.4.10 Institutional separation works

Dedicated Coroner's Courts or offices with specialized infrastructure and staff improve efficiency and effectiveness, unlike embedding coroners within general court systems. Such separation supports specialized workflows and focused resource allocation (Australian Coroners Information Council, 2018; Malaysian Bar Council, 2018).

3.4.11 Professional standards are necessary

The establishment of professional standards, mandatory training, and quality assurance mechanisms significantly boosts coroner system credibility and effectiveness. Professionalization fosters ongoing competence and public confidence (Chief Coroner's Guidance, 2019; Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

3.5 Reforms and improvement proposals

Based on the comparative analysis and the weaknesses identified in Malaysia's existing coroner system, several reform proposals have been developed. These proposals aim to modernize the system and align it with international best practices while taking into account Malaysia's specific legal, institutional, and social context.

3.5.1 Reform proposal 1: professionalization and separation of coroner role from judicial function

The first and most fundamental proposal for reforming Malaysia's coroner system is to completely separate coroner duties from the Sessions Court judge role and establish the coroner as a distinct, full-time, specialized professional position that operates independently from the regular judiciary (Malaysian Bar Council, 2018). This transformative structural change directly addresses the core systemic weaknesses that have long plagued the Malaysian model, as evidenced by comparative analysis with

mature coroner systems in England & Wales, Australia, and Canada, where dedicated full-time coroners consistently deliver superior investigative quality, greater public confidence, and operational efficiency compared to Malaysia's overburdened dual-role arrangement where Sessions Court judges handle inquests as an additional responsibility alongside their primary judicial caseloads (Australian Coroners Information Council, 2018; Chief Coroner's Guidance, 2019).

By creating a professionalized coroner cadre, Malaysia can eliminate the inherent role conflict that currently forces judge-coroners to balance the passive neutrality required for judicial adjudication with the proactive, truth-seeking investigation demanded by death inquiries, fundamentally different operational paradigms that create unsustainable tension and compromise investigative depth (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Saner, 2010). A dedicated full-time coroner would develop in-depth, specialized expertise in forensic medicine, pathology, death investigation procedures, and coroner-specific law through continuous professional development, enabling complex multidisciplinary investigations and producing credible findings that withstand rigorous legal and public scrutiny—capabilities currently unattainable by part-time judge-coroners lacking such focused training (Chief Medical Examiner's Office, 2016; Matthews, 2007). Moreover, full-time status would dramatically improve case availability and processing speed, directly tackling Malaysia's chronic inquest delays that often span years due to judges prioritizing criminal and civil dockets over coronial work, thereby expediting family closure, restoring eroded public trust, and enabling timely preventive recommendations (Malaysian Bar Council, 2018).

Implementation would begin with merit-based recruitment criteria emphasizing domain-specific qualifications including professional credentials in law or medicine, substantial experience in death investigation or forensic pathology, proven proficiency in coroner procedures, and demonstrated integrity verified through independent vetting, mirroring international standards that prioritize expertise over generic judicial tenure (Chief Coroner's Guidance, 2023; Australian Coroners Information Council, 2018). Appointments would follow a rigorous, transparent process featuring public advertisement, objective published criteria, and comprehensive assessment by an independent panel of judicial, medical, and forensic experts, culminating in merit-based selection by the Judicial and Legal Services Commission or a dedicated Coroner Appointments Commission subject to parliamentary oversight to prevent politicization

(Malaysian Bar Council, 2018). Coroners would serve fixed renewable terms of 5-7 years with independent performance evaluations, bolstered by constitutional security of tenure during good behaviour to protect investigative independence from external pressures (Saner, 2010). Competitive remuneration equivalent to senior judicial officers, augmented by forensic training allowances, institutional support, and comprehensive professional development funding, would attract elite legal-medical talent and position coronial service as a prestigious career pathway (Matthews, 2007). This comprehensive reform package would elevate Malaysia's coroner system from a judicial adjunct burdened by conflicts and resource constraints into an autonomous professional institution aligned with global best practices, fundamentally enhancing death investigation quality, transparency, and public confidence while addressing documented deficiencies that undermine the system's credibility (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

3.5.2 Reform proposal 2: establishment of National Coroner's Office

The proposal to establish a National Coroner's Office in Malaysia seeks to create a centralized coordinating and oversight body responsible for all coroners nationwide (Malaysian Bar Council, 2018). This centralized office would perform multiple crucial functions aimed at enhancing the effectiveness, professionalism, and consistency of coronial operations across Malaysia. It would be tasked with setting leadership standards and professional guidelines, ensuring that practices comply with best international benchmarks and are uniformly applied throughout all jurisdictions (Australian Coroners Information Council, 2018). One of the office's key roles would be to facilitate professional development by providing guidance, training, and continuous education programs for coroners, helping them stay current with advances in forensic medicine, death investigation protocols, and relevant legislation (Chief Coroner's Guidance, 2019). Furthermore, the office would institute quality assurance and audit mechanisms to monitor coroner performance, guaranteeing adherence to established standards and fostering accountability. This would be complemented by a research and development function, which would systematically study coronial practices, monitor emerging forensic trends, and highlight policy improvements, thereby driving continual system enhancement tailored to evolving medico-legal challenges (Shamshol Azwa Martadza &

Muhamad Helmi Md Said, 2023). The office would also act as the public face of the coronial service, managing communications with the media and public to improve transparency and maintain public trust in the death investigation process.

In terms of governance, the National Coroner's Office should be structured to maximize independence and operational autonomy. At the helm would be a Chief Coroner, appointed for a defined term, to provide strategic leadership and oversight (Chief Coroner's Guidance, 2019). An advisory board composed of senior coroners, forensic experts, legal professionals, and representatives of civil society would offer policy guidance, ensuring the office's responsiveness to diverse stakeholder interests. The operational side would be divided into specialized divisions tasked with distinct functions: training and professional development, quality assurance and audits, research and standards formulation, and public affairs and communications. Such a structure ensures that each critical domain receives focused attention and resources.

To maintain transparency and accountability, the Chief Coroner should be required to submit an annual report to Parliament detailing the system's performance metrics, investigation statistics, outcomes, challenges, and recommendations for further reform (Malaysian Bar Council, 2018). This formal accountability mechanism would provide legislative oversight while also informing the public and the medical-legal community of the system's impact and areas for improvement.

Establishing a National Coroner's Office aligns Malaysia with international best practices, as similar bodies exist in jurisdictions such as England & Wales, Canada, and Australia, where centralized coordination has significantly advanced the professionalism, consistency, and public confidence in death investigations (Australian Coroners Information Council, 2018; Chief Coroner's Guidance, 2019). Given Malaysia's current fragmented and judiciary-embedded system, this reform promises to inject the much-needed institutional capacity, specialized focus, and independence essential for credible, efficient, and ethically sound coronial services (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

3.5.3 Reform proposal 3: establishment of Independent Coroner's Court

The third reform proposal advocates the establishment of an independent Coroner's Court in Malaysia, separate from the Sessions Court and the general judiciary,

to provide the coronial system with its own institutional identity and dedicated resources (Malaysian Bar Council, 2018). This reform addresses systemic inefficiencies where coronial investigations are conducted within general courts, resulting in competition for court time and resources with criminal and civil cases, which has contributed to significant procedural delays and public dissatisfaction. By creating a separate Coroner's Court, the system can be optimized specifically for death investigations, allowing dedicated staffing, infrastructure, and tailored procedural rules that better meet the specialized requirements of inquests (Australian Coroners Information Council, 2018; Chief Coroner's Guidance, 2019). Institutional separation also enhances the independence of coroners by shielding them from potential conflicts of interest and undue influence from the regular judiciary and political actors (Matthews, 2007; Saner, 2010). Additionally, a dedicated court increases public visibility and confidence in coronial processes, reinforcing transparency and accountability.

The proposed Coroner's Court would consist of a principal national institution with regional branches in major urban centers such as Kuala Lumpur, George Town, Ipoh, Johor Bahru, Kota Kinabalu, and Kuching. The court's leadership would include a Chief Coroner overseeing national operations and Senior Coroners heading regional courts. Staffing would comprise full-time and part-time coroners, court officers, investigation officers trained in death investigation techniques, and liaison officers coordinating with police, forensic laboratories, medical experts, and victim support services. This infrastructure ensures effective case management and multidisciplinary collaboration crucial for thorough death investigations (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Payne-James et al., 2013). The Coroner's Court should have broad jurisdiction over deaths occurring under suspicious or unexplained circumstances, deaths in custody, workplace fatalities, and deaths of persons of official importance. Equipping the Court with statutory powers to summon witnesses, compel testimony, order post-mortem and forensic examinations, access medical and police records, and make definitive findings and prevention recommendations is essential to fulfilling its mandate (Malaysian Bar Council, 2018).

This model conforms to international best practices demonstrated in jurisdictions such as England & Wales, Canada, and Australia, where independent coronial courts enjoy functional autonomy, specialized expertise, and public trust. The Malaysian Bar and other reform advocates have consistently emphasized that adopting such an

institutional model is vital for transitioning from the current fragmented and part-time coroner system toward a more effective, credible, and humane death investigation framework (Malaysian Bar Council, 2022). Given these well-documented deficiencies and international evidence, the establishment of an independent Coroner's Court represents a cornerstone of comprehensive coronial reform in Malaysia, essential for upholding human rights, judicial transparency, and public confidence in death investigations.

3.5.4 Reform proposal 4: modernization of Coroner Appointment Procedures

The fourth reform proposal centers on overhauling the coroner appointment process in Malaysia through comprehensive legislative modernization, replacing the opaque and inadequate framework under Criminal Procedure Code (Sections 329-341) with transparent, merit-based procedures enshrined in a dedicated Coroners Act (Malaysian Bar Council, 2018). Currently, coroners are appointed exclusively from Sessions Court judges without mandatory qualifications in forensic medicine, death investigation techniques, or coronial procedures, resulting in inconsistent expertise levels and widespread public concerns about professional suitability for complex medico-legal inquiries (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Gan, 2018). This systemic deficiency has been repeatedly highlighted by the Malaysian Bar Council, which advocates for statutory reforms to professionalize appointments and ensure competence (Malaysian Bar Council, 2022).

The proposed Coroners Act must establish mandatory professional qualifications, requiring minimum 5-7 years' experience as qualified lawyers with demonstrated death investigation exposure, forensic pathologists, or medical practitioners with postgraduate forensic training, verified through certified coronial programs and practical assessments (Noorfajri Ismail et al., 2024). Appointments would follow a competitive, multi-stage process: nationwide public advertisement of vacancies, independent application screening by a Coroner Appointments Committee comprising Judicial Commission representatives, senior forensic pathologists, and experienced advocates, followed by rigorous interviews evaluating domain-specific knowledge, investigative aptitude, and ethical judgment, with final recommendations submitted to the Judicial and Legal

Services Commission for approval subject to parliamentary notification for transparency (Malaysian Bar Council, 2018; Suhakam, 2021).

To protect independence, coroners would receive fixed 5-year renewable terms with constitutional security of tenure during good behaviour, permitting removal only through independent tribunal processes for proven incapacity or misconduct, thereby shielding them from political pressures while maintaining accountability via annual performance evaluations by the Chief Coroner (Suhakam, 2021). Post-appointment, mandatory continuous professional development programs covering forensic updates, inquest procedures, inter-agency coordination, and ethical standards would address critical knowledge gaps among current judge-coroners, ensuring sustained competence evolution (Noorfajri Ismail et al., 2024; Malaysian Judiciary, 2017).

This targeted legislative reform directly responds to longstanding Malaysian critiques that generic judicial experience inadequately equips coroners for modern death investigations involving advanced forensic analysis and multi-disciplinary coordination (Gan, 2018). By institutionalizing explicit qualifications, structured transparency, tenure protections, and professional development, the reform transforms coroner appointments from administrative judicial assignments into a specialized meritocracy, significantly elevating investigation quality, procedural fairness, and public confidence in Malaysia's coronial system (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023; Malaysian Bar Council, 2022).

3.5.5 Reform proposal 5: professional development and training

The fifth reform proposal establishes mandatory professional development and training programs for all coroners in Malaysia to address the critical knowledge gaps that currently undermine death investigation quality. Newly appointed coroners must complete comprehensive induction training covering legal knowledge of coroner law, Criminal Procedure Code provisions, and constitutional principles governing inquests; forensic knowledge including pathology principles, death investigation procedures, toxicology, and criminal/accidental death analysis; case management skills for records, complex inquiries, and scheduling; and professional skills such as family communication, interviewing techniques, report writing, and public presentations (Malaysian Bar Council, 2018; Noorfajri Ismail et al., 2024). This structured induction, modeled on international

standards, ensures new coroners possess foundational competencies absent in the current judge-coroner system (Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

Continuing professional development requires minimum 40 hours of annual approved training, including updates on case law, legislative changes, forensic science advances, emerging death investigation issues, and skills workshops. Specialist training addresses particular death types such as custody fatalities, workplace accidents, complex forensic cases, and multi-jurisdictional inquiries, while regular forums, conferences, and peer networking facilitate best practice sharing across jurisdictions (Malaysian Bar Council, 2022; Gan, 2018). These programs, delivered through the National Coroner's Office with partnerships from medical faculties and forensic institutes, ensure sustained competence evolution critical for modern medico-legal demands (Suhakam, 2021; Malaysian Judiciary, 2017).

This training framework responds directly to Malaysian critiques documenting inadequate preparation among judge-coroners for forensic complexities, transforming the system through institutionalized professionalization that elevates investigation standards, procedural consistency, and public confidence (Noorfajri Ismail et al., 2024; Shamshol Azwa Martadza & Muhamad Helmi Md Said, 2023).

4 CONCLUSION

Malaysia's coroner system, although based on the Criminal Procedure Code, requires comprehensive reform to tackle its inherent weaknesses and to reach the level of professionalism, efficiency, and public trust seen in countries with advanced coronial systems. The present framework appoints Sessions Court judges as coroners, who carry out these duties alongside their regular judicial responsibilities. This dual role creates fundamental conflicts and restricts the development of the specialized expertise necessary for investigating complex deaths. Consequently, the system experiences delays, suffers from resource inadequacies, and lacks institutional independence, all of which have eroded public confidence and limited the system's ability to ensure thorough and just death investigations for the deceased and their families.

In comparison, established coroner systems in England & Wales, Australia, and Canada feature full-time, specialised coroners operating within independent bodies supported by dedicated infrastructure and expert personnel. This professionalisation leads

to improved investigation quality, public credibility, and the effective prevention of similar deaths through coroner recommendations. International experience clearly demonstrates that investing in such a professionalized coronial system yields substantial improvements in justice delivery and public trust in the legal process.

The reform proposals outlined, which include separating the coroner role from judicial duties, setting up a National Coroner's Office, creating independent Coroner's Courts, modernising legal frameworks, instituting comprehensive training, and implementing robust audit mechanisms, collectively aim to transform Malaysia's coroner system into a world-class institution. These measures require legislative reform, institutional capacity building, dedicated funding, and political commitment despite possible resistance or initial costs.

The benefits of such reforms would be widespread: families of the deceased would experience faster inquests and clearer insights into causes of death; the judiciary would gain enhanced professionalism and legitimacy; public safety would improve through effective preventive recommendations; and Malaysia would bolster its international reputation by aligning with global justice standards. Fundamentally, modernizing and professionalizing Malaysia's coroner system ensures the impartial, thorough investigation of deaths requiring official scrutiny, serving the cause of justice, supporting bereaved families, and upholding public accountability.

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Authors' Contribution

All 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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