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CORONER'S PREVENTIVE ROLE IN OCCUPATIONAL AND INDUSTRIAL CALAMITIES: A FUNDAMENTAL LEGAL REVIEW

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ABSTRACT

This paper focuses on the coroner's investigative role that relates to occupational death cases. Any death caused by industrial calamities occurred in the course of employment needs to be investigated thoroughly. The methodology used in this study is qualitative approach, which involves analysing data gathered through legislation, cases-law and official statistics; and comparative analysis with other jurisdictions. This research finds that the Malaysian occupational death investigation system needs to be reformed as the coronial institution is able to serve as an effective death investigator especially in giving recommendations for the prevention of future similar deaths.

Keywords: *Occupational Safety, Coroner's Investigation, Inquest, Prevention of Similar Deaths*

ABSTRAK

Kertas ini memberikan fokus kepada peranan coroner berkaitan dengan kes-kes kematian dalam pekerjaan. Kematian yang disebabkan musibah industri semasa dalam pekerjaan memerlukan siasatan yang menyeluruh. Metodologi yang digunakan dalam kajian ini berdasarkan pendekatan kualitatif, melibatkan analisa data menerusi sumber perundangan, laporan kes-kes mahkamah dan statistic rasmi; dan analisa perbandingan dari bidang kuasa yang lain. Kajian mendapati bahawa sistem siasatan kematian semasa dalam pekerjaan di Malaysia memerlukan pembaharuan yang menyeluruh kerana institusi koroner berupaya menjadi penyiasat kematian yang efektif terutamanya bagi memberikan syor membendung kematian serupa berulang.

Kata kunci: *Keselamatan Pekerjaan, Siasatan Koroner, Inkues, Membendung Kematian Berulang*

Introduction

This paper examines the role of coroner as a judicial death investigator in occupational fatalities cases in Malaysia. Special attention is given to the nexus between his coronial duties and duty to promote occupational safety. Focuses upon such connection can help us in bridging the gaps and thus will create an interdisciplinary interaction between coronial investigations as a medico-legal device to detect real cause of death behind occupational fatalities. The study reveals that major gap which exists in coroner's investigation in occupational fatality is due to 'systemic failure' i.e. poor legal framework, non-coordination between parties, lack of knowledge and expertise. This paper is inspired from a model known as 'Occupational Death Investigation and Prevention Model' developed by the Accident Research Centre of Victoria, Australia (Bugeja, Ibrahim & Brodie 2010).

Thus, this study provide for an alternative legal review to give a clear description of the coroner's official function and machinery in the prevention of industrial fatalities by examining his crucial involvement in the chain of networks between medical cause of death and the industrial sciences of occupational safety. This may influence his judicial thought and legal intellectual disposition of cases

to make recommendation in preventing occupational fatalities. The rationale for the focus on the major investigative role of the coroner is to give due recognition to the coronial function in the process of investigation of industrial death cases i.e. coroner's recommendation for preventive measures.

The first part of this paper concentrates on the literature review which comprises the background of the coroner's office and the coronial recommendation. The second part revisits the concept of coronial system and duty to prevent similar death. Whereas the final part focuses on the possibility of having an integrated system between the coronial institution with the occupational health and safety operation, for the benefit of human capital development in Malaysia with reference to Victorian model.

Literature Review

Though the institution of coroner has been in existence for more than a decade, there is limited literature (in the form of books) written globally, and remarkably there are no textbooks on coroner's law in Malaysia. There are only two articles written on the subject that can be considered as an authoritative academic text. Mimi Kamariah Majid (1995) *Inquiries of Deaths* is the first article that outlining the legal framework and the practice of coroner's inquest. It covers the background, duties, powers and current situation as well as legal analysis on the coroner's procedural law. The article is purely an academic analysis of the legal provisions of Criminal Procedure Code (Act 593) (CPC). Abdul Rani Kamarudin (2007) *Inquiries of Deaths under the Malaysian Criminal Procedure Code* has expanded the discussion on coroner's duties towards the recent inquest cases and critically suggested that coroner's court has become history, and the task is now taken by Magistrate who operates in a Magistrate's court setting with its own rules of evidence and procedure. Both articles however did not touch on the death investigation in occupational cases, and there is no literature on industrial death investigation in Malaysia.

Paul Matthews (2011) *Jervis on the Office and Duties of Coroners* is the first textbook that extensively discusses the roles and functions of the coroner in both medical and legal perspectives within British legal system (substantive and procedural). The book is a 'bible' to all practitioners that involved in the coroner's work and being a major influence to the profession itself. It consists of a compilation of all laws and regulatory sources (which includes Acts, Rules and Regulations) in conducting death investigation in UK. The book provokes the readers' thought on coroner's involvement in safeguarding public health. Freckelton & Ranson (2006) *Death Investigation and the Coroner's Inquest* is a good book which critically analyses the role of the coroner in death investigation which also includes death cases due to occupational fatality. The book examines the need not just to maintain but also to strengthen the coronial institution as an independent death investigator in order to prevent future death. Although it was written based on Australian coronial legal regime, the book also comparatively examines the coronial law in some commonwealth countries. The book emphasises the inquest findings, recommendations and reports as a 'rider' to facilitate the adoption of measures to avoid the incidents of avoidable deaths.

Paul Matthews (2010) *Recent Developments in Coronial Case law in the United Kingdom* explains the relationship between coroner and public health. It commented that the most important aspect of a coronial system is that it should benefit and be seen to benefit the health and safety of the public. Coroner's investigation on unnatural death is crucial as there may be implications for public health or safety. Therefore it concluded that coronial law these days is undoubtedly closely associated with human right law e.g. the 'right to life'. Ismail (2010) *Application of International Convention on Human Rights in British Coronial System as an example for Malaysia* has established the nexus between the coroner's investigation and human rights aspect thus proposed the application of international laws on human rights to Malaysian coronial system as the current system failed to play effective roles to prevent future death. Belinda Baker (2010) *Recent Developments in Coronial Case Law* highlighted the importance of coroner investigation to investigate death arise from employment as to identify the true cause of death whether it is caused by occupational hazardous activities or natural disease.

As for the legislation text, this article refers to two Acts i.e. *Criminal Procedure Code (Act 593) (CPC)* and *Occupational Safety and Health Act 1994 (Act 514) (OSHA)*. *CPC* provided for the legal powers

and jurisdiction given to the First Class Magistrate to act thus having full power to investigate death as the coroner. Part XXXII of *CPC* (Sections 328 to 341A) classified all death investigation process as one of the 'Special Proceedings' under the Act. It explains the power accorded to the police and also government medical officer in medico-legal investigation e.g. post mortem, releases of body and exhumation processes. Part VIII of *OSHA* 1994 (Sections 32 to 34) specifies the duty to notify any death due to occupational calamities in four situations i.e. occupational accidents, dangerous occurrence, occupational poisoning and occupational disease. These duty lies upon the employer to lodge such notification to the nearest occupational safety and health officer, while the registered medical practitioner who believes the occurrences of any occupational calamities shall have a duty to report to the Director General for Department of Occupational Safety and Health (DG DOSH) so that the DG DOSH may direct for an inquiry to be held.

Bugeja, Ibrahim and Brodie (2010) *Occupational Death Investigation and Prevention Model for Coroners and Medical Examiners* are the only resource that explains the need to have an interdisciplinary interaction between coroners and medical personnel in occupational fatality as it is an avoidable death. They had drawn the author's attention to the existence of Work-Related Liaison Service (WRLS) in Australia and outlined the details of WRLS as a framework in the development of the death investigation and prevention model in occupational death cases.

Methodology

The research methodology adopted for this paper is 'qualitative' i.e. methods of data collection through 'observation' or document 'content legal analysis' (Yaqin 2007). The paper approaches is doctrinal which consists theoretical, terminological, academic as well as conventional research. This paper focuses on the role of coroner in conducting death investigation in occupational fatality in Malaysia and the challenges it encounters. Content analysis is applied with analytical and critical approaches throughout the discussion. The method applied in this paper involves content analysis using data-gathering techniques such as library and document analysis from legal sources e.g. law journals or publication, statutes and commentary. These data are later analysed comparatively between data generated from the domestic legal resources and other data gathered from commonwealth countries namely UK, Australia and New Zealand. The basic aim of this paper is to discover, analyse and present in a systematic form, facts, provisions, conceptual framework, legal operational or application of certain laws, through library and online based study (armchair research method). This paper also relies on government or departmental published database. The main legislation referred to in this article is CPC and OSHA 1994. This paper proposes a framework of occupational death investigation and prevention model for coroner at the end of discussion, with reference to Australian jurisdiction.

Results and Discussion

Coronership: Background and Evolving Roles

The term 'coroner' derived from the word *'coronator'* i.e. a public officer whose task was to maintain order, or controller of the *'corona'* or circle of audience. In 925 AD, the office was upgraded as *'keeper of the pleas of the Crown'* or in Latin known as *'custos placitorum coronae'*. Coroner's existence can be traced since the Anglo-Saxon and early mediaeval periods up until it been given legal recognition as 'coroner' formally by Council of Eyre in 1194 and later royal charters in 1200. Throughout its existence, coronership has proved to be a remarkably persistent and fluid institution, adjusting its shape and focus from revenue-raising for the crown, administering important aspects of outlawry, dealing with Royal Fish and shipwrecks, facilitating the provision of compensation to relatives of deceased persons, and extending in some places into the investigation of not just homicides but fires, explosions, disasters and accidents (Freckelton & Ranson 2006). From the 18th century, the principal role of the coroner is been to clarify the public record in relation to the causes and circumstances of unexpected, unnatural and violent deaths. In 19th century, the focal point of coroner's investigations tended to relate to society's accommodation between industrialisation and the vulnerability of workers and others who were institutionalised (Freckelton 2008).

Beginning from 1980s, the public health movement increasingly highlighted the interplay as well as awareness between social and environmental factors in health, with the aim of managing problems identified as posing a health threat to the community (Martin & Johnson 2001). For that purpose, Freckelton considers coroner and inquests as part of the state's public health apparatus. He gave two reasons, firstly based on the judgement in R v South London Coroner; ex. Parte Thompson (1982) 126 Sol Jo 625, where Lord Lane CJ stressed the need for the inquest process to uncover the facts sufficiently to permit the adoption of counter-measures which characterising the role of the inquest as being 'to seek out and record as many of the facts surrounding the death as public requires'. Secondly, the broader form of the coronial inquest process which involving death investigation may allay rumours or suspicion, and thereby to ensure that no foul play or wrongdoers slips through the net (Freckelton & Ranson 2006). The Brodrick Report (1971) concluded that in modern society today coroner's inquest should serve on the basis of public interest i.e. not just to determine the medical cause of death but to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths and to advance medical knowledge within the medical fraternity. In consideration of public interest, the coroner should also preserve the legal interest of the deceased's person's family, heirs or other interested parties concerned.

Inquest and Coroner's Recommendation

Coroner's duty to investigate any death cases involves the 'inquest' proceeding which is an inquiry based investigation method. It is an inquisitorial style of investigative process which presided by the coroner and considers as 'fact finding exercise' in gathering all data and facts pertaining to the death of the deceased (Paul Matthews 2002) (Dorries 2004) (Mimi Kamariah 1995). Unlike in criminal or civil trial, in an inquisitorial inquiry, the questioning of witnesses by the inquiry is not an examination-in-chief, nor is it cross-examination. Hearsay evidence may be sought. Opinions, whether or not expert, may be sought. Questions to which the questioner does not know the answer will frequently be asked and will be asked because the questioner does not know the answer. Whereas the techniques of questioning witnesses in adversarial litigation can be set aside. The questioning process is, or should be, a part of a thorough investigation to determine truth. It is not a process designed either to promote or to demolish a 'case' (Scott 1995). In Thompson's case (1982) stressed that in an inquest, there are no parties, no indictment, no prosecution, no defence and no trial. It is simply an attempt to establish facts. Hence a process of prosecutor accuses and the accused defends is inapplicable in death enquiry. The perimeter and objectives of inquest has been elaborated further in the case of *Public Prosecutor v Shanmugam & Others* [2002] 6 MLJ 562 where coroner's inquest although court of law, it was essentially set up to investigate and ascertain the cause of death (beyond medical cause of death under section 328 of CPC). Apart from being shackled by a limited mandate, a coroner was also not bound to follow the usual procedure of law courts.

The main function of holding an inquest on a dead body is to determine certain facts about the deceased, the cause of death, and the circumstances surrounding both the death and the cause. As a fact-finding inquiry by a coroner, four important questions need to be answered but they are limited to factual questions by a coroner i.e. the identity of the deceased, place of his death, time of death and how the deceased came to his death. As an exclusive jurisdiction of the coroner, an inquest in Malaysia is an enquiry presided by judicial officer a first class magistrate who will assume the power of a coroner in holding investigation towards any sudden and unnatural death. It is inquisitorial in nature in which the coroner acted pro-actively to investigate not just the medical cause but also the circumstances which lead to the demise of the deceased. Unlike adversarial legal system, inquest is a 'facts finding exercise' or an 'exploration of facts' in which any person whose having substantial interest may participate as a witness giving their account of what that they know in the said proceeding. In *Sara Lily & Another v. Public Prosecutor* [2004] 7 CLJ 335, was held that a person must be able to show that they have a 'real, substantial and reasonable' interest before being given permission to participate in inquest as to prevent a floodgate in inquest.

There is no specific coroner's legislation in Malaysia although special Coroner's Court was established in 2013 (Ismail, 2018) and transfer of jurisdiction from magistrate to Session Court Judges via judicial

circular (Srimurugan Alagan, 2014). Unlike in Singapore, UK, Australia and New Zealand that have their specific laws and Coroner's Court on fulltime basis. The substantive procedure in conducting inquiries of death in this country can be found in Criminal Procedure Code (the "CPC") (Act 593) with amendment which came into force on 10 January 1976 making it applicable throughout the country. In *Public Prosecutor v Shanmugam* [2002] 6 MLJ 562 at 571-572 explained the legal implication of such amendment that position of magistrate that was no different to the archaic coroner when holding an inquiry of death and must confine himself to the evidence made available to him, and at the end of the day shall decide on that evidence alone. The guesswork is certainly out. While if any verdict is based on probability and not on the established facts, that verdict must certainly be quashed out and an open verdict returned.

One of the important historical functions of coroners is to facilitate the adoption of measures to avoid the incidences of avoidable deaths, by means of riders or recommendations. This known as 'coroner's recommendation' which identify failures and suggests changes that should be made in relation to matters of public health and safety. As risk management and occupational health and safety have grown into important vocations, together with integrated systems for coroner's inquiry, the application of these disciplines as part of a coroner's investigation has assumed greater importance (Freckelton & Ranson 2006) (Matthews 2011).

Rule 43 of Coroners' Rules 1984 (UK) provides the power of coroner when holding the inquiry to make recommendation if in his opinion there is evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future and action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances. The recommendation in a form of a report must be given to the person who the coroner believes may have power to take such action. The coroner in practice must announce his intention to lodge such report before the end of the inquest but failure to do so will not prevent such report to be made. When making such recommendation, the coroner must serve a copy of his report to several parties i.e. the Lord Chancellor and the interested parties. The Lord Chancellor may publish such report through a judicial gazette and will send such report to other party that deemed having interest towards such case.

Rule 3 of Coroners' (Amendment) Rules 2008 provides a statutory obligation, to whom who received such reports, to give a written response containing details of any action or preventive measures that has been taken or which it is propose will be taken that arises from such report. The respective party must provide for a written explanation in the event where there were no such actions or preventive measures being taken. They also must make a written representation to coroner about the release of such response. This response must be made within 56 days beginning with the day on which the report was sent and extension of time can be given upon coroner's discretion. The coroner shall sent copies of such response to Lord Chancellor and respective interested party, in which later will decide whether the response should be fully or partially release and to prepare the summary of such response.

In *Perre v Chivell* [2000] SASC 279 [4] it was held that the coroner's office now is much different to its early form. According to the judge's commentary in that case, nowadays, particularly in Australia, New Zealand and Canada, the overt emphasis of many coroners is upon making recommendations to help prevent injury and death, as well as providing accurate statistical information as to causes of death. It is been observed that several jurisdiction in commonwealth countries provide for the right of a coroner to make comments or recommendations.

Table 1: Coroner's Jurisdiction to make Comments or Recommendations in Commonwealth Countries

	Country	**Legislation (Acts, Rules or Regulations)**	**Section/Rules**
1.	United Kingdom	Coroners' Rules 1984	43
2.	Australia		

	a) Australia Capital Territory	Coroners Act 1997 (ACT)	52(4)
	b) New South Wales	Coroners Act 1980 (NSW)	22A
	c) Northern Territory	Coroners Act 1993 (NT)	26(1)(b), 27(1)
	d) Queensland	Coroners Act 2003 (Qld)	46
	e) South Australia	Coroners Act 2003 (SA)	25
	f) Tasmania	Coroners Act 1957 (Tas)	28(3), 30(1)
	g) Victoria	Coroners Act 1985 (Vic)	19(2), 21(3)
	h) Western Australia	Coroners Act 1996 (WA)	25(3)
3.	New Zealand	Coroners Act 1988 (NZ)	15(1)(b)
4.	Scotland	Fatal Accidents and Sudden Death Inquiry Act 1976	6(1)(c)
5.	Hong Kong	Coroners Ordinance	44(2)(a-c)
6.	Ireland	Coroners Act 1962	31

Occupational Fatalities Investigation

Occupational fatalities considers as a major public health problem. In 2003 an estimated 345 719 fatal occupational injuries occurred worldwide (ILO, 2003). Thus the application of public health principles to death investigation may potentially improves the capacity to prevent harm as it strengthens the understanding of injury determinants and prevention interventions. Coroner plays vital role in public health as they are the investigator of such fatalities that also include identification and promotion of prevention interventions. It was universally recognised that occupational injury is particularly complex because it interfaces with other injury settings and involves a range of mechanisms and agents. Therefore, comprehensive investigation of occupational deaths required an understanding of many risk factors including hazardous exposure, design and physical and organisational environments, followed by a multifaceted approach to prevention including education and training, protective equipment, regulation and enforcement and engineering controls (Stout NA, 2002).

Where the inquest being held and the death may have been caused by an injury received during the course of employment, and the deceased belonged to a trade union at the time of death, a person appointed by that trade union may be allowed to actively participate in the proceeding including the right to examine witnesses and right to a disclosure of related documents e.g. post mortem report, investigation reports etc., as they are 'properly interested person' to the proceeding (Matthews 2002). In England, death due to industrial disease is classified as unnatural death in which the coroner must hold an inquest to ascertain the cause of death and to make recommendation on the related matter. The report from Ministry of Justice released by Department of Statistics (UK) revealed that the verdict returned by the coroner on industrial disease as follows:

Table 2: Inquest Verdict of Industrial Disease Returned in England and Wales 2009-2011

Year	**Verdict of 'Industrial Disease' Returned**
2009	2623
2010	2560
2011	2569
Total	**7752**

In Malaysia, the statistic of industrial fatalities as recorded by DOSH raised concern as the number of deaths cases are at an alarming rate. For example, the death toll caused by occupational accidents from 2009 until 2011 that being investigated by DOSH are as follows:

Table 3: Occupational Accidents (Fatality Cases) Investigated by DOSH 2009-2011

Year	No. of Victims
2009	224
2010	185
2011	176
Total	**585**

From the statistic above the highest fatality rate are in the construction sector with the total of 188 deaths cases being recorded from 2009 to 2011. While based on the number of foreign workers compensated for fatality in industrial accidents, Hassan & Ismail (2012) have observed the figure as the following:-

Table 4: Number of Foreign Worker Compensated for Fatality in Industrial Accidents

Year	Fatality
2010	465
2011	503
Total	**968**

The death investigation process for industrial death can be found under Part VIII OSHA from section 32 to section 34. Section 32(1) specifies the duty to notify any death due to occupational calamities in four situations i.e. occupational accidents, dangerous occurrence, occupational poisoning and occupational disease that lies upon the employer to make such notification to the nearest occupational safety and health officer. Section 33(2) states about the duty of registered medical practitioner who attend or visit a patient believes to be suffering from any occupational disease listed in Third Schedule of the Factories and Machinery Act 1967 (Act 139) (FMA) and any disease named in any regulation or order made by the Minister under OSHA, occupational poisoning shall have a duty to report the matter to the DG DOSH.

Section 33 empowers DG DOSH to direct an inquiry if in his opinion the said inquiry ought to be held into the nature and cause of the accident, dangerous occurrence, occupational poisoning or occupational disease by an occupational safety and health officer. In exercising this duty, DG DOSH may appoint one or more persons of engineering, medical or other appropriate skills and expertise to serve as assessors in any such inquiry. Section 34 explains the power of occupational safety and health officer at inquiry. OSHA provides that "for the purpose of holding an inquiry under this Act, an occupational safety and health officer shall have the power to administer oaths and affirmations and shall vested with the powers of a First Class Magistrate for compelling the attendance of witnesses and the production of documents…and all persons summoned to attend the inquiry shall be legally bound to attend." A careful analysis towards sections 33 and 34 shows that the occupational death investigation process existed in OSHA, and empowers occupational safety and health officer to act as 'occupational death investigator' with powers vested of a magistrate which is the same with provisions of CPC pertaining to the death inquiry.

The Major Gaps

There are limitations towards coroner's investigation which include: coroners' lack of knowledge or training in public health, policy development and injury prevention; the paucity of resources to identify or examine known risk and contributory factors comprehensively, evaluate system failures and the effectiveness of counter-measures; and the lack of time, expertise and resources required to consider the potential implications for similar workplaces comprehensively. As a result, injury determinants are

not systematically identified from the investigation, limiting coroners' ability to make recommendations on injury prevention (Bugeja, Ibrahim & Brodie 2010).

Ismail (2010) is in the opinion that the provision on inquest under CPC can be considered as outdated, outmoded, archaic and in dire for a law reform and revision. This is due to the fact that the law on coroner's investigation in other jurisdiction has undergone the process of law reform. The law on coroner in Malaysia is being merged together with other criminal procedure, as the common law clearly states that coroner's investigation is inquisitorial in nature, such codification with criminal procedure i.e. adversarial system may cause 'systemic disorder or failure'. As a result of such failure had caused uncertainty towards the current practice and procedure by the coroners. This can be seen in a few inquest cases that have been reviewed on various grounds e.g. uncertainty as to the 'right of audience' and difficulty in ascertaining the interested party to the proceeding in *Sara Lily & Another v Public Prosecutor* [2004] 7 CLJ 335; erred in delivering verdict by specifically spelling out the penal offence committed by somebody who had directly caused the deceased to come to his death in the case of *In Re Anthony Chang Kim Fook, Deceased* [2007] 2 CLJ 362; refusal in discovery of documents to the parties concerned in *Retnarasa Annarasa v Public Prosecutor* [2008] 4 CLJ 90; being biased, superficial and failure to consider the evidence as a whole in the case of Public *Prosecutor v Shanmugam & Ors* [2002] 6 MLJ 562.

Inquest is not compulsory under the CPC and since an option is given to the magistrate (Coroner) to record the cause of death without holding an inquiry provided he is satisfied as to the cause of death, in most cases the magistrate will resort to it. What the magistrate does is to study the sudden death report and if the evidence attached therein indicates that a certain verdict is appropriate, he or she would record that verdict. Only in doubtful cases would he or she conduct a full scale open inquiry in court (Mimi Kamariah Majid 1995). Other example of systemic failure in our law is 'over used' or 'over reliance' of autopsy report by coroner until the report being admitted without further thorough investigation. This scenario can be seen from both cases i.e. *Ho Kooi Sang v University Malaya* [2004] 2 MLJ 516 and *In Re Inquest into the Death of Sujatha Krishnan, Deceased* [2009] 5 CLJ 783. By over reliance over the autopsy report it went overboard section 328 of CPC that define 'cause of death' as to include not only the apparent cause of death as ascertainable by inspection or post-mortem examination of the body of the deceased, but also all matters necessary to enable an opinion to be formed as to the manner in which the deceased came by his death and as to whether his death resulted in any way from, or was accelerated by, any unlawful act or omission on the part of any other person.

There is also no provision on coroner's recommendation in CPC. The non-existence of such provision is fatal towards coroner's primary duty to curb the recurrence of similar fatality. The term of reference of local magistrate in holding inquiries of death can be found in section 337 i.e. to inquire when, where, how and after what manner the deceased came by his death and also whether any person is criminally concerned in the cause of the death. These term of reference for the magistrate provided above are not comprehensive, lacking in clarity and open to public debate. Inquest cases reported since 1971 to 2008 showed no reference towards the issue of circumstances of which the deceased came to his death and the absent of verdict to prevent similar fatalities by the coroner (Ismail 2010). *In Re Inquest into the Death of Sujatha Krishnan, Deceased* [2009] 5 CLJ 783 is the one and only case that mentioned about coroner's recommendation. Briefly in that case the evidence disclosed during the inquiry on the missing samples taken from the deceased and the failure to conduct a mandatory post-mortem although had been requested by the investigation officer. Although the coroner decided that such failures were disturbing factors to the case and acknowledged the role of the coroner in United Kingdom and Australia in giving recommendations if he thinks that it is necessary to prevent future fatalities, the learned coroner refused to do so as it would run foul of section 339 of CPC. Ismail (2010) disagreed with the learned coroner's verdict. He added that such contention is irrelevant as the said provision relates to the power of Public Prosecutor to require the coroner's enquiry to be held and did not restraint the coroner from making any verdict on prevention from such future fatalities. It is noteworthy that this inquest proceeding was initiated by the coroner's own initiative after the coroner was dissatisfied with the report from the investigation officer and without any direction from the Public Prosecutor. If in Sara Lily's case, the judge had invoked section 5 of CPC to adopt rule 20(2) UK Coroners Rules 1984 on properly

interested issue, therefore there was no reason for not referring to the same law to adopt rule 43 of the same (Coroners Rules 1984).

As for the inquiry under OSHA, the research revealed that there was no data about inquiry being held under section 34 of the Act. Current practice shows that when there was occupational fatality occurred, a person (be it whether individual or corporation) responsible may be charged either under section 302 (for murder) or 304 (culpable homicide not amounting to murder) or 304A (causing death by negligence) of the Penal Code. Indictment under section 302 is unlikely to be invoked by Public Prosecutor as the provision requires higher degree of proof and clear intention to commit murder. In most cases, the charges framed was under section 304 i.e. offence for culpable homicide not amounting to murder, or causing death by negligence under section 304A as the standard of proof was based on 'res ipsa loquitor' i.e. the situation speaks for itself. In other word, they only need to show that the employer was negligent for example failure to provide safety precaution or measures that resulted to the death towards the person in the course of his employment; or suffers from industrial disease due to failure to provide safe working environment. It simply the case being transferred to Public Prosecutor office for further court's process without referring to coroner's court. This can be shown that there were non-coordination practices between DOSH and the coroner in industrial fatality.

The Victorian Model

The situation differs in Australia. There is coordination existed between Victorian Occupational Health and Safety Authority (Work Safe) Australia and Victorian State Coroner's Office. Coroner in Victoria under section 21(3) of Coroners Act 1985 (Vic) is obliged to report to the Director of Public Prosecutions (DPP) if the coroner believes that an indictable offence has been committed in connection with a death and this include occupational fatality. DPP will later determine whether to prosecute any person with suitable indictment based on the facts and coroner's recommendation. In order to strengthen occupational death and injury prevention via coroners' recommendation, an occupational death investigation and prevention team, the Work-Related Liaison Service (WRLS), was established at the Victorian Coronial Services Centre in Australia. It is noteworthy that in Victoria, the coroner's court and Victorian Institute for Forensic Medicine (VIFM) are at the same vicinity hence showed close relationship between coroners and forensic-science and medicine community (Freckelton & Ranson 2006). The establishment of WRLS following recognition by the Victoria State Coroner in other hand will assist the coroner in death investigation and prevention service to specifically in the area of occupational fatalities. WRLS mission was to assist the coroner's by providing evidence-based information on injury risk factors and interventions hence facilitating effective inter-agency collaboration with stakeholders with a role in injury prevention and control. It was established within the coroner's death investigation system with its operation written into the State Coroner's Office internal policy and procedures (Bugeja, Ibrahim & Brodie 2010).

Conclusion

This article find that the coroner plays vital role in investigating the death either unnatural or sudden and this include occupational death. It is his role to forwarded any report or recommendation in the event the evidence disclosed or shows during inquest that there is a strong probability or circumstances creating a risk of other death may occur or will continue to occur in future. Thus such report is crucial as to eliminate or to reduce the risk of death created by such circumstances. This study found that such duty to make recommendation fall under his responsibility towards keeping the public health and safety as beneficial towards the protection of public as well as social security. In the case of industrial death investigation and power to make coroner's report in Malaysia the legal provision is silent on the matter. All deaths will be investigated and no specific attention being given towards occupational health and safety prevention recommendation by the coroner so far. The study also reveals the non-existence of cooperation and coordination between coroner's court and DOSH, unlike between SafeWork and Victorian Coroner in Australia, there is no counter preventive measures and collaboration between DOSH and coronial institution in Malaysia to avoid industrial death. It is proposed that Malaysia should enact special Coroners Act or legislation and establish a fulltime coroner's office with power to make

report and recommendation to the parties whom coroner's beliefs having authority to take remedial action. This would ensure all industrial accidents and fatality will be put under scrutiny as to bring the beginning justice towards the bereaved. It is been accepted that there is no legal system which is perfect neither suitable nor applicable as universal standard to all jurisdictions. But by having a law reform towards CPC and legal transformation towards coronial institution it may reduce instances of similar future industrial death. As the law in Malaysia is still 'young' when it comes to inquest (as per coroner's verdict in *In Re Inquest into the Death of Sujatha Krishnan, Deceased* [2009] 5 CLJ 783 at 788), there must be a coordination or interplays between DOSH and coroner's office in investigating the occupational deaths cases so as to protect the life of the workers at large and guarantee safe occupational environment for better industrial productivity.

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