Occasional Paper

Coronial Law and Practice in the Solomon Islands: The Need for Reform

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> Discovering the truth of a person's death is vitally important for the family, friends and the community of the deceased. The families of those whose lives are cut off by avoidable death want to spare others the same fate. Modern coroners are expected to recognise these needs and to respond thoughtfully and compassionately to families and communities affected by a sudden, unexpected and tragic death. Coroners operate in a multidisciplinary environment to undertake expert investigations into preventable deaths. These include deaths that would not have occurred but for systemic failures.
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> The broader value of an inquest to the community includes uncovering the underlying causes of death, providing an independent review and investigation of the deaths of individuals in the care or custody of state agencies, making recommendations to avoid future fatalities, and assisting in personal and community grieving processes.
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> – Professor Ray Watterson[1]

Coronial law in the Solomon Islands is governed by the *Death and Fire Enquiries Act* [Cap 9] ('*Act*').[2] The *Act* appears to be ignored by most of those in the law and justice sector vested with the responsibility for ensuring it is followed.

Practitioners, police and magistrates often appear to lack of an understanding of the functions of a coroner.[3] In this paper reference is made to, *inter alia*, the historical role of the coroner, and the tensions and similar functions that exist between coronial inquiries and police investigations.

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1 Professor Ray Watterson, 'Responding to Unexpected Death', Paper for the New South Wales and Australian Capital Territory Indigenous Legal Service Workshop, 2007.

2 Reproduced as Attachment A to this paper.

3 Former Principal Magistrate Wilson says, '[i]nquiries into deaths and fires by Magistrates/Coroners in Solomon Islands have been misunderstood for a long time.' Quoted in *Report on Attendance at the 16th Annual Australasian Coroners' Society Conference*, December 2006.

The Historical Role of the Coroner

The role of a coroner has declined since the middle ages, however, the reason why the coronial system is sometimes regarded as a secondary and minor part of the justice system has more to do with misunderstanding of the importance of the functions that a coroner should perform. It remains a very important component of the justice system, and if properly functioning of significance in promoting the rule of law.

To place the coronial system, as it currently exists in the Solomon Islands, in context it is useful to consider the history of the office of coroner. The uncertainty of its origin is described in Halsbury's Laws of England as follows:

> The office of coroner is of great antiquity, and no satisfactory account of its origin can be given. It is said to have existed in the time of the Anglo-Saxon kings, but the authority for this statement is doubtful. The right to elect a coroner for London appears to have been granted to the citizens by Henry I. In 1194 the justices of Eyre were directed to see that in every county three knights and a clerk as custodian of the pleas of the Crown should be chosen. The office may, therefore, be safely assumed to have existed at least as early as the beginning of the thirteenth century, and there is other evidence to show that officers having powers similar to those of coroners were in existence before that date.
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> It is to be noticed that, while the officer whom the citizens of London were empowered to elect under the charter of Henry I was to hold pleas of the Crown as well as to keep the records, the officers whom the justices were to see appointed in each county were only to keep the pleas. The curtailment in the duties of the office was confirmed by the provision of Magna Carta that 'no sheriff, constable Escheator, coroner, or any of our bailiffs shall hold pleas of our Crown'.[4]

It seems to be accepted that the *Statute De Officio Coronatis* (1276) is the first document that sets out the jurisdiction of coroners. It contains in modern parlance the following words:

> The coroner should go to the place where any person is slain, or suddenly dead or wounded, or where houses are broken, or where treasure is said to be found, and should by his warrant to the bailiffs or constables summon a jury out of the four or five or six neighbouring towns to make inquiry upon view of the body; and the coroner and jury should inquire into the manner of killing and all the circumstances that occasioned the party's death; who were present, whether the dead person was known, and where he lay the night before; they should examine the body to see if there be any signs of strangling about the neck, or of cords about the members, or burns. Also weapons should be viewed and inquiry made with what weapons.
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> And the coroner may send his warrant for witnesses, and take their examination in writing; and if any appear guilty of the murder he should inquire what goods, corn and land he hath; and then the dead body should be buried. A coroner may likewise commit

4 Butterworths, *Halsbury's Laws of England*, Volume 9(2) (4th ed, 1998) 471, 801.

> the person to prison who is by his inquisition found guilty of the murder: and the witnesses should be bound by recognizances to appear at the next assizes.[5]

The reason for the office of the coroner being established in England has been judicially attributed to the concerns of members of 'even the most primitive societies' to have explained 'unusual, violent or suspicious deaths'.[6]

During mediaeval times in England, the coroner was involved in protecting the King's interests including protecting his revenue, as well as in investigating death. The control on the power of the sheriff and the protection of revenue sources by use of coroners may not have been totally effective. R. F. Hunnisett makes this point in the following way,

> The medieval coroner is thought to have been of a far higher character, less oppressive and less extortionate than the sheriff. He may have been, but he nevertheless practised extortion regularly, if moderately.[7]

The usual form of extortion was taking money to hold an inquest, or if money was not forthcoming 'taking of the upper garment from the dead body', or causing a felon's 'chattels to be appraised at less than their true value' and retaining the difference.[8]

It has been suggested that the first reference to coroners appeared in the *Articles of Eyre* 1194, and that coroners were used to 'check the increasing corruption practiced by sheriffs who were royal bailiffs, the King's administrative officials at a local level'.[9] The 'true origins' of the coroner it is said should be dated from the Council of Eyre in 1194.[10]

The coroner's role as revenue protector has disappeared and the function as a death investigator has been greatly modified. In the time of Henry I, coroners were engaged in the investigation of cases involving a variety of crimes and accidents. As the Australian commentator McKeough has written,

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5 Cited in K Waller, *Coronial Law and Practice in New South Wales* (3rd ed, 1994) 2.

6 Kirby P, *Herron v Attorney-General for NSW* (1987) 8 NSWLR 601, 603.

7 R F Hunnisett, *The Medieval Coroner* (1961) 118.

8 Ibid 122.

9 Jill McKeough, 'Origins of the Coronial Jurisdiction' (1983) 6 *University of New South Wales Law Journal* 191.

10 Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006) 5.

> The coroner's legal process of inquiry was known as the *inquisitor*, or inquest and meant merely an inquiry of any sort, not just into death. The coronial inquests were held on arson, rape, dead bodies, treasure trove, royal fish and wrecks of the sea.
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> Inquests were held on other matters if a special writ so directed, and all of these investigations were carried out with the aid of a jury. The coroner also heard confessions of felons, dealt with abjurations of the realm and oversaw the processes of *turning approver* and *exigent*. The latter was a process of demanding a person's presence in the county court, non-compliance resulting in outlawry.[11]

An important aspect of the coroner's function was to keep basic records of their activities. So that:

> When an eyre was imminent the coroner would transcribe [those records] on a roll, which consisted of larger pieces of parchment either sewn together at the top and rolled up (Exchequer fashion) or else sewn together end to end and rolled up (Chancery fashion). The coroner's roles were 'of record', meaning they could not be traversed in any way. The concept of the record began with the Doomsday Book, which could not be questioned either. It stated facts which were the truth. Thus developed an early antecedent of the concept of precedent as we know it.[12]

The contemporary coroner still has a role in record keeping in so far as they should be recording the manner and cause of all unnatural deaths; and making such information available to government and the public. The importance of such an activity was emphasised by Principle Magistrate Wilson when he said, 'Inquiries into deaths and fires by Magistrates/Coroners in Solomon Islands have been misunderstood for a long time. They provide a forum for the gathering of a lot of information which, if analysed, may assist Government in policy matters and the allocation of money and resources to areas of need'.

Although removed from the pressures that caused the creation of the position, largely through the development of common and statute law, the role of inquirer into death remains, in large part, unchanged.

A coroner can play a role in assisting police in homicide investigations where the identification of an offender, sufficient to allow a charge, has not occurred. A coroner is required to take into account the interests of relatives, where such interests are raised. These activities, however, remain subservient to the function of determining manner and cause of death.

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11 McKeough, above n 9, 193.

12 Ibid.

Apart from investigation of death cases, coroners can investigate the origin and cause of fires. The investigation of the origin and cause of fires is referred to in this work but not analysed in depth.

The coroner is an investigator, and sometimes in the position of a last resort facilitator for police investigators. This analysis appears to be supported by Thomas MacNevin in 1884 when he advises coroners that they should seek the advice of police before embarking on inquiry. He advised:

> It would be desirable, *whenever practicable*, to communicate with the chief or nearest officer of police in the district, with a view of ascertaining whether any clear ground exists for suspecting that death may have been caused by some foul means, before the Government is put to the expense of such inquiries. The Coroner on receiving information of a suspicious death should, if satisfied of its correctness, proceed with all possible expedition to the spot where it is said that the body lies, taking with him a Bible, writing materials, forms of inquisition, recognizances to bind over witnesses and to prosecute, warrant for the burial of the body, and for the apprehension and commitment of any person who may be charged by the verdict with any crime, and a sufficient quantity of foolscap paper for taking the necessary depositions.[13]

The role of the police, *inter alia*, is to investigate crime and, in this process, gather relevant, probative evidence; and where possible apprehend and bring suspects before a court. Suspects are presumed innocent until such time as they are found guilty beyond reasonable doubt by a properly constituted court.[14] Similarly, a coroner can investigate, *inter alia*, suspicious deaths which may be crimes, gather relevant and probative evidence and, where considered appropriate, refer for consideration the prosecution of individuals to the Director of Public Prosecutions.

Although there are many distinctly different functions, a coroner in most cases relies primarily on the police for assistance. This is the case even where an inquest or inquiry is dispensed with and the function is mainly administrative, in such cases a coroner reviews the evidence collected by the police. As is the case with police, fact gathering is the primary function of a coroner: any findings or recommendations have no direct consequences. Lord

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[13] Thomas MacNevin, *Manual for Coroners and Magistrates in New South Wales* (2nd ed, 1884) Government Printer, 18.

[14] *Woolmington v DPP* [1935] AC 253; *Evidence Act 1995* (NSW) s 89.

Lane CJ in *Reg v South London Coroner; Ex parte Thompson*[15] emphasises the fact finding function of an inquest. He states that,

> Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring whichever metaphor one chooses to use.

One of the distinctions between police investigations and coronial investigations is that any person with a bona fide interest can have a role in a coronial inquiry. This is provided for in s 14 of the *Death and Fire Enquires Act* which states:

> **Appearance of counsel**
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> **14** Any person who satisfies the Magistrate that he has a bona fide interest in the subject-matter of an inquiry under this Act, and any other person by leave of the Magistrate, may attend the inquiry in person or may be represented by counsel or solicitor.

Appearance of parties and the examination of witnesses at inquests or inquiries are specified by legislation. However, as is the case with police, a coroner cannot determine whether or not a case against an accused has been proven beyond reasonable doubt. Coroners though, unlike police, have a further limitation in that they cannot bring a criminal charge against any person.

The authority of coroners in colonial times extended to issuing warrants and committing for trial. The criminal jurisdiction functions of coroners in the colony of New South Wales are described by MacNevin as follows,

> In his judicial capacity he has to inquire when anyone comes to his death suddenly or violently, how and by what means such death was cause.
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> The inquiry of the Coroner must it seems be restricted to the cause of death of the person upon whom the inquest is taken, and cannot be extended to accessories *after* the fact. He may, however, inquire of accessories *before* the fact, for such are instrumental to the death. It is not his province to accuse anyone or to arrest any suspected person beforehand, or even to assume, and act on the assumption, that deceased met his death by foul means, although, in the case of a *verdict* implicating a supposed murderer, the

[15] The Times, 9 July 1982.

> Coroner has the further duty imposed on him of committing the accused, and binding over the witnesses against him to appear at the trial.[16]

A coroner may exercise some judicial power but such power is limited in scope. In exercising the functions conferred by statute and common law, a coroner can engage in both inquisitorial and adversarial investigative methods. The investigative method employed outside of hearings primarily involves a review of police generated documentation.

In *Musumeci v Attorney General of NSW & Anor* Ipp JA, with whom Beazley JA agreed, stated that:

> Mr Johnson emphasised the investigatory nature of an inquest. Mr Basten SC, senior counsel for the claimant, emphasised the adversarial process inherent in an inquest. Courts have found it difficult to characterise the precise juristic nature of an inquest. For my part, I do not think it necessary to embark on that exercise. I think it sufficient to note, firstly, that it is a hybrid process containing both adversarial and inquisitorial elements. Secondly, coroners exercise judicial power, notwithstanding the executive nature of their functions. Thirdly, the proceedings in the Coroner's Court involve the administration of justice.[17]

There is a tension between the 'adversarial and inquisitorial elements'. However, of greater significance, are the powers and the extent to which those powers can be exercised by a coroner. As far as reasonably possible the *Act* should address and offer guidance about the way the inquisitorial and adversarial elements are to be employed. This can, in part, be done by clarifying the role of the rules of evidence in the *Act*. It may also require some training sessions for people who spend their working lives exclusively employing the adversarial approach in hearings. It is particularly important for coroners to understand the extent of the powers given to them through an inquisitorial system.

Appointment of Coroners

Section 12 of the *Death and Fire Enquiries Act* makes provision for the appointment of corners. It states:

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16 MacNevin, above n 13, 13.

17 [2003] NSWCA 77 at [33]; 57 NSWLR 193. see also See *R v South London Coroner, Ex Parte Thompson* (1982) 126 SJ 625 (cited in *Annetts v McCann* at 616 by Toohey J), *Fairfax Publications Pty Ltd v Abernethy* [1999] NSWSC 826 per Adams J, *Maksimovich v Walsh* at 327–328 per Kirby P and 337 per Samuels JA, *Mirror Newspapers Limited v Waller* (1985) 1 NSWLR 1 at 6, *Herron v Attorney General for NSW* (1987) 8 NSWLR 601 per Kirby P at 608.

Appointment of other persons for holding inquiries

12 (1) There may be appointed from time to time one or more fit and proper persons for the purposes of holding inquiries under this Act, any such appointment being made, in the case of a public officer, pursuant to the Constitution, and otherwise by the Chief Justice:

Provided that any person so appointed shall only exercise the powers thereby conferred upon him in the event of a Magistrate being unable to hold an inquiry owing to illness or absence or any other reasonable cause.

(2) All the powers of a Magistrate under this Act shall be thereupon vested in any such person appointed as aforesaid.

(3) Every such person shall before exercising any of the powers conferred upon him as herein before provided make and subscribe before any Magistrate the oath prescribed in the Schedule to this Act.

The appointment of magistrates as coroners is usual in other common law jurisdictions. This may be done because of perceived resource limitations, and historical practice. However, in it is now not unusual for the appointment of magistrates who have as their fulltime role that of coroner.

In the Solomon Islands it may be appropriate to appoint a chief coroner who could be responsible for administering the coronial system, assisting other magistrates who a performing the functions of a coroner, and being specifically tasked to do those cases that have a high public profile such as deaths in custody.

Function – Determine Manner and Cause of Death

Section 2 of the *Death and Fire Enquiries Act* provides the circumstances for the holding of an inquiry. It states:

Magistrate may hold inquiry in cases of sudden or suspicious death

2 Whenever a Magistrate shall have been informed, or shall have reason to believe or suspect, that the death of any person occurring or of any person who may be found dead within Solomon Islands has been brought about or accelerated either by violence, or by accident, or by any unnatural cause, or that such person has died a sudden death of which the cause is unknown he may if he shall think fit, at such time and place as he shall fix, hold an inquiry into the cause of the death of such person.

The primary function of a coronial inquest or inquiry[18] is to make findings about the 'manner and cause of death'. The 'manner of death' meaning the circumstances surrounding the death.

In *Ex parte Flock; re Featherstone,* Wallace P stated:

> Without going into the history of the Coroners Act it can I think be said that the phrase 'manner and cause' has been given wide meaning and so as to *enable* coroners' juries to return verdicts which implicate or exculpate individuals in respect of the death under consideration. But I do not think they are compelled so to do.[19]

The 'manner and cause' of death is interpreted by coroners as meaning the circumstances surrounding the death of an individual, which may or may not include a person of interest.[20]

Form of Death Investigation

A coroner can conduct investigations without police involvement. The practice however is for the coroner to utilise the police investigation and seek assistance from them. The coroner conducting a death or fire inquiry should have a very good understanding of best practice investigative methods, and have the explicit power to ensure police carry out all necessary investigations.

In the event that coroner is not trained in best investigative methods and police do not carry out the required investigations then some of the problems discussed below can occur. The problems highlighted below also show the need for the police to have a proper understanding of their ethical obligations, as well as their functional duties.

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[18] An 'inquest' usually refers to a coronial investigation into a death, and an 'inquiry' usually means a coronial investigation into the cause of a fire. Such investigations can involve a public hearing, but not in every case.

[19] (1967) 86 WN (NSW) Pt 2, 349, 350.

[20] A 'person of interest' is regarded as one who may be directly involved in the death and therefore possibly the subject of criminal charges – a suspect.

Coroners are very limited in the investigations that they can undertake without the involvement of police. For example, they cannot search or seize or engage in surveillance operations where listening devices should be used. That can be regarded as a significant limitation especially in death in custody cases where the death occurred in police custody. The traditional justification for the use of the police to carry out coronial investigations is provided by former New South Wales State Coroner Kevin Waller. He contended:

> Investigations on behalf of the coroner are carried out by police. While it is sometimes suggested that a body other than police should perform this function, no one has indicated from where this force would be recruited. The police force is a disciplined body with well-established lines of authority. It has access to vast resources, including finance, transport, (land, sea and air), manpower, expertise (fingerprinting, ballistics, document examination, criminal records) and special purpose squads. In most cases it is the best and indeed the only body able to carry out a proper investigatory role.[21]

The praise given to the police force generally by former coroner Waller needs to be considered in the light of more contemporary evidence about systemic problems that can exist within the police force. In the final report of the Royal Commission into the New South Wales Police Service, Commissioner Wood makes, *inter alia,* the following findings about entrenched and systemic corruption with the Police Service.

> Despite regular inquires and efforts at reform the Service has rarely been free of corruption. What is of concern arising out of the present inquiry is the manner in which corruption has expanded from those forms commonly seen in connection with regulatory forms of policing, to the active involvement of police in planning and implementing criminal activity, sometimes in partnership with known criminals and on other occasions, in competition with them. This finding mirrors the experience of the 1994 Mollen Inquiry which similarly found that corruption within the New York Police Department (NYPD) was no longer confined to fortuitous opportunity or to protection provided by way of a blind eye to selected criminal activities, but often arose because police created and actively planned similar activities.[22]

Criticism of coroners and their relationship with investigative police has been longstanding even if not recognised as legitimate by former State Coroner Waller. The close relationship between police and coroners was recognised and criticised by Commissioner JH Wootten during the Royal Commission into Aboriginal Deaths in Custody. Commissioner Wootten was particularly concerned with police culture, its influence on police officers involved in

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[21] Kevin Waller, *Coronial Law and Practice in New South Wales* (1994) 6–7.

[22] J R T Wood, Commissioner, Final Report, *Royal Commission into the New South Wales Police Service*, Volume 1, May 1997, p 189, [6.7].

investigating other police and the acquiescence of coroners to the police investigative findings. He was of the view that,

> In most of the cases which the Commission has investigated the coronial inquiry has been largely shaped by the proceeding police investigation, although there have been recent exceptions. Often the inquest has consisted of no more than perfunctory running through a brief supplied by police. Unsatisfactory coronial inquiries have usually been the prisoner of inadequate police inquiries. If we are to continue with the system whereby deaths are investigated for the coroner by police the quality of police investigation is of tremendous importance.
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> In my experience as a Royal Commissioner I have become very conscious of the existence of a 'police culture' – a set of ingrained attitudes and ideas that are widespread in the police force and are very resistant to change. There is a very great blindness in that culture to the problems of police investigating police, and a very great reluctance to acknowledge the possibility of wrong-doing by police. Again and again deaths in custody have been subjected to no really independent investigation and the brief for the coroner has been prepared by the very officer who was in charge of the prisoner and whose conduct should have been subject of scrutiny. Even when investigation is under the control of a separate unit like the Internal Affairs Branch, the officers who come in often act as thought their function is to defend the local police and demonstrate their innocence rather than to carry out an independent investigation.
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> There can be great facades of independent supervision which in practice mean absolutely nothing. In one Victorian inquiry counsel for the police argued that the fact that the officer preparing the coronial brief was the officer who had been in charge of the prisoner was not objectionable, because he was under the scrutiny of a host of independent eyes – a doctor who came to examine the body, a CIB detective, the inspector in charge and the Internal Investigation Branch. One by one the relevant witnesses were called. The doctor said that he only certified the death and was not concerned to examine the body; the detective said that his only function was to take photographs; the inspector said that his task was purely administrative and not investigative; and the Internal Investigation Branch representative said that his function was to 'oversight', which turned out to mean that he just accepted what he was told by the officer in charge. It was almost comical at times to see how everybody passed the buck for such investigations.
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> It is remarkable how in police investigations of police the need is not seen for the same scrutiny of evidence as in other cases. It is elementary in general crime investigation that a suspect is interviewed quickly, and that if there are a number of people involved steps are taken to prevent them conferring and putting together an agreed version. I doubt that this has been done in any of the deaths in custody which I have investigated. In most cases police were not even interviewed but allowed to write their own statements at leisure, the leisure being any time up to a week or a fortnight before the inquest. Even where police have been interviewed, no steps have been taken to prevent prior discussion and agreement between them, and what they say has not been tested or probed.[23]

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[23] J H Wootten, 'Deaths in Custody', *Coronial Inquiries,* at public seminar by the Institute of Criminology, Sydney, 10 October 1990, 9–11.

Royal Commissioners' Wootten and Wood are not isolated when making their criticisms of police investigations and corruption. In the case of Edward James Murray, a coronial inquest was held into his death which occurred in Wee Waa Police Station on 12 June 1981. He was 21 years of age and police allege that he was placed in a police cell shortly after 2pm and was found hanging from a bar above the cell door very soon after 3pm. He had committed no crime and was placed in preventative detention because he was intoxicated.[24]

The Royal Commission into Aboriginal Deaths in Custody examined his case and Commissioner Muirhead found in respect of the police investigation that:

> The police investigation into Eddie's death was inadequate, based on assumptions that he had committed suicide and that the officers involved were 'reputable and dependable'. The combination of the autopsy, the police investigation and other factors including destruction of clothing, or its remnants without consultation with the family inevitably gave rise to disquiet and suspicion which are likely to persist.[25]

A coroner can conduct investigations without police involvement. The practice, however, is for the coroner to utilise the police investigation and seek assistance from them. In New South Wales, police are also seconded to the coroner's office to assist. The State Coroner determines the degree of involvement of seconded police officers in an investigation. Seconded police officers usually have an administrative and advisory function rather than an investigative role.

An inability of a coroner to carry out a competent investigation may have adverse ramifications for the deceased's family and potentially the community. The failure to provide sufficient investigative powers and resources probably ensures failure in many cases. However, even where a person has been charged with a serious indictable offence there is no legal requirement that a thorough and competent criminal investigation occur before trial. In *Penny v The Queen*[26] Callinan J, with whom the rest of the court agreed, emphasised the role of the investigatory process. He stated:

> [T]hough a better investigation may, and probably should have, been conducted, there is no general proposition of Australian law that a complete and unexceptionable

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[24] Robert Cavanagh and Roderic Pitty, *Too Much Wrong: Report on the Death of Edward James Murray* (1999) 12.

[25] J H Muirhead, *Report of the Inquiry into the Death of Edward James Murray*, Government Printer, 25 January 1989, 133.

[26] (1998) HCA 51.

> investigation of an alleged crime is a necessary element of the trial process, or indeed of a fair trial. That is not to give any imprimatur to incomplete, unfair or insufficient police investigations. Indeed there may be cases in which deficiencies in the investigation might be of such significance to a particular case as a whole that the accused will be entitled to an acquittal or a retrial. But that will all depend on the facts of the particular case. Mason CJ in *Jago v District Court (NSW)* may be taken to be alluding to precisely such a possibility in the following passage:
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> 'Moreover, objections to the discretion to prevent unfairness give insufficient weight to the right of an accused person to receive a fair trial. That right is one of several entrenched in our legal system in the interests of seeking to ensure that innocent people are not convicted of criminal offences. As such, it is more commonly manifested in rules of law and of practice designed to regulate the course of the trial. But there is no reason why the right should not extend to the whole course of the criminal process and it is inconceivable that a trial which could not fairly proceed should be compelled to take place on the grounds that such a course did not constitute an abuse of the process.'

The unfairness to an accused and therefore potentially a miscarriage of justice can arise because of the failure of police to carry out, in a full and proper manner, their investigatory duty. An incompetent coronial investigation can lead to the truth not being revealed and, potentially, offenders escaping trial. Significant assistance can be provided by coroners to find the manner and cause of death who are provided with sufficient resources, including statutory power, and who are knowledge of best investigative methods. There may be some resource difficulties in the Solomon Islands but well qualified coroners would undoubtedly assist the justice system, and with death prevention.

Function – Recommendations

In most common law jurisdictions the function and procedures to be followed by a coroner, are now governed more by statute than by the common law. In the Solomon Islands this is not the case, because of the brevity of the statute.

In Australian States and the Territories the primary function of a coroner is to attempt to determine a person's identity, the date and place of death, and the manner and cause of death. This fact finding exercise is usually undertaken with the assistance of the police; following police investigations that have not resulted in the laying of criminal charges. An ancillary function, which may have had its genesis in medieval England,[27] is the prevention of injury and death.

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[27] Graeme Johnstone, 'Coroner's inquiries and recommendations', Hugh Selby (ed) *The Inquest Handbook,* Federation Press 1988, 38.

The prevention of deaths is an increasingly important function of a coroner as noted in the case of *People First of Ontario v Niagara (Regional Coroner)*.[28] In this case the court found that the public interest required a greater emphasis on the recommendation function. The Court stated:

> The public interest in Ontario inquests has become more and more important in recent years. The traditional investigative function of the inquest to determine how, where, and by what means the deceased came to her death, is no longer the predominant feature of every inquest. That narrow investigative function, to lay out the essential facts surrounding an individual death, is still vital to the families of the deceased and those who are directly involved in the death.
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> A separate and wider function is becoming increasingly significant; the vindication of the public interest in the prevention of death by the public exposure of conditions that threaten life. The separate role of the jury in recommending systemic changes to prevent death has become more and more important. The social and preventative function of the inquest which focuses on the public interest has become, in some cases, just as important as the distinctly separate function of investigating the individual facts of individual deaths and the personal roles of individuals involved in the death.[29]

The authority to make recommendations is enshrined in legislation in all states and territories in Australia. It has taken the form of a statutory discretion given to coroners to make 'recommendations' or 'comments'. Recommendations do not form part of any findings and have no legal effect.

In the Solomon Islands reliance would need to be placed on the common law if a magistrate determined to make a recommendation design to assist with death prevention.

The importance of the role of coroners in making recommendations was stressed the by former Principal Magistrate, Stephen Wilson, in his 'Report on Attendance at the 16th Annual Australasian Coroners' Society Conference'. He stated in his conclusion:

> The role of the Coroner is also educational in that recommendations by him or her have the potential to reduce the repetition of incidents resulting in the unnecessary loss of life that effect not only the loved ones of those who have died but the wider community.
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> Compliance with the Act will also encourage compliance with other Acts of Parliament that have fallen into disuse including of *Birth and Death Registration Act* and the *Safety at Work Act*.

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28 (1991) 85 DLR (4th) 174.

29 Ibid 183–184.

Function – Inquiries into Fires

Section 11 of the *Death and Fire Inquiries Act* states:

> **Fire inquiry**
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> **11** A Magistrate may hold an inquiry into the cause and origin of any fire occurring within Solomon Islands when, in his opinion, the circumstances of the fire require an inquiry; and for such purpose a Magistrate shall have and may exercise all or any of the powers conferred by Part I of this Act in so far as the same shall be applicable.

The section seems to give magistrate (coroner) a wide discretion in terms of whether or not to hold an inquiry. In my view there is a need to provide additional guidance in the *Act*.

Function – Death in Custody

Apart from the fundamental function of a coroner to investigate the manner and cause of death, and what has traditionally been a secondary function to make recommendations, there exists, in many coronial jurisdictions the requirement for coroners to investigate deaths in custody. This function is reflected in section 4 of the *Death and Fire Enquiries Act.* It states:

> **Death in prison**
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> **4** An inquiry shall be held by a Magistrate into the cause of all deaths in Solomon Islands of all persons confined in any prison or other place of lawful detention.

This section despite its misleading title ‘death in prison’ refers to ‘other place of lawful detention’ which would include a place where police were holding a person. The inclusion of the words ‘lawful detention’ potentially only adds complexity for a coroner investigating a death in custody.

In cases where the death occurs in police custody there is a need for the investigating coroner to have a good understanding of best practice investigative methods than may be the case in other circumstances.

The Role of Forensic Pathology

The body of the deceased, and the scene of the death, have always been both essential evidence, and a source of such evidence. The need for coroners to carefully consider such evidence before making findings about manner and cause of death is a vital part of coronial procedure. In medieval England coroners were required to hold inquests into deaths that were unnatural, sudden, suspicious, or in prison. A limitation on a coroner was that the inquest could only be held if the body was found. Furthermore, the inquest was required to be held at the site where it was found. R F Hunnisett describes the duty to hold an inquest and the limitations on performing it during a plague or famine in the following way:

> Holding inquests upon dead bodies was the duty which exercised the medieval coroner most frequently, as the surviving coroners' rolls show. Indeed, in times of plague or famine its burden could become insupportable. During the famine of 1257–8, for example, so many people died of hunger in the eastern counties that the coroners were unable to view them all; permission was therefore granted for the bodies to be viewed and buried by the men of the neighbourhood with the coroner, unless a wound was found or there was any suspicion of homicide. Normally, however, the coroner had to view and hold an inquest upon the bodies of all those who died unnaturally, suddenly or in prison, or about whose death there might or was said to have been any suspicious circumstances.[30]

In New South Wales the duty to hold an inquest at the scene of death with the body *in situ* remained until the introduction of the *Coroners Act* 1960. Dowling CJ, Willis and Stephen JJ are reported in the Sydney Herald of 18 September 1839 as supporting the requirement that an inquest to be conducted at the scene with the body because it allowed the evidence to be received in an unaltered state. They placed emphasis on the fact that the evidence could best be adduced from the body of the deceased and from living witnesses if it was done at the scene. Their reported views are:

> By the Statute *de officio coronatoris*, IV Edw 1, st 2, which was passed in affirmance of the common law, the Coroner, upon information, shall go to the place where any beslain or suddenly dead or wounded, and forthwith summon a jury to enquire into the circumstances attending and the cause of the death, and the jury must view the body. Although the Statute alluded to does not say expressly, that the Coroner shall take his inquest on view of the dead body, yet it is clearly laid down by all the books, that an inquest of death can be taken by a Coroner *super visum corporis* only, and if there be no view, the inquisition is void. This is an essential part of the duty of the Coroner, to the intent of making due enquiry as to the cause of the death for the purposes of public justice. In truth the body itself is part of the evidence before the jury, and if they see it before, and not after, they are sworn, a material part of the evidence is given when the

[30] R F Hunnisett, above n 7, 9.

> jury are not upon oath. It is essential then, for the ends of justice, that the inquest should have the dead as well as the living witnesses untampered with before them, in order to enable them to arrive at a just conclusion.[31]

The author of the New South Wales manual for coroners, Thomas MacNevin, in the late 19th Century, described the duty of coroners to hold inquests only after viewing the body, when he provided the following rules:

> An inquest of death can be taken by a Coroner *super visum corporis* only, and he has no authority to hold the inquest without first viewing the body in company with the jury; and if he do so, the inquisition is void, as being an extra-judicial proceeding.
>
> It has already been observed that an inquest cannot be held on a Sunday, nor can a body be *viewed* on that day, for the reasons before stated.
>
> If the body cannot be viewed, the Coroner can do nothing. Therefore, when the body cannot be found, or has lain so long before the view that no information can be obtained from an inspection of it, or is so decomposed that a view would be or no service, the Coroner cannot take the inquest; but in such cases an ordinary magisterial inquiry by a Justice of the Peace should be held as to the cause of death.[32]

The perceived need to have the body to be viewed at the scene in order to ensure that evidence was not tampered with has in large part been overcome by the use of crime scene examination techniques that can accurately record the scene for later scrutiny. The use of medical practitioners to examine, record and provide an opinion about the cause of death has also largely removed the need for coroners or coroners' juries to view bodies. However, a view of a possible crime scene, with a body present or otherwise, remains of potential assistance in determining the manner and cause of death. Whether a view of the crime scene is taken or not, coroners rely upon the information provided by police officers who have crime scene examination responsibilities. In particular, photographs taken of the deceased *in situ* are often tendered at hearing and are available for parties given leave to appear. Similarly, photographs taken of the deceased during autopsy procedures are available and can be tendered.

Although coroners have a right, at common law, to the possession of a body the subject of a coronial inquiry they often fail to ensure that appropriately qualified medical practitioners

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[31] *R v Russell* [1839] NSW Supreme Court 65, Source: *Sydney Herald*, 18 September 1839.

[32] MacNevin, above n 13, 19.

perform autopsies. This is a major issue in suspicious death cases, or where criminal or civil liability may need to be determined.

The relevant sections of the *Act* in the Solomon Islands are:

Post-mortem examination of body

6 Whenever it is expedient that the dead body of any person should be examined by a duly qualified medical practitioner the Magistrate shall forthwith issue an order to any such medical practitioner to make a post-mortem examination of the body of the deceased person.

Medical practitioner to make post-mortem when required

7 Every medical practitioner who is required to make a post-mortem examination as in the last preceding section provided shall thereupon make such examination as may enable him to ascertain as far as possible the cause of death; and shall send a report thereof to the Magistrate requiring the examination.

Penalty for failure to comply with order

8 Every medical practitioner who fails or neglects to comply with the provisions of the last preceding section, unless he shows good and sufficient cause for not complying with the same, shall be liable on summary conviction to a fine of twenty dollars.

Fee for post-mortem

9 A medical practitioner for making a post-mortem examination of a body of a deceased person when required as aforesaid, and for his report thereon to the Magistrate, shall receive such fee, if entitled thereto, as the Rules Committee under section 90 of the Constitution, may from time to time prescribe.

The sections need further clarification, for example, the words in section 6 'whenever it is expedient' provide little if any guidance.

The utilisation of medical practitioners, who are not qualified forensic pathologists, can have outcomes that do not identify a cause of death or that identify a cause that is incorrect.

It may be appropriate to state in the *Act* that the coroner has possession of the body of a deceased until such time as all relevant examinations have been completed. Currently, the only section of the *Act* which may by inference support the proposition is section 3 which states:

> **Magistrate may order disinterment of body**
>
> **3** If a body shall have been interred before an inquiry shall have been held the Magistrate may, if he shall think fit, by warrant under his hand order the disinterment of such body for the purpose of the inquiry and such disinterment shall be made accordingly.

Application of Coronial Law and Practice in the Solomon Islands

In his *Report on Attendance at the 16th Annual Australasian Coroners' Society Conference*, Principal Magistrate Stephen Wilson relevantly found that: the coronial system in the Solomon Islands does not function in accordance with the *Act*; deaths are not reported to a coroner; post mortem examinations appear to be performed contrary to the provisions of the *Act*; fires that occurred during the Honiara riots were not reported; police do not comply with the provisions of the *Act*. He states:

> The Coronial process in the Solomon Islands does exist. However, it does not function in accordance with the Act. In the six months that I have been in Solomon Islands, I am aware of only one report of a death, that being on 16th November 2006 following a death in custody at Rove Prison. That death was reported to me by the Commandant of Rove Prison in accordance with the Prisons Regulations and is now subject to an inquiry under the Act.
>
> Regrettably, regular reports of deaths described as "suspicious" or clearly caused in unnatural circumstances are reported by police to the media. Those reports are published in the local print media. However, they are not reported to the Magistrate in accordance with the Act. Despite media reports that police will prepare reports on deaths to the Coroner none have been received.
>
> Further, media reports suggest that police regularly authorize post mortem examinations following deaths. This practice appears to be contrary to the provisions of the Act which give that power only to a Magistrate.
>
> Similarly, to this time no report has been made to Magistrates following the fires of the Honiara riots in April 2006.
>
> At the request of the Chief Magistrate, an attempt was made to re-introduce compliance with the Act and to recommence the Coronial process in Solomon Islands in September 2006. A meeting was held with the Deputy Commissioner (Operations Support), SIPF

> who expressed the view that Police were not compelled by law to refer matters to the Coroner.
> Since that meeting police have reported in the newspaper many deaths they describe as "suspicious" including the death of three children in Tetere from a suspected poisoning; the suspected death of 3 police officers en route Honiara to Yandina by boat; the finding of the body of a young child at the beach; several multiple drownings in boating incidents; the death of a girl at Town Ground following the Trade Fair; and the death on 24th November 2006 of a worker in a workplace incident.
>
> It is my opinion, shared by fellow Magistrates, that the Police do have a statutory obligation to report deaths to a Magistrate, given that deaths are reported to Police by members of the community and are investigated by Police. A unit on the Deaths and Fire Inquiries Act is taught at the RSIP Academy.
>
> My attempts to reintroduce compliance with the Act also resulted in the development by myself and a Police Prosecutions Adviser of a Training Manual on the law relating to the Act. That Manual now awaits further action.

The *Act* does not specify the duty of police to comply with directions given by a coroner. Reliance could be placed on section 58 of the *Magistrates' Court Act* [Cap 20] which states:

> **Duty of Police to obey Magistrates**
>
> **58** All members of the Police Force are hereby authorised and required to obey the warrants, orders and directions of a Magistrate in the exercise of his criminal jurisdiction, and, in so far as such obedience may be authorised and required by any Act in that behalf, of his civil jurisdiction.

In order to remove any doubt that police might have about their need to comply with a coroner's directions it would be preferable to have a section of the Act clearly specify police responsibilities and duties.

Proposals for Advancing Coronial Law and Practice in the Solomon Islands

The *Deaths and Fires Inquiries Act* needs to be amended to clarify, *inter alia*, the following:

1 The powers and functions of coroners generally;

2 The role, if any, that the rules of evidence have during hearings;

3 The role of forensic pathologists;

4 Role of the Office of Director of Public Prosecution and Police Prosecutors in assisting coroners during the hearing phase of an inquiry;

5 The directive powers of coroners in when utilising police investigate resources;

6 The procedures to be followed when investigating a death in custody case;
7 The procedures to be followed when investigating deaths while a person is in the care of a medical practitioner;
8 The role and function of coroners if a recommendation is to be made;
9 The reporting requirements by government, government agencies and other bodies when a recommendation is made to them by a coroner;
10 The procedures to be followed in a fire inquiry;
11 The method of recording keeping and dissemination of data required of coroners;
12 The law in respect of the privilege against self incrimination;
13 Immunity against prosecution provisions;
14 The form of findings, generally;
15 The form of findings where it is concluded that a known person has committed a criminal offence, or in the case of suicide, or where an open finding is needed;
16 Re-opening inquiries; and
17 Appeal procedures following a coroners findings.

One of the difficulties in having a very brief statute, and therefore having to rely on the common law is that it is sometimes difficult to find the relevant law, and if found it may be ambiguous or not helpful in the circumstances existing in the Solomon Islands.

The provision of a detailed and appropriate statute for coronal law and practice is a necessary but not a sufficient condition to allow for the effective operation of the coronial system.

Robert Cavanagh
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23 August 2011

Attachment A

Death and Fire Enquiries Act [Cap 9]

LAWS OF SOLOMON ISLANDS

[1996 EDITION]

CHAPTER 9
DEATH AND FIRE INQUIRIES

AN ACT TO PROVIDE FOR INQUIRIES INTO THE CAUSES OF DEATH OR OF FIRE

[15th December 1926]
9 of 1926
6 of 1967
LN 46A of 1978
LN 88 of 1978

Short title

1. This Act may be cited as the Death and Fire Inquiries Act.

PART I
DEATH INQUIRIES

Magistrate may hold inquiry in cases of sudden or suspicious death

6 of 1967, Sched
LN 46A of 1978

2. Whenever a Magistrate shall have been informed, or shall have reason to believe or suspect, that the death of any person occurring or of any person who may be found dead within Solomon Islands has been brought about or accelerated either by violence, or by accident, or by any unnatural cause, or that such person has died a sudden death of which the cause is unknown he may if he shall think fit, at such time and place as he shall fix, hold an inquiry into the cause of the death of such person.

Magistrate may order disinterment of body

3. If a body shall have been interred before an inquiry shall have been held the Magistrate may, if he shall think fit, by warrant under his hand order the disinterment of such body for the purpose of the inquiry and such disinterment shall be made accordingly.

Death in prison
LN 46A of 1978

4. An inquiry shall be held by a Magistrate into the cause of all deaths in Solomon Islands of all persons confined in any prison or other place of lawful detention.

Powers of Magistrate
6 of 1967, Sched

5. For the purpose of every inquiry held under or by virtue of the provisions of this Act the Magistrate holding the same shall have powers like to those vested in the Court in respect of the following matters –

   (a) for administering oaths or affirmations to witnesses and compelling them to give evidence;

   (b) for compelling the attendance of witnesses and the production of documents;

   (c) for the punishment of contempt if committed in the presence of the Magistrate during the inquiry.

Post-mortem examination of body
6 of 1967, Sched

6. Whenever it is expedient that the dead body of any person should be examined by a duly qualified medical practitioner the Magistrate shall forthwith issue an order to any such medical practitioner to make a post-mortem examination of the body of the deceased person.

Medical practitioner to make post-mortem when required
6 of 1967, Sched

7. Every medical practitioner who is required to make a post-mortem examination as in the last preceding section provided shall thereupon make such examination as may enable him to ascertain as far as possible the cause of death; and shall send a report thereof to the Magistrate requiring the examination.

Penalty for failure to comply with order

8. Every medical practitioner who fails or neglects to comply with the provisions of the last preceding section, unless he shows good and sufficient cause for not complying with the same, shall be liable on summary conviction to a fine of twenty dollars.

Fee for post-mortem
6 of 1967, Sched
LN 46A of 1978
LN 88 of 1978

9. A medical practitioner for making a post-mortem examination of a body of a deceased person when required as aforesaid, and for his report thereon to the Magistrate, shall receive such fee, if entitled thereto, as the Rules Committee under section 90 of the Constitution, may from time to time prescribe.

Penalty for failure to report unnatural death
6 of 1967, Sched

10. Every person becoming aware of any unnatural death or of any death by violence or by accident and who neglects to notify the nearest Magistrate, or to notify the same at the nearest police station, shall on summary conviction be liable to a fine of ten dollars or to imprisonment for any period not exceeding one month.

PART II
FIRE INQUIRIES

Fire inquiry
6 of 1967, Sched
LN 46A of 1978

11. A Magistrate may hold an inquiry into the cause and origin of any fire occurring within Solomon Islands when, in his opinion, the circumstances of the fire require an inquiry; and for such purpose a Magistrate shall have and may exercise all or any of the powers conferred by Part I of this Act in so far as the same shall be applicable.

PART III
MISCELLANEOUS

Appointment of other persons for holding inquiries
6 of 1967, Sched
LN 46A of 1978

12. (1) There may be appointed from time to time one or more fit and proper persons for the purposes of holding inquiries under this Act, any such appointment being made, in the case of a public officer, pursuant to the Constitution, and otherwise by the Chief Justice:

Provided that any person so appointed shall only exercise the powers thereby conferred upon him in the event of a Magistrate being unable to hold an inquiry owing to illness or absence or any other reasonable cause.

(2) All the powers of a Magistrate under this Act shall be thereupon vested in any such person appointed as aforesaid.

(3) Every such person shall before exercising any of the powers conferred upon him as herein before provided make and subscribe before any Magistrate the oath prescribed in the Schedule to this Act.

Penalty for giving false evidence

13. Any person who at or in any inquiry held under the provisions of this Act shall upon oath or affirmation wilfully and corruptly give false evidence upon a matter material to such inquiry shall be deemed to be guilty of the crime of wilful and corrupt perjury and may be prosecuted and punished accordingly.

Appearance of counsel
6 of 1967, Sched

14. Any person who satisfies the Magistrate that he has a bona fide interest in the subject-matter of an inquiry under this Act, and any other person by leave of the Magistrate, may attend the inquiry in person or may be represented by counsel or solicitor.

THE SCHEDULE

LN 46A of 1978

OATH TO BE TAKEN BY A PERSON APPOINTED UNDER SECTION 12

I, A.B., do swear that I will well and truly serve our Sovereign Lady the Queen, and will act diligently and truly to the best of my ability for the doing of right and for the good of the people, touching the matter of any inquiry I may be called upon to hold under the provisions of the Death and Fire Inquiries Act.

Sworn before me at this day
of , 19 .

Magistrate