



Government of Samoa

Samoa
Law Reform Commission
Komisi o le Toefuataiga o Tulafono a Samoa

CORONERS ORDINANCE 1959
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Preface

The role of coroners is unique and significant given that they inquire into the manner of deaths of persons who have died under suspicious and unknown circumstances. A coroner is an official primarily responsible for investigating deaths, particularly some of those happening under unusual circumstances, and determining the cause of death.

However, the specific roles of coroners can significantly vary between jurisdictions. For example, in many jurisdictions following the English system, such as Samoa and New Zealand, coroners are often legal officers such as lawyers. By contrast, in the USA, a medical examiner model is preferred, with a medical doctor typically filling the position. However, regardless of the model, the overall role is the same - to review deaths, find the causes of death, and once determined to make recommendations for avoiding similar deaths occurring in the future. The role requires not only an ability to assess deaths and risk, but it also requires a thorough understanding of how to balance their formal duties, with the need to respect the sensibilities and needs of a grieving family.

The Coroners Ordinance 1959 (“Coroners Ordinance”) is the current relevant legislation governing the work of coroners in Samoa. Significant changes and developments in the actual work of coroners have taken place in the intervening decades. Regional and technological changes have also significantly impacted the work of coroners. As such, there is an urgent need for reform of the Coroners Ordinance in Samoa. To address this pressing need, government provided a reference to the Samoa Law Reform Commission (“Commission”) in November 2008 to review the Coroners Ordinance.

As part of this law reform initiative, the Commission engaged in preliminary research and consultation. An interim Issues Paper was produced in September 2009 (*Coroners Ordinance 1959 Issues Paper IP 02/09*) This “Issues Paper” assisted in the public consultation process which occurred in February 2010. During public consultations, responses were given from key stakeholders in the coronial system notably including the Chief District Court Judge District Court Judge who is principally in charge of coronial work in Samoa. These responses will be addressed in this final report as a way forward in the review of the Coroners Ordinance.

Public comments went broader than discussion of the Issues Paper. Indeed, many of the comments raised a broader range of issues about the current legislation in Samoa.

The review of the Coroners Ordinance has assisted in identifying some of the current concerns associated with the work of coroners in Samoa. Some of the concerns identified include:

- 1) The need to reform the current system of appointment of coroners in Samoa;
- 2) The need to extend the jurisdiction of coroners to include deaths of persons with special needs, deaths while under medical treatment, suicides and deaths of women as a result of pregnancy or while giving birth.

- 3) Ambiguities with terms explaining causes of death such as ‘unnatural death’ for the purpose of the inquest; and
- 4) The need to improve the role and performance of coroners having regard to comparable jurisdictions;

The often-quoted Ontario Coroners’ motto is ‘to speak for the dead in order to protect the living’¹. If Samoa would like to have a coronial system with this as its goal, then an urgent overhaul of the current legislation and practices is necessary.

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¹ **Ontario Code of Ethics for Coroners’** July 2005 in “Law Commission 2000 ‘ *Coroners’* Report 62, Wellington”

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1. The Process of Coronial Inquiry

1.1 The State has a vital role in ascertaining, as precisely as possible, the cause and manner of all deaths so that suspicious foul play, homicide or neglect of human life can be fully investigated². The aim is to identify practices that have cost human lives and then to modify or eliminate them. While the names for these professionals differs between jurisdictions (such as USA which appoints *medical examiners*), coroners in most jurisdictions generally act in similar capacities. Their role is not to determine the civil or criminal responsibility; but instead, make and offer recommendations to improve public safety and prevention of death in similar circumstances.³

Background

1.2 *The Births, Deaths and Marriages Registration Act 2002* requires that all deaths of persons occurring in Samoa must be registered. The Registrar⁴ must be notified of every death in Samoa and must also be advised of the cause of death. The relevant authority, usually the responsible doctor in hospital, must first determine the cause of death through their own thorough inquiry, and then provide that information to the Registrar with a medical certificate certifying the cause of death in a prescribed form.⁵

Coronial Inquiry

1.3 In certain cases where the responsible doctor requires further investigation to determine the cause of death or has reasonable cause to suspect that the death was the result of violence or unnatural death, the death must be reported to a coroner.⁶ The coroner will then commence an inquiry into the cause of death. This inquiry includes ordering a *post mortem* to be carried out by the responsible doctor in respect of the death. Should the results of the *post-mortem* satisfactorily determine the cause of death, an inquest is not necessary.

1.4 Any person in Samoa who has knowledge of the death of any person, including discovering a dead person, has a duty to report this knowledge to a police constable (“constable”). In such cases, the constable will notify the coroner of any death over which the coroner has jurisdiction, under the Coroners Ordinance⁷, and also to the Commissioner of Police and Prisons (CPP). The CPP shall then make the necessary inquiries into the death.

1.5 Typical types of cases referred to the coroner include sudden death by unconfirmed cause; death as a result of accidents of various origins; homicides; ‘dead on arrival to hospital’ cases; unattended deaths out of hospital and all other causes of death which do not fully satisfy the first-level inquiry of the attending medical practitioner.⁸

² Law Commission 2000 ‘Coroners’ Report 62, Wellington

³ *Ibid* at n2, page 4

⁴ *Births, Deaths and Marriages Registration Act 2002* (Samoa) s3(1) Registrar means the Registrar of Births, Deaths and Marriages appointed under section 3(1)

⁵ *Ibid* at n4, section 47

⁶ *Ibid* at n4, section 48

⁷ *Coroners Ordinance 1959* (Samoa) section 4

⁸ Paksoy.N 1988 ‘Pattern of coroner’s post-mortems in a Pacific island society (Western Samoa)- <http://www.persee.fr> (Accessed 24/08/2010)

Following a report of a death, the coroner must decide if it is necessary to hold an inquest to determine the cause of the death. It may also be necessary for a *post mortem* or autopsy to be performed to establish the specific medical cause of death.

1.6 The coroner may direct any inquiries the coroner thinks proper to be made and may authorize any medical practitioner to hold a *post mortem* examination of the body and to report the result to the coroner in writing. Where the coroner, as a result of the *post mortem* examination or further inquiries carried out by him or her, is satisfied that the death was due to natural causes, and did not take place in such place or in such circumstances as to necessitate the holding of an inquest, the coroner may decide not to hold an inquest.⁹ A coroner may also decide not to hold an inquest if he or she is satisfied having considered the material produced from preliminary inquiries (statements of witnesses and medical reports) as to the cause and circumstances of death.

Inquest hearing

1.7 In the event that the coroner is not satisfied from preliminary inquiries as to the cause of death, he or she may decide to hold an inquest. The coroner shall then fix the date, time and place of the inquest, and shall give notice in accordance with section 14 of the Coroners Ordinance. An inquest is a court hearing in which the Court gathers information to assist in determining the cause and circumstances of death and if appropriate, to make recommendations that may prevent similar deaths occurring in the future.¹⁰ The Court calls witnesses to give evidence of what they know about the death. An inquest is not a trial; rather it is an investigative process to shed light on the cause and circumstances of the death. The hearing for inquests are held in public except in circumstances where the coroner considers it desirable in the interests of justice, decency, or order to exclude all or any persons from proceedings.¹¹

1.8 An inquest shall be conducted for the purpose of establishing¹²:

- a) The fact that a person has died;
- b) The identity of the deceased person;
- c) When, where, and how the death occurred.

1.9 Once the coroner has considered all the evidence before him or her at the inquest, the coroner shall then give a finding and shall sign a certificate as to the cause of death.¹³ The coroner shall then forward the certificate to the Registrar for registration of death in accordance with the *Births, Deaths and Marriages Registration Act 2002* of Samoa. Subsequently, copies of such certificate, together with all depositions of

⁹ One major benefit of a post-mortem is that it provides detailed information about the person's medical condition prior to death and so gives an understanding of the various factors that may have contributed to the person's death. Even if the cause of death may seem clear, the person may have had a medical condition that was apparent during life.

¹⁰ The Coronial Process Information for family and friends: *When a person dies: South Australian State Coroner's Court* (www.courts.sa.gov.au) (Accessed 24/08/2010)

¹¹ *Coroners Ordinance 1959* (Samoa) section 16

¹² *Ibid* at n11, section 12

¹³ *Ibid* at n11, section 21

witnesses will be forwarded to the Commissioner of Police and Prisons and the Chief Executive Officer of the Ministry of Health.

- 1.10 In cases where it appears to the coroners in the course of an inquest that death may have been self inflicted, the coroner may direct that no report of the proceedings shall be published until the coroner has made his or her finding.¹⁴ Once the coroner finds that the death was self-inflicted, no report of the proceedings shall be published unless the coroner authorizes publication. However, the details of the deceased person and findings of a coroner that the death was self inflicted can be published.

2. Appointment of Coroners

Introduction

- 2.1 This chapter considers the areas for reform relating to the appointment of coroners which includes extending the appointment to medically qualified personnel or setting down test qualifications for coroners. It will also look at a coronial system that is separate from the judiciary.
- 2.2 The following discussion will also provide an overview of the system of appointment in Samoa and compare this to systems in New South Wales (“NSW”), New Zealand (“NZ”) and Papua New Guinea (“PNG”).
- 2.3 The Coroners legislation in NZ and NSW have been modernized. The following discussion will also briefly consider the system of appointment of medical examiners, rather than coroners, as typified in the United States of America (“USA”). Both models will be discussed in this review.

Background

Samoa

- 2.4 The Chief Justice and all other judges of the Supreme Court and District Court judges are deemed coroners by virtue of holding office.¹⁵ A medical practitioner appointed with specific or general authority by the Chief Executive Officer of the Ministry of Health can also act as a coroner in a limited capacity - only to discharge the duty of a coroner to conduct the burial of a body.¹⁶

New Zealand

- 2.5 Lawyers holding practicing certificates and have been practising for at least 5 years are qualified to be coroners. The Governor General makes the appointment, on the advice of the Attorney General, after consultation with the Minister of the Crown.
- 2.6 A District Court judge is also deemed a coroner by virtue of his or her office (s103). A chief coroner and relief coroners are also appointed in accordance with ss104 and 105 of the Coroners Act 2006. An acting chief coroner is also appointed in the event

¹⁴ *Coroners Ordinance 1959* (Samoa), s 19 & *District Courts Act 1969* (Samoa), s16

¹⁵ *Ibid* at n14 s8

¹⁶ *Ibid* at n14, s11

the chief coroner is unable to act. The chief coroner oversees the work of other coroners in NZ and is responsible for issuing guidelines or protocols to coroners in relation to the performance of the coroner's functions.¹⁷

New South Wales

2.7 All persons appointed as coroners in NSW must be lawyers and all persons appointed as assistant coroners must be members of the staff of the Attorney General's Department. A magistrate in NSW is eligible to be appointed as a state coroner or a deputy state coroner.¹⁸ He or she is appointed in writing by the Governor General. A magistrate can also be appointed as a coroner or assistant coroner for certain parts of NSW by the Governor on the advice of the Minister.¹⁹

2.8 A person may not be appointed as a Coroner if that person is 72 years of age and older unless the Minister recommends to the Governor that the person's appointment is appropriate.

Papua New Guinea

2.9 The district officers who are senior principal magistrates are coroners by virtue of their office and have jurisdiction, power and authority throughout the country.²⁰ District officers are appointed to respective provinces within which they have jurisdiction, power and authority as coroners. The Judicial and Legal Services Commission²¹ can appoint a person to be a coroner by notice in the National Gazette and specify the province or provinces within which he or she has the jurisdiction, power and authority to hold inquests.

United States of America

2.10 The Commission has also considered systems of appointment of coroners in the USA. The office of coroner varies based on the jurisdiction/state in the USA. In some jurisdictions, such as Monterey County, California, the coroner and the sheriff are one and the same. In other states such as Utah, the coroner's office is referred to as the chief medical examiner. Physicians or other medical professionals with specialized training in fields like toxicology or forensic medicine are appointed as chief medical examiners, as in the case of New York.²²

2.11 Regardless of whether the person appointed is an elected coroner or forensic medical officer in the USA, the primary duties are the same as both inquire into manner of deaths that occur under unnatural, suspicious, violent or other circumstances dictated by USA statutes²³.

Submissions

¹⁷ "Report 62- Coroners' Law Commission (NZ) August 2000 (Chapter 3)

¹⁸ Coroners Act 2009 (NSW) ss4A

¹⁹ Ibid at n18, ss 5

²⁰ Coroners Act 1953 (PNG) ss3

²¹ The Judicial and Legal Services Commission is established pursuant to section 183 of the Constitution of the Independent State of Papua New Guinea. They consist of the Minister responsible for the National Justice Administration, the Chief Justice, the Deputy Chief Justice, the Chief Ombudsmen and member of Parliament.

²² *The Medical Examiner Act* (<http://health.utah.gov/ome/act.html>) (Accessed 2/07/2010)

²³ *The Medical Examiner Act* (<http://health.utah.gov/ome/act.html>) (Accessed 2/07/2010)

- 2.12 The Commission raised questions for public submissions concerning areas for reform, for instance, whether the appointment of coroners should be extended beyond lawyers and whether there should be a modified organizational structure for the appointment of coroners in Samoa.
- 2.13 Written submissions received by the Commission expressed the view to move towards a modified system for the appointment of coroners similar to systems in NZ and Australia. However, submissions did not specify what system(s) should be adopted.
- 2.14 Further submissions from stakeholders suggested expanding the pool of coroners to include the appointment of lawyers, rather than just judges. This suggestion also included the idea of having a separate body other than the judiciary to appoint coroners. The Chief District Court Judge submitted that a proposed body to appoint coroners should be wider than the judiciary although he did not specify an appropriate body.
- 2.15 Some stakeholders suggested reviewing the current system of appointment to allow judges to directly appoint coroners. Stakeholders also emphasized the need to review the law in context – particularly with regards to the limited availability of existing resources in Samoa to implement any changes. Practical changes to this law must be mindful of resource issues, in order to implement any practical changes to the existing coronial system. Stakeholders questioned whether Samoa has the necessary resources to pay for additional coroners, and/or establish a separate body to appoint coroners.

Commission's views

- 2.16 There are no provisions outlining the relevant qualifications or eligibility criteria to become coroners in Samoa other than the provision stating that Supreme Court judges and District Court judges are coroners by virtue of holding office.
- 2.17 The system in Samoa follows the English system which appoints legal officers (lawyers) to be coroners as opposed to the USA where Medical Examiners are often elected.
- 2.18 The Commission is of the view that persons appointed as coroners in Samoa should be either legally or medically qualified to undertake coronial work. A person appointed as a coroner must have undergone some test of his or her qualifications to perform the duties of a coroner. Inquiries into causes of deaths can be technical and complex particularly if it involves advanced scientific techniques. As stated earlier in this report, an inquest is an investigative process and not a trial. Therefore it does not necessarily call for legally qualified persons.
- 2.19 A coroner must have a fair knowledge and understanding of the background of cases that he or she inquires into in order to make determinations that are fair and

justifiable. The objective is for coroners to make and offer recommendations to improve public safety and prevent death in similar circumstances.

- 2.20 One of the concerns raised during public consultations is the delay in releasing the deceased for burial. Some members of the public expressed strong views that they were ‘left in the dark’ when coronial inquiries were conducted and had inadequate information about the process, the length of time and the expected release date of the deceased. It appears that such comments are directly linked to the insufficient number of coroners available in Samoa to conduct coronial inquiries. There are currently only four Supreme Court judges (including the Chief Justice) and two District Court judges.
- 2.21 It is important to separate the coronial system in Samoa from the judiciary for its efficient and effective operation. For instance, a separate system would lessen the burden on judges in having to hear court cases and conduct inquest hearings at the same time. This would eventually open up opportunities to potential candidates to be appointed as coroners in Samoa; for instance, lawyers with the relevant experience, and medical practitioners or medical examiners (as in the case of USA).
- 2.22 The current system does not provide for a body to appoint coroners. Rather, judges are automatically deemed coroners by virtue of holding judicial office. Thus it is very important that coroners should follow similar procedures as practiced in comparable jurisdictions whereby a coroner is appointed upon advice of the relevant Minister. This is to ensure that the person appointed has the confidence and trust of the people to conduct inquest hearings.
- 2.23 The move towards establishing a body to appoint coroners should consider financial implications and resources needed for its operation.

Recommendation 1: The system of appointment of coroners should be modified by outlining criteria in the Coroners Ordinance requiring that a coroner must be i) either legally or medically qualified ii) must have undergone some test or training relevant to duties of a coroner iii) sufficient years of experience, preferably minimum of 5 years as a legal or medical practitioner.

Recommendation 2: Coroners should be appointed by a body separate from the judiciary to ensure that the person elected has the required skills and expertise. For instance, a proposed body consisting of the Chief Justice, the relevant Minister, a senior medical practitioner and a nominated representative from the community (similar to the Judiciary Legal Services). The ultimate aim is the separation of the Coroners Court from the Judiciary.

3. Jurisdictions and Functions of a Coroner

Introduction

- 3.1 This section considers reforms to the jurisdiction of coroners in Samoa. This includes whether to extend the jurisdiction of coroners to include inquires into specific types of issues such as: suicide; missing persons; deaths of those with special needs; death as a result of surgical/medical/dental treatment, death of mothers during pregnancies or while giving birth and issues of elderly abuse and neglect.
- 3.2 It will also look at comparable jurisdictions, namely NZ, NSW, PNG and the USA and specific cases for which coroners in these jurisdictions can hold inquests. This chapter also makes a number of other recommendations, having regard to recent developments in coronial work in the region. With the rise in technology and modern ideas, new cases have emerged requiring thorough coronial inquiry to provide answers to grieving families and relatives.
- 3.3 The issues of ‘unnatural death’ and ‘missing persons’ will be dealt with following this chapter.

Background

Samoa

- 3.4 Section 4 of the Coroners Ordinance provides for cases in which a coroner in Samoa can hold an inquest and includes:
- reasonable cause to suspect that the person has died either a violent or an unnatural death; or
 - any person who has died a sudden death of which the cause is unknown.
- 3.5 There are also general provisions in section 4 which require an inquest to be conducted. For instance, where a person has died while in the legal custody of a Superintendent,²⁴ or a person who died in such a place or under such circumstances that in accordance with the provisions of any enactment, an inquest is required to be held.²⁵
- 3.6 An inquest can also be held where a coroner is informed that a person has died while in custody as a mental patient or while committed to the care of the Child Welfare Officer or in such circumstances that an inquest is necessary or desirable to be held.²⁶ In situations where a body is destroyed or cannot be recovered, and pursuant to section 15 which requires the viewing of the body, the Coroner may report the facts to the Attorney General, who then determines whether to hold an inquest.²⁷

²⁴ *Coroners Ordinance* 1959 (Samoa) ss 4(b)

²⁵ *Ibid* at n22, s4(c)

²⁶ *Ibid* at n22, s7

²⁷ *Ibid* at n22, s7

New Zealand

3.7 Section 13 of the NZ Act provides for cases in which a coroner in NZ has jurisdiction to inquire. These cases include ‘death without known cause, suicide, or unnatural or violent death’. Interestingly, suicide is specified in ss 13(1)(a) of the NZ Act. Secondly, a coroner has jurisdiction to inquire into deaths for which no doctor’s certificate is given.²⁸ The jurisdiction of coroners to inquire into manner of deaths extends to deaths during ‘medical, surgical, or dental operation, treatment’²⁹, and ‘any death that occurred while the woman concerned was giving birth, or that appears to have been a result of that woman being pregnant or giving birth’.³⁰ Death while in official custody or care, such as death of a child or young person is also specified in the NZ Act³¹.

New South Wales

3.8 Coroners have quite extensive jurisdiction to inquire into manner of deaths in NSW. The jurisdiction of coroners is divided into three categories (ss 17(1) as follows:

- inquests concerning deaths and suspected deaths of persons;
- inquests concerning fires and explosions that do not involve deaths or suspected deaths; and
- miscellaneous matters relating to the exercise of any such jurisdiction.

3.9 Inquests concerning deaths and suspected deaths are ‘reportable deaths’ in NSW. Examples of these are detailed in s.6 of the NSW coroner’s legislation³². This can be an expansive category. Indeed, in some instances, this may cover unexpected medical outcomes from health procedures, leading to death. Coroners also have broad jurisdiction to inquire into deaths of children and disabled persons.

Papua New Guinea

3.10 Section 2 of the PNG Act provides for the appointment of coroners within their own specific province(s) over which he or she has jurisdiction. The PNG Act is also fairly broad, and includes a number of specific provisions as well. The broad mandate of the PNG coroners is detailed in s 7 of the PNG Act and provides for jurisdiction of coroners to inquire into the manner and cause of the death of a person. Similar to NZ, coroners in PNG also inquire into the death of a person who died while under an anesthetic in the course of a medical, surgical or dental operation or an operation of a like nature.³³ In PNG, a coroner may inquire into the death of a person, or make inquiries concerning the cause and origin of any fire.

3.11 There is also an inquiry in relation to the death of a person who died within a year and a day after the date of an accident where the cause of the death is directly

²⁸ *Coroners Act 2006* (NZ), ss13(1)(b)

²⁹ *Ibid* at n26, ss13(1)(c)

³⁰ *Coroners Ordinance 1959* (Samoa) ss13(1)(d)

³¹ *Ibid* at n26: s13 (1)(g)- the death of a child or young person while that child or young person i) is in custody or care of an Iwi Social Services or a Cultural Social Service, or the Director of a child and Family Support Service; or (ii) is in the charge of any person or organization...

³² *Coroners Act 2006* (NSW): s6- death is a reportable death if the death occurs in any of the following circumstances: a) the person died a violent or unnatural death b) sudden death of which the cause is unknown c) death under suspicious or unusual circumstances d) death as a result of non-attendance of medical practitioner...etc

³³ *Coroners Act 1953* (PNG), s7(1)

connected to the accident. The death of a person who has drowned or died a sudden death of which the cause is unknown; or died under suspicious or unusual circumstances, is also provided for in section 7.

United States of America

3.12 In the USA, ‘medical examiners’ or ‘enforcement officers’ inquire into violent, unnatural, unknown and suspicious deaths. While some states such as Utah and Minnesota have left these terms undefined, others offer more concrete definitions.

3.13 In Utah, for example, inquiries are investigated by the Office of the Medical Examiner and include, for example, death by violence, death by suicide and death by unknown causes. Death by violence or violent death is defined in the legislation as ‘death resulted by the deceased’s exposure to physical, mechanical or chemical forces’. This includes, for example death which appears to have been due to homicide, death which occurred during or in an attempt to commit rape, mayhem, kidnapping, robbery, burglary, housebreaking, extortion, or blackmail accompanied by threats of violence.³⁴

3.14 ‘Suicide’ is defined in the Utah legislation as ‘death caused by an intentional and voluntary act of a person who understands the physical nature of the act and intends by such act to accomplish self-destruction’. ‘Sudden death while in apparent health’ is labeled in other states as ‘unknown deaths’. In Utah, such death is defined as ‘apparently immediate death without obvious natural cause, death during or following an unexplained syncope (fainting) or coma, or death during an acute or unexplained rapidly fatal illness’.

3.15 In Kentucky, the statute requires that death which appears to be other than natural death be reported to the coroner. The legislation defines ‘natural death’ as death occurring by the unassisted operation of natural causes (e.g. old age or apparent sickness), as distinguished from a violent death. ‘Violent death’ is defined as death caused or accelerated by the interference of human agency.³⁵

3.16 Some states in the USA, such as Minnesota, provide lengthy and specific lists of types of death that are to be investigated. This is also similar to legislation in NZ and NSW.

3.17 This specific detailing may constitute an effort by state legislatures to emphasize policy choices ensuring that specific *types* of death are investigated and looked into, as opposed to focusing on more general terms such as ‘unnatural’, ‘violent’, ‘unknown’ and ‘suspicious’. For instance, in Minnesota, coroners can inquire into specific deaths of children (sometimes qualified by an age), deaths due to drowning, and deaths that occur suddenly while in apparent health. Such specificity indicates policy priorities of government.

³⁴ Utah Code Annotated. ss26 (4-2)

³⁵ Kentucky revised Statues Annotated. Ss72.025.

Submissions

- 3.18 Public consultations held in Savaii and Upolu showed an overwhelming response to some of the issues raised in this chapter. The current, but outdated Coroners Ordinance is quite limited in scope and does not broadly indicate the death cases into which a coroner has jurisdiction to inquire. The issues raised in public consultations consider specific death cases in comparable jurisdictions such as deaths of those with special needs, suicide cases, death as a result of medical, surgical or dental treatment, missing persons and deaths of women resulting from pregnancy or while giving birth.
- 3.19 Submissions from the Upolu consultations support extending the jurisdiction of coroners to inquire into cases of mothers who have died as a result of pregnancy or giving birth. This was justified on the basis of the increased number of deaths involving mothers in hospitals.
- 3.20 There were concerns raised in consultations as to why inquests are conducted. The Commission explained that an inquest is necessary to determine the cause of death, especially in circumstances where foul play or homicide may have been involved. Submissions from Savaii support extending the inquiry into cases raised by the Commission such as suicide cases, deaths while under surgical, medical or dental treatment and deaths of mothers as a result of pregnancy or giving birth.
- 3.21 Given the severity of these cases, there is a need to inquire for the purpose of establishing the proper causes of death. Stakeholders submitted the need to specify a time frame for conducting the inquest to address the issue of delay in releasing the deceased's body, as family members often demand immediate release of the body for burial.
- 3.22 The Commission also actively engaged the Samoan Special Needs and Disability communities. Submissions received from these representatives strongly support extending the jurisdiction of the coroner in Samoa to inquire into deaths of people with special needs, particularly children. This is to ensure such deaths are thoroughly investigated as these children may be prone to abuse by guardians or family members.
- 3.23 On the other hand, submissions by the Chief District Court Judge put forward the view that deaths of children and those with special needs are already covered in the Coroners Ordinance. The judge further submitted that terms such as 'unnatural death' and 'unknown causes' in the Coroners Ordinance already covers suicide cases, missing persons and the deaths of women as a result of pregnancy and child birth, death while under a medical, surgical or dental operation and procedure. Hence, there is no need to further specify these cases. However, he proposed that such cases are more relevant in the realm of civil law rather than coronial law.
- 3.24 Consultations were also held with members of the Samoan private bar. Submissions by one private law firm strongly supported extending the jurisdiction of coroners to cases raised in the Issues paper. However, the submission specifically cautioned about the need to have appropriate resources available for implementation.

3.25 Although this issue is not the focus of this Report, there were strong views supporting the involvement of family members of deceased persons in the inquiry and for them to be better informed as to the process. This is a sensitive issue as family members demand answers as to why the inquiries are prolonged. It was explained by the Commission that the purpose of an inquiry is to determine causes of deaths that are unnatural or occur under suspicious circumstances.³⁶ Respecting the sensibilities of grieving families is vital and can be achieved by information-sharing and transparent public education about the processes involved in a coroner's inquiry.

Commission's views

3.26 The *provisions* for coronial inquiries in Samoa are broad and general in nature: section 4 does not define specific terms such as "violent" and "unnatural" deaths, nor does it provide listed examples of types of cases for inquiry. As such, it may be broadly interpreted. However, the *jurisdiction* of coroners to inquire into the manner of deaths is somewhat unclear. Coroners Ordinance does not provide a list of cases into which a coroner in Samoa can inquire and as such, it is overly open to interpretation, without adequate guidance or clarity.

3.27 Many comparative jurisdictions have taken a more comprehensive and detailed approach, indicating by specific description both the provisions for coronial inquiry and the jurisdiction of the inquiry.

3.28 Legislation in comparative jurisdictions has been updated to set out clearly the different categories of cases for inquiries by coroners. For example, in NSW, the category of 'reported death' specifically includes inquests concerning deaths and suspected deaths. Lengthy lists of cases under 'reported death' are also provided in section 6 of the NSW Act, which includes specific cases of suicide, missing persons, death of disabled persons, death as a result of surgical, medical and dental treatment and death of mothers while giving birth. This method of clear description in the legislation can also be found in NZ and PNG.

3.29 Some jurisdictions in the USA offer even more concrete and detailed definitions of terms such as 'violent death', 'suicide' and 'unknown deaths'. For instance, the Minnesota statute offers a lengthy list of cases including death of children, deaths due to drowning and deaths that occur suddenly while in apparent health.

3.30 It would be useful for the Coroners Ordinance to be modified to provide clarity to general terms such as 'violent death' or 'unnatural death', by providing specific lists of cases for inquiries by coroners in Samoa to ensure that certain types of deaths are addressed and investigated and to support Samoa's policy initiatives.

3.31 It is recommended that Samoa adopt similar definitions to Minnesota (USA) for 'violent death', 'suicide' and 'unknown deaths' to be incorporated into the Coroners Ordinance. This will assist coroners in their line of work as the definitions for these

³⁶ *Coroners Ordinance 1959* (Samoa), s24

terms would be provided. This may also assist family members in coming to terms with how the person concerned died.

3.32 The Coroners Ordinance should be also amended to include specific types of death, such as suicide cases, missing persons, death of those with special needs, death as a result of surgical, medical or dental treatment, or death of mothers while giving birth or during pregnancy. This will also ensure that certain unexplained deaths in Samoa (death of women while giving birth, sudden death while in apparent health) are fully addressed and investigated.

Elderly abuse and neglect

3.33 Although this issue was not raised in the Issues Paper and public consultations, it is a critical issue that needs to be addressed and considered given trends in legislation in Commonwealth nations (such as Canada) and beyond. Such cases of elderly abuse and neglect should be an area in which a coroner in Samoa should have jurisdiction to inquire into given that the elderly are mostly looked after in families and villages by caregivers or family members. The Commission is of the view that issues of elderly abuse and neglect should be addressed in the Coroners Ordinance.

Recommendation 3: The Coroners Ordinance should be amended to provide a non-exhaustive list of cases into which a Coroner in Samoa can inquire. The Coroners Ordinance should incorporate specifically deaths of those with special needs and children, death as a result of surgical, medical or dental treatment, death of mothers while giving birth or while pregnant, and issues of elderly abuse and neglect.

Recommendation 4: The term ‘violent death’ should be defined in the Coroners Ordinance given the increasing number of such deaths occurring in Samoa. Recommended to adopt the definition in the Minnesota statute (USA), where relevant.

3.34 The following part addresses the issues of ‘unnatural death’ and ‘missing persons’, as raised in the Issues Paper, and the Commission’s recommendations on areas for reform.

4. Unnatural Death

Background

Samoa

4.1 Section 4(1) of the Coroners Ordinance provides that a person who has died either a ‘violent or **unnatural death**’ is subject to a coronial inquiry. The uncertainty in how to interpret the term ‘unnatural death’ under section 4(1) of the Coroners Ordinance was raised both in the Issues Paper and during the public consultation process. The closest definition of this concept of unnatural death can be found in ss 6 and 7 of the Coroners Ordinance³⁷.

³⁷ *Coroners Ordinance 1959* section 6 –(Inquest need not held in certain circumstances 1)Where any sudden death of which the cause is unknown is reported to a Coroner and the Coroner is of the opinion that further inquiries or a post mortem examination may prove

4.2 Unexpected natural disasters such as the tsunami that struck Samoa in September 2009, has given rise to a specific need to clarify the necessary guidelines and processes to follow in this kind of disaster. Currently the coronial legislation does not provide guidelines to follow in cases of catastrophic natural disasters with a high death toll such as a tsunami. Experiences from the September 2009 tsunami in handling the deceased reveal a great need to streamline processes involved to meet certain timelines. Such processes include identification of deceased and issuing of death certificates. A problem experienced post-tsunami was the delay in issuing death certificates of deceased given the lengthy paper work and inquiries given the high death toll. This issue calls for reassessment and re-evaluation of the processes involved in the event of such natural disasters given their catastrophic nature. This should take into account interests of aggrieved family members who await death certificates of their loved ones for funeral arrangements. Another issue to consider relates to persons who have gone missing at sea to date and how such cases can be dealt with under the Coroners Ordinance³⁸.

New Zealand

4.3 Deaths from suicide, **unnatural**, violent or unknown cause are defined in section 13(1) (a) of the NZ legislation as follows: ‘every death that appears to have been without known cause, or unnatural or violent’. Such deaths are obliged to be reported to police under section 14(2) as soon as is practicable.

4.4 Deaths that must be reported under section 14(2) include ‘*deaths for which no doctor’s certificate is given (s13(1)b), deaths during medical, surgical, or dental operation or treatment (s13(1)c), any death that occurred while the woman concerned was giving birth, or that appears to have been the result of that woman being pregnant or giving birth (s13(1)d)*’.

New South Wales

4.5 The term ‘unnatural death’ is included under the expression ‘reported death’ in section 6 of the NSW legislation. This expression is defined largely by reference to the kinds of deaths to be reported for the general purpose of an inquest under the NSW Act. Section 6 prescribes inquests broadly for the purposes of investigating “violent or unnatural death, sudden death which the cause is unknown, death under unusual or suspicious circumstances, death where a person has not been attended by a medical practitioner during the period of six months immediately before the person’s death, the persons death was not a reasonably expected outcome of a health-related procedure, and death while in or temporarily absent from a declared mental health facility”.

4.6 This definition has been extended by common law in Australia. In the case of *George Patrick v Wilson*³⁹, the Tasmanian Courts defined ‘unnatural death’ as violent death or a sudden death where the cause is unknown and there is no evidence that the

an inquest to be unnecessary...Section 7-Inquest where body destroyed or irrecoverable- Where a coroner has reason to believe that a death has occurred in such circumstances that an inquest ought to be held and, because of provisions of section 15...

³⁸ Issues Paper “*Review of Coroners Ordinance*”, Samoa Law Reform Commission, 2009

³⁹ PH [1994] TASSC 65

person did suffer such a death. Also, the term ‘unnatural death’ is associated with violent deaths such as death brought on by trauma, poisoning, drowning, asphyxia or electrocution.⁴⁰

Papua New Guinea

4.7 The term ‘unnatural death’ is not specifically used in the legislation. Instead, related terms such as ‘sudden death of which the cause is unknown’ or ‘died under suspicious or unusual circumstances’ are used to describe some of the causes of death for which an inquest in PNG is conducted.

United States of America

4.8 The Commission also considered the USA jurisdiction and deaths subject to coronial inquiries, termed medical examiner inquiries. The terms ‘violent’, ‘unnatural’ and ‘suspicious’ are frequently used throughout some jurisdictions in the USA and some jurisdictions have left these terms undefined. The term ‘suspicious’ is often notably undefined.

4.9 However, many jurisdictions in the USA do use defined terms. For example, Kentucky defines in its statutes ‘natural death’ as death occurring by the unassisted operation of natural causes. The state of Utah uses terms such as ‘suspicious’, ‘unusual circumstances’ and ‘sudden death while in apparent health’ or ‘unknown deaths’. While many of the jurisdictions in the USA do not offer specific definitions of the term ‘unnatural death’, this term is supplemented in some jurisdictions by lengthy lists of specific types of death that are to be investigated. For instance, Minnesota requires deaths that are ‘unnatural’ to be reported to the local medical examiner or coroner.

4.10 In addition to these general requirements, Minnesota further provides other detailed cases of deaths which must be investigated⁴¹. For instance:

- a) deaths due to fire or burns;
- b) deaths related to pre-natal and postpartum maternal deaths;
- c) deaths of inmates of public institutions;
- d) deaths that occur in the course of one’s employment;
- e) deaths due to culpable neglect or abuse;
- f) deaths of children;
- g) deaths where the person is not identified;
- h) deaths where poison or drugs are in the body;
- i) deaths due to motor vehicle accidents;
- j) deaths due to drowning;
- k) deaths due to Sudden Infant Death Syndrome;
- l) deaths where the body is cremated before an examination can take place;
- m) deaths resulting from disease which may constitute a threat to the public health;
- n) deaths not attended by a physician;

⁴⁰ *Coroner Bill 2002 Explanatory Notes*, Tasmania.

⁴¹ *Minnesota Annotated Statutes 2009 (USA)* s 390.11

- o) deaths that occur suddenly while in apparent health; and
- p) certain types of deaths occurring in a hospital or under a physician's care.

4.11 The above lengthy list may constitute the effort by legislators in Minnesota to ensure that certain unexplained deaths or suspicious deaths are thoroughly investigated. The above list seems to address deaths of children, unexpected deaths, elderly abuse and neglect and deaths of mothers during pregnancies or while giving birth in hospitals.

Submissions

4.12 Submissions from stakeholders expressed the view that it is preferable to clearly define what constitutes unnatural death in the Coroners Ordinance, although a definition was not proposed. The Chief District Court Judge submitted that the definition of 'unnatural death' need not be broadened as it is already clear in the Coroners Ordinance.

4.13 Submissions during public consultations expressed the view that there should be a time frame to carry out inquiries for unnatural deaths. They also proposed that inquiries must be thoroughly carried out to ensure that section 12 of the Coroners Ordinance is satisfied.⁴² In the event of a natural disaster such as a tsunami, stakeholders raised the need to streamline processes involved in handling deceased particularly given its catastrophic nature (high death toll). In such a disaster, a coroner in performing his primary role must take into account the interests of family members affected and comply, in every way possible, with timeframes and policies in facilitating issuance of death certificates.

4.14 Stakeholders also expressed their concern that natural death as a result of old age may be suspicious in circumstances where caregivers fail to provide the necessary care to the elderly. This may very well relate to the issues of elderly abuse and neglect previously mentioned above.

Commission's views

4.15 The term 'unnatural death' is not commonly defined in NZ, NSW and PNG. This seems to be the trend in jurisdictions that the Commission has considered for this Report. Many of the jurisdictions have left the term 'unnatural death' undefined; however the term is included under the category of reported death, such as in NSW.

4.16 Terms commonly used in legislation in Samoa, NZ and NSW include violent death, death where the cause is unknown or under unusual circumstances. PNG does not use the term 'unnatural death' in its legislation; however a list of types of deaths is provided in section 7(1) of the PNG Act⁴³.

⁴² Section 12 *Coroners Ordinance*: Purpose of an inquest to establish that a) a person has died b) the identity of the deceased person c) when, where and how the death occurred.

⁴³ Coroners Act 1953 (PNG) Section 7(1)- A coroner has jurisdiction to inquire to death of a person who: a) was killed; or b) was drowned; c) died a sudden death of which the cause is unknown; or d) died under suspicious circumstances or unusual circumstances'.

- 4.17 In the USA in general, statutes do not offer any definitions of ‘unnatural death’. Jurisdictions such as Utah and Minnesota have left this term undefined.
- 4.18 The Commission is of the view that the term ‘unnatural death’ should remain undefined given the general trends in legislation. Alternatively, the undefined broad term can be made clearer by including a non-exhaustive list of types of cases to be investigated. For easier reference in the regional context the NZ and Australia should be adopted in the Coroners Ordinance of Samoa.
- 4.19 An emergency plan should be formulated aimed at streamlining processes involved in a natural disaster with a high death toll such as a tsunami. This emergency plan is only activated in the event of a tsunami or other serious natural disasters. This emergency plan is provided under the Disaster and Emergency Management Act 2007; however, the Commission recommends specifying this issue in the Coroners Ordinance.

Recommendation 5: The term ‘unnatural death’ should remain undefined given trends in comparable jurisdictions. However, specific non-exhaustive lists of cases where a coroner in Samoa can inquire should be provided in the Coroners Ordinance for easier reference. It is recommended that provisions similar to NZ and Australia be adopted. For guidance, the Commission recommends section 14(2) (NZ) and section 6 (NSW).

Recommendation 6: An emergency plan provision should be incorporated in the Coroners Ordinance in cases of catastrophic natural disasters such as a tsunami. This emergency plan aims to simplify and facilitate processes involved such as issuance of death certificates. This emergency plan should form part of the National Disaster Management Plan established under section 9 of the Disaster and Emergency Management Act 2007.

5. Missing Persons

Background

Samoa

5.1 Currently, Samoa’s legislation does not specifically address the issue of ‘missing persons’ with regard to coronial enquiry. This lack of provision is explored in the Issues Paper.

New Zealand

5.2 NZ loosely addresses ‘missing persons’ in its legislation by way of s.59 (b)(i) which requires a coroner to open an inquiry if he or she is *satisfied* that it is likely that the person concerned is dead and that the person’s body is *lost*. This jurisdiction also extends to cases where the deceased’s body is destroyed and irrevocable.

New South Wales

5.3 Similar to NZ, section 27(c) loosely addresses ‘missing persons’. The closest provision is where it appears to the coroner that ‘*it has not been sufficiently disclosed whether the person has died, or the person’s identity and the date and place of the person’s death have not been sufficiently disclosed.*’

Papua New Guinea

5.4 The relevant provision is section 20 of the PNG Act, which requires a Coroner to inquire into the cause and circumstances of the disappearance of missing persons. This is to determine whether the person is in fact alive. This inquiry is conducted upon the basis that the person has been missing for the period of 6 (six) months after the date of the report, or otherwise, when the Coroner is of the opinion to conduct an inquiry or the Attorney General directs a Coroner to carry out an inquiry.

5.5 In most common law jurisdictions a missing person can be declared legally dead (*dead in absentia*) after seven years. This time frame may be reduced in certain cases, such as deaths in major battles or mass disasters such as the September 11, 2001 attacks.

Submissions

5.6 A District Court Judge submitted that missing persons need not be specified in the Ordinance as it is already covered. Submissions by a private law firm stated that it would be preferable to specify a time limit where a missing person can be declared dead.

Commission’s view

5.7 The Commission is of the view that ‘missing persons’ should be defined in the Coroners Ordinance. Although missing persons may be included by general reference into the Samoan context, it is recommended that a clear statement to this effect would be helpful. Jurisdictions such as PNG offer a more specific provision relating to inquiry of missing persons and provide a useful model for Samoa.

5.8 It may also be helpful to use guidelines provided by the NSW legislation which requires a coroner to satisfy himself or herself on the balance of probabilities that the identity or details of the person concerned has not been sufficiently disclosed. It is recommended that language for the Coroners Ordinance require that the coroner must: - 1) satisfy him or herself that the person concerned is in fact dead and 2) that the person’s identity is not sufficiently disclosed.

Recommendation 7: The Coroners Ordinance should be amended to include provisions relating to ‘missing persons’ similar to section 20 of the PNG Act. A time frame of 6(six) months or more is preferred for determination of a ‘missing person’. Alternatively, a proviso should be incorporated stating that ‘*the coroner must satisfy him or herself that that the identity and details of the person concerned has not been sufficiently disclosed*’. The Commission recommends guidance from section 27(c) of the NSW Act.

6. Role of Coroners

Background

6.1 The traditional role of coroners has always been to inquire into deaths of person who have died as a result of ‘unnatural causes’, ‘suspicious causes’ and ‘unknown causes’. Section 4 of the Coroners Ordinance provides for the role of coroners in Samoa.

6.2 The role of coroners has evolved from just inquiring into the various manners of deaths, into a dynamic, educational and preventive role. This shift is sometimes referred to as a ‘modern coroner’. This evolutionary shift is notably seen in jurisdictions such as NSW and NZ contexts.

6.3 In the NZ legislation, the role of coroners extends to a ‘preventative role’. This includes making specific and relevant recommendations to reduce the chances of deaths in circumstances similar to those in which the death occurred and to protect property⁴⁴.

Preventative role

6.4 The modernization of the coronial role in the comparator jurisdictions of NZ and NSW specifically includes a broad and preventative mandate. In addition to addressing specific causes of death, coroners’ recommendations may also be directed to both public and private bodies. In terms of public bodies, it is typical for a modern coroner’s reports to make recommendations to government departments regarding needed improvement for practices, systems, road safety, and maintenance of public property or licensing of certain individuals or organizations. In the private context, a modern coroner’s report may make suggestions as to product quality or production, safe workplace practices and public health or safety in general.

Educational role

6.5 In complement with the modern coroners’ preventative role is their public educator’s role. A modern coroner makes efforts to ensure that information and key learning gathered in specific cases lead to a broader public educational mandate. For instance, if a particularly dangerous act or chemical is located, the coroner can lead the charge in bringing this matter to public light and provide public education. In this regard, the modern coroner should develop appropriate relationships with media, in order to publicize relevant coronial findings and recommendations. However, this public education role will need to be balanced against potential negative effects on the relatives of the deceased. Overall, however, the role of the modern coroner is to ensure that their timely advice and reports can be adopted by the public, leading to preservation of lives and property.

6.6 The modern role of coroners lends further support to a separate coronial system whereby coroners (who are not judicial officers) can engage with the public and

⁴⁴ Coroners Act 2006 (NZ), s57(3),s4(b)

media to educate the public in order to lessen preventable deaths. Judicial officers can then concentrate on their core roles and functions.

Commission's views

6.7 The role of a modern coroner is crucial to the development of the role of coroners in Samoa. Consultation around these issues indicated an interest in ensuring that the learning of the coroner should benefit all Samoans.

6.8 The role of coroners has substantially changed over the years. This is particularly evident in recent developments in coronial legislation in the comparator region. The move towards the preventative and educational roles of coroners is crucial in the sense that the public will be informed and made aware of the outcome of certain inquest cases, and lessons to be learnt from those.

6.9 A more modern role of the coroner will allow an opportunity for family members and relatives of the deceased to engage in an inquiry. It may also bring increased peace of mind for families and relatives to see that the loss of their loved one is not without a broader meaning. Key learning from each death, as appropriate, will be able to proactively assist in the public safety of all Samoans.

6.10 The 'preventative' and 'educational' role of coroners should form a key part of the role of coroners in Samoa similar to that in NZ and NSW.

Recommendation 8: The Coroners Ordinance should be amended to incorporate new provisions relating to the modern coroner. The preventative and educational role of the modern coroner should form part of the roles and functions of a coroner in Samoa. The proposed provision should be placed at the end of the Coroners Ordinance, as part of '*S.21.Finding of Coroner at an inquest*' or where relevant. Recommended to look at similar provisions in NZ and Australia for regional consistency.

7. Other Issues

Inquest Hearings on Affidavit

7.1 One of the issues raised by one of the coroners in Samoa (Chief District Court Judge) is a provision that allows inquest hearings to be conducted by way of affidavit which does not require the attendance of witnesses to give oral evidence. This issue was raised following cases of multiple deaths such as those of the September 2009 tsunami. The concern is the delay in proceedings as a number of witnesses had to be called to give evidence relating to each inquest. Also, these witnesses who were traumatized following the tsunami were subjected to give evidence at hearings. Although this is common practice, a more practical avenue was proposed to allow inquest hearings to be conducted on papers or by way of affidavit to facilitate issuance of certificate as to the cause of death, and to consider the psychological

status of traumatized witnesses of the tsunami and other catastrophic events. Traumatized witnesses should not be required to attend hearings and give evidence.

7.2 Section 17 of the Coroners Ordinance 1959 requires the attendance of witnesses to tender their evidence respecting the facts in issue. There is no specific provision that allow Coroners to conduct inquest hearings by way of other procedures such as affidavit which does not require attendance of witnesses. The Commission has looked into other comparable jurisdiction such as NZ for guidance on this issue and how it can be applied into the Samoan context.

7.3 One of the relevant provisions in the NZ Act 2006 is section 77 (1) which provides hearings to be on papers and chambers findings. This section applies to a coroner who is satisfied that no person who, under section 76⁴⁵, is a person from whom evidence is generally to be heard for the purposes of an inquiry, wishes to give evidence in person for the purposes of the inquiry. Further to this provision, a coroner to whom subsection (1) applies, may, instead of holding an inquest, hold a hearing on the papers and make chamber findings if the coroner:

- a) gives notice under section 81 (date...etc, and notice of inquest) of the coroner's proposal to hold a hearing on the papers and make chamber findings, as if that proposal were an inquest; and
- b) has, at or after the end of the period referred to in subsection (3), received no notification of an intention to give evidence in person from a person who, under section 76, is a person is generally to be heard for the purposes of an inquiry.

7.4 Section 90 (1) (a) of the NZ also provides for 'evidence by written statement confirmed by witnesses'. In this provision, a witness at an inquest may give any evidence by tendering a previously prepared written statement and confirming it on oath or affirmation if:

- a) the coroner is satisfied that there is no reason making it desirable for the witness to give evidence orally.

Recommendation 9: The Coroners Ordinance should provide for inquest hearings to be conducted by way of affidavit or other practical arrangements which can facilitate the issuance of certificates as to the cause of death and to consider the psychological status of traumatized witnesses. The Commission recommends following the relevant provisions above in the NZ Act for guidance.

Time Frame for coronial investigations by Police

7.5 The Coroner (District Court Judge) also raised the need to incorporate a time frame for police officers to expeditiously undertake coronial investigations to avoid unnecessary delay in inquest hearings. Past experiences have shown a backlog of

⁴⁵ Section 76 – People from whom evidence generally to be heard.

coronial inquiry matters due to the delay in completing investigations and subsequently leading to prolonged coronial findings. Section 23 of the current legislation provides that it shall be the duty of the Police to assist at all inquests, inquiries and investigations. However, no specific time frame is stipulated for carrying out these investigations.

7.6 Sections 17 and 115 of the NZ Act requires: 1) investigations by police of deaths reported under the Act; and 2) Police to help coroners' investigations under the Act. There is no specific time frame provided in the NZ Act for police to carry out investigations, however, such investigations must be made necessary to achieve the purpose of the Act in relation to the death. Section 116 of the NZ Act requires the Police to provide administrative support necessary to enable coroners to perform their role efficiently and effectively. Again, a time frame is not specifically provided here.

7.7 The purpose of the NZ Act as provided in section 3 considers i) *the cultural and spiritual needs of family of, and of others who were in a close relationship to, a person who has died and ii) the public good associated with a proper and timely understanding of the causes and circumstances of the death.* These are important factors that need to be considered by police and coroners in NZ when conducting coronial inquiries.

7.8 The Commission is of the view that coronial legislation in Samoa should follow the same direction as NZ of not specifying a time frame for investigations. There are cases where investigations may take longer than expected given the complexity of evidence such as blood testing, DNA samples particularly deceased persons that have gone missing for years. On the other hand, there are cases that may be solved immediately within weeks of investigations. Time frame varies depending on the nature of reported cases and setting a time frame may not be the most practical option at this stage given the sensitivity of issues involved in these cases.

7.9 However, in the event a time frame is required to be specified, the Commission proposes 12-24 months for completion of police investigations. The Commission also recommends a provision in the new Coroners legislation to empower coroners to order police to carry out investigations expeditiously and within the stipulated time frames.

Recommendation 10: The Commission recommends incorporating 'Purpose section' or 'Guiding principles' into the Coroners Ordinance to guide coroners and police in carrying out their investigations. These guiding principles must take into account the 'cultural and spiritual needs of grieving families and friends' and must ensure that these investigations are carried out effectively and efficiently. Proposed time frame is 12-24 months and a new provision empowering the coroners to order police to carry out investigations expeditiously and within the stipulated timeframes

List of Recommendations

Recommendation 1: The system of appointment of coroners should be modified by outlining criteria in the Coroners Ordinance requiring that a coroner must be i) either legally or medically qualified ii) must have undergone some test or training relevant to duties of a coroner iii) sufficient years of experience, preferably minimum of 5 years as a legal or medical practitioner.

Recommendation 2: Coroners should be appointed by a body separate from the judiciary to ensure that the person elected has the required skills and expertise. For instance, a proposed body consisting of the Chief Justice, the relevant Minister, a senior medical practitioner and a nominated representative from the community (similar to the Judiciary Legal Services). The ultimate aim is the separation of the Coroners Court from the Judiciary.

Recommendation 3: The Coroners Ordinance should be amended to provide a non-exhaustive list of cases into which a Coroner in Samoa can inquire. The Coroners Ordinance should incorporate specifically deaths of those with special needs and children, death as a result of surgical, medical or dental treatment, death of mothers while giving birth or while pregnant, and issues of elderly abuse and neglect.

Recommendation 4: The term ‘violent death’ should be defined in the Coroners Ordinance given the increasing number of such deaths occurring in Samoa. Recommended to adopt the definition in the Minnesota statute (USA), where relevant.

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Recommendation 6: An emergency plan provision should be incorporated in the Coroners Ordinance in cases of catastrophic natural disasters such as a tsunami. This emergency plan aims to simplify and facilitate processes involved such as issuance of death certificates. This emergency plan should form part of the National Disaster Management Plan established under section 9 of the Disaster and Emergency Management Act 2007.

Recommendation 7: The Coroners Ordinance should be amended to include provisions relating to ‘missing persons’ similar to section 20 of the PNG Act. A time frame of 6(six) months or more is preferred for determination of a ‘missing person’. Alternatively, a proviso should be incorporated stating that ‘*the coroner must satisfy him or herself that the identity and details of the person concerned has not been sufficiently disclosed*’. The Commission recommends guidance from section 27(c) of the NSW Act.

Recommendation 8: The Coroners Ordinance should be amended to incorporate new provisions relating to the modern coroner. The preventative and educational role of the modern coroner should form part of the roles and functions of a coroner in Samoa. The proposed provision should be placed at the end of the Coroners Ordinance, as part of ‘*S.21.Finding of Coroner at an inquest*’ or where relevant. Recommended to look at similar provisions in NZ and Australia for regional consistency.

Recommendation 9: The Coroners Ordinance should provide for inquest hearings to be conducted by way of affidavit or other practical arrangements which can facilitate the issuance of certificates as to the cause of death and to consider the psychological status of traumatized witnesses. The Commission recommends following the relevant provisions above in the NZ Act for guidance.

Recommendation 10: The Commission recommends incorporating ‘Purpose section’ or ‘Guiding principles’ into the Coroners Ordinance to guide coroners and police in carrying out their investigations. These guiding principles must take into account the ‘cultural and spiritual needs of grieving families and friends’ and must ensure that these investigations are carried out effectively and efficiently. Proposed time frame is 12-24 months and a new provision empowering the coroners to order police to carry out investigations expeditiously and within the stipulated timeframes.

Persons and Organizations who made Submissions to the Inquiry

Name

Judge Vaepule Vaemoa Vaai

Tamati Law Firm

Public in Savaii

Public in Upolu

Nuanua o le Alofa

The British Columbia Law Institute

Glossary of Acronyms and Abbreviations

[Abbreviation]

[full name]

Coroners Ordinance

Coroners Ordinance (Samoa) 1959

NZ

New Zealand

NSW

New South Wales (Australia)

USA

United States of America

