

# **SAMOA**

## **LAW REFORM COMMISSION**

CORONERS ORDINANCE 1959  
**Issues Paper IP 02/09**

**December 2009**

## **Preface**

This is a preliminary scoping law reform project (“Project”) to review the current law surrounding the work of coroners in Samoa. The Samoa Law Reform Commission (“Commission”) has been mandated to review and suggest areas of reform of the Coroners Ordinance 1959. The Commission will then provide recommendations on how the current law and practice can be reformed in a way that is best suited to the Samoan context. In getting to this point, it is important to consider coronial work and legislation in other jurisdictions, with the ultimate aim of the resultant legislation assisting coroners in their work.

The Commission has employed for this Issues Paper, the form of questions and a closing date for responses (^). This paper therefore discusses the issues and poses questions for consideration. The intention is to enable detailed and practical consideration of the issues.

We emphasize that we are not committed to the views indicated and any provisional conclusions should not be taken as precluding further consideration of the issues.

We are grateful for the assistance of the following people who provided comments on earlier drafts of this paper: Peter Lown, (Director, Alberta Law Reform Institute), David Elliot, (Consultant Legislative Drafter), Judge Craig Coxhead, (Maori Land Court), Gregory Blue, (Staff Lawyer, British Columbia Law Institute), Wayne Renke, (Professor & Vice Dean, Faculty of Law, University of Alberta), Eileen Skinnider, (Associate, The International for Criminal Law Reform and Criminal Justice Policy), Helen Aikman, (QC, Thorndon Chambers), Heather Kay, (Executive Officer, Law Reform Commission of Western Australia), and Annemieke Holthius, (Criminal Law Policy Section, Justice Canada), and last but not least, Justice Vui Clarence Nelson whose ideas for reform of this Ordinance started the process.

We emphasize however that the views expressed in this paper are those of the Commission and not necessarily those of the people who have helped us.

Submissions or comments on this paper should be sent by the 19<sup>th</sup> of March 2010, to the Executive Director, Samoa Law Reform Commission, Private Bag 974 or by email to lawreform@ag.gov.ws.

## **Introduction**

The issues paper considers the current law and practice relating to the Coroners Ordinance 1959. The paper discusses issues raised during preliminary consultations with the relevant stakeholders. It also looks at relevant laws from comparable jurisdictions such as New South Wales (NSW) (Australia), New Zealand (NZ) and Papua New Guinea (PNG). The choice of comparable jurisdictions was made based on suggestions tendered in preliminary consultations with the relevant stakeholders.

*The content of the issues paper will be as follows:*

<b>1) IS THERE A NEED FOR CHANGE?</b>	3
1.1 Current Law and Practice in Samoa-Coroners Ordinance 1959	3
<b>2) ISSUES ON CURRENT LAW AND PRACTICE</b>	6
2.1 Who can be appointed as a Coroner?	6
2.2 The jurisdictions and functions of a Coroner	10
<b>3) ANALYSIS</b>	16
3.1 Appointments	17
3.2 Roles and Functions	18
3.3 Modern Coroner	19
3.3.1 Preventative	19
3.3.2 Educational	19
<b>4) SUMMARY OF QUESTIONS</b>	20
<b>5) CALL FOR RESPONSES</b>	21

## **1) IS THERE A NEED FOR CHANGE?**

### *1.1) Current Law and Practice- Coroners Ordinance 1959*

The Coroners Ordinance 1959 (“Ordinance”) defines the legal boundaries for coronial work in Samoa. It repealed the Coroners Ordinance 1921 and section 6 of the Ordinances Amendment

Ordinances 1934. According to records of *Parliamentary Debates*, the Attorney General's speech in 1959 to the Legislative Council revealed that the Coroners Ordinance 1921 which was passed by the then Legislative Council only stated in very loose terms that the English law relating to coroners is to be applicable to Samoa (then Western Samoa).<sup>1</sup> At the time, there was a great need for a comprehensive and relevant guide to assist coroners in their work. Consequently, the Coroners Ordinance 1959 was enacted to respond to the need for an appropriate guide to regulate the work of coroners.<sup>2</sup>

In accordance with section 4(1) of the Ordinance, the work of a coroner in Samoa begins when the coroner is informed by a constable that a person is dead and that there is reasonable cause to suspect that the person:

- i) *has died either a violent or unnatural death; or*
- ii) *has died while in the legal custody of the Superintendent of a penal institution;*  
*or*
- iii) *has died in such a place or under such circumstances that in accordance with provisions of any enactment other than the Ordinance, an inquest is requested to be held.*

Section 4(2) requires that a Coroner shall hold an inquest where the coroner is informed that any person has died of a sudden death of which the cause is unknown provided that in any such case the Coroner may decide, in accordance with section 6, not to hold an inquest.

Subsequently an inquest is then conducted by the coroner in Samoa as to the cause of death of such a person. An inquest shall be conducted by the Coroner for the purpose of establishing:

- i) *the fact that a person has died;*
- ii) *the identity of the deceased person; and*
- iii) *when, where and how the death occurred.*

The Ordinance does not clearly define “unnatural death” as stated in section 4 above. The closest interpretation of unnatural death may be provided under section 6 and 7 of the

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<sup>1</sup> Samoa, *Parliamentary Debates*, Legislative Assembly, 3 August 1959, p 10 (as per speech of Attorney General at the time).

<sup>2</sup> Samoa, *Parliamentary Debates*, Legislative Assembly, 3 August 1959, p 10 (as per speech of Attorney General at the time).

Ordinance which could mean “...any sudden death of which the cause is unknown”<sup>3</sup>, or “...where an inquest is conducted given that a person’s body is destroyed or irrecoverable”<sup>4</sup>. However, this still poses a problem given the ambiguity of the term unnatural death. Given the recent September 29/09 tsunami that struck Samoa, there were difficulties in addressing section 4 of the Ordinance as there was no clear legal basis in handling death cases resulting from an unexpected natural disaster such as a tsunami. There is also a loophole in the Ordinance with regards to addressing missing persons from the tsunami whose bodies have still not been found to date. This issue of missing persons needs to be addressed under the Ordinance specifically. It is also important that the Ordinance clearly provides a time-frame in which a person can be declared dead given that such person has been missing for a period of time. The issue of time-frame is not addressed in the Ordinance.

In some cases, the coroner directs a post mortem to be conducted. The coroner then authorizes a medical practitioner to carry out a post mortem<sup>5</sup>. This post mortem is a preliminary examination of the deceased to determine whether an inquest is necessary. In the event that the post mortem results find that the deceased died of natural causes and death did not take place in such a place or in such circumstances as to necessitate the holding of an inquest as stipulated in Section 4, an inquest is not conducted<sup>6</sup>. The coroner may at anytime before the termination of inquest authorize any medical practitioner within the meaning of section 2 of the Medical Practitioner Act 1975 other than the medical practitioner who, to the knowledge of the coroner has attended the deceased person immediately prior to his or her death, to perform a post mortem of the body of the deceased person.<sup>7</sup>

In the event that the coroner decides to hold an inquest, he or she will then fix the date, time and place of the inquest and proceedings are to be heard in public except where the coroner considers it desirable in the interests of justice, decency, or order to not hold a public hearing. The Coroner may exclude all or any persons from the whole or any part of the proceedings at the inquest, or may prohibit the publication of any part of the evidence given at the inquest.

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<sup>3</sup> Section 6 of the Coroners Ordinance 1959.

<sup>4</sup> Section 7 of the Coroners Ordinance 1959.

<sup>5</sup> Section 9 of the *Coroners Ordinance 1959* (WS).

<sup>6</sup> Section 6 of the Coroners Ordinance 1959 (WS).

<sup>7</sup> Section 9 of the Coroners Ordinance 1959 (WS).

During the hearing of the inquest, the coroner shall examine on oath all persons who tender their evidence in relation to the inquest and all other persons whom the coroner thinks are expedient to examine for the purpose of resolving the inquest. Upon hearing the evidence of the witnesses at the inquest, the coroner shall put into writing this evidence and the evidence shall be read over and signed by each witness and by the coroner. After considering all the evidence, the coroner shall give a finding and shall sign a certificate as to the facts specified in the prescribed form. Subsequently, the coroner shall forward the certificate to the Registrar appointed under the Births, Deaths and Marriages Registration Act 2002. The coroner shall also forward copies of certificates together with all depositions of witnesses, to the Commissioner of Police and to the Chief Executive Officer of the Ministry of Health (“MOH”).

In circumstances where death was suspected to be self-inflicted, no report of the proceedings shall be published by the coroner unless he or she is satisfied that the circumstances surrounding the death of a person may have in fact been self-inflicted. In finding that the death was self-inflicted, report of the proceedings of the inquest shall be published by the coroner excluding details of the deceased, such as name, address, occupation and the cause of death.

The coroner upon request from the Commissioner of Police can hold an inquiry as to the cause and origin of any fire and as to the effectiveness or otherwise of the measures taken to deal with such fire and all other incidental matters in connection with the fire. The provisions of the Ordinance shall also apply to such an inquest.

## **2.) ISSUES ON CURRENT LAW AND PRACTICE**

### **2.1) Who can be appointed as a Coroner?**

- **Samoa**

In Samoa, the Chief Justice and all other Judges of the Supreme Court of Samoa are coroners by virtue of holding office under the Ordinance.<sup>8</sup> A District Court judge by virtue of his or her office is deemed to have been appointed a coroner.<sup>9</sup> A medical practitioner appointed with specific or general authority by the Chief Executive Officer of the MOH can act as a coroner

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<sup>8</sup> *Coroners Ordinance 1959* (WS) s 2.

<sup>9</sup> *District Courts Act 1969* (WS) s 9.

but only to discharge the duty of a coroner to order the burial of a body.<sup>10</sup> This is in cases where the death occurred in a remote part of Samoa and it is impracticable to bring the corpse body of the deceased person to Apia and in cases where it is impracticable for a coroner to attend.<sup>11</sup>

- **New South Wales**

The relevant legislation in NSW is the Coroners Act 2009 ('NSW Act'). In the NSW Act, a magistrate is eligible to be appointed in writing by the Governor as a state coroner or a deputy state coroner.<sup>12</sup> 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.<sup>13</sup> The Act gives magistrates jurisdiction, powers and duties imposed on coroners unless they are appointed as a state coroner or deputy state coroner.<sup>14</sup>

Generally in NSW, all persons appointed as coroners must be Australian lawyers and all persons appointed as assistant coroners must be members of the staff of the Attorney General's Department.<sup>15</sup> The appointments of coroners and assistant coroners can be for a certain period.<sup>16</sup> A person may not be appointed as a Coroner if that person is seventy two (72) years of age and older unless the Minister recommends to the Governor that the person's appointment is appropriate.

In contrast, the Chief Justice and all other Judges of the Supreme and District Courts of Samoa are coroners by virtue of holding judicial office. In NSW, there is a hierarchy of coroners where the highest is the state coroner who oversees the work of other coroners, and there is also a deputy state coroner followed by coroners and assistant coroners appointed from the staff of the Attorney General of NSW. These coroners in NSW are appointed by the Minister or Governor.

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<sup>10</sup> *Coroners Ordinance 1959* (WS) s 11.

<sup>11</sup> *Coroners Ordinance 1959*(WS) s 11.

<sup>12</sup> *Coroners Act 2009* (NSW) s 4A.

<sup>13</sup> *Coroners Act 2009* (NSW) s 5.

<sup>14</sup> *Coroners Act 2009*(NSW) s 10.

<sup>15</sup> *Explanatory Notes* on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>16</sup> *Explanatory Notes* on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<b>Questions:</b>	<ol style="list-style-type: none"> <li>1. <i>Should the Ordinance clearly define what constitutes an ‘unnatural death’?</i></li> <li>2. <i>Should Samoa have a Coronial system separate from its Supreme and District Courts?</i></li> <li>3. <i>Should Samoa limit the appointment of Coroners to Judges and Magistrate? Or should it extend to Samoan lawyers?</i></li> </ol>
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- **New Zealand**

The relevant legislation in NZ is the Coroners Act 2006 (‘NZ Act’). In NZ, apart from a District Court Judge being a coroner by virtue of his/her office,<sup>17</sup> a person holding a practicing certificate as a barrister or solicitor for at least five (5) years is eligible to be appointed as a coroner.<sup>18</sup> The Governor General makes the appointment, on the advice of the Attorney General after consultations with the Minister of the Crown.<sup>19</sup> The NZ Act also provides for the appointment of chief coroners<sup>20</sup> and relief coroners.<sup>21</sup> It further provides for the appointment of acting chief coroners to act as chief coroners in the event that the chief coroner is unable to act for reasons stated in the NZ Act. The maximum number of coroners in NZ is twenty (20).<sup>22</sup>

In comparison, the District Court Judge in NZ is similar to that in Samoa in the sense that they are both deemed to have been appointed as coroners by virtue of their offices. In contrast, there are number of coroners to be appointed in NZ such as chief coroners and relief coroners who are, in accordance with the NZ Act, required to hold practicing certificates as a barrister and solicitor for at least five (5) years. On the other hand, the coroners in Samoa consist of the Chief Justice and all judges of the Supreme and District Courts. In relation to qualifications, the Ordinance is silent on any requirements or qualifications of being a coroner in Samoa, other than by judicial office. The hierarchy of coroners in NZ as stated in its Act highlights a downward approach in the way it conducts its work. For instance, there is a chief coroner that oversees the work of coroners. This is not the case in Samoa.

<sup>17</sup> *District Courts Act 1947* (NZ) s 8(d).

<sup>18</sup> *Coroners Act 2006* (NZ) s 103.

<sup>19</sup> *Coroners Act 2006* (NZ) s 103.

<sup>20</sup> A chief coroner’s main function is to ensure the integrity and effectiveness of the coronial system in New Zealand. They oversee and coordinate coronial services in New Zealand.

<sup>21</sup> *Coroners Act 2006* (NZ) ss 104 and 105.

<sup>22</sup> *Coroners Act 2006* (NZ) s 109.

<b>Questions:</b>	<p>4. <i>Should Samoa follow the NZ approach in the appointment of Coroners on the qualification that he or she has had a practicing certificate as a barrister or solicitor for 5 years?</i></p> <p>5. <i>Should Samoa adopt a hierarchy of Coroners similar to NZ where there is a Chief Coroner, coroners and relief coroners?</i></p> <p>6. <i>Should Samoa have a maximum number of coroners?</i></p>
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- **Papua New Guinea**

In PNG, district officers are coroners by virtue of their offices and have jurisdiction, power and authority throughout the country.<sup>23</sup> The Judicial and Legal Services Commission can also appoint a person to be a coroner by notice in the National Gazette and specifying the province or provinces within which he/she has jurisdiction, power and authority to hold inquests.<sup>24</sup>

A medical practitioner can act as a coroner in PNG provided that he/she did not attend to the deceased professionally at the time of death or period just before the time of death.<sup>25</sup>

The qualifications of those who can be appointed coroners reveal that Samoa differs from the appointment of Coroners in PNG in the sense that in Samoa, a person is appointed as a coroner by virtue of their offices as Judges of the Supreme Court or the District Court. In PNG, the appointment of a coroner is any person who is appointed by the Judicial and Legal Services Commission.

Medical practitioners can act as coroners in PNG provided that he or she did not attend to the deceased professionally at time of death or the period just before the time of death. Similarly, a medical practitioner in Samoa can act as a coroner but only, to order the burial of a body, in circumstances where it is impracticable for a coroner to discharge such duty.<sup>26</sup>

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<sup>23</sup> *Coroners Act 1953* (PNG) s 3. District Officers are Senior Principal Magistrates who are appointed to respective provinces within which have jurisdiction, power and authority as Coroners. There are 20 Provinces and therefore there are 20 Coroners in each of these provinces appointed by the Judicial and Legal Services Commission of PNG to perform this authority. (as per definition given by Mr Bernard Koae (Principal Legal Officer to PNG Judiciary via email on Monday 29<sup>th</sup> June 2009).

<sup>24</sup> *Coroners Act 1953* (PNG) s 2.

<sup>25</sup> *Coroners Act 1953* (PNG) s 4.

<sup>26</sup> *Coroners Act 1959* (WS) s. 11

<b>Questions:</b>	<p>7. <i>Should a Coroner in Samoa be appointed by some other body apart from virtue of them holding office as judges?</i></p> <p>8. <i>If so, what body?</i></p> <p>9. <i>Should Samoa allow medical practitioners to be appointed as coroners if they attended to the deceased professionally at the time of death or just before the time of death?</i></p>
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## 2.2) The Jurisdiction and Functions of a Coroner

- **Samoa**

In Samoa, a coroner has the jurisdiction to determine the manner of death of a person believed to have: 1) died a violent or unnatural death; 2) died while in the legal custody of the superintendent of a penal institution; or 3) died in a place or under circumstances in accordance with the provisions of another Act, requires an inquest.<sup>27</sup> A coroner also has authority to inquire into the death of a person who died suddenly from an unknown cause.<sup>28</sup> The outcome of a successful inquest will determine the identity of the dead person as well as the time, place and cause of death.<sup>29</sup>

The Ordinance also gives a coroner the authority to inquire into matters relating to fires.<sup>30</sup> That is, to determine the cause and origin of any fire and the effectiveness of the measures taken to deal with such fire. When exercising these powers, functions or duties conferred or imposed under the Ordinance a coroner assumes the powers, privileges, authorities and immunities possessed by a Judge of the Supreme Court of Samoa.<sup>31</sup>

A Coroner may order the burial of a body under section 10 of the Ordinance provided that the death has been reported and no post mortem examination is needed. A medical practitioner on the other hand, can also act as a coroner under section 11 of the Ordinance but only to order the burial of a body where a death has occurred in some remote part of Samoa where it is impracticable for a Coroner to attend.<sup>32</sup>

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<sup>27</sup> *Coroners Act 1959 (WS) s 4 (1).*

<sup>28</sup> *Coroners Act 1959 (WS) s 4 (2).*

<sup>29</sup> *Coroners Act 1959 (WS) s 12.*

<sup>30</sup> *Coroners Act 1959 (WS) s 22.*

<sup>31</sup> *Coroners Act 1959 (WS) s 3.*

<sup>32</sup> *Coroners Act 1959 (WS)s.11*

There is no provision in the Ordinance in relation to missing persons. The only provision is in relation to where a body is destroyed or irrecoverable. The provision provides that an inquest may be held in respect of the death and the details must be reported to the Attorney General. The Ordinance does not provide how long a person is missing before they are declared dead. The Common Law stipulates that a period of 5 years is given before a person is declared dead. This is usually the case in relation to the settlement of estates.

- **New South Wales**

In NSW, functions of coroners are dependent on the hierarchy of coroners. The functions of a state coroner are to oversee and coordinate coronial services in NSW and to ensure all deaths, suspected deaths, fires and explosions to which a coroner has jurisdiction over are properly investigated. A deputy state coroner performs functions delegated by the state coroner and other functions imposed on the deputy state coroner under the NSW Act. Coroners (members of AGO) have all the functions conferred on coroners under the NSW Act; however, they do not have the functions of a state coroner or deputy coroner unless appointed to such an office under the NSW Act. The functions of an assistant coroner are to provide the relevant information and assistance to a state coroner. The assistant coroner also performs other functions that are delegated by the state coroner, such as ordering the disposal of the remains of a deceased, using post mortem investigation directions, dispensing with the holding of inquiries if a fire or explosion does not occur in suspicious circumstances, and also dispensing with the holding of inquiries if a fire involved only a motor vehicle.

A state coroner and a deputy coroner in NSW have extensive jurisdiction. They have jurisdiction to hold inquests concerning deaths and unsuspected deaths, deaths in custody or as a result of police operations, deaths of children and disabled persons, and inquiries concerning fire and explosions. In comparison, coroners in Samoa have jurisdiction to hold inquests in similar circumstances as NSW but only to the extent of violent and unnatural deaths or death resulted from being in custody or generally in other circumstances required by the Ordinance. Other such cases as specified in the NSW Act are not specified in the Ordinance, for instance, deaths of children and disabled persons.

The Commission points out that the Coroners Act 2009 (NSW) has made a number of changes to the jurisdiction and powers of coroners in NSW. The first of these changes is in relation to the current provisions relating to the reporting and investigation of deaths resulting from the use of anesthetic. It is being replaced with provisions relating to deaths that are not reasonably expected outcomes of health procedures.<sup>33</sup> Secondly, the current provisions that require a death to be reported to the relevant Minister if a medical practitioner did not attend the deceased person in the three (3) months preceding death, are replaced with provisions that extends that period to 6 months.<sup>34</sup>

The NSW Act has seen the extension of the current jurisdiction of coroners in NSW, authorizing them to direct relevant personnel to review the medical records of a deceased person and report on such a review.<sup>35</sup>

In addition, coroners are also authorized to dispense with an inquest or post mortem examination in cases where the coroner is satisfied that the deceased person died of natural causes and the deceased person's family does not wish it to be conducted.<sup>36</sup>

However, an inquest or post mortem examination that has been withheld may be revived in the light of the discovery of new evidence and facts.<sup>37</sup>

The power of coroners to make non-publication orders is extended under the NSW Act to prohibit publication by means of the internet.<sup>38</sup> The use of jury in coronial proceedings is limited to situations where the State Coroner directs it at an inquest or inquiry that is to be presided over by the State Coroner.<sup>39</sup>

<b>Questions:</b>	<i>10. Should the roles and functions of a Coroner in Samoa extend to inquiries into explosions?</i>
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<sup>33</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>34</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>35</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>36</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>37</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>38</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

<sup>39</sup> Explanatory Notes on the Coroners Act 2009 at <http://www.parliament.nsw.gov.au> (accessed 18 June 2009).

	<p><i>11. Should the jurisdiction of Coroners in Samoa extend to the deaths of children and disabled persons?</i></p> <p><i>12. Should the jurisdiction of a Coroner in Samoa extend to the deaths that are not reasonably expected outcomes of health procedures?</i></p> <p><i>13. Should the jurisdiction of a Coroner in Samoa be extended to deaths resulting from natural disasters?</i></p> <p><i>14. Should Samoa adopt a time limit on the reporting of deaths in which a coroner has jurisdiction over?</i></p> <p><i>15. Should the Ordinance specify a time limit where missing people are declared dead?</i></p> <p><i>16. Should assessors ever be used in coronial proceedings in Samoa?</i></p>
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- **New Zealand**

The role of coroners in NZ and Samoa is similar as they both hold inquests where a person has died resulted from:

- i) a violent or unnatural death;*
- ii) died under the custody or care of any penal institution or other services; or*
- iii) died from unknown causes.*

The purpose of conducting inquests in NZ and Samoa is also similar in the sense that inquests are conducted for the purpose of establishing:

- i) that a person has died;*
- ii) the identity of the deceased person; and*
- iii) when, where, and how the death occurred.*

On the other hand, the role of coroners in NZ is more comprehensive and broader in scope, for instance, suicide cases, inquiry into deaths of persons that had occurred while under a medical, surgical or dental operation or procedure, and inquiry into deaths of women who have died resulting from giving birth. The role of coroners in Samoa, as far as inquests are concerned, vaguely extends to cases of fire but this is upon request from the Commissioner of Fire and Emergency Services (formerly known as Chief Fire Officer). Other cases where a coroner in

Samoa holds inquests are stated generally in the Ordinance and are not listed specifically as in the NZ Act. For instance, a person who '*died in such a place or under such circumstances that...an inquest is required to be held*' is quite general a provision and needs to be clarified in the Ordinance.

The question that arises is whether the scope of coronial work in Samoa should be as extensive as possible to cover any case of suspicious and unknown deaths as stated in NZ Act and whether examples of such cases should be specifically laid out in the Ordinance

The procedure in conducting inquest proceedings are also quite similar given that coroners in both NZ and Samoa determine time and date to hold an inquest and for such inquest to be held before a coroner sitting alone. The rules of evidence relating to examining witnesses in inquest proceedings are also similar and inquests are required to be opened to the public (unless otherwise approved by the coroner taking into account the interests of justice, decency or order).

In the majority of cases, the cause of death is established by a post-mortem examination. In NZ, a post mortem may be performed by a pathologist who is a listed pathologist in NZ to assist during an inquest or in cases where the coroner has opened but not completed an inquest. The primary purpose of the post mortem is to enable the coroner to decide whether to hold an inquest.

Similarly in Samoa, the coroner may direct a post mortem to be conducted by a medical practitioner under the Medical Practitioners Act 1975 if he or she is of the opinion that a post mortem may prove an inquest to be unnecessary. In the event that the post mortem examination finds that the death was due to natural causes and did not take place in such places or in such circumstances as to necessitate the holding of an inquest, the Coroner in Samoa may decide not to hold an inquest. In NZ, a more stringent approach is given to coroners before they can decide to hold a post mortem and there are certain criteria laid down in the NZ Act that they must firstly consider before making decisions. The coroners in NZ also decide whether to hold a post mortem based on information already available to him or her and the extent the post mortem would resolve the issue in question.

The NZ Act specifically extends the role of a coroner to include making relevant comments and recommendations to reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred and to protect property.<sup>40</sup> In Samoa, the Ordinance does not provide for making recommendations and comments. There is only an inquest finding to be made by a coroner but the substance or content of this finding is not specified in the Ordinance.

<b>Questions:</b>	<p><i>17. Should the role of Coroners in Samoa extend to cases of suspicious and unknown deaths?</i></p> <p><i>18. Should Samoa's ordinance list specific circumstances over which a coroner may have jurisdiction? E.g. Suicide cases, inquiry into deaths of persons that had occurred while under a medical, surgical or dental operation or procedure and women who have died in childbirth?</i></p> <p><i>19. Should the role of a Coroner in Samoa include the making of relevant comments and recommendations to reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred and to protect property?</i></p>
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- **Papua New Guinea**

In PNG, a coroner has jurisdiction to investigate the manner and cause of death of a person who died only within the province or provinces within which he/she has jurisdiction. The manner and cause of death in which the coroner in PNG has jurisdiction to inquire into extends to a wide range of circumstances e.g. death resulted while under anesthetic, surgical or dental operation. These manners of deaths are not specified in the Ordinance in Samoa, however, coroners in PNG and Samoa are similar as they both inquire into deaths resulted from unknown causes, suspicious or unusual circumstances and deaths while in custody or penal institutions.

A coroner in PNG has jurisdiction to hold inquiries into the cause and origin of a fire<sup>41</sup> and in respect of missing persons<sup>42</sup>. Similarly, coroners in Samoa hold inquiries into the cause and

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<sup>40</sup> Coroners Act 2006 (NZ) s 4(b).

<sup>41</sup> Coroners Act 1953 (PNG) s 17.

<sup>42</sup> Coroners Act 1953 (PNG) s 20.

origin of fire but this is on the request of the Commissioner of Fire and Emergency Services (formerly known as the Chief Fire Officer). The case of missing persons are not provided and specified in the Ordinance. A coroner in PNG can re-open an inquest that was closed by him/her or another coroner if he/she (coroner) is of the opinion that it should be re-opened or where there is a request by an authorized person to re-open an inquest.<sup>43</sup> In contrast, there are no such provisions in the Ordinance, however, there are provisions where the Supreme Court in Samoa may order an inquest to be held or opened given that a coroner refuses or neglects to hold an inquest.

Another similarity between Samoa and PNG is that coroners have the power to hold inquests into deaths that occur within their jurisdiction. A coroner in PNG may only perform his or her functions within the province over which he or she has jurisdiction. In contrast, Samoa is a small country that does not have provinces. The functions of Coroners in Samoa are performed only in Samoa and do not extend outside of Samoa. However, the functions of a coroner in the two countries are similar in that they are to inquire into the cause of death of a person who dies under suspicious circumstances, an unnatural death or in relation to fires.

<b>Questions:</b>	<p><i>20. Is it appropriate for Samoa to extend the functions of a Coroner to inquire into deaths while undergoing medical treatment?</i></p> <p><i>21. Should the role of a Coroner extend to inquiring into missing persons?</i></p> <p><i>22. Should legislation allow a Coroner to re-open or authorize a person to re-open an inquest in the event of fresh and new evidence?</i></p>
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### 3) ANALYSIS

As already stated in the content, the existing Coroners Ordinance of Samoa was enacted approximately fifty years (50) ago in 1959. There is no record of any reform of the Ordinance to address issues facing coronial work in Samoa in light of modern developments in science and the needs and expectations of society. As evident from similar Coronial legislation in NSW, NZ and PNG (‘comparable jurisdictions’), there have been developments in the role of coroners in these jurisdictions. In general, the primary role of a coroner is the same in Samoa

<sup>43</sup> The persons authorized to request a Coroner to re-open or hold an inquest under section 21 of the Coroners Act 1953 (PNG) are the Commissioner of Police, a Superintendent of Police, and the husband or wife, father, mother, sister, brother, son, daughter or guardian of the deceased person.

and comparable jurisdictions. They all inquire to establish: *that a person has died; the person's identity; when and where the person died; the cause of death; and circumstances of the death.* However, the extent of circumstances and manner of deaths in which coroners have jurisdiction to inquire into, have recently expanded elsewhere. In comparable jurisdictions, recent developments in technology and scientific knowledge have broadened the scope of cases into which a coroner can inquire. Subsequently, the extensive jurisdiction of coroners in comparable jurisdictions necessitates the need for more coroners to undertake coronial work in those jurisdictions. This is quite evident from the hierarchy of coroners in NSW and NZ.

### 3.1) Appointments

In Samoa and comparable jurisdictions, almost all coroners are appointed by virtue of holding judicial office. The appointment of coroners in NZ seems to differ in the sense that coroners are appointed by the Governor on the advice of the Minister. This is also in the case of NSW as far as District Court Judges are concerned. The staff of the Attorney General's Office in NSW can also be appointed as assistant coroners. With respect to qualifications, the requirements for coroners in NZ are that they must be lawyers holding practicing certificates as barristers and solicitors. This qualification does not exist in the coronial legislation in Samoa.

The question that arises is whether it is practical and necessary to extend the appointment of coroners to lawyers holding practicing certificates in Samoa. This approach depends on the demand for coroners in Samoa to undertake coronial work. A consideration is the number of cases in Samoa reported to coroners for inquiries. It is also noted that in Samoa, coroners who are Judges, are required to balance their court cases with the conducting of inquests. This means that the amount of work of the Judges is enormous. The issue that arises is whether the work of coroners should be independent from the judicial system. This will mean that the work of coroners is concentrated to coronial functions. This may result in coronial work being conducted expediently. There are financial implications in this approach as funds will be needed to establish a separate coronial office. If persons other than judicial officers are appointed as coroners, technical assistance will be required to train those who will be appointed as coroners. However, given the significant nature of coronial work, great emphasis must be placed on the work of coroners to ensure that justice is served by providing answers to causes and manners of deaths reported to them.

### 3.2) Roles and Functions

The purpose of coroners, as stated in the NZ Act, is to help prevent deaths and promote justice through investigations and thorough inquiries into causes and manners of unexplained deaths. The findings of these investigations and inquiries result in coroners making recommendations or comments that, if drawn to the public attention, may reduce the chances of the occurrence of other deaths similar to those in which unexplained deaths occurred. It is crucial that coroners must perform or exercise his or her functions without delay.

The primary roles of coroners in Samoa and comparable jurisdictions are similar as they are all required to conduct inquiries into the manners and causes of unexplained deaths. However, there have been developments in roles of coroners in comparable jurisdictions. The jurisdiction of coroners in comparable jurisdictions extends to areas in which a person has died while under medical attention or cases involving pregnant women and disabled children. This may have resulted from the availability of modern scientific technology that provides answers for these cases. There are also cases such as suicide and death of a person whilst under specific custody services such as social services, Police and other services which are clearly specified in the legislation of NZ and NSW.

The jurisdiction of coroners in Samoa is limited to certain cases stated in the Ordinance. The causes of deaths in which a coroner can inquire into are not as comprehensive as the cases provided in legislation of comparable jurisdictions. The question raised is whether it is really necessary for Samoa to expand the scope of coronial jurisdiction to include instances mentioned in comparable jurisdictions. The issue here is whether coroners in Samoa have the capacity to handle extended new cases and whether we have the technical assistance and methodology to resolve the same. Should there be a need to expand the scope of coronial work in Samoa, then there will be a great need for Samoa to engage consultants specializing in specific areas to assist medical officers and police in the conducting of inquests. On the other hand, extending the role of coroners in Samoa may be advantageous in the sense that a number of unknown causes of deaths may be resolved thus serving justice to the people of Samoa.

### 3.3) Modern Coroner

The jurisdiction and role of modern coroners are now quite challenging and rather diverse in comparison to that previously in the mid twentieth century. The roles of coroners in NZ and NSW have moved from being purely administrative and judicial to being preventative and educational.

#### 3.3.1) Preventative

Coroners are required to comment and make relevant recommendations at the end of an inquest on how to prevent or avoid similar deaths, fires or explosions from occurring in the future.

These recent legislative developments in the coronial laws of NZ and NSW complement the roles of coroners. As a result, not only do they ensure that justice is served by providing answers but they also use their findings to save lives and prevent or minimize future injuries to persons and properties. Recommendations may be directed to government departments to improve practices, systems, road safety, and maintenance of public property or licensing of certain individuals or organizations. They can also be directed at private organizations, in relation to safe workplace practices and public health or safety in general.

#### 3.3.2) Educational

In conjunction with coroners' preventative role is that of being public educators. In this regard, the media can play a significant role in publishing the coronial findings and recommendations. However, care has to be taken that it does not have negative effects on the relatives of the deceased. However, it should be noted that timely advice could save lives and property.

Overall, the preventative and educational roles of coroners as discussed above is significant to the role of coroners in Samoa. However, the focus should be on the development of its current administrative and judicial roles. For instance, there should be strong guidelines and measures for Coroners in Samoa to assist them in ensuring that cases reported are dealt with expediently and efficiently. The implications for a movement towards preventative and educational approaches would mean that coroners in Samoa have the added duty to ensure that their recommendations and findings are widely dispersed while taking into account the interests of

the people involved. The move towards preventative and educational roles demands a certain number of coroners in Samoa to undertake these additional roles.

#### **4) SUMMARY OF QUESTIONS**

1. *Should the Ordinance clearly define what constitutes an 'unnatural death'?*
2. *Should Samoa have a Coronial system separate from its Supreme and District Courts?*
3. *Should Samoa limit the appointment of Coroners to Judges and Magistrate? Or should it extend to Samoan lawyers?*
4. *Should Samoa follow the NZ approach in the appointment of Coroners on the qualification that he or she has had a practicing certificate as a barrister or solicitor for 5 years?*
5. *Should Samoa adopt a hierarchy of Coroners similar to NZ where there is a Chief Coroner, coroners and relief coroners?*
6. *Should Samoa have a maximum number of coroners?*
7. *Should a Coroner in Samoa be appointed by some other body apart from virtue of them holding office as judges?*
8. *If so, what body?*
9. *Should Samoa allow medical practitioners to be appointed as coroners if they attended to the deceased professionally at the time of death or just before the time of death?*
10. *Should the roles and functions of a Coroner in Samoa extend to inquiries into explosions?*
11. *Should the jurisdiction of Coroners in Samoa extend to the deaths of children and disabled persons?*
12. *Should the jurisdiction of a Coroner in Samoa extend to the deaths that are not reasonably expected outcomes of health procedures?*
13. *Should the jurisdiction of a Coroner in Samoa be extended to deaths resulting from natural disasters?*
14. *Should Samoa adopt a time limit on the reporting of deaths in which a coroner has jurisdiction over?*
15. *Should the Ordinance specify a time limit where missing people are declared dead?*
16. *Should assessors ever be used in coronial proceedings in Samoa?*

17. *Should the role of Coroners in Samoa extend to cases of suspicious and unknown deaths?*
18. *Should Samoa's ordinance list specific circumstances over which a coroner may have jurisdiction? E.g. Suicide cases, inquiry into deaths of persons that had occurred while under a medical, surgical or dental operation or procedure and women who have died in childbirth?*
19. *Should the role of a Coroner in Samoa include the making of relevant comments and recommendations to reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred and to protect property?*
20. *Is it appropriate for Samoa to extend the functions of a Coroner to inquire into deaths while undergoing medical treatment?*
21. *Should the role of a Coroner extend to inquiring into missing persons?*
22. *Should legislation allow a Coroner to re-open or authorize a person to re-open an inquest in the event of fresh and new evidence?*

## **5) CALL FOR RESPONSES**

There are a total of twenty two (22) questions for consideration and response. It is not necessary however to respond to all questions. It is preferred that responses be in writing.

Responses on this paper should be sent by the 19<sup>th</sup> of March 2010, to the Executive Director, Samoa Law Reform Commission, Private Bag 974 or by email to [lawreform@ag.gov.ws](mailto:lawreform@ag.gov.ws).