Medicine and the Law

Of Deaths and the Crown

Unpacking Our Coronial System

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This is the first article of a three-part series. In this, the authors will focus on historical developments of the coronial process and provide an overview of the process. Part 2 will focus on the parties involved in a Coroner's Inquiry and Part 3 will focus on the various phases of a Coroner's Inquiry.

"The only two certainties in life are death and taxes" is an oft-heard saying,[a] but how many of us know that there used to be a job overseeing both of these human certainties in medieval England?

In the beginning

In that era, the office bearers of the *custos placitorum coronae*, meaning "keeper of the pleas of the Crown" in Latin, not only had to travel to various localities to investigate causes of sudden and unnatural deaths, they also collected taxes for the Crown as part of the job scope.[b] That was the origin of the term "coroner", derived from the French *couronne* and Latin *corona*, meaning "crown", for whom the office bearer served.

Fast forward a millennium, the coroner as we know it today has shed the tax collector role but continues with the critical function of investigating causes of sudden and unnatural death. Singapore's first coroner Andrew Farquhar was appointed in 1827,[1,c] after Sir Stamford Raffles founded Singapore in 1819. For a period of time in early colonial Singapore, medical doctors were appointed as coroners.[1] When the Criminal Procedure Code 1900 was introduced in the Straits Settlement Crown colony of Singapore,[2] it imported a coronial system that was quasi-criminal and fault-finding in nature.[3] This meant that in addition to determining the circumstances under which the deceased came by his/her death, the coroner also had to inquire whether any person was criminally liable. These provisions remained when Singapore achieved independence in 1965 as a sovereign republic, and were eventually repealed with the enactment of the Coroners Act (CA) in 2011.

A unique feature of the Coroner's Court is that proceedings are known as Inquiries or Inquests. This is because these proceedings are undertaken in an inquisitorial setting with the coroner taking a lead role in investigating the cause of death and proactively asking questions of the witnesses and parties before the Court. This is in contrast with the proceedings in the civil and criminal courts which follow the adversarial process, whereby opposing parties take on a "combative" stance and decide the evidence to adduce before the court to prove their respective case, while the judge is akin to a passive impartial referee who determines the outcome in terms of liability (and quantum if applicable in civil courts) based on the merits of each party's case.

From fault-finding to fact-finding

The CA which came into effect on 2 January 2011 changed the nature of our coronial system from fault-finding to that of fact-finding,[4] in line with the approach taken in the UK, New Zealand, Australia and Hong Kong. A key justification for the change is that under the Singapore Constitution, the public prosecutor has the discretionary power to control the proceedings for any offence,[5] including the power to decide whether a person should be prosecuted. It is therefore unnecessary for the coroner to come to any conclusion on criminal responsibility. Instead, the coroner's primary role is to focus on fact-finding for the cause of death. The public prosecutor may still take cognisance of the coroner's findings, if relevant in deciding whether to prosecute any person associated with the death.[6] The inquisitorial nature of coronial proceedings remains unchanged under the CA.

The following provisions of the CA set out the statutory framework of the coronial process. As can be seen, the crux of the state coroner's role is to focus on ascertaining the facts and circumstances leading to a death, instead of apportioning blame.

i. Section 27(1) of the CA provides that the purpose of an Inquiry into the death of any person is to inquire into the cause of and circumstances connected with the death. To this end, a Coroner's Inquiry must be directed at ascertaining, insofar as these matters may be ascertained, (a) the identity of the deceased, and (b) how, when and where the deceased came by his death. All these concern findings of fact.

ii. Section 27(2) of the CA provides that a coroner at an Inquiry shall not frame a finding in such a way as to determine any question of criminal, civil or disciplinary liability. For example, it is not for the coroner to make any finding that any person is guilty of a criminal offence, liable for medical negligence, and/or guilty of professional misconduct or disreputable conduct. Nonetheless, if the coroner is of the view that there were lapses in medical care which caused or contributed to a patient's death, he/she is not precluded from making findings where liability may be inferred from the facts determined or recommendations made, short of framing these findings as one of criminal, civil and professional disciplinary liability.

iii. Section 45 of the CA provides that no oral testimony or conditioned statement admitted in the course of an Inquiry shall be admissible in any subsequent judicial or disciplinary proceedings as evidence of any fact stated therein, other than proceedings for an offence under the CA or an offence of giving or fabricating false evidence under any written law.

What is "death"?

Notably, although death is a prerequisite for the CA to be invoked, the term "death" is nowhere defined in the CA. It should come as no surprise that due to the advancement in medical technology, the definition of death has changed over the years. In the past, the common law approach has been to leave the determination of death to the medical experts, with the only criteria being cardiac death. However, developments in medical technology which now allow for a patient to be kept alive by machines while the heart is removed (for example, in a transplant) have stretched the definition of cardiac death beyond its limits.

By way of a statutory amendment in 1998, the Interpretation Act (IA) stipulates that a person is regarded to have died on the occurrence of either (a) an irreversible cessation of circulation of blood and respiration in the body of the person, or (b) a total and irreversible cessation of all functions of the brain of the person.[7]

The concept of cardiac death and brain death have been referred to in criminal[8] and tort[9] cases respectively, albeit not engaging the IA definitions. The enquiry as to whether there has been irreversible cessation of circulation of blood and respiration is to be determined according to the standards of medical practice.[7] On the other hand, total and irreversible cessation of all functions of the brain is determined based on the following statutory criteria:[7]

i. The person's condition is undoubtedly due to irremediable structural brain damage, and the diagnosis of any disorder which can lead to the irreversible cessation of all functions of the person's brain must have been fully established;

ii. That there is no suspicion that the person's condition is due to depressant drugs, hypothermia or metabolic and endocrine factors; and

iii. That the person's cessation of spontaneous respiration is not caused by neuromuscular blocking agents or other drugs.

The Interpretation (Determination and Certification of Death) Regulations[10] further stipulate the main criteria for determining brain death as follows:

i. The pupils are fixed and non-reactive to strong light;

ii. No corneal reflex;

iii. No spontaneous motor response to painful stimulus, excluding spinal reflexes;

iv. No oculocephalic reflex;

v. No gag reflex or reflex response to tracheobronchial stimulation;

vi. No vestibulo-ocular response on instillation of 50 cubic centimetres of ice-cold water into each ear; and

vii. No spontaneous respiration even with carbon dioxide tension at 50 millimetres or more of mercury.

The brain death criteria may also be supplemented by other tests contained in the First Schedule to these Regulations, namely, (i) cerebral angiography to confirm that there is no intracranial blood flow, or (ii) radionuclide scan to confirm no intracranial perfusion.

Death reporting obligation

According to the State Courts' Annual Report 2020,[11] the total Coroner's Court caseload was 4,125 cases in 2019 and 4,219 cases in 2020. The Annual Report, however, does not provide a breakdown of the types of coroner's cases. In a written answer given by Minister for Law Mr K Shanmugan to Member of Parliament Ms Sylvia Lim's parliamentary question,[12] it was noted that in 2019 and 2020, there were 1,961 investigations into unnatural deaths which were reported to the State Coroner. Out of these 1,961 investigations, a Coroner's Inquiry was not held for 1,413 (72%) investigations. Besides these generic numbers, there is no publicly available statistical information on medical-related death cases which underwent the coronial process. Such deaths that end up as coroner's cases are wide-ranging. Broadly speaking, cases directly or indirectly related to the use of anti-coagulants; iatrogenic deaths resulting from surgical repairs, perforations and punctures; deaths relating directly or indirectly to septicaemia; deaths resulting from adverse drug reactions; and deaths relating directly or indirectly to peritonitis may be made the subject of Coroner's Inquiries.[d]

A medical or healthcare practitioner who (i) attended to a person professionally at or immediately before the person's death or during the person's last illness, or (ii) is present at or after the death of a person, and who has reasonable grounds to suspect that the deceased had undergone or received any medical treatment or care that may have caused or contributed to the death of the deceased, shall report the death to a police officer in the prescribed form within 24 hours upon being aware of that death.[4] Failure to do so without reasonable excuse is an offence.

The reporting of such medical-related deaths will trigger police investigations. However, if the coroner is satisfied that the death was due to natural causes, he/she may decide not to hold an Inquiry.[4] This can happen, for example, where the post-mortem examination report by the forensic pathologist concluded that there was a natural cause for the death even though the patient died following the medical treatment, and the patient's next-of-kin have no issues or concerns that require ventilation in an Inquiry. ◆

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7. Interpretation (Amendment) Act 1998. Available at: https://bit.ly/3N9o8Ny.

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11. Singapore Courts. One Judiciary Annual Report 2020. Available at: https://bit.ly/3CZtN3O. Accessed 24 July 2021.

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Notes

a. This quote has sometimes been attributed to Mark Twain but online resources have commented that Benjamin Franklin is more likely to have been the source.

b. For a quick history lesson, the speech "The Coronial Jurisdiction: Lessons for Living" by The Honourable Wayne Martin AC Chief Justice of Western Australia at the 2016 Asia Pacific Coroners Society Conference, Perth is illuminating. It is available at https://bit.ly/37FYRdz, last accessed 19 July 2021.

c. Andrew Farquhar was likely a son of Singapore's First Resident William Farquhar: https://bit.ly/3L1BMQM.

d. These categories and some of the case studies were discussed in the book Coroner's Practice in Medical Cases.